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4. Combating Vulnerabilities – the CRC's Role in Children's Social Well-Being and Right to Health

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Abstract Children are not vulnerable. Children are held in vulnerable situations due to societal structures and institutions keeping them from experiencing strength, social well-being and health. This chapter discusses whether state obligations according to the UN Convention on the Rights of the Child (CRC) Art. 24 on the right to health require policy work on societal structures and institutions read in light of CRC Art. 2 on the right to non-discrimination and the theory of substantive equality.

Keywords right to health | substantive equality | dimensions of vulnerability

4.1 INTRODUCTION

This chapter's aim is to explore whether children's human rights as laid down in the UN Convention on the Rights of the Child (CRC) play a role in keeping children in a place of vulnerability or whether they support children's strength and as such enhance children's social well-being. The main research question is, thus, whether the CRC's legal rights and its relevant legal sources include mechanisms to support children's experience of strength and, thus, support the child's right to health. To answer this question, the term "vulnerability" is defined as it is understood and used in Section 4.2. Without a viable and reliable definition of the term "vulnerability", the discussion on the CRC's human rights impact on the rights holder's experience of vulnerability and health would lack a benchmark. In connection with the discussion of the term "vulnerability", the term "strength" will also be addressed. In addition, the term "social well-being" in relation to the child's right to health will also be discussed in Section 4.2.

The analysis of whether the CRC has what it takes to combat vulnerability and enhance children's strength is performed through two sub-questions: What is the

scope of states' legal obligation to combat children's vulnerability? And does the CRC contain human rights norms that address and combat the child's experience of vulnerability? Furthermore, is the state not only obliged to combat the child's experience of vulnerability but also positively obliged to enhance the strength of a child?

The interpretation of the CRC's human rights is based on the "general rule of interpretation" of treaties as described in the Vienna Convention on the Law of Treaties, stating that "a treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in light of its object and purpose."[1] With human rights treaties, such as the CRC, however, there is a special nature that makes their interpretation lean toward teleological and effectiveness elements over the textual approach.[2] Human rights treaties are not based entirely on the contractual principle of reciprocity. Although states bind themselves to human rights treaties and expect other parties to do the same, the beneficiaries of the quasi-contractual relationship are not necessarily the states themselves but the individuals within those states.[3] Considering the purpose of protecting individuals, "the generally recognized rule […] of interpretation for human rights texts calls for a liberal interpretation of rights, and a narrow interpretation of restrictions. Furthermore, rights are not to be interpreted statically but rather dynamically in the light of relevant societal developments."[4]

Next to the wordings of the CRC's articles, the interpretation of the human rights norms will include so-called soft law instruments, such as General Comments published by the UN Committee on the Rights of the Child (the CRC Committee). These General Comments express the interpretation of legal rights and obligations laid down in the CRC by its supervisory body, the Committee. Including such soft

1 Vienna Convention on the Law of Treaties, Art. 31(1).

2 James C. Hathaway, *The Rights of Refugees under International Law* (Cambridge: Cambridge University Press, 2005), 48–74; Sarah Joseph, Jenny Schultz and Melissa Castan, *The International Covenant on Civil and Political Rights: Cases, Materials, and Commentary* (Oxford: Oxford University Press, 2nd Ed., 2004) 28 ("It is generally recognized that human rights texts should be interpreted liberally, so corresponding limitations are to be construed narrowly"). See also ECtHR, *Soering v. UK* (Series A, No. 161, 1989), 34; ECtHR, *Artico v. Italy* (Series A, No. 37, 1980); ECtHR, *Loizidou v. Turkey* (Series A, No. 310, 1995), 23 (interpreted to make safeguards practical and effective).

3 Matthew Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development* (Oxford: Oxford University Press, 1995), 3.

4 Manfred Nowak, *U.N. Covenant on Civil and Political Rights: CCPR Commentary* (Kehl: N.P. Engel, 2nd Revised Ed., 2005), XXVII; see also United Nations Economic and Social Council, *Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights* (UN Doc. E/CN.4/1985, Annex, 1985), Art. I. A. 4 & 5.

law sources as relevant sources of interpretation ensures an interpretation that is in line with the treaty's context in the light of the treaty's object and purpose.

4.2 THE CONCEPTS OF "HEALTH" AND "SOCIAL WELL-BEING"

Article 24(1) of the CRC obligates state signatories to the Convention to recognise the right of the child to the enjoyment of the highest available standard of health and to facilities for the treatment of illness and rehabilitation of health. It further obligates states to strive to ensure that no child is deprived of his or her right of access to such healthcare services. The wording shows that the right to health for the child covers three areas. Firstly, the child shall enjoy the highest available standard of health. Secondly, the child shall receive treatment for illness and rehabilitation. Thirdly, no child shall be deprived of access to healthcare services.

The term "health" in the CRC Article 24 is to be understood in line with the World Health Organization's (WHO) understanding of this term.[5] In the Constitution of the WHO, states have agreed to regard health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.[6] According to the CRC Committee, this approach emphasises the need to eliminate exclusion and reduce social disparities in health; organise health services around people's needs and expectations; integrate health into related sectors; pursue collaborative models and policy dialogue; and increase stakeholder participation, including the demand for and appropriate use of services.[7] The WHO has not defined the term "social well-being". Yet, by including not only physical and mental well-being but also social well-being in its definition of the term "health", the WHO's definition of "health" is in consistency with the biopsychosocial model of health. Whereas the traditional medical model defines health as the absence of illness or disease and emphasises the role of clinical diagnosis and intervention, the biopsychosocial model includes physiological, psychological and social factors in health and illness.[8]

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5 UN Committee on the Rights of the Child, *General Comment no. 15 (2013) The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24)*, CRC/C/GC/15, (April 17, 2013), para. 5.

6 Preamble of the Constitution of the World Health Organization (WHO) as adopted by the International Health Conference, New York, 22 July 1946.

7 CRC/C/GC/15, para. 4.

8 Iain Crinson, "Section 3: Concepts of Health and Wellbeing," Faculty of Public Health, Health Knowledge (last accessed 21 October 2024), https://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4a-concepts-health-illness/section2/activity3.

Graham Scambler, professor of sociology at the University College London specialising in medical sociology, argues that 10 dimensions of vulnerability exist with potential relevance to people's health, health-related quality of life and longevity: i) anomie, ii) alienation, iii) powerlessness, iv) marginalisation, v) exclusion, vi) stigmatisation, vii) deviance, viii) cultural imperialism, ix) loneliness, and x) symbolic violence.[9] These types of vulnerabilities are not mutually exclusive and can be interconnected, overlap, or be experienced simultaneously. And they can all make you sick.[10]

The WHO's and the CRC Committee's understanding of the term "health" coincides partly with Scambler's view of dimensions of vulnerability heightening the risk of lack of well-being. The inclusion of *social well-being* in the term "health" represents an understanding that the social contexts in which children live affect the child's experience of well-being. Thus, negative social contexts – or, as the Committee puts it, "social disparities" – can express and even enhance a child's illness. If these negative social contexts, these vulnerabilities, are not addressed and worked against, the child will not experience social well-being; in contrast, the child will experience illness. Scambler's 10 identified vulnerabilities have an impact on the social well-being of the child. Therefore, addressing these dimensions of vulnerabilities supports the recognition of the right of the child to the enjoyment of the highest attainable standard of health; ref. CRC Article 24(1).

4.3 THE CONCEPTS OF "VULNERABILITY" AND "STRENGTH"

Legal scholars have discussed and contested the norm of vulnerability, specifically in human rights discourse.[11] Children are understood as vulnerable, having limited powers of agency. This understanding represents a "deficit conception of childhood".[12] Martha Fineman and others have questioned whether specific understandings of vulnerability in human rights discourse increase, instead of

9 Graham Scambler, "Dimensions of Vulnerability Salient for Health: A Sociological Approach", *Society, Health and Vulnerability*, vol. 10(1) (January 2019).

10 Scambler, "Dimensions of Vulnerability", 1.

11 Marie Elske C. Gispen, "Vulnerability and the Best Interests of the Child in Tobacco Control," *The International Journal of Children's Rights*, vol. 29 (August 2021): 589–608.

12 Tamar Schapiro, "What Is a Child?" *Ethics*, vol. 109(4) (April 2024): 715–738; Gareth B. Matthews, "Getting Beyond the Deficit Conception of Childhood: Thinking Philosophically with Children," in *Philosophy in Schools*, eds. Michael Hand and Carrie Winstanley (London: Continuum, 2008), 27–40.

decrease, the presumed vulnerable position.[13] If human rights are linked to the label of the vulnerable child, human rights norms support a stigmatising and victimising effect.[14] Even though the child as an embodied vulnerable individual receives support and assistance through a human-rights-based approach, this approach can also increase the risk of stigmatisation, identity politics and the denial of agency. Legal norms that are understood only to address embodied vulnerability can become a control mechanism on the child rather than empowering it.[15] Thus, sceptics of the norm of vulnerability in human rights discourse question whether human rights "have what it takes" to support the child's experience of strength.

The term "the child's strength" or "the child's experience of strength" is based on a variety of research on the interconnectivity of vulnerability and strength. In the field of public health, for example, researchers explore preconditions for transforming demanding experiences of risk and weakness to strength and resources.[16] The relationship between the experience of vulnerability and strength is also discussed in research related to ethics and healthcare.[17] Also in research on children's health, development, and education, the interconnectivity and relationship of vulnerability and strength are visible, often linked to resilience studies.[18] These

13 Martha A. Fineman. "The Vulnerable Subject: Anchoring Equality in the Human Condition," *Yale Journal of Law and Feminism*, vol. 20(1) (May 2008): 1–23; Lourdes Peroni and Alexanda Timmer, "Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law," *International Journal of Constitutional Law*, vol. 11(4) (December 2013): 1056–1085.

14 Kate Brown, "'Vulnerability': Handle with Care," *Ethics and Social Welfare*, no. 5 (August 2011): 313–321, 316; Martha A. Fineman, "Equality, Autonomy, and the Vulnerable Subject in Law and Politics," in *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics*, eds. Martha A. Fineman and Anna Grear (London: Routledge, 2013), 16; Peroni and Timmer, "Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law," 1056–1085.

15 Veronika Flegar, "Who Is Deemed Vulnerable in the Governance of Migration – Unpacking UNHCR's and IOMs Policy Label of Being Deserving of Protection and Assistance," *Asiel- & Migrantenrecht*, vol. 8 (May 2019): 374–383, 383.

16 Kirsti Malterud and Per Solvang, "Vulnerability as Strength: Why, When and How?" *Scandinavian Journal of Public Health*, vol. 33, Suppl. 66 (October 2005): 3–6, 3.

17 Elizabeth Mollard, Holly Hatton-Bowers and Julie Tippens, "Finding Strength in Vulnerability: Ethical Approaches When Conducting Research with Vulnerable Populations," *Journal of Midwifery & Women's Health*, vol. 65(6) (November/December 2020), 802–807.

18 Lori Peek, "Children and Disasters: Understanding Vulnerability, Developing Capacities, and Promoting Resilience – An Introduction," *Children, Youth and Environments*, vol. 18(1) (2008): 1–29; Patrice L. Engle, Sarah Castle and Purnima Menon, "Child Development: Vulnerability and Resilience," *Social Science & Medicine*, vol 43(4) (September 1996): 621–635.

various research areas lead to the decision to include "strength" as part of the understanding of children's social well-being and health and to ask whether the CRC includes legal obligations that enhance the child's experience of strength, respectively the child's strength.

Scambler's dimensions of vulnerabilities largely address structural deficits in society and societal institutions. Though the dimensions of vulnerability are experienced by the individual child, such as loneliness or powerlessness, they are inflicted on the child by societal structures and institutions. The dimensions of vulnerability focus on situational and structural vulnerabilities, rather than on embodied factors.[19] This focus on the societal structures and institutions the child grows up in recognises that the child is held in a vulnerable position, rather than defining the child as being "vulnerable" as such. From this it follows that a human-rights-based approach supports the altering of societal structures and institutions responsible for the child's social well-being, supports the child's experience of, and as such supports the child's right to the highest attainable standard of health.

In what follows, the analysis answers the question of whether the CRC's legal rights and its relevant legal sources include mechanisms for addressing and combating the societal structures and institutions upholding dimensions of vulnerabilities and supporting the child's experience of strength or whether it cements the connotations of the embodiment of the "vulnerable child" per se. The analysis starts by presenting Scambler's dimensions of vulnerabilities that are linked to societal structures and institutions – dimensions of vulnerabilities that affect the child's social well-being and therefore the child's health.

4.4 DIMENSIONS OF VULNERABILITIES AND THE CHILD'S HUMAN RIGHT TO HEALTH

"Anomie" is a dimension of vulnerability that refers to the sense of being *lost*, without compass, drifting, or being estranged. In sociology nowadays it is transcribed as "normless", often due to the lack of sense of belonging to a community and lack of narratives that afford comfort and protective security.[20] The dimension of "alienation" refers to the child becoming alienated from its very humanity as it becomes a thing-like part in the machinery of production. This dimension is clearly linked to the worker's experience of alienation, but one might ask

19 Flegar, "Who Is Deemed Vulnerable," 374–383, 380.

20 Scambler, "Dimensions of Vulnerability," 2. This dimension is linked to the work of Durkheim; Emile Durkheim, *Suicide* (London: Routledge & Kegan Paul, 1897).

whether the vulnerability dimension may also be related to a child's experience of societal institutions and structures to which it belongs. Both alienation and anomie can be regarded as correlates of, and at times causal mechanisms inducing, powerlessness.[21]

The dimension of "powerlessness" describes the child's lack of any material but often also social and cultural capital, which leads to lack of power.[22] The lack of any of those capitals causes a lack of influence, but not only that. Scambler and Tjora point out that powerlessness can in fact be a function of the absence of those "familiarity bonds" that bring solace, comfort and community- or network-based, health-bestowing sustenance.[23] Habermas points to the experience of powerlessness when all parties are acting in good faith but in accord with a pre-set agenda to the advantage of one or more or none of the participants.[24]

"Marginalisation" and "exclusion" relate to the experience of collectivities pushed to the edge of societies, putative "misfits" represented by stereotypes. The collectivities are "othered" to reinforce definitions of what is normal and acceptable.[25] Furthermore, "exclusion", especially "social exclusion", disguises the inconvenience of enduring structural inequalities.[26]

The dimension of vulnerability called "stigmatisation" denotes non-conformance with norms governing how people should "be" rather than how they should behave. Scambler and Hopkins suggest that stigma be defined in terms of "ontological" rather than "moral" deficits. A child rendered vulnerable by stigmatisation is, thus, a child who possesses a socially undesirable and unacceptable attribute, trait or condition.[27]

"Deviance" describes the experience of being blamed for morally unacceptable behaviour. In this understanding of vulnerability, the child finds itself in a situation where it experiences discrimination on the grounds of moral unacceptability.

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21 Scambler, "Dimensions of Vulnerability," 2.

22 Pierre Bourdieu, *The Logic of Practice* (Cambridge: Cambridge University Press, 1980).

23 Scambler, "Dimensions of Vulnerability," 2, referring to Graham Scambler and Aksel Tjora, "Familiarity Bonds: A Neglected Mechanism for Middle-Range Theories of Health and Longevity? " *Medical Sociology Online* (October 2012): 161–178.

24 Scambler, "Dimensions of Vulnerability", 2, referring to Jürgen Habermas, *Theory of Communicative Action, Vol 2: Lifeworld and System: A Critique of Functionalist Reason* (Cambridge: Polity Press, 1989).

25 Scambler, "Dimensions of Vulnerability," 2.

26 Scambler, "Dimensions of Vulnerability," 2.

27 Scambler, "Dimensions of Vulnerability", 3, referring to Graham Scambler and Anthony Hopkins, "Being Epileptic: Coming to Terms with Stigma," *Sociology of Health and Illness*, vol. 8 (March 1986): 26–43.

This discrimination leads to a sense of self-blame.[28] Children experience "cultural imperialism". This dimension of vulnerability refers to echoes of historical and imperialist notions of ethnic superiority and superordination over those of ethnic inferiority and subordination.[29] Referring to the work of Pinderhughes, Scambler states that "racism is a conspicuous product of cultural imperialism and frequently translates into 'internal colonialism'".[30]

At first sight, "loneliness" would appear to be an individual phenomenon. However, it has strong social determinants and can be the product of social structure and culture.[31] The final dimension of vulnerability is "symbolic violence", first discussed by Bourdieu. The term "symbolic violence" refers to the subordinating effects on people of hidden structures that reproduce and maintain social domination in covert ways. Symbolic violence is at its most basic level an unequal relationship, a power imbalance between people, the effects of which involve voluntary submission to relations of domination.[32] Described as a vulnerability by Graham, it is the experience of the "tacit understandings" of how to conform, and those failing to conform are rightly castigated and exposed to public condemnation and sanctioning.[33]

These dimensions of vulnerability do not exhaust any other biological or psychological mechanisms that induce vulnerability and, when in place, present a risk to well-being. The social dimensions of vulnerability presented, however, elucidate the interconnectedness between biological, psychological and social dimensions. A top athlete's genes are crucial ingredients for winning performances, yet "only 'people' have emerged victorious, and personhood can only be fully articulated in the context of social relations."[34] When the athlete has a winning performance, a combination of biological, psychological and social mechanisms comes into play, and each one contributes to causal tendencies.[35]

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28 Scambler, "Dimensions of Vulnerability," 3.

29 Scambler, "Dimensions of Vulnerability," 3.

30 Scambler, "Dimensions of Vulnerability," 3, referring to Charles Pinderhughes, "Toward a New Theory of Internal Colonialism," *Socialism and Democracy*, vol. 25(1) (March 2011): 235–256.

31 Scambler, "Dimensions of Vulnerability," 3. See also Fay B. Alberti, *A Biography of Loneliness – The History of an Emotion* (Oxford: Oxford University Press, 2019).

32 Claudio Colaguori, "Symbolic Violence and the Violation of Human Rights: Continuing the Sociological Critique of Domination," *International Journal of Criminology and Sociological Theory*, vol. 3(2) (June 2010): 388–400, 389, 392.

33 Scambler, "Dimensions of Vulnerability", 3, referring to Bourdieu, "The Logic of Practice".

34 Scambler, "Dimensions of Vulnerability," 1.

35 Scrambler, "Dimensions of Vulnerability," 1.

Moreover, none of these social dimensions of vulnerability in any sense stand alone; rather, they can be causally interrelated in complex ways. A child belonging to the marginalised Sámi population can be stigmatised and subsequently develop experiences of alienation, which again can lead to loneliness. Being shamed for belonging to the Sámi population might lead to deviance, blaming oneself for not being or acting "right", with a conscious commitment to counter and defeat enacted and felt deviance.[36]

The 10 dimensions of vulnerabilities are closely linked to the types of assets by which a child's life (and an adult's life, for that matter) is characterised: social, cultural, spatial, symbolic, and material assets.[37] Access to these assets supports the child's experience of strength. Certainly, access to and enjoyment of these assets may vary over time, spread throughout the "life course". Yet, the life course of a child is no longer than 18 years, according to the CRC, and the childhood years are exceptionally important. For the individual child, there is not much time for any alteration or change of assets. Can the CRC contribute in any way to enhance the child's access to certain assets closely linked, on the one hand, to the experience of dimensions of vulnerability and, on the other, to the experience of strength and by that the experience of social well-being?

4.5 THE SCOPE OF LEGAL OBLIGATIONS AND THE RIGHT TO HEALTH

The right to health is part of a group of human rights often referred to as "social rights". Though it is broadly recognised that all human rights are interconnected and that no right has more or less worth than the other, there are scholars that question whether social – and economic – rights are "real rights" or whether these types of human rights are merely about politics. This discussion addresses the question of where to draw the line between legal rights, legal obligations, and policies. It is probably not possible to find a definite answer to where to draw the line, but it is important to discuss the blurry line as it informs the scope of discretionary power a state may have when designing social policies, policies that are highly relevant to the child's social well-being and thus to the realisation of the child's right to health. Thus, the answer to the question of "real rights" or "mere politics" matters because it answers the question of when a state can be held legally

36 Scambler, "Dimensions of Vulnerability," 3.

37 Scambler, "Dimensions of Vulnerability," 5, referring to Graham Scambler and Sasha Scambler, "Theorizing Health Inequalities: The Untapped Potential of Dialectical Critical Realism," *Social Theory and Health*, vol. 13 (2015): 340–354.

accountable for policy choices and for its ways of implementing policies or lack thereof.[38] Can the state be held legally accountable for violating the child's right to health if it does not implement policies and concrete steps regarding structures and institutions that would support the child's strength instead of leaving the child in a vulnerable position?

In general, social rights, such as the right to health, are understood to be "contextual, contingent and continuing".[39] The legal obligation to provide a child's right to health is "generally considered to be incapable of immediate implementation owing to the considerable expense involved in realisation."[40] This understanding is visible in the wording of the UN Covenant on Economic, Social and Cultural Rights (ICESCR) Article 2(1). It requires merely that a party "undertakes to take steps … to the maximum of its available resources" toward "achieving progressively the full realisation" of the rights contained in the ICESCR. However, even though there is a conditioned obligation on economic, social and cultural rights allowing states to achieve the full realisation progressively, the wording of ICESCR

38 The discussion is often linked to the question if social rights are enforceable in the courts, and if social rights can be part of constitutional rights. See, for example, Cass R. Sunstein, "Against Positive Rights," in *Western Rights? Post-Communist Application*, ed. András Sájo (Kluwer Law International, 1996), 225–232, 225; Wiktor Osiatynski, "Social and Economic Rights in a New Constitution for Poland," in *Western Rights? Post-Communist Application*, ed. András Sájo (Kluwer Law International, 1996), 233–272; Cass R. Sunstein, *Designing Democracies: What Constitutions Do* (Oxford: Oxford University Press, 2002); Frank B. Cross, "The Error of Positive Rights," *48 UCLA Law Review*, vol. 13 (2000–2001): 858–923; Katherine Eddy, "Welfare Rights and Conflict of Rights," *Res Publica*, vol. 12 (2006): 337–356; David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford: Oxford University Press, 2007); Sandra Fredman, *Human Rights Transformed: Positive Rights and Positive Duties* (Oxford: Oxford University Press, 2008); Malcom Langford, "The Justiciability of Social Rights: From Practice to Theory," in *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law*, ed. Malcom Langford (Cambridge: Cambridge University Press, 2008), 3–45; Katherine G. Young, *Constituting Economic and Social Rights* (Oxford: Oxford University Press, 2012); Gustavo Arosemena, "Retrieving the Differences: The Distinctiveness of the Welfare Aspect of Human Rights from the Perspective of Judicial Protection," *Human Rights Review*, vol. 16(3) (2015): 239–255. For a short summary of the discussion, see also Julia Köhler-Olsen, "Growing Up in Families with Low Income – The State's Legal Obligation to Recognize the Child's Right to an Adequate Standard of Living," in *Transformative Law and Public Policy*, eds. Sony Pellissery, Babu Mathew, Avinash Govindjee and Arvind Narrain (New York: Routledge, 2019), 151–170.

39 Michael Dennis, and David Stewart, "Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?," *American Journal of International Law*, vol. 98 (2004): 462–515, 479.

40 Craven, *The International Covenant on Economic, Social, and Cultural Rights: A Perspective on Its Development*.

Article 2(1) also contains an unconditioned obligation to "take steps". The UN Committee on Economic, Social and Cultural Rights (UNESCR) interprets these two types of state obligations as, on the one hand, a "progressive obligation of results" and, on the other, an "immediate obligation". The former obligation accepts that ensuring the social well-being of all children, and thereby the realisation of the child's right to health, is a process over time. The latter obligation requires states to actively pursue the obligation to progressively realise the child's right to health by taking steps and by guaranteeing that the child's right to health "will be exercised without discrimination".[41] The CRC Committee has adopted this understanding when it comes to states' obligation to realise economic and social rights.[42] In General Comment no. 15 on the child's right to the enjoyment of the highest attainable standard of health, the CRC Committee defines the scope of states' legal obligation by stating that "[a]ll States, regardless of their level of development, are required to take immediate action to implement these obligations as a matter of priority and without discrimination of any kind".[43]

Based on both UN Committees' analysis and interpretation of the scope of state obligation regarding the realisation of the right to health, it is reasonable to argue that although financial and economic constraints might hinder the full implementation of policies that restructure societal structures and institution, states are obligated to take immediate active steps to implement the child's right to health without any form of discrimination.

Legal scholar Sandra Fredman has contributed to dismantling the right to non-discrimination, moving beyond the concept of prohibiting discrimination on certain grounds towards the ultimate aim of achieving equality. Fredman introduces the term "substantive equality". Substantive equality, according to Fredman, can only be achieved by tackling four dimensions that uphold inequality rather

41 UN Committee on Economic, Social and Cultural Rights, *General Comment no. 3: The Nature of States Parties' Obligations (Art. 2, para. 1 of the Covenant)*, E/1991/23 (December 14, 1990), p. 1, para. 1 and 2.

42 UN Committee on the Rights of the Child, *General Comment no. 5 (2003) on General Measures of Implementation of the Convention on the Rights of the Child (Arts. 4, 42 and 44, para. 6)*, CRC/GC/2003/5 (November 27, 2003), para. 6–8.

43 CRC/C/GC/15, para. 72. The reference to "these obligations" regards the states' three types of obligations relating to human rights, including children's right to health: to respect freedoms and entitlements, to protect both freedoms and entitlements from third parties or from social or environmental threats, and to fulfil the entitlements through facilitation or direct provision, see CRC/C/GC/15, para. 71.

than tackling grounds of discrimination.[44] These four dimensions are first, the redistributive dimension which addresses and recognises classifications that lead to detriment and disadvantage and permits affirmative action and expressly differential treatment to redress previous disadvantage; second, the recognition dimension, which addresses stigma, stereotyping, prejudice and violence and requires long-term policies to decrease stigma and stereotyping; third, the participatory dimension of the right to non-discrimination and equality, which requires the combating of social marginalisation and exclusion; and fourth, the transformative dimension, which recognises that equality, also an equal right to health, is not necessarily about sameness but that different identities and characteristics should be respected and even celebrated.[45]

Fredman's four dimensions correlate to Scambler's 10 dimensions of vulnerability. For example, Scambler's dimensions of powerlessness, stigmatisation, exclusion and marginalisation are addressed by Fredman's dimensions of recognition and participation. Both dimensions of substantive equality address and recognise stigma and stereotyping and call for policies that combat social marginalisation and exclusion. Also, the aim to achieve substantive equality based on the right to non-discrimination and equality requires policies that contain a transformative dimension. This dimension recognises that the realisation of the right to health is not about sameness, but that different identities and characteristics should be respected and even celebrated. Scambler writes about the vulnerability dimension of cultural imperialism referring to echoes of historical and imperialist notions of ethnic superiority and superordinance over those of ethnic inferiority and subordinance. Fredman's dimension of transformation requires targeted policies in healthcare that not only respect and celebrate different identities and characteristics but also combat the "othering" of collectivities to reinforce definitions of what is normal and acceptable. Policies that implement the right to health for children must work to change enduring structural inequalities.

Although Article 2(1) of the CRC does not explicitly mention the aim of substantive equality, the right to non-discrimination shall protect each person's right to equal access to their rights. Equality is an intrinsic part of the right to non-discrimination. This can also be seen in the Human Rights Committee's General Comment no. 18, which underlines the importance of taking special measures to diminish or eliminate conditions that cause discrimination. The Human Rights

44 Sandra Fredman, "Emerging from the Shadows: Substantive Equality and Article 14 of the European Convention on Human Rights," *Human Rights Law Review*, vol. 16(2) (2016): 273–301.

45 Sandra Fredman, "Emerging from the Shadows," 273–301.

Committee emphasises that states should take specific actions to correct general conditions of a certain part of the population that prevent or impair the enjoyment of human rights.[46] The CRC Committee, moreover, addresses underlying structural and social factors that might keep children from experiencing social well-being and infringing the right to health.

So far, it has not been discussed whether the CRC can bolster access to assets that might support the child's strength and lead to the diminishing of dimensions of vulnerabilities that are counterproductive to the child's health. Relevant norms in such a discussion are, among others, CRC Article 12 on the child's right to participation, Article 27 on the right to an adequate standard of living, Articles 28 and 29 on the right to education, and Article 30 on the child's right to enjoy his or her own culture, profess and practise his or her own religion, and use his or her own language.

In general, there is little reason to question whether implementing these rights and others supports the diminishing of the 10 dimensions of vulnerabilities that threaten the child's social well-being. However, the diminishing, or even elimination, of the vulnerabilities that support the child's experience of strength can only be achieved if these rights are realised and implemented in a way that ensures substantive equality.

4.6 THE RIGHT TO HEALTH AS A TOOL FOR THE SOCIAL WELL-BEING OF THE CHILD

Having analysed the scope of state obligations regarding the child's right to health, the next question to pose and discuss is whether the child's right to health implies that states have the legal obligation to combat vulnerabilities, support the child's strength, and as such enhance the child's social well-being. Human rights are individual rights. States are obligated towards the rights holder staying in the state's territory. Health is individual, perceived as an individual experience, often linked to the individual's choices, or is foreordained and fated. The human right to health in CRC Article 24(1) might be read as to address the embodied vulnerability of the child. In case of a sick child, the state must strive to ensure the child the right to access to healthcare services. The state must also implement measures that prevent the child from becoming sick.

Article 24(2) demands that states pursue the full implementation of the right of the child to the enjoyment of the highest attainable standard of health. It explicitly

46 Human Rights Committee, *General Comment no. 18: Non-discrimination* (November 10, 1989), para. 10.

mentions concrete aims that increase the states' chance of fulfilling their obligation of conduct to fully implement this right and even suggests some appropriate measures. Article 24(2)(c) highlights the application of readily available technology, the provision of adequate nutritious foods and clean drinking water, and awareness of environmental pollution, whereas letter (e) mentions access to education and the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation, and the prevention of accidents. Also, guidance for parents and family planning education and services are suggested as appropriate measures; ref. Article 24(2)(f).

The non-exhaustive suggestions in Article 24(2) on states' measures to pursue the full implementation of the child's right to health relate to some extent to the assets linked to the dimensions of vulnerability. The application of readily available technology, the provision of adequate nutritious foods and clean drinking water, the awareness of environmental pollution, information and education point to measures that address matters of structural and social types, all having an influence on the well-being of children.

The types of measures suggested in Article 24(2) might be especially relevant to those collectivities that are pushed to the edge of societies, experiencing social exclusion and enduring structural inequalities. Children in these collectivities can experience the "marginalisation" and "exclusion" dimensions of vulnerability, as well as stigmatisation and often "cultural imperialism", which can even lead to self-blame and "deviance". Indeed, the measures suggested as appropriate in Article 24(2) will not be able to alter these dimensions of vulnerability. However, structural and institutional changes can contribute to diminish negative consequences of a lack of social, spatial and symbolic assets in the community to which the child belongs.

The UN Committee on the Rights of the Child seems to acknowledge that the pursuit to implement the child's right to health must "address the underlying determinants of health".[47] Structural determinants mentioned explicitly by the Committee are the global economic and financial situation, poverty, unemployment, migration and population displacements, war and civil unrest, discrimination and marginalisation, climate change, and rapid urbanisation.[48] Simultaneously, strong evidence exists for effective structural interventions.[49]

Several dimensions of vulnerability are closely related to children, their families and communities being discriminated against. Societies marginalise certain communities – often communities that are lacking material, social and cultural capital.

47 CRC/C/GC/15, para. 2.
48 CRC/C/GC/15, para. 5.
49 CRC/C/GC/15, para. 5.

The marginalisation expresses cultural imperialism, echoing historical and imperialist notions of ethnic and cultural superiority and superordination over those of ethnic inferiority and subordination. A lack of material, social and cultural capital and a resultant marginalisation and stigmatisation supported by cultural imperialism leave communities on the edge of society powerless. These communities are often left with few social, spatial, material, cultural and symbolic assets.

The CRC Committee emphasises states' obligation to ensure that the child's health is not undermined as a result of discrimination.[50] According to CRC Article 2(1), grounds for discrimination are related to assets, or lack of such assets, and thereby closely linked to dimensions of vulnerability. States are obliged to ensure the child's right to health without discrimination of any kind, irrespective of the child's or his or her parents' race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. Experiencing discrimination based on these statuses mentioned in CRC Article 2(1) is likely to create several of the dimensions of vulnerabilities that work against the aim of ensuring the child's social well-being and health.

The Committee recognises that children in disadvantaged situations, children growing up with few assets and in underserved areas (lack of spatial assets), should be a focus of efforts to fulfil children's right to health. In General Comment no. 15, the Committee states furthermore that factors should be identified at national and subnational levels "that create *vulnerabilities* for children or that disadvantage certain groups of children".[51]

Certainly, the Committee's comments regarding what states should "do", what policies they should adopt, are not to be understood as legal obligations. However, the realisation of economic, social and cultural rights not only comprises, as stated above, an obligation to progressively achieve results, but also comprises certain immediate obligations of conduct, taking steps with all appropriate means and without any form of discrimination. The immediate obligations of conduct exist irrespective of a state's resources at hand for the realisation of economic, social and cultural rights. It is therefore reasonable to require and expect that states take steps that combat structural and social institutions and practices that uphold discrimination against children and groups of children belonging to collectivities pushed to the edge of societies, and, as such, positively support the child's experience of strength. Otherwise, vulnerabilities created by these discriminatory structures, as well as social institutions and practices, work against the obligation to progressively realise the child's right to health.

50 CRC/C/GC/15, para. 8.

51 CRC/C/GC/15, para. 11.

4.7 CONCLUDING REMARKS

The main question for this chapter is whether the CRC's legal rights and its relevant legal sources include mechanisms to support children's experience of strength and, thus, support the child's right to health. The experience of strength, as well as that of being vulnerable, is not a fixed position one finds oneself in. There are days and periods where one experiences strength; the same applies for vulnerability. These experiences are personal to everyone. That said, these individual experiences can be linked to external factors, factors Scambler has called the 10 dimensions of vulnerabilities. These 10 dimensions have a direct influence on individuals' social well-being. Children's – and adults' – social well-being has a major impact on their experience of health. Therefore, the establishment of factors that enhance social well-being, and, conversely, the elimination or at least diminishing of 10 dimensions that make us all vulnerable and affect our social well-being in a negative way, is paramount to our experience of health.

Member states to the CRC are obliged to realise the child's right to health in a non-discriminatory way, according to CRC Article 2. This obligation immediately requires states to actively take steps to progressively realise the child's right to health. From this, it follows that activities taken by the state authorities must decrease or even abolish factors that hinder the child from experiencing the right to health in a non-discriminatory way. The scope of the state's obligation to realise the child's right to health is, thus, to take active steps that are in accordance with the child's right to substantive equality. The state's obligation on the child's right to health is, furthermore, not merely understood as covering the individual child's right to healthcare. Article 24 of the CRC and its interpretation by the UN Committee on the Rights of the Child, read together with other relevant rights of the CRC, emphasise the state's obligation to realise that the right to health must include work on societal structures and institutions that lead to non-well-being and hinder the fulfilment of the child's right to health.

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