A Commentary on the United Nations Convention on the Rights of the Child

Article 24

The Right to Health

Asbjørn Eide and Wenche Barth Eide

Martinus Nijhoff Publishers

Article 24

The Right to Health

A Commentary on the United Nations Convention on the Rights of the Child

Editors

André Alen, Johan Vande Lanotte, Eugeen Verhellen, Fiona Ang, Eva Berghmans and Mieke Verheyde

Article 24

The Right to Health

By

Asbjørn Eide and Wenche Barth Eide

University of Oslo

MARTINUS NIJHOFF PUBLISHERS
LEIDEN • BOSTON
2006

This book is printed on acid-free paper.

A Cataloging-in-Publication record for this book is available from the Library of Congress.

Cite as: A. Eide and W.B. Eide "Article 24. The Right to Health", in: A. Alen, J. Vande Lanotte, E. Verhellen, F. Ang, E. Berghmans and M. Verheyde (Eds.) *A Commentary on the United Nations Convention on the Rights of the Child* (Martinus Nijhoff Publishers, Leiden, 2006).

ISSN 1574-8626
ISBN 90-04-14733-0

Cover image by Nadia, 1 1/2 years old.

http://www.brill.nl

PRINTED IN THE NETHERLANDS

CONTENTS

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
BFHI	Baby-Friendly Hospital Initiative
CRC	International Convention on the Rights of the Child
CRC Committee	UN Committee on the Rights of the Child
CESCR	International Covenant on Economic, Social and Cultural Rights
CESCR Committee	UN Committee on the Covenant on Economic, Social and Cultural Rights
CEDAW	International Convention on the Elimination of Discrimination against Women
CEDAW Committee	UN Committee on the Elimination of Discrimination against Women.
CERD	International Convention on the Elimination of All Forms of Racial Discrimination
CERD Committee	UN Committee on the Elimination of All Forms of Racial Discrimination
FAO	Food and Agriculture Organisation
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
ICPD	1994 International Conference on Population and Development
IFPRI	International Food Policy Research Institute
ILO	International Labour Organisation
ITN	Insecticide-Treated Bednet
MTCT	Mother-To-Child Transmission
OHCHR	Office of the United Nations High Commissioner for Human Rights
PEM	Protein-Energy Malnutrition
SCN	UN System Standing Committee on Nutrition
STD	Sexually Transmittable Disease
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
WASH campaign	Water, Sanitation and Hygiene campaign
WHA	World Health Assembly
WHO	World Health Organisation
WSSCC	Water Supply and Sanitation Collaborative Council

AUTHOR BIOGRAPHY

Asbjørn Eide is former Director of the Norwegian Institute of Human Rights at the University of Oslo and is presently visiting Professor at Lund University, Sweden. He served for 20 years (until 2004) as elected member of the expert UN Sub-Commission on Promotion and Protection of Human Rights, in which capacity he prepared several studies for the United Nations, one of them dealing with the right to food as a human right. He has published extensively and edited with C. Krause and A. Rosas the textbook 'Economic, Social and Cultural Rights' (The Hague, Nijhoff, 2001).

Wenche Barth Eide is Associate Professor at the Department of Nutrition, University of Oslo, and Co-director of the International Project of the Right to Food in Development (IPRFD). She is Co-Chair of the Working Group on 'Nutrition, Ethics and Human Rights' of the UN System Standing Committee on Nutrition (SCN). Her special interests are the global dimensions of nutrition including the linkages with nutrition and human rights. She is co-editor with Uwe Kracht of *Food and Human Rights in Development*, (Antwerp, Intersentia, 2005).

TEXT OF ARTICLE 24

ARTICLE 24	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.	1. Les Etats parties reconnaissent le droit de l'enfant de jouir du meilleur état de santé possible et de bénéficier de services médicaux et de rééducation. Ils s'efforcent de garantir qu'aucun enfant ne soit privé du droit d'avoir accès à ces services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:	2. Les Etats parties s'efforcent d'assurer la réalisation intégrale du droit susmentionné et, en particulier, prennent les mesures appropriées pour :
(a) To diminish infant and child mortality;	(a) Réduire la mortalité parmi les nourrissons et les enfants;
(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;	(b) Assurer à tous les enfants l'assistance médicale et les soins de santé nécessaires, l'accent étant mis sur le développement des soins de santé primaires;
(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;	(c) Lutter contre la maladie et la malnutrition, y compris dans le cadre de soins de santé primaires, grâce notamment à l'utilisation de techniques aisément disponibles et à la fourniture d'aliments nutritifs et d'eau potable, compte tenu des dangers et des risques de pollution du milieu naturel;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;	(d) Assurer aux mères des soins prénatals et postnatals appropriés;
(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;	(e) Faire en sorte que tous les groupes de la société, en particulier les parents et les enfants, reçoivent une information sur la santé et la nutrition de l'enfant, les avantages de l'allaitement au sein, l'hygiène et la salubrité de l'environnement et la prévention des accidents, et bénéficient d'une aide leur permettant de mettre à profit cette information;
(f) To develop preventive health care, guidance for parents and family planning education and services.	(f) Développer les soins de santé préventifs, les conseils aux parents et l'éducation et les services en matière de planification familiale.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.	3. Les Etats parties prennent toutes les mesures efficaces appropriées en vue d'abolir les pratiques traditionnelles préjudiciables à la santé des enfants.
4. 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.	4. Les Etats parties s'engagent à favoriser et à encourager la coopération internationale en vue d'assurer progressivement la pleine réalisation du droit reconnu dans le présent article. A cet égard, il est tenu particulièrement compte des besoins des pays en développement.

CHAPTER ONE

INTRODUCTION*

1. Article 24 sets out the right of the child to the enjoyment of the highest attainable standard of health. It does not provide a right of the child to be healthy – no legal instrument can do that – but it spells out obligations of States Parties to adopt measures which, if implemented, will ensure the highest attainable standard of health taking into account the genetic and other biological predispositions of the individual child and the risks that children are exposed to.

2. The main content of Article 24 is therefore an elaboration of the measures that States Parties should take to implement their obligations under the CRC. While the Article is relatively detailed compared to many of the others, the provisions are nevertheless broad and general, which is unavoidable for a legal instrument which is intended for world-wide application and which must be interpreted in light of the great variety in conditions and possibilities, which also change over time. Guidance for its interpretation must therefore be sought in other sources.

3. From a legal point of view, of the most relevant sources are the decisions and recommendations of the CRC Committee, composed of a group of experts from the different parts of the world and elected by the States Parties which have entrusted the Committee with the monitoring of their implementation of the CRC, and the negotiations which led up to the adoption of the Convention (the '*travaux préparatoires*').

The practice of the Committee is set out in its general comments and its concluding observations. The general comments are detailed and systematic observations of a general nature made by the Committee, spelling out the shared opinion of its members on the issues which should be addressed, including detailed recommendations of the measures that should be taken by the States Parties. While the General Comments are, strictly speaking, of a recommendatory nature, they carry great weight as authoritative statements and are therefore of central importance for the interpretation of the provisions of the CRC.

---

* October 2005.

4. While Article 24 deals with the health-related rights of the child, it corresponds closely to Article 12 of the CESCR, which sets out health-related rights for everyone, adults and children alike. Consequently, Article 12 of the CESCR and the practice of the CESCR Committee, including its own general comments, provide highly relevant material for the interpretation of Article 24 of the CRC.[1] In addition to the practice of the treaty bodies, attention must also be given to the relevant recommendations and decisions made by UN specialized agencies and other UN bodies. Of particular importance for Article 24 are recommendations and other documents adopted by the WHO and UNICEF, and the document entitled 'A World Fit for Children' adopted by the United Nations General Assembly at its special session on children held in 2002 by resolution S-27/2. This document reviews the progress made in the 12 years since the World Summit for Children held in 1990, and contains a plan of action where a healthy life for children constitutes the first of four broad issue areas.

[1] The website of the Office of the High Commissioner for Human Rights contains the full texts of the general comments and the concluding observations both of the CRC Committee and the CESCR Committee following their examination of individual States Parties' official reports on the implementation of the convention in their countries. Under the title 'Compilation of General Comments and General Recommendations Adopted by Human Rights Bodies', a collection of all these general comments adopted up to May 2004 have been published by the UN Secretariat (UN Doc. HRI/GEN/1/Rev.7). The website address for the General Comments of the CRC Committee is www.ohchr.org/english/bodies/crc/comments.htm. Those of the CESCR Committee are found under www.ohchr.org/english/bodies/cescr/comments.htm.

CHAPTER TWO

COMPARISON WITH OTHER INTERNATIONAL HUMAN RIGHTS PROVISIONS

5. As a core concern in modern human rights, the right to health is recognized in numerous international instruments. Article 25 (1) of the Universal Declaration of Human Rights affirms that '[e]veryone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services'. Under Article 12 of the CESCR, States Parties recognize 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and enumerates 'steps to be taken by the States parties [. . .] to achieve the full realization of this right'.

The right to health is also recognized, *inter alia*, in Article 5 (e)(iv) of the CERD, and in Articles 11 (1)(f) and 12 of the CEDAW. Also several regional human rights instruments recognize the right to health, such as the European Social Charter of 1961 as revised (Article 11), the African Charter on Human and Peoples' Rights of 1981 (Article 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (Article 10).

6. Health is a global, national and individual concern and is the subject of intensive international cooperation, coordinated in particular by the WHO. The preamble of the constitution of the WHO states that '[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition', and adds that '[h]ealthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development'.

7. Article 24 generally falls within the category of economic and social rights. Its full implementation depends therefore in part on the resources available to the State, including international assistance to less developed countries. All human rights are interdependent and indivisible, however. The division often made between civil and political rights on the one hand and economic, social and cultural rights is generally unfortunate and

particularly inappropriate in the area of children's rights, which is why no such separation is made in the CRC.

It has to be recognized, however, that many economic and social rights are not made justiciable in most countries, which means that they cannot be directly used as a basis for litigation through regular court procedures. This is slowly changing – in some countries, such as India and South Africa, courts have to some extent been willing to apply such rights in their decisions. But the importance of legal justiciability should not be exaggerated. There are many ways in which the rights can be asserted outside the legal framework. States are obliged in good faith to implement the treaties they have ratified, and they can be held morally and politically responsible, even if legal sanctions are not always available. Assuming that their ratification is an indication of a clear commitment, what is most important for States to know is the best ways in which they should implement the body and the spirit of the CRC.

8. Taking into account that the right to health is set out also in Article 12 of the CESCR, the practice of the UN Committee on Economic, Social and Cultural Rights in regard to that article is of considerable value for the elucidation of the content also of Article 24 of the CRC. General Comment No. 14 on the right to health, adopted by the CESCR Committee in 2000,[2] is therefore given central attention in the following analysis of the content of Article 24 of the CRC, together with the five general comments adopted by the CRC Committee. More generally, 'soft law' – including commitments made by the World Health Assembly or in other relevant contexts – is taken into account in interpreting the provisions of Article 24 in this contribution.

9. The right of the child to the highest attainable standard of health is closely related to and dependent upon the realisation of other human rights. The enjoyment by the child and its parents or guardians of economic and social rights, such as the right to food, housing, work, education, as well as civil and political rights, such as the right to life, to freedom of expression and information, and the application of general human rights principles of equality, non-discrimination and dignity, are preconditions for the effective enjoyment of the right to health.

10. Article 24 must be interpreted and applied in the light of the other rights in the CRC. Its scope of application covers *all persons under the age of 18* (Article 1). Consequently, measures for health protection must focus not

[2] CESCR Committee, *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (UN Doc. E/C.12/2000/4, 2000) (hereinafter: CESCR Committee, *General Comment No. 14*).

only on infants and small children, but also on adolescent youth, and different measures are required for children in different age groups. Furthermore, the child's right to health must be ensured without discrimination by the State or any of its agents irrespective of the child's or parent's or guardian's race, colour, sex and other grounds, and the child must also be protected against any discrimination by third parties on the basis of the status, activities, opinions or beliefs of the child's parents, legal guardians or family members (Article 2). In all actions concerning his or her health, the best interests of the child shall be a primary consideration (Article 3).

11. Of particular importance for Article 24 is the general obligation of States Parties under Article 3 (2) and 3 (3) of the CRC to ensure the child necessary protection and care, and to ensure that institutions, services and facilities responsible for the care and protection of the child, particularly in the areas of safety and health, conform with the standards established by competent authorities.

12. Several other provisions of the CRC have a bearing on the right to the health of the child. One of these is the child's inherent right to life and the obligation of States to ensure to the maximum extent possible the survival and development of the child (Article 6). Another set of concerns is addressed in Article 19, requiring States to take measures to protect the child from all forms of physical or mental violence, injury or abuse also when committed by parents or guardians.

13. Closely related to Article 24 is the provision concerning mentally or physically disabled children in Article 23. States have undertaken a responsibility, subject to available resources, to encourage and extend assistance to the disabled child and/or those responsible for her or his care. This shall include effective access to health care services, rehabilitation services, and the fullest possible social integration and individual development.

14. The right of the child to benefit from social security, including social insurance (Article 26), is of particular importance to ensure that children do not suffer excessively from poverty of the parents. As stated in Article 26 (2), the benefits should take into account the resources and the circumstances of the child and persons having responsibility for the maintenance of the child, as well as any other consideration relevant to an application for benefits made by or on behalf of the child.

15. Directly relevant is also the right of the child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development, as set out in Article 27 of the CRC. While the parent(s) or

other responsible for the child have the primary responsibility to secure adequate conditions of living for the child, the States Parties shall take appropriate measures to assist them to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

16. Essential is also the right of the child to education, laid down in Articles 28 and 29 of the CRC. Education contributes to the development of the child's mental and physical abilities, its ability to seek and to receive information, and its gradually increasing ability to make the right choices in issues of relevance to health as well as in other matters.

17. The primary responsibility to ensure healthy behaviour and the avoidance of health risks rests with the parents or guardians of the child and with the child itself when sufficiently mature to take such responsibility. The State shall in general respect the responsibilities, rights, and duties of the parents to provide direction and guidance to the child in the exercise of its rights (Article 5). This applies also to guidance in relation to health-related behaviour and choices. The State has the main responsibility, however, for health care policies, institutions and measures, both preventive, curative and rehabilitative.

18. As with all other human rights, the obligations of the State concerning the right of the child to enjoy the highest attainable standard of health falls into three broad categories: the obligations to *respect*, *protect* and *fulfil*.[3] In turn, the obligation to fulfil contains obligations to facilitate, provide and promote. The obligation to *respect* requires States to refrain from interfering, directly or indirectly, with the enjoyment by the child of its right to health or with the rights of parents or guardians to take the necessary steps for the health of the child. The obligation to *protect* requires States to take measures that prevent third parties from causing harm to the child's health, or from interfering with the access of the child to health care. The State is also obliged to take measures, when necessary, to protect the child against abuse or neglect by the child's parents. Finally, the obligation to *fulfil* requires

[3] The analytical use of the threefold level of State obligations (respect, protect and fulfill) is now generally applied in works on human rights, in particular with regard to economic, social and cultural rights. It is consistently used by the CESCR Committee, see *e.g.* CESCR General Comments No. 12, 13, 14 and 15. On General Comments and their location, see Introduction and note 1.

States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right of the child to health.

19. The duty of the States to *respect* the right of the child to health implies a duty not to deny or limit equal access for all children, including those who belong to minorities, asylum seekers and illegal immigrants, to preventive, curative and rehabilitating health services. States should also respect the freedom of parents or guardians to rely on and make use of traditional preventive care, healing practices and medicines, unless such practices lead to neglect or abuse of the child's needs.[4]

The obligation to respect the right of the child to health furthermore implies that the State must abstain from applying or condoning coercive medical treatments, unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (see further the CESCR Committee's General Comment No. 14 para. 34). States should also respect the freedom of the parents and the adolescent child to seek health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters.

20. Obligations to *protect* include obligations of the State to control the marketing of medical equipment and medicines by third parties, and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. It also includes an obligation to protect the child from practices by the parents or guardians of the child which are detrimental to the health of the child. States are also obliged to ensure that harmful social or traditional practices do not interfere with the right of the child to the highest attainable standard of health. They must protect the child against harmful practices such as female genital mutilation and take all necessary measures to protect girl children from gender-based violence.

Where health services are privatized, the States must adopt legislation or take other measures ensuring equal access to health care and health-related services provided by third parties and ensure that privatisation does

[4] *Cf. infra* No. 105–109.

not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services for every child.

21. The obligation to *fulfil* requires States Parties, *inter alia*, to give sufficient recognition to the right of every child to the highest attainable standard of health in the national political and legal systems by law and policy measures. It must ensure that in its national health policy, detailed and specific measures are included to address the particular needs of the child as set out in Article 24 (2). States must ensure provision of health care, including immunisation programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritionally adequate and safe food and potable drinking water, basic sanitation and adequate housing and living conditions. The States must ensure appropriate training of doctors and nurses, the availability of hospitals and other health care institutions throughout the country, and must engage in appropriate information campaigns. The details are spelled out under the relevant sections of Article 24 (2), 24 (3) and 24 (4) and are further discussed below.

As spelled out in CESCR General Comment No. 14 para. 37, the obligation to *fulfil* (*facilitate*) requires States *inter alia* to take positive measures that enable and assist children and the communities in which they live to enjoy the right to health. States Parties are also obliged to *fulfil* (*provide*) a specific right contained in the Covenant when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal. The obligation to *fulfil* (*promote*) the right to health requires States to undertake actions that create, maintain and restore the health of the population, including the children. Such obligations include: (i) fostering recognition of factors favouring positive health results, *e.g.* research and provision of information; (ii) ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups; (iii) ensuring that the State meets its obligations in the dissemination of appropriate information relating to healthy lifestyles and nutrition, harmful traditional practices and the availability of services; (iv) supporting people in making informed choices about their health.

CHAPTER THREE

THE SCOPE OF ARTICLE 24

1. *Article 24 (1)*

1.1 *'States Parties recognize the right of the child to the highest attainable standard of health . . .'*

22. As stated in the introduction, Article 24 does not provide for a right of the child to be healthy, which no agent or authority can guarantee. The normative content of 'the highest attainable standard of health' is a right to the best possible health outcomes taking into account both the child's biological preconditions and its living conditions as well as its access to health care. It includes both physical and mental health.

23. The newborn child's biological preconditions are determined in part genetically, in part by other factors, including the conditions of the mother during pregnancy (see further the discussion under Article 24 (2)(d) below). Pre-natal care (of the mother and the foetus) is therefore of vital importance for the health of the child after birth.

24. The child's living conditions depend in part on the socioeconomic situations of the parents or guardians, which are affected by a wide range of factors including poverty or past or present discrimination on the grounds of race, descent (*e.g.* caste), ethnicity or other factors. Poverty naturally has a strong impact on living conditions, including housing, nutrition, hygiene, or access to clean water. The child's living conditions are also affected by environmental conditions such as pollution. Health conditions can also be affected, positively or negatively, by cultural factors and traditions.

25. The possibility to enjoy the highest attainable standard of health is also affected by the behaviour of the parents or guardians, and later by the child itself when it grows old enough to make its own choices. During its earliest years, the physical and mental health of the child is heavily dependent on the care given to it by parents or guardians. Neglect or improper treatment can severely interfere with the child's health. The adoption by the child itself of unhealthy or risky lifestyles, pertaining to smoking, drugs, sexual

behaviour and inappropriate diets particularly during adolescence, may play an important role with respect to the child's health.

26. Some policies and practices of the State can have serious negative impact on the health situation of the child. Political persecution, imprisonment or torture of the parents, guardians or of the child itself can affect the future health of the child. Evictions and displacement can have lasting negative consequences on the mental as well as physical health. Another example would be the lack of prevention by the State of industrial or other activity which leads to harmful pollution.

27. Gender discrimination can in various ways have negative impact on the health of children, not only on the girl child but on all children. Discrimination within the household in poor families in some parts of the world may have as one of its consequences that women in child-bearing age are malnourished and give birth to malnourished children whose brain capacity can be negatively affected. Furthermore, the lack of sexual and reproductive freedom of women due to cultural traditions may prevent them from ensuring appropriate spacing of children. This can lead to inadequate care for the many children that might result, particularly because the mother in a poor family has a large number of other tasks to perform to ensure the survival of the family. Among the results of such situations is inadequate attention to risk factors affecting the child.

28. In its General Comment No. 14, the CESCR Committee has interpreted the right to health as 'an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health'.[5] The Committee also points out that a further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels. This conception based on Article 12 of the CESCR is equally applicable to the right of the child to the highest attainable standard of health as set out in Article 24 of the CRC.

29. In sum, the enjoyment of the highest attainable standard of health depends on a wide range of factors, some of which can be addressed in

[5] CESCR Committee, *General Comment No. 14*, para. 11.

terms of health care services, while others are related to more general policies within the State, directly or indirectly related to health protection. Policies in the areas of sanitation, water supply, environmental protection including prohibition of smoking in public places, food security and safety, are all relevant to the health of the child. The general standard of health among the population and in particular of those in the lower income ranges depends also on social security policies and measures to prevent and counteract discrimination of all kinds.

1.2 *'... and to facilities for the treatment of illness and rehabilitation of health'*

30. Curative facilities must be available in sufficient quantity and be accessible to all, in the different parts of the country, within the physical reach of all sections of the population, and available without any discrimination on prohibited grounds. The facilities should include primary health care institutions which can provide first aid, including essential drugs, as defined by the WHO Action Programme on Essential Drugs,[6] trained medical and professional personnel, and should also include more elaborate institutions such as hospitals to deal with the more complicated health issues.

31. Facilities for health rehabilitation are essential to the child and are therefore expressly listed in Article 24, though not found in Article 12 of the CESCR. Early and timely rehabilitation can prevent or significantly reduce the danger or effect of permanent disability resulting from illness or accidents, and is therefore also addressed in Article 23 of the CRC which deals with disabled children.

1.3 *'States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services'*

32. This provision imposes a strong duty of action by the State to ensure that health care services are available and accessible to all. The *travaux préparatoires* make this clear.[7] The term 'no child shall be deprived of his or

[6] See WHO Model List of Essential Drugs, updated periodically in WHO Drug Information, available at http://www.who.int/medicines/organization/par/edl/eml.shtml.

[7] See 'Article 24' in S. Detrick, *A Commentary on the United Nations Convention on the Rights of the Child* (The Hague, Martinus Nijhoff Publishers, 1999) (hereinafter S. Detrick, *A Commentary*), with further details in S. Detrick (ed.), *The United Nations Convention on the Rights of the Child. Guide to the Travaux Préparatoires* (The Hague, Martinus Nijhoff Publishers, 1992) (hereinafter S. Detrick, *Travaux Préparatoires*).

her right of such health care facilities' emerged initially as a compromise between conflicting views on whether and to which extent health care services for children should be given free of charge. While the representatives of some countries argued in favour of a general system of free health services, others (notably the United States) argued against it. The compromise first adopted was that 'the States Parties shall strive to ensure that no child is deprived for financial reasons of his right to access to such health care services'. The implication was that while it might be permissible to demand charges for services for those who without too great difficulties could pay for them, lack of means should not prevent any child having such access.

33. This means that the State must strive towards making services economically accessible to all children and to their parents or guardians on behalf of the children. Health facilities, goods and services must be made affordable for all. The CESCR Committee has stated that payment for healthcare services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.[8]

34. The CESCR Committee has also pointed out that inappropriate health resource allocation can lead to discrimination that may not be overt. For example, investments should not disproportionately favour expensive curative health services which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.

35. Article 24 also implies that States should strive to make the services physically accessible to every child throughout the country. In the negotiations over the term 'that no child is deprived for financial reasons of his right to such health care services', it was pointed out that there might also be other reasons than financial that could deprive the child of such access.[9] In many developing countries there is a higher concentration on health services in urban than in rural areas. Deprivation can thus exist when the services are too remote from where the child is living. It was therefore decided to make the sentence more general and to drop the words 'for

---

[8] CESCR Committee, *General Comment No. 14*, para. 12.
[9] S. Detrick, *A Commentary* (note 7), p. 403 at note 27.

financial reasons' so that it now reads 'shall strive to ensure that no child is deprived of her or his access to such health care services'.

The CRC Committee specifically requests States Parties to provide information on the distribution of both general and primary health care services in the rural as well as the urban areas.[10]

36. The formulation that *no* child shall be deprived of these services is also a reminder that there must be no discrimination in access, irrespective of the child's or the parents' or legal guardians' race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status (see Article 2 of the CRC). The State must also take all appropriate measures to ensure that the child is protected against all forms of discrimination by private parties on the basis of the status, activities, expressed opinions, or beliefs of the parents or guardians (Article 2 (2) of the CRC).

37. In its Guidelines for State Reporting, the CRC Committee therefore requests information on the extent to which children have access to and benefit from medical assistance and health care, and on the persisting gaps, including by gender, age, ethnic and social origin, as well as measures adopted to reduce existing disparities.

38. Special attention must be given to the right to access of the girl child, including adolescent girls, to appropriate health services which have the capacity to take measures to prevent and treat diseases affecting girls and women, and which can provide affordable health care including sexual and reproductive services as appropriate.

39. Article 2 of the CRC expressly prohibits discrimination on the ground of disability. Consequently, States must strive to ensure that children with disability have full and equal access to health services. Moreover, such children are entitled to special care and assistance, including health care services, and it shall be free of charge whenever possible (Article 23 (3) of the CRC).

40. Special attention needs to be given to the access to health care of certain vulnerable groups. States must ensure that there be no discrimination on grounds of race and ethnicity. In practice, the children of some disadvantaged

[10] CRC Committee, *General Guidelines for Periodic Reports* (UN Doc. CRC/C/58, 1996) (hereinafter CRC Committee, *Guidelines for State Reporting*), para. 95.

groups face special difficulties. The CRC Committee has expressed serious concern over the disparity in the health status between indigenous and non-indigenous children.[11] In many countries of Eastern and Central Europe, the Roma face increasing difficulties due to the transition to a market economy, with privatisation of health services or increasing requirements of user fees, for which they cannot pay. In its Concluding Observations regarding Bosnia and Herzegovina, for instance, the Committee expresses serious concerns that some 90 per cent of Roma have no health insurance, which results in their *de facto* exclusion from access to health care.[12] Attention must also be given to other forms of exclusion which would constitute violations of Article 24. In countries which regulate and restrict the freedom of movement and residence, children of groups which are considered to be living in illegal settlements are sometimes sought to be excluded from the health services. This would constitute a violation of Article 24 since the duty of the State extends to everyone within the jurisdiction of the State (Article 2 (1) of the CRC).

With regard to refugee children and asylum seekers, Article 22 of the CRC requires States to take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee shall receive appropriate protection and humanitarian assistance. The CRC Committee requests in its Guidelines for State Reporting that States should indicate the extent of protection and assistance given to such children in enjoying the rights set out in the CRC. The Committee mentions in this regard explicitly Article 24 together with Articles 7, 20 and 28. Developed countries must be considered to be under a duty to extend the same services to such children as to others within their jurisdiction. For refugees in developing countries, services will often be provided in cooperation with or by international agencies such as the UNHCR and non-governmental organisations such as the Red Cross and Red Crescent organisations.

The CESCR Committee has argued that special considerations have to be born in mind when dealing with the right to health of persons belonging to such peoples.[13] It considers that indigenous peoples have the right to specific measures to improve their access to health services and care. These health

---

[11] See *e.g.* CRC Committee, *Concluding Observations: Australia* (UN Doc. CRC/C/15/Add.268, 2005), paras. 47 and 48.

[12] CRC Committee, *Concluding Observations: Bosnia and Herzegovina* (UN Doc. CRC/C/15/Add.260, 2005), para. 47.

[13] CESCR Committee, *General Comment No. 14*, para. 27.

services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health. The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected. The Committee notes that, in indigenous communities, the health of the individual is often linked to the health of the society as a whole and has a collective dimension.

2. *Article 24 (2): 'States Parties shall pursue the full implementation of this right and shall take appropriate measures'*

41. Full implementation requires the State to undertake all appropriate legislative, administrative and other measures for the implementation of the rights set out in Article 24. The required measures go beyond health services. Preventive measures cover a wide area, including those outlined in the CRC Committee's General Comments No. 3 (on HIV/AIDS)[14] and No. 4 (on adolescents).[15] Measures must be undertaken not only in the areas of social welfare and health services, but in education, environmental management and in many other areas. This means that many different branches of government need to be involved.

42. States shall undertake the necessary measures 'to the maximum extent of their available resources'[16] and, where needed, within the framework of international cooperation.[17] The reference to 'the maximum available resources' implies an immediate obligation to start adopting measures that are within the means of the State, and to progressively advance the realisation of the right when additional resources become available. States Parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the rights set out in Article 24.

---

[14] CRC Committee, *General Comment No. 3: HIV/AIDS and the Rights of the Children* (UN Doc. CRC/GC/2003/3, 2003) (hereinafter CRC Committee, *General Comment No. 3 on HIV/AIDS*).

[15] CRC Committee, General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child (UN Doc. CRC/GC/2003/4) (hereinafter CRC Committee, *General Comment No. 4 on Adolescent Health*).

[16] Article 4 of the CRC.

[17] On the latter point *cf. infra* No. 110 *et seq.*

43. Whether the measures adopted are 'appropriate' depend to some extent on the particular situation of the country and the conditions prevailing in different parts of the country, the rural as well as the urban. The measures must address the needs of the poor as well as of those who are better off. Specific attention must be given to address the needs of persons belonging to vulnerable groups such as the indigenous, the minorities, those of low castes in countries where the caste system still exist, as well as measures addressing the situation of the members of the dominant groups. Measures appropriate for the girl child as well as for the boy child need to be taken. Attention must also be given to the needs of children living in institutions such as orphanages, and special protection is required for street children and others living in exceptionally difficult conditions (see preamble to the CRC).

44. The CRC Committee has noted with concern that in implementing their obligations under the Convention, States Parties have not given sufficient attention to the specific concerns of adolescents as rights holders and to promoting their health and development. This motivated the Committee to adopt its General Comment No. 4 on Adolescent Health in order to raise awareness and provide States Parties with guidance and support in their efforts to guarantee the respect for, protection and fulfilment of the rights of adolescents, including through the formulation of specific strategies and policies. States Parties have to provide special protection to homeless adolescents, including those working in the informal sector. Homeless adolescents are particularly vulnerable to violence, abuse and sexual exploitation from others, self-destructive behaviour, substance abuse and mental disorders. States Parties are required, *inter alia*, to develop strategies for the provision of appropriate education and access to health care, and of opportunities for the development of livelihood skills. Adolescents who are sexually exploited, including in prostitution and pornography, are exposed to significant health risks, including sexually transmitted diseases (STDs), HIV/AIDS, unwanted pregnancies, unsafe abortions, violence and psychological distress. They have the right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity (Article 39 of the CRC). The Committee considers it to be the obligation of States Parties to enact and enforce laws to prohibit all forms of sexual exploitation and related trafficking; to collaborate with other States Parties to eliminate inter-country trafficking; and to provide appropriate health and counselling services to adolescents who have been sexually exploited, making sure that they are treated as victims and not as offenders.

2.1 *Article 24 (2)(a): 'To diminish infant and child mortality'*

45. Infant and child mortality rates provide one of the most important indicators of the social and economic development of a country and can be quite revealing of the degree to which the right to health is given attention and given priority in resource allocation within the country. Infant mortality has been a widely used indicator of a country's level of development, alone or as part of more composite indices, and mortality of children under five years of age is another good indicator. On top of the list of measures to be adopted by States is therefore the requirement to diminish infant and child mortality. It is also included in Article 12(2) of the CESCR which requires States to make provisions 'for the reduction of the still-birth rate and of infant mortality and for the healthy development of the child'. The need to diminish the mortality of children is necessary also in order to implement Article 6 of the CRC, which states that every child has an inherent right to life and that States shall ensure to the maximum extent possible the survival and development of the child. To reduce child mortality is also one of the eight Millennium Development Goals (Goal 4), with a target for 2015 to reduce by two thirds, from 1990, the mortality rate among children under five. Looking back, in 1960 more than 1 child in 5 in the developing regions died before age 5. In 1990 the rate was down to 1 in 10 which gave hope that child mortality could be cut by a further two thirds by 2015. Unfortunately advances slowed down in 1990.[18] It is therefore important that the MDG is pursued through a rights based approach in concert with the relevant provisions of the CRC.

46. Infant mortality rate is the probability that a newborn child will die during its first year, expressed as number of children per 1,000 born alive who are likely to die within the first year of life. Under five mortality rate is the probability that a newborn baby will die before reaching age five, if subject to current age-specific mortality rate for the area in question. The probability is expressed as a number per 1,000 children under five.

The World Bank reports that in 2002 the average under-five mortality rate was 121 deaths per 1,000 live births in low-income countries, 40 in lower-middle-income countries, and 22 in upper-middle-income countries. In high-income countries, the rate was less than 7. In certain regions among low-income countries the rate may be especially high – thus in 15 such countries, 14 of which are in Africa, the average rate is more than 200 per 1000.[19]

[18] The Millennum Development Goals Report, United Nations, 2005.
[19] World Bank, *World Development Indicators* (Washington D.C., World Bank, 2003), p. 9.

47. Such average figures will almost always mask differences between socio-economic and/or ethnic groups. Even among the low-income countries there are vast differences in child mortality, reflecting the differences in political will, organisational capacity and the dissemination of knowledge and education between different countries with similar levels of GNP per capita. Also in high-income countries there are vulnerable groups where the rate is considerably higher than the average – exemplified by the Roma in Europe, and the indigenous people in the Americas or Australia.

Another example comes from the United States: the 'Center for Disease Control' in Atlanta (USA) states that during the 20th century, while infant mortality rates in the United States as a whole declined by 90%, many of the largest US cities continue to have high infant mortality rates compared with national rates. The inner cities are often those where the poorest part of the population lives, including many of the Afro-Americans. Studies of infant mortality by region document persisting geographic disparities and differences across racial/ethnic groups, including blacks and hispanics.[20]

48. For approximately 70 percent of the deaths before the age five in low-income countries, the direct cause is a disease or a combination of malnutrition and disease that would be preventable in a high-income country: acute respiratory infections, diarrhoea, measles, and malaria. Malnutrition, unsafe water and lack of proper sanitation make the diseases deadly in low-come countries while their risks are small in high-income countries. The combination of measles and malnutrition is the major cause of the high level of child death in sub-Saharan Africa. The risks of measles can be substantially reduced by vaccination, but the coverage of vaccination is still much too low in the poorest developing countries, particularly in Africa.[21]

49. High rates of child mortality are linked to poverty and insufficient public intervention to address the issue. It can be significantly influenced by appropriate health- and nutrition-related interventions, some of which can be made at quite low cost. The reduction of the infant mortality and healthy development of the child requires measures to improve child and maternal

---

[20] *Racial and Ethnic Disparities in Infant Mortality Rates - 60 Largest U.S. Cities, 1995-1998* (available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5115a4.htm). This review provides references to several articles on the issue.

[21] A particularly useful source of information about the distribution and causes of child mortality, and about considerations of conditions for reducing it in accordance with the Millenium Development Goals and what it would cost, is a series of "Child Survival papers" I-V published in The Lancet in 2003 by members of the *Bellagio Child Survival Study Group*. The papers can be downloaded from http://www.who.int/child-adolescent-health/publications/ CHILD_HEALTH_Lancet_CS.htm

health, emergency obstetric services when required, sexual and reproductive health services, including access to family planning and adequate care including appropriate feeding patterns. Reducing poverty and making needed structural changes to improve living conditions of the poorer or vulnerable part of the population clearly must be high priorities for developing countries. The control of diseases refers to States' individual and joint efforts to, *inter alia*, make available relevant technologies, using and improving epidemiological surveillance and data collection on a disaggregated basis, the implementation or enhancement of immunisation programmes and other strategies of infectious disease control. However, two other factors that also affect the likelihood of babies dying during their first year are more immediately amenable to change: the age at which women have their children and the length of the interval between births. These factors, in turn, are strongly affected by the use of modern contraceptive methods to control the timing of their births.

50. Much is thus known about what would be needed to diminish infant and child mortality, but there are obstacles both from a resource point of view and from several socio-cultural dimensions during changing times. Important among the obstacles is the difficulty of physical and economic access to appropriate and affordable health services, especially in the more remote rural areas. To have access to health services and to be aware of the importance of preventing upcoming ill-health and disease, are two dimensions of the same problem: often people are too far away from the nearest health facility to find it worthwhile going there unless a child is seriously ill already and then it may be too late. This underlines both the importance of and difficulties in extending information, education and support to parents, communities and children themselves.[22]

51. Some of the traditional practices that have protected mothers before and after birth and that allowed them a longer spacing of births, are also gradually diminishing: one example is the past practice of sexual abstinence for many months after the birth of a child. This has been weakened by declining levels of polygamy in Sub-Saharan Africa, by greater exposure through the mass media to modern concepts of what constitutes a healthy married life and by women's desire to stop their husbands from going to commercial sex workers.[23] Clearly the response to this decline is not a return

[22] *Cf. infra* No. 88–98.
[23] Alan Guttmacher Institute Home Page at http://www.agi-usa.org/index.html.

to polygamy, but to develop other ways to protect the woman against frequent pregnancies.

52. Another traditional protection against frequent pregnancies has been breastfeeding, where the greatest contraceptive effect is seen when breastfeeding is exclusive and before menstruation recommences. Breastfeeding also strengthens the immunity of the child due to its content of immunologic components that play a role in the protection of the nursing infant. It has unfortunately been undermined by the use of breastmilk substitutes and bottlefeeding, which jeopardizes the child's health because it is often prepared under dirty conditions or may contain intrinsic pathogenic bacteria to which the non-breastfed child is more vulnerable. Greater attention must therefore be given to reemphasize the importance of exclusive breastfeeding for the first six months with continued breastfeeding for two years or beyond,[24] and to the full implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions. Regarding the risk of vertical transmission of HIV from mother to child through breastfeeding, this has been addressed and proper recommendations have been given by the CRC Committee in its General Comment No. 3 on HIV/AIDS. The Committee has pointed out that even in populations with high HIV prevalence, the majority of infants are born to women who are not HIV-infected. For the infants of HIV-negative women and women who do not know their HIV status, the Committee emphasizes, consistent with Articles 6 and 24 of the Convention, that breastfeeding remains the best feeding choice.[25]

2.2 *Article 24 (2)(b): 'Ensure the provision of necessary medical assistance and health care to all children, with emphasis on the development of primary health care'*

53. The requirement that medical assistance and health care must be provided to all without discrimination has been discussed above.[26] Two issues will be further discussed here: the meaning and content of primary health care, and the challenge to care for children posed by the HIV/AIDS pandemic.

---

[24] *Cf. infra* on the 'Global Strategy for Infant and Young Child Feeding' in No. 76.
[25] For detail on this important issue *cf. infra* on Article 24(2)(d) in No. 81–87.
[26] *Cf. supra* No. 36–40.

Primary health care

54. The content of primary health care was elaborated a few years before the start of the negotiations of the CRC, in the 1978 Declaration of Alma Ata on Primary Health care, a conference sponsored by WHO and UNICEF. The Declaration was endorsed by the United Nations General Assembly by resolution 34/43 of 19 November 1979.

55. According to Article VI of the Declaration of Alma Ata, primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology. Such care should be made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development. It should form an integral part of the country's health system, of which it is the central function and main focus.

56. Primary health care is the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work. It constitutes the first element of a continuing health care process. According to Principle VII of the Declaration of Alma Ata, primary health care addresses the main health problems in the community, and should provide promotive, preventive, curative and rehabilitative services.

57. Primary health care, as set out in Principle VII of the Declaration of Alma Ata, includes at least education concerning prevailing health problems and the methods of preventing them,[27] promotion of food supply and proper nutrition,[28] an adequate supply of safe water and basic sanitation,[29] maternal and child health care, including family planning,[30] immunisation against the major infectious diseases (which is essential for the reduction of child mortality), prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs.

58. Primary health care envisages small, but widely accessible institutions. It should be distinguished from more elaborate varieties including tertiary

[27] *Cf. infra* No. 99-104.
[28] *Cf. infra* No. 68-80.
[29] *Cf. infra* No. 68-80 and 88-98.
[30] *Cf. infra* No. 99-104.

health care which consists in high-tech, high cost institutions, with highly equipped and staffed hospitals. In low-income countries, allocation of resources to tertiary health care benefits only a small number of people and detracts from the ability to reach everyone, in rural as well as urban areas, with primary health care. Article 24 must be understood to demand priority allocation to primary health care.

59. The requirements which a satisfactory health care system should fulfil have been spelled out in General Comment No. 14 adopted by the CESCR Committee under the following headings: availability, accessibility, acceptability and quality. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State Party. Health facilities, goods and services have to be physically and economically accessible to everyone without discrimination, within the jurisdiction of the State Party. They must also be acceptable. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, *i.e.* respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.[31]

The need to make health facilities and services sensitive to gender and life-cycle requirements has a particular significance concerning health care for children. The CRC Committee has repeatedly expressed concern that health services are generally still insufficiently responsive to the needs of children under 18 years of age, in particular adolescents. In the view of the Committee, children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgemental, do not require parental consent and are not discriminatory.

60. Primary health care has to promote adequate food and feeding patterns for young children. Malnutrition, combined with communicable diseases, is a major cause of child mortality in developing countries. However, it is important to keep in mind that malnutrition is not always due to too little food, but can also be caused by unhealthy choice of food and inappropriate feeding patterns, particularly for the youngest children. When food is prepared with unsafe water and under general unhygienic conditions, it increases

[31] For details, see CESCR Committee, *General Comment No. 14*, para. 12.

the risk of diarrhoea which contributes to and aggravates malnutrion.[32] Under such conditions it is particularly important that primary health care protects, promotes and supports exclusive breastfeeding for six months with continued breastfeeding for two years or beyond. This will help protect the child in the critical period after weaning when it is introduced to solid food which may introduce new risks of infections and malnutrition.

The HIV/AIDS epidemic

61. A major challenge facing the health care system is the HIV/AIDS epidemic. Where it is widespread it effects children in multiple ways, as infected persons, as children of infected parents, or in other ways. The CRC Committee has therefore elaborated General Comment No. 3 on HIV/AIDS.

62. The CRC Committee notes in this General Comment that, initially, children were considered to be only marginally affected by the HIV/AIDS epidemic. However, it has been found that, unfortunately, children are at the heart of the problem. Quoting the Joint United Nations Programme on HIV/AIDS (UNAIDS), the CRC Committee finds the most recent trends alarming: in most parts of the world, the majority of new infections are among young people between the ages of 15 and 24, sometimes younger.

63. The Committee further notes that women, including young girls, are increasingly becoming infected. In most regions of the world, the vast majority of infected women do not know that they are infected and may unknowingly infect their children. Consequently, many States have recently registered an increase in their infant and child mortality rates. Adolescents are also vulnerable to HIV/AIDS because their first sexual experience may take place in an environment in which they have no access to proper information and guidance. Children who use drugs are at high risk.

64. The Committee observes that while the issue of children and HIV/AIDS is perceived as mainly a medical or health problem, in reality it involves a much wider range of issues. The right to health is of central importance, but the Committee points out that HIV/AIDS impacts so heavily on the lives of all children that it affects all their rights - civil, political, economic, social and cultural. 'The rights embodied in the general principles of the Convention - the right to non-discrimination (Article 2), the right of the child to have his/her interest as a primary consideration (Article 3), the right to life,

[32] *Cf. supra* No. 45–52.

survival and development (Article 6) and the right to have his/her views respected (Article 12) – should therefore be the guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support'.[33]

65. The Committee further notes that gender-based discrimination combined with taboos or negative or judgemental attitudes to sexual activity of girls often limit their access to preventive measures and other services, and States Parties are therefore called upon by the Committee to eliminate gender-based discrimination since customary norms of discrimination increase the susceptibility of children to HIV/AIDS. Such discrimination impacts often more on girls than boys in the context of HIV/AIDS.

66. In the context of HIV/AIDS and taking into account the evolving capacities of the child, States Parties are encouraged to ensure that health services employ trained personnel who fully respect the rights of children to privacy (Article 16 of the CRC) and non-discrimination in offering them access to HIV-related information, voluntary counselling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, and free or low-cost contraceptive, methods and services, as well as HIV-related care and treatment if and when needed, including for the prevention and treatment of health problems related to HIV/AIDS, *e.g.* tuberculosis and opportunistic infections.[34]

67. In some countries, even when child- and adolescent-friendly HIV-related services are available, they are not sufficiently accessible to children with disabilities, indigenous children, children belonging to minorities, children living in rural areas, children living in extreme poverty or children who are otherwise marginalized within the society. In others, where the health system's overall capacity is already strained, children with HIV have been routinely denied access to basic health care. States Parties must ensure that services are provided to the maximum extent possible to all children living within their borders, without discrimination, and that they sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live.

---

[33] CRC Committee, *General Comment No. 3 on HIV/AIDS*, para. 5.
[34] *Ibid.*, para. 20.

2.3 *Article 24 (2)(c): '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'*

68. This provision was initially proposed by India and reflected in particular the dominant problems facing children in many developing countries. A large number of children, particularly in the poorer sector of the population, die before the age of five, due to a combination of malnutrition, unsafe water and sanitation, and communicable diseases. The concern was that, while risks can be substantially reduced through readily available technology such as immunisation against the common childhood diseases and oral rehydration therapy in the case of diarrhoea, this alone is not enough: it is also essential to ensure provision of adequate food and nutritious diets, clean drinking water, proper sanitary facilities, and not least the reduction of contaminating dangerous waste through the promotion of effective waste management.

At an earlier stage of the drafting, Algeria had presented a proposal dealing specifically with the right to food and adequate nutrition. It was not adopted in the form it then had, but many of the concerns subsequently found their way into the convention. The proposal by Algeria would also have recognized the need for special protection for infants and young children as regards food, particularly in developing countries. To that end States Parties would have been called upon to actively protect, promote and support breastfeeding in all countries as the only natural method of feeding babies, put an end to the practices of multinational firms aimed at commercial promotion of breastmilk substitutes which have direct and indirect adverse impact on children, especially in the developing countries, adopt and comply with the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions, and to make all possible use of scientific and technological expertise in order to produce adequate, sufficient and diversified food products of the best possible quality and make them available to children.[35]

69. The right to adequate food, as part of the right to an adequate standard of living, is covered by Article 11 of the CESCR. Its content has been clarified by the CESCR Committee in its General Comment No. 12, adopted in 1999.[36]

---

[35] For details, see S. Detrick, *Travaux Préparatoires* (note 7), p. 411 with references.

[36] CESCR Committee, *General Comment No. 12: The Right to Adequate Food (Art. 11)* (UN Doc. E/C.12/1999/5, 1999).

The right to adequate food has been interpreted by that Committee to imply availability and accessibility of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture.[37]

Dietary needs implies that the diet as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages throughout the life cycle and according to gender and occupation. Measures may therefore need to be taken to maintain, adapt or strengthen dietary diversity and appropriate consumption and feeding patterns, including breastfeeding, while ensuring that changes in availability and access to adequate food supply as a minimum do not negatively affect dietary composition and intake.[38]

Free from adverse substances sets requirements for food safety and for a range of protective measures by both public and private means to prevent contamination of foodstuffs through adulteration and/or through bad environmental hygiene or inappropriate handling at different stages throughout the food chain; care must also be taken to identify and avoid or destroy naturally occurring toxins.[39]

70. Lack of safe water and sanitation remains one of the world's most urgent health issues: according to a UNICEF and WHO 2005 report 'Water for Life', some 1.1 billion people worldwide still lack safe water and 2.6 billion have no sanitation. UNICEF states that up to a third of all disease globally is thought to be caused by environmental factors such as polluted water and air, and emphasizes that children become particularly vulnerable to disease because, on the one hand, their bodies are not yet fully developed so they have less resistance to disease, on the other young children breathe more air, drink more water and eat more food in proportion to their weight than adults do, so they take in bigger doses of any contaminants. Women are key to creating lasting change, but national water and sanitation plans are still leaving women out, thus services for women and girls must be priority for water and sanitation. In 2001 the Water Supply and Sanitation Collaborative Council (WSSCC)[40] launched the 'WASH' campaign (Water,

[37] *Ibid.*, para. 8.
[38] *Ibid.*, para. 9.
[39] *Ibid.*, para. 10.
[40] The WSSCC was set up in 1990 by virtue of a United Nations General Assembly resolution to maintain the momentum of the International Decade for Water Supply and Sanitation in the 1980s and to enhance collaboration among developing and developed countries.

Sanitation and Hygiene) – a global advocacy effort involving all partners and supporters of the WSSCC. In general, programmes and campaigns tend to encourage communities' own efforts to promote a clean environment and personal hygiene, while UNICEF also works to make people understand their rights to assistance when needed for clean water and a clean environment. Management of waste adds to the range of efforts needed for this.[41]

The elements in this paragraph are closely linked. Since the lack of clean water and proper sanitation aggravate malnutrition,[42] the right to safe water must be considered to be inherent in the right to 'adequate nutritious foods', as well as in the right to health. In its General Comment No. 15 on the right to clean water, the CESCR Committee has dealt with this right as inherent in Articles 11 and 12 of the CESCR (the right to an adequate standard of living including food, and the right to the highest attainable health, respectively).[43] The CESCR Committee argues that whereas the right to water applies to everyone, States Parties should give special attention to those individuals and groups who have traditionally faced difficulties in exercising this right, including children. The Committee urges States Parties to take steps to ensure that children are not prevented from enjoying their human rights due to the lack of adequate water, be it in educational institutions and households or through the burden of collecting water. Provision of adequate water to educational institutions currently without adequate drinking water should be addressed as a matter of urgency. Women leaders in WASH therefore help governments to link women with sanitation and hygiene programmes, and support the UNICEF drive to put safe water and basic sanitation into all primary schools by 2015.[44]

71. At the time of the drafting of CRC, including Article 24, 'malnutrition' was considered to be synonymous with 'undernutrition' and was mainly perceived to interact with unsafe water, bad sanitation and communicable

---

[41] See for example: http://www.silentscourge.com/Children_and_Pollution.html.

[42] In its concluding observations, the CRC repeatedly expresses its concern over air and water pollution and environmental degradation which have serious consequences for children's health and development, and the great regional differences within countries concerning in access to safe drinking water and sanitation. See *e.g.*: CRC Committee, *Concluding Observations: the Philippines* (UN Doc. CRC/C/15/Add.259, 2005), para 60.

[43] CESCR Committee, *General Comment No. 15: The Right to Water* (UN Doc. E/C.12/2002/11, 2003).

[44] The WASH group met at UNICEF in September 2005 to set out a plan of action for Africa, where 19 per cent of women spend more than one hour on each trip to fetch water (joint press release at http://www.unicef.org/media/media_28260.html).

diseases to cause the tragically high death toll of children, as reflected in Article 24 (2)(c). There are still parts of the world where this remains the main problem, especially with regard to macronutrients or so-called protein-energy malnutrition (PEM) particularly in some of the African countries, while micronutrient deficiencies (lack or inadequate intake of vitamins and minerals) is a problem found in all countries.

72. Today, however, one faces increasingly more complex situations which require more diversified responses. One now needs to pay attention to the distinction between communicable and non-communicable diseases in association with nutrition, recognizing that both types affect most regions of the world alike although to varying relative degrees within the developing world. Among the non-communicable diseases we see a rapid rise of such diseases that are related to changes in lifestyle, including reduced physical activity and the consumption of diets with reduced nutritional quality. While the two categories were earlier typically referred to as diseases of the developing vs. developed countries respectively, a number of factors have led to the current understanding of an accelerating 'nutrition transition' and a resulting 'double burden of disease' facing the developing countries.

73. The prevalence of obesity, diabetes (Type 2) and cardiovascular diseases figure increasingly higher on the disease statistics, the first two presenting risks also to children and adolescents. There is now growing evidence that childhood obesity, that earlier was rampant particularly in the United States, is on the increase in many Latin American countries and certain parts of South-East Asia and the Pacific. The causes are several and include changing dietary consumption towards high energy, low-nutrient food items including fat-rich snacks and drinks containing high levels of sugar. The more classical forms of undernutrition and related communicable diseases continue to dominate in certain regions, notably in Africa South of Sahara and South Asia, as well as in very poor communities in Latin American countries and the Pacific.

This 'double burden of disease' points to changing needs and priorities within developing countries' health systems research and planning, often with considerable consequences for already strained health budgets as prioritized needs multiply. This should be kept in mind when we in the following look at implications for States Parties as related to each of the broad categories separately. Also, while 'children' range from the newborn through eighteen years of age, the earliest years of life will set different demands than those of the school child growing into adolescence.

74. Given these developments the WHO has established that the term 'malnutrition' be used for all forms of manifestations of inadequate diets acting together with confounding factors, such as bad personal or environmental hygiene, insufficient care for the vulnerable age groups, or reduced physical activity. This is all the more important as both 'under-nutrition' and 'over-nutrition' may be caused or accentuated by poverty and unsatisfactory living conditions.

75. For *infants and young children*, good nutrition is at the core of their physical and mental development. But good nutritional status demands more than 'nutritious food' which contributes to only one of the three pillars necessary for this to prevail: an adequate *diet*, adequate *care* and access to adequate *health services*, the latter including pre- and post-natal care for both the infant and the mother[45] and vaccination programmes. Not least has the concept of 'care' gained ground in the years following the adoption of the CRC, expanding the conditions for good nutritional status and absence of disease to include also the physical and psychological factors implied in ensuring good feeding and eating habits and the associated desirable psychosocial stimuli from parents and other caretakers.

76. The special role of the diet is at the core of the comprehensive 'Global Strategy for Infant and Young Child Feeding' adopted by the World Health Assembly in May 2002. The Executive Board of the WHO had, at its 101st session in January 1998, called for a revitalisation of the global commitment to appropriate infant and young child nutrition, and in particular breastfeeding and complementary feeding. In close collaboration with UNICEF, a consultative, science-based process was set in motion to assess infant and young child feeding practices, review key interventions, and formulate a comprehensive strategy for the next decade. The final integrated and comprehensive strategy constitutes a guide for developing country-specific approaches to improving feeding practices based on previous standards, such as the International Code of Marketing of Breast-milk Substitutes, the Innocenti Declaration, the Baby-Friendly Hospital Initiative, ILO Maternity Protection Convention and Recommendation and relevant Codex Alimentarius standards.

Breastfeeding stands out in the Global Strategy as a unique combination of energy, nutrients, liquid, anti-infective characteristics and care in one package to be exclusively provided to the infant for the first six months of

[45] *Cf. infra* No. 81.

life and thereafter together with the attentive provision of timely, adequate and safe complementary foods for two years or beyond.[46] However, a number of infants will not enjoy the benefits of optimal breastfeeding. They include children born to HIV positive mothers who choose not to breastfeed and children whose mothers have died (as may be the case during complex emergencies). To address the nutritional needs of children who are not breastfed after 6 months of age, WHO convened an informal meeting in Geneva in March 2004. Based on a background document that examined the feasibility to design adequate diets using locally available foods in five settings, participants developed guiding principles for feeding the non-breastfed child 6–24 months of age. These principles examine various scenarios, namely where infant formula is available, where animal source products are available, and where no animal source products are available.[47]

77. Turning to *adolescents*, one in every five people in the world is an adolescent – defined by the WHO as a person between 10 and 19 years of age. Out of 1.2 billion adolescents worldwide, about 85% live in developing countries and the remainder live in the industrialized world. As noted by WHO, UNFPA and UNICEF,[48] adolescents are generally thought to be healthy. By the second decade of life, they have survived the diseases of early childhood, and the health problems associated with ageing are still many years away. Death seems so far removed as to be almost unthinkable. Yet many adolescents do die prematurely. Every year, an estimated 1.7 million young men and women between ages of 10 and 19 lose their lives – mostly through accidents, suicide, violence, pregnancy-related complications and other illnesses that are either preventable or treatable. Many others contract diseases which will be with them for the rest of their life.

In 1995, WHO with the United Nations Population Fund and the United Nations Children's Fund jointly convened a Study Group on 'Programming for Adolescent Health'. On the basis of current experiences, especially in developing countries, the group reviewed the scientific evidence regarding the effectiveness of key interventions for adolescent health, highlighted the essential factors and strategies needed to establish, implement and sustain

---

[46] WHO (1981) International Code of Marketing of Breast-milk Substitutes. Available from: http://www.who.int/nut/documents/code_english.PDF, or http://www.ibfan.org/english/resource/who/fullcode.html.

[47] WHO, *Feeding the non-breastfed child 6–24 months age* (UN Doc. WHO/FCH/CAH/04.13, 2004). Available from: http://www.who.int/child-adolescent health/New_Publications/NUTRITION/WHO_FCH_CAH_04.13.pdf.

[48] *Cf. infra* next para.

programmes for adolescent health, developed a common framework for country programming, and recommended priority actions to accelerate and strengthen programming for adolescent health, including the global and regional support needed for country-level programming.[49] Subsequently several country examples were provided of ongoing adolescent health and development programmes to illustrate how these programmes are learning from experience and growing in confidence.[50]

It was emphasized that programme efforts need to take into account that adolescents are not alike and that interventions and the way they are delivered will vary according to differing needs and circumstances. For country level actions the Study Group recommended the following general framework:

- Make the case for adolescent health. Advocate the need for adolescent health policies and programmes, including sexual and reproductive health, on the basis of the public health and economic benefits which accrue from investing in the health and development of young people.
- Describe needs and generate commitment. Cosponsor situation analyses and planning activities, with the meaningful involvement of young people, such as creating multisectoral national task forces or convening national workshops, in order to forge coalitions with interested organisations and develop common plans of action.
- Build capacity. Initiate collaborative training and sensitisation for country nationals (including young people) and agency staff to improve and sustain programming for adolescent health.
- Sustain action. Support the implementation of country action plans and/or other clearly focused activities, mobilizing local resources and building on existing infrastructures within the public, NGO and private sectors.
- Demonstrate feasibility. Support those approaches which have the potential to be taken to scale in cost-effective and sustainable ways. In order to study the lessons learned, carry out joint programme reviews, complementary to programming processes.
- Share the knowledge. Intensify means used to share information within the country that focuses on health status of adolescents and successful programming experiences.

---

[49] WHO, UNFPA and UNICEF, *Action for Adolescent Health. Towards a Common Agenda. Recommendations from a Joint Study Group* (Geneva, WHO, 1997), available at http://www.who.int/child-adolescent-health/New_Publications/ADH/WHO_FRH_ADH_97.9.pdf.

[50] WHO, *Growing in confidence. Programming for adolescent health* (UN Doc. WHO/FCH/CAH/02.13, 2002), available at http://www.who.int/reproductive-health/publications/cah_docs/cah_02_13.pdf.

- Understand and evaluate. Support the monitoring, evaluation and operations research of programmes, including the use of appropriate indicators, putting this information to use to inform the community and improve the quality and coverage of programmes.

The Study Group also recommended priority actions to accelerate and strengthen programming for adolescent health, including the global and regional support needed for country-level programming.

78. The CRC Committee pointed, in its General Comment No. 4 on Adolescent Health, to the dangers that early marriage and pregnancy pose to sexual and reproductive health, including HIV/AIDS. More generally, it pointed out that adolescents, both girls and boys, are at risk of being infected with and affected by sexually transmitted diseases (STDs), including HIV/AIDS. States should ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible. To this end, States Parties are urged (a) to develop effective prevention programmes, including measures aimed at changing cultural views about adolescents' need for contraception and sexually transmitted diseases (STDs) prevention and addressing cultural and other taboos surrounding adolescent sexuality; (b) to adopt legislation to combat practices that either increase adolescents' risk of infection or contribute to the marginalisation of adolescents who are already infected with STDs, including HIV; (c) to take measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care.

79. The Committee also expressed its concern about the influence exerted on adolescent health behaviours by the marketing of unhealthy products and lifestyles. In line with Article 17 of the CRC, the Committee urged States Parties to protect adolescents from information that is harmful to their health and development, while underscoring their right to information and material from diverse national and international sources. States Parties are therefore urged to regulate or prohibit information on and marketing of substances such as alcohol and tobacco, particularly when it targets children and adolescents, as provided for in the Framework Convention on Tobacco Control (2003) of the WHO.

80. Although not explicitly dealt with by the CRC Committee, there are also other potentially harmful, although less visible, effects of aggressive marketing, *i.e.* food products with false health claims (one of the most perverted examples being vitaminized sugar-rich candies!) or in other ways contributing to unbalanced and unhealthy diets; these products may be more difficult to

fight in a free market, but advocacy against disinformation to children and adolescents by the food industry should find ample support in Article 24 for States Parties who should see it as their obligation to try to set limits to promotional practices that may negatively affect the health of these groups.

2.4 *Article 24 (2)(d): 'Ensure pre- and post-natal health care for expectant mothers'*

81. States Parties are required to take measures to 'ensure appropriate pre-natal and post-natal health care for mothers'. The concept has been described to include the prevention and management of risk factors for low birth weight and premature birth; the ensuring of a clean environment for birth; the maintenance of thermal control and respiratory support; and the initiation of breastfeeding immediately after birth,[51] but it has to be seen in a wider context and requires attention also to other factors.

82. While the formulation in Article 24 (2)(d) appears to focus only on the care of the mother who will give or has given birth, the focus today is increasingly on pre- and post-natal care both for mothers *and* infants. The 1996 WHO publication containing the 'Mother-baby package'[52] states:

> *'Birth is a risky event for babies too. The complications that cause the deaths and disabilities of mothers also damage the infants they are carrying. Of 8.1 million infant deaths each year, around one-half occur during the neonatal period, i.e. before the baby is one month old. Every year, there are 4 million neonatal deaths of which two-thirds occur during the first week of life. And, for every early newborn death, at least another infant is stillborn. These perinatal and neonatal deaths are largely the result of the same factors that cause the deaths and disabilities of mothers. Newborns die or are disabled because of poor maternal health, inadequate care during pregnancy, inappropriate management and poor hygiene during delivery, during the first critical hours after birth, lack of newborn care and discriminatory care.'*

83. The importance of seeing the care of a mother and her offspring together has increased even more as new theories have been brought to the fore about the possibility that the organism of a malnourished mother may not be capable to nourish the yet unborn adequately and at the critical periods in foetal live. Contrary to what was originally believed, *i.e.* that the unborn will always draw sufficient energy and nutrients form the blood of the mother at the cost of her own malnutrition, it is now well documented that foetal

---

[51] G. Van Bueren, *The International Law on the Rights of the Child* (The Hague, Martinus Nijhoff Publishers, 1995), p. 305.

[52] *Cf. infra* No. 86.

growth will be constrained by an inadequate nutritional environment in the womb and result in a newborn that has not attained its growth potential. Such infants are therefore disadvantaged before they enter the world.

84. Furthermore, the so-called Barker hypothesis[53] postulates that several common adult diseases may be related to impaired foetal growth, and that this may be caused either by nutritional inadequacies at particular stages of pregnancy, or by disrupting genes in the very early stages of foetal life by various environmental, including nutritional, influences. The precise mechanisms are not yet known but research points to the possibility for a 'nutritional programming' for diseases such as high blood pressure, noninsulin-dependent diabetes, coronary heart disease, and cancer in adult life. Combined with the shifts in dietary patterns and lifestyle resulting from urbanisation and rapid economic development, this may accelerate the emergence of adult consequences of early undernutrition - but so can also poverty which may imply too high intakes of foods with high fat and sugar content as cheap sources of food energy but with low levels of essential nutrients such as vitamins and minerals.[54]

85. A group of international and national agencies, including UNICEF, UNFPA, the WHO, the World Bank and others co-sponsored the first Safe Motherhood Conference (Nairobi, 1987), and has worked together since then to realise the goals of the global Safe Motherhood Initiative - specifically to reduce the burden of maternal death and ill-health in developing countries. As a group and as individual organisations, these agencies raise international awareness about safe motherhood, set goals and programmatic priorities for the global initiative, support national programmes, stimulate research, mobilize resources, provide technical assistance, and share information to make pregnancy and childbirth safe. It was a global effort to reduce maternal mortality and morbidity, seeking to enhance the quality and safety of women's lives, through the adoption of a combination of health and non-health strategies:

- Ensuring women's access to health services;
- Raising women's awareness of health services;

---

[53] D.J. Barker, 'Fetal Origins of Coronary Heart Disease', *British Medical Journal*, No. 311, 1995, pp. 171-174. See also http://bmj.bmjjournals.com/cgi/collection/barker_hypothesis?notjournal=bmj and http://embryology.med.unsw.edu.au/Defect/page10.htm.

[54] *Cf. supra* No. 73.

- Promoting women's right to decide whether and when to have children, by providing access to family planning services;
- Increasing the numbers of healthcare providers (midwives, doctors, nurses and traditional birth attendants);
- Improving training for healthcare providers.

86. A decade later, in 1996, the WHO described the situation in a publication called 'Mother-baby package: Implementing safe motherhood in countries', where it was noted that much progress had been made in the last 10 years towards a better understanding of the problem of maternal mortality, but only a few countries have adopted national programmes of sufficient magnitude to make a major impact on the level of maternal mortality. The WHO therefore launched the 'Mother-baby package' as a practical guide to improve the health of the mother and infant.[55]

87. One of the most serious and difficult issues concerning the pre- and postnatal care of mother and child is the problem of mother-to-child transmission of HIV. It has been addressed by the CRC Committee in its General Comment No. 3 on HIV/AIDS.[56] The Committee points out that mother-to-child transmission (MTCT) is responsible for the majority of HIV infections in infants and young children. Infants and young children can be infected with HIV during pregnancy, labour and delivery, and through breastfeeding. To prevent MTCT of HIV, States Parties must take steps, including the provision of essential drugs, *e.g.* anti-retroviral drugs, appropriate antenatal, delivery and post-partum care, and making HIV voluntary counselling and testing services available to pregnant women and their partners. The Committee recognizes that anti-retroviral drugs administered to a woman during pregnancy and/or labour and, in some regimens, to her infant, have been shown to significantly reduce the risk of transmission from mother to child. However, in addition, States Parties should provide support for mothers and children, including counselling on infant feeding options to help mothers make informed choices of feeding methods.

In its General Comment No. 3 on HIV/AIDS, the CRC Committee reminds States Parties that counselling of HIV-positive mothers should include information about the risks and benefits of different infant feeding options, and guidance on selecting the option most likely to be suitable for their situation.

---

[55] WHO, *Implementing safe motherhood in countries* (Geneva, WHO, 1996), available at: http://www.who.int/reproductive-health/publications/MSM_94_11/MSM_94_11_table_of_contents.en.html.

[56] CRC Committee, *General Comment No. 3 on HIV/AIDS*, paras. 25–27.

Follow-up support is also required in order for women to be able to implement their selected option as safely as possible. Even in populations with high HIV prevalence, the majority of infants are born to women who are not HIV-infected. For the infants of HIV-negative women and women who do not know their HIV status, the Committee emphasizes, consistent with Articles 6 and 24 of the CRC, that breastfeeding remains the best feeding choice. For the infants of HIV-positive mothers, available evidence indicates that breastfeeding can add to the risk of HIV transmission by 10–20 per cent, but that lack of breastfeeding can expose children to an increased risk of malnutrition or infectious diseases other than HIV. Current WHO/UNICEF recommendations are that, where replacement feeding is affordable, feasible, acceptable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first months of life and should then be discontinued as soon as it is feasible. However, research in the area of vertical transmission of HIV through breastfeeding is not completed, and States should therefore consider the most recent authoritative recommendations.[57]

2.5 *Article 24 (2)(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'*

88. The primary responsibility for the protection of the child's health rests with the parents or guardians and with the child itself as it becomes sufficiently mature. It is therefore essential that the parents or guardians and the child have as complete knowledge as possible on the possible risks and the ways to avoid them, including knowledge about the health care options that are available, whether provided by the State or by private actors. The State is under an obligation to ensure that they have at least basic knowledge regarding child health and nutrition, and they must be supported in the acquisition and use of this knowledge. Several requirements flow from this provision. The State must ensure that relevant, updated knowledge is available, that this knowledge is made available to all segments of the population,

[57] These include Guideline 10(5) of the *Voluntary Guidelines to support the progressive realization or the right to adequate food in the context of national food security*, prepared by an intergovernmental working group under the FAO Committee on World Food Security in 2003–2004 and adopted by the FAO Council in November 2004.

that there is a sufficient educational level in all parts of the population to be able to absorb this knowledge, and that supporting facilities exist to make use of the knowledge.

Ensuring that relevant and updated knowledge exists, requires the existence within the State of relevant institutions which seek, systematize, analyze and disseminate the relevant knowledge. This will normally take place through an interaction between relevant government ministries, research and tertiary educational institutions, including medical faculties, nutrition institutes and various paramedical institutions to engage in research and continuously update the knowledge base. Furthermore, there must be adequate training of the health professions and community health workers, and the training must be of a kind that enables them to work both with policy makers and public authorities at all levels and with communities in mobilizing all responsible actors to enable a healthy environment for and appropriate health care of the children and of women in child-bearing age.

While it is common to put most emphasis on the role of the health system in these regards, health authorities often do not prioritize nutrition among the critical health factors, unless it concerns saving malnourished children in late stages requiring rehydration to prevent death. Preventive nutrition efforts, including nutrition education and supplementary feeding through the health system, get much less attention than they should be given when the long-term cost for the national health system of malnutrition and related disabilitating disease and loss of quality of productive life is taken into account. Economists are now taking an interest in this. Notable is the 'Nutrition and Development Series' of publications issued by the Asian Development Bank in collaboration with the International Food Policy Research Institute (IFPRI) which reviews and applies scientific evidence on nutrition impact in order, *inter alia,* to better 'target nutrition improvements at poor women and children, with benefits to families, communities and nations throughout the life cycle'.[58]

Taking into account the insufficient promotion by health ministries of nutrition as a preventive measure, it is necessary to make also other sectors

[58] Asian Development Bank, Nutrition and Development Series 2001–1004. Titles include: *Investing in Child Nutrition in Asia; Manila Forum 2000: Strategies to Fortify Essential Foods in Asia and the Pacific; Improving Child Nutrition in Asia; Attacking the Double Burden of Malnutrition in the Asia and the Pacific; What Works? A Review of the Efficacy and Effectiveness of Nutrition Interventions; The Nutrition Transition and Prevention of Diet-Related Chronic Disorders; Food Fortification in Asia: Improving Health and Building Economies*, available from: http://www.adb.org/documents/books/nutrition/default.asp.

recognize and promote the importance of nutrition to make them understand that good nutritional health among the population will have positive implications for what they are trying to achieve, and thereby make them active partners in the efforts to improve nutrition.[59] By way of example, while nutritionists are concerned about the often low iron status of children in school age in many developing countries, given its effect on lowered attentiveness and results in class and the risk of corresponding de-motivation by teachers, it may not help to work through the health system alone; rather the educational authorities must be brought to understand their responsibilities for a proper school meal (and possible iron supplementation to selected children as needed), which in turn will help the schools to succeed in their educational efforts.

89. These multiple responsibilities are reflected in the 'Global Strategy for Infant and Young Child Feeding'[60] and explicitly formulated in terms of government obligations: '*The primary obligation of governments is to formulate, implement, monitor and evaluate a comprehensive national policy on infant and young child feeding. In addition to political commitment at the highest level, a successful policy depends on effective national coordination to ensure full collaboration of all concerned government agencies, international organizations and other concerned parties. This implies continual collection and evaluation of relevant information on feeding policies and practices. Regional and local governments also have an important role to play in implementing this strategy*'.[61] It advocates detailed action plans to accompany the comprehensive policy including defined goals and objectives, a timeline for their achievement, and – most importantly – allocation of responsibilities for the plan's implementation and measurable indicators for its monitoring and evaluation.

90. The Strategy points out that other concerned parties must also be involved, ranging from health professional bodies to health workers including midwives, nurses, nutritionists and dieticians, and a variety of non-governmental groups. The strategy lists charitable and religious organisations, consumer associations, mother-to-mother support groups, family clubs, and

---

[59] UN System Standing Committee on Nutrition and International Food Policy Research Institute, *Nutrition - a Foundation for Development. Twelve Policy Briefs* (Geneva and Washington D.C., SCN and IFPRI, 2003). These are briefs on of the latest research findings in nutrition as they relate to other development sectors, designed to facilitate dialogue between nutrition and other development professionals. Available from: http://www.unsystem.org/SCN/Publications/html/publications.html.

[60] *Cf. supra* No. 76.

[61] Global Strategy for Infant and Young Child Feeding, para. 35.

child-care cooperatives.[62] Commercial enterprises as manufacturers of industrially processed foods intended for infants and young children should ensure that such foods comply with international standards and those producing breastmilk substitutes must ensure that their marketing practices comply with the principles and aim of the International Code of Marketing of Breast-milk Substitutes and subsequent WHA resolutions.[63] Employers should ensure that maternity entitlements of all women in paid employment are met, including breastfeeding breaks or other workplace arrangements, in accordance with the ILO Maternity Protection Convention and Recommendation. Trade unions have a direct role in negotiating this and security of employment for women of reproductive age.[64]

91. In ensuring basic knowledge of child health and nutrition, the Strategy underlines that the advantages of breastfeeding should be given a prominent attention. Whenever possible there should be exclusive breastfeeding for six months of age. 'Exclusive' means that there should be no other intake whatsoever in terms of water or other drinks or any form of solid food. Only then will the breastmilk have maximum protective value against infections through the effect of its own natural content of antibodies. In settings where water is unsafe and hygiene and sanitation is unsatisfactory, exclusive breastfeeding is also the only way to remedy risks of contamination. In all settings there is also the risk of intrinsic pathogenic contamination of replacement products, such as powdered infant formula. Appropriate complementary feeding after six months of age is of no less importance. During the first years of life, the child should whenever possible be fed several times a day due to their limited stomach capacity to handle sufficient food for their energy needs per meal. During that period it is therefore also essential that the child's diet is sufficiently energy dense (high in calories per volume unit of food), and that it contains the appropriate mix of micronutrients - minerals and vitamins - for healthy development, reduced

[62] *Ibid.*, paras. 40–43. It is important not to rely on the health system alone in providing support to breastfeeding mothers as it may currently in many countries not have the sufficient *capacity* for adequate support. As expressed by one commentator: '*The almost 50 years history of La Leche League and the other women's organizations around the world amply demonstrate that it is NOT necessary to be a health worker to be able to support adequate breastfeeding practice. In fact, much of the energy of these volunteers is spent trying to undo the damage that uninformed health workers impose on uninformed mothers*'. This makes it all the more important to change this situation. See http://www.pronutrition.org/archive/200310/msg00012.php.

[63] Global Strategy for Infant and Young Child Feeding, para. 44.

[64] *Ibid.*, para. 45.

susceptibility of disease and lower mortality from childhood diseases. Sufficient vitamin A to prevent deaths from common childhood diseases like measles is a particular case in point.

92. Good nutrition does not come about merely by giving nutritious food, although this of course remains essential. Equally important is the concept of adequate care – which typically includes the need for sufficient time for frequent and peaceful child feeding but also the psychological stimulus that ought to go with it, as well as the importance of actively preventing disease so that the child can fully utilize the food offered to it (thus being without fever, diarrhoea or other things that will interfere with intake of food and its digestion and utilisation in the body).

93. Still, the content of the nutrition messages and advice must not be seen in isolation from the opportunities available to follow it. As set out in Article 24 (2)(e), the mother must be supported in the use of the knowledge. An often cited example is when the requirement for frequent young child feedings during the day clashes with rural mothers' need to use time in the fields or, like typically urban mothers, in income generating activities leaving their children with grandparents or siblings (who may thereby themselves be prevented from going to school). Support in the use of the knowledge can be arranged in several ways and can most often be relatively simple and low-cost: ensuring crèches at work places, mobilizing simple kindergartens in the communities with mothers rotating in taking responsibility for guarding, caring and feeding, and education of grandmothers rather than only mothers, to mention some.

94. While almost all women can breastfeed their children, cultural and societal obstacles often hinder many of those wishing to do so. A broader awareness must be promoted in order to achieve active support for the lactating mothers as a joint responsibility or duty of society as a whole to help infants enjoy their right to breastmilk as the most fully adequate food and specific to the human species and which also enables them to enjoy the highest attainable physical and mental health, on the one hand, from its protective functions against infections and the ideal nutritional composition and important growth factors and, on the other hand, from the warmth, love and intimacy with the mother through the act of nursing. A number of responsible actors come into play, including the family and above all the husband, the health care institutions and others. The CRC Committee often calls on State Parties to promote breastfeeding and to strengthen the implementation of the International Code of Marketing on Breastmilk

Substitutes.[65] An especially successful initiative has been the Baby-Friendly Hospital Initiative (BFHI) (WHO/UNICEF, 1992) launched by WHO and UNICEF, which is based on the 'Ten Steps to Successful Breastfeeding' prepared by WHO and UNICEF in 1989.

95. Support in the use of appropriate knowledge is needed in various forms and at all subsequent levels during young childhood and adolescence, based on national action plans which should promote a holistic approach to ensuring appropriate food supplies and information about food choices for good health and physical and mental wellbeing. Contradictory policies should be avoided, such as when health promoting worldwide activities to improve the nutrition of schoolchildren by promoting increased intake of fruit and vegetables among children in school age - so far predominantly in Europe and North America by ensuring both availability and education about its health benefits – are being counteracted by schools establishing high sugar containing drink vendors on the school premises.

96. There are several channels for the dissemination of knowledge: the more conventional but still most important ones are the regular educational system, in particular through primary and early secondary school education, and the networks of health care institutions. Nutrition education and other health promotion has however often focussed on the message alone without taking into account the changing environments affecting children's and adolescents' perceptions and behaviour. Research to understand these critical factors must be strengthened everywhere to capture the critical factors at play in particular local settings. When mothers do not immediately follow advice it is often not a question of ignorance or unwillingness to do the best for the child, but the lack of capacity to do so, for example in terms of access to resources and the availability of time to care for the child due to the many competing demands on the woman in the balance between reproductive and productive activities for the household and family as a whole. One promising avenue in some developing countries is to link nutrition and other health education to micro-credit schemes for women, combining the opportunity to increase resources and knowledge about how to utilise them in the best interests of their children.[66]

---

[65] See *e.g.* CRC Committee, *Concluding Observations: China* (UN Doc. CRC/C/15/Add.271, 2005), para. 63.

[66] In 1988, the NGO 'Freedom from Hunger' (based in Davis, California) developed the world's first integrated microcredit/health and nutrition education program. Today, its 'Credit with Education' program is serving over 176,000 families in some of the poorest countries on earth. See http://www.freefromhunger.org.

97. The pivotal role of the regular educational institutions must be emphasized. It is essential that every child has access to adequate education, as required by Article 28 and 29 of the CRC. The CRC Committee points out, in General Comment No. 1 para. 9, that education must also be aimed at ensuring that essential life skills are learnt by every child and that no child leaves school without being equipped to face the challenges that he or she can expect to be confronted with in life.[67] A positive contribution would be the establishment of school gardening, as strongly promoted by FAO.

There are still serious shortcomings in the access to education, mainly linked to poverty and underdevelopment but also due to traditional practices. Particularly serious is the unsatisfactory level of educational attendance by girl children. This undermines the capacity, when the girl grows up to become a mother, to provide adequate health information to her child. In its place, the mother sometimes transmits habits and traditional practices which can be harmful to the child, including those preventing exclusive breastfeeding during the first months of life. The low level of educational attendance by girls in some societies also put the adolescent girl child at considerable risks due to insufficient health-related knowledge.

Ensuring education for all and in particular ensuring education for all girls is therefore an essential contribution to the advancement of child health. But it is also important to ensure that the content of education is such that it does address the significant issues related to health. Among issues which need attention is the need for adequate knowledge on reproductive health and sex education. There are still in some societies problems of resistance to adequate education about reproductive health, including knowledge about family planning and contraception, and lack of support in the use of such knowledge due to difficulties in access to condoms and other devices for contraception and prevention of infection.

98. The HIV/AIDS epidemic has placed this problem, and ways to overcome it, high on the international agenda. The CRC Committee has pointed out in its General Comment No. 3 on HIV/AIDS[68] that education can and should empower children to protect themselves from the risk of HIV infection. The Committee emphasizes that effective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting

---

[67] CRC Committee, *General Comment No. 1: The Aims of Education* (UN Doc. CRC/GC/2001/1, 2001).

[68] CRC Committee, *General Comment No. 3 on HIV/AIDS*, particularly section 'A. Information on HIV prevention and awareness-raising', paras. 16 and 17.

health-related information, including sexual education and information, and that, consistent with their obligations to ensure the right to life, survival and development of the child (Article 6 of the CRC), States Parties must ensure that children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality. States Parties must make efforts to address gender differences as they may impact on the access children have to prevention messages, and ensure that children are reached with appropriate prevention messages even if they face constraints due to language, religion, disability or other factors of discrimination. Particular attention must be paid to raising awareness among hard-to-reach populations. Children should have the right to access adequate information related to HIV/AIDS prevention and care, through formal channels, *e.g.* through educational opportunities and child-targeted media, as well as informal channels targeting street children, institutionalized children or children living in difficult circumstances. Children require relevant, appropriate and timely information which recognizes the differences in levels of understanding among them, is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality in order to protect themselves from HIV infection.

2.6 *Article 24 (2)(f): 'develop preventive health care, guidance for parents, and family planning education and services'*

Preventive health care

99. Primary health care, discussed above,[69] includes both measures of prevention, cure and rehabilitation. Prevention includes a wide range of activities, from education and information on health risks and ways to avoid them, to more direct measures to support persons in avoiding risks in specific settings.

Family planning education and services

100. Family planning education and services have major implications for the health of the child. Family planning depends heavily on the empowerment of the woman to control her reproductive health and to ensure adequate child spacing. Ensuring gender equity and equality, and the empowerment of women depends in part on overcoming cultural, social and economic constraints that limit women's access to education, as well as providing

[69] *Cf. supra* No. 54–60.

universal access to reproductive health services that allow them to control their fertility. Large families dilute the assets of poorer households, and unwanted births deepen household poverty. Smaller families allow more investment in each child's education and health.

At the international level the most important organisation addressing these issues is the United Nations Family Planning Association. At the 1994 International Conference on Population and Development (ICPD) in Cairo, 179 countries agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. The conference adopted a 20-year Programme of Action, which focused on individuals' needs and rights, rather than on achieving demographic targets.

Advancing gender equality, eliminating violence against women and ensuring women's ability to control their own fertility were acknowledged as cornerstones of population and development policies. Concrete goals of the ICPD Programme of Action centred on providing universal education; reducing infant, child and maternal mortality; and ensuring universal access by 2015 to reproductive health care, including family planning, assisted childbirth and prevention of sexually transmitted infections including HIV/AIDS.

101. In 1999, the United Nations General Assembly convened a special session to review progress towards meeting the goals. After reviewing the topics highlighted in the ICPD Programme of Action, the special session (known as ICPD+5) agreed on a new set of benchmarks. One of them related to 'Reproductive health care and unmet need for contraception'.

The UN General Assembly recommended that '*[. . .] Governments should strive to ensure that by 2015 all primary health care and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods (such as male and female condoms and microbicides if available) to prevent infection. By 2005, 60 per cent of such facilities should be able to offer this range of services, and by 2010, 80 per cent of them should be able to offer such services*'.[70] Furthermore it recommended: '*Where there is a gap between contraceptive use and the proportion of individuals expressing a*

[70] Resolution of the UN General Assembly of 2 July 1999, *Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development* (UN Doc. A/RES/S-21/2, 1999), para. 53.

desire to space or limit their families, countries should attempt to close this gap by at least 50 per cent by 2005, 75 per cent by 2010 and 100 per cent by 2050. In attempting to reach this benchmark, demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients.'[71]

HIV/AIDS

102. In recent years, the HIV/AIDS epidemic has emerged as a major challenge both to preventive and curative health care, and many new international conferences have been held to adopt measures for the prevention of the spread of the epidemic as well as care for the persons affected and of their dependents. In 2001, the United Nations General Assembly again convened a special session on this issue. In the Declaration of Commitment on HIV/AIDS,[72] the General Assembly recommended that States shall ensure, by 2005, a wide range of prevention programmes.

103. The prevention shall include information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity. In addition, the prevention shall include expanded access to essential commodities, including male and female condoms and sterile injecting equipment, as well as harm-reduction efforts related to drug use, expanded access to voluntary and confidential counselling and testing, safe blood supplies, and early and effective treatment of sexually transmittable infections.

104. The Assembly called on States to ensure that by 2005 at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection, in full partnership with young persons, parents, families, educators and health-care providers.

In the same resolution, the General Assembly also set targets for substantial reduction of infants infected with HIV by ensuring that pregnant women accessing antenatal care have information, counselling and other HIV

[71] *Ibid.*, para. 58.

[72] Adopted by UN General Assembly resolution of 27 June 2001 (UN Doc. S-26/2, 2001) under the heading 'Global crisis - global action'.

prevention services available to them, and by increasing the availability of and providing access for HIV-infected women and their babies to effective treatment to reduce mother-to-child transmission of HIV, as well as through effective interventions for HIV-infected women, including voluntary and confidential counselling and testing, and access to treatment, especially anti-retroviral therapy.

3. *Article 24 (3): 'States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'*

105. While there may be several traditional practices harmful to children within some cultures,[73] the main issue in focus during the negotiations and undoubtedly the most serious one is the phenomenon of female genital mutilation. The victims of those mutilations are mainly young adolescent girls. In WHO Fact sheet No. 241 on Female Genital Mutilation,[74] the long-term consequences of FGM are said to include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, dyspareunia (painful sexual intercourse) and sexual dysfunction and difficulties with childbirth. It also has consequences for psychosexual and psychological health: genital mutilation may leave a lasting mark on the life and mind of the woman who has undergone it. In the longer term, women may suffer feelings of incompleteness, anxiety and depression.

106. The Office of the United Nations High Commissioner for Human Rights has produced an information document entitled Fact Sheet No. 23, concerning Harmful Traditional Practices Affecting the Health of Women and Children.[75] It describes studies and measures conducted by the United Nations, including an action plan adopted by the Sub-Commission on Prevention of Discrimination and Protection of Minorities in its resolution 1994/30 of 26

---

[73] *E.g.* in its Concluding Observations on Nepal, the Committee notes with concern that certain harmful traditional practices continue to prevail in the State Party, most notably the caste system and traditions such as the *Deuki, Kumari, Jhuma, Badi, Kamlari* and *Chaupadi,* causing extreme insecurity, health hazards and cruelty to girl children, and expressed its regret at the absence of legal prohibition and sufficient interventions on the part of the State Party to address harmful effects of these traditional practices: CRC Committee, *Concluding Observations: Nepal* (UN Doc. CRC/C/15/Add.261, 2005), para. 67.

[74] WHO, *Fact sheet No. 241: Female Genital Mutilation* (Geneva, WHO, 2000), available at http://www.who.int/mediacentre/factsheets/fs241/en/index.html.

[75] OHCHR, *Fact sheet No. 23: Harmful Traditional Practices Affecting the Health of Women and Children,* available at http://www.ohchr.org/english/about/publications/docs/fs23.htm.

August 1994. The action plan recommends the adoption at national level of legislation prohibiting practices harmful to the health of women and children, particularly female genital mutilation. Governmental bodies should be created to implement the official policy adopted and be involved in activities undertaken to combat such practices. Courses on the ill effects of female genital mutilation and other traditional practices should be included in training programmes for medical and paramedical personnel. Instruction on the harmful effects of such practices should be included in health and sex education programmes.

107. The Committee on the Elimination of Discrimination of Women (CEDAW) requested in its General Recommendation No. 14[76] that States include in their national health policies appropriate strategies aimed at eradicating female circumcision in public health care. Such strategies could include the special responsibility of health personnel, including traditional birth attendants, to explain the harmful effects of female circumcision.

108. The World Health Assembly adopted in 1994 its resolution WHA47.10, entitled 'Maternal and child health and family planning: Traditional practices harmful to the health of women and children'. In this resolution, the Assembly urged all member States to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation, childbearing before biological and social maturity, and other harmful practices affecting the health of women and children.

Under the African Union, the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, which brings together 26 African countries and four affiliated European countries, adopted in 2003 a 'Common Agenda to achieve Zero Tolerance to FGM' and declared February 6 as the 'International Day of Zero Tolerance to FGM'. The CRC Committee remains concerned, however, that in some African countries FGM is not specifically prohibited by law and is still widely practiced.[77]

109. The Parliament of the Council of Europe has in its resolution 1247 (2001) on female genital mutilation called on governments *inter alia* (i) to introduce specific legislation prohibiting genital mutilation and declaring genital mutilation to be a violation of human rights and bodily integrity; (ii) to take steps to inform all people about the legislation banning the

[76] CEDAW Committee, *General Recommendation No. 14: Female Circumcision*, available at http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom14.

[77] See *e.g.* CRC Committee, *Concluding Observations: Uganda* (UN Doc. CRC/C/15/Add.270, 2005), para. 55.

practice before they enter Council of Europe Member States; (iii) to adopt more flexible measures for granting the right of asylum to mothers and their children who fear being subjected to such practices; (iv) to adopt specific time limits for prosecution that enable the victims to go to court when they reach the age of majority, and to grant organisations the right to bring action; (v) to prosecute the perpetrators and their accomplices, including family members and health personnel, on criminal charges of violence leading to mutilation, including cases where such mutilation is committed abroad; (vi) to conduct information and public awareness-raising campaigns to inform health personnel, refugee groups and all groups concerned by this question about the dangerous consequences of genital mutilation for the health, physical well-being and dignity of the women concerned, about their right to personal fulfilment and about the customs and traditions that are in contradiction with human rights.

4. *Article 24 (4): 'States Parties undertake to promote and undertake international cooperation with a view to achieving progressively the full realisation of the right recognized in this Article. In this respect, particular account shall be taken of the needs of developing countries'*

110. All members of the United Nations have undertaken commitments under Articles 55 and 56 of the UN Charter to cooperate in order to achieve solutions, *inter alia*, of international economic, social, health and related problems. It is broadly recognized that the realisation of health requires intensive cooperation both inside countries and between countries. Taking into account the multidimensional factors which influence conditions of health in each of the national societies and in the world at large, many different agencies have to be involved, since health requires action on a very broad front.

111. There are two aspects to the requirement set out in Article 24(4) of the CRC. The first is to in general promote and make use of international cooperation in order to facilitate the protection and the full realisation of the right of the child to health; the second is to take special measures to meet the needs of the developing countries, many of whom will be in need of international assistance to secure for all their children the highest attainable standard of health.

112. Several United Nations agencies and programmes have important roles to play in both regards. The key function assigned to WHO in realizing the

right to health at the international, regional and country levels, is of paramount importance. Among other UN programmes and funds, UNICEF plays a prominent role regarding nutrition and health rights of the child. The United Nations Development Programme and the United Nations Population Fund also have essential roles to play. In regard to HIV/AIDS, the UNAIDS is the main framework of cooperation.

113. The role of these agencies is reflected in Article 45 of the CRC, according to which the specialized agencies, UNICEF and other United Nations organs shall be entitled to be represented during the meetings of the CRC; the Committee may also invite them to provide expert advice on the implementation of the Convention, and the Committee may invite them to submit their own reports on the implementation of the Convention in areas falling within the scope of their activities.[78] Additionally, the Committee 'shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications'.[79]

114. The choice of appropriate health-related policies, both preventive and curative, is under continuous discussion in the WHO, and guidelines and recommendations are elaborated as new insights and needs emerge or are recognized. When formulating and implementing their national strategies on the right to health, States Parties should avail themselves of technical assistance and cooperation of WHO. This is particularly important for those developing countries that have limited capacity for research and knowledge-based policy formulation regarding some of the more difficult areas of health. Under Article 15 of the CESCR, everyone has the right to benefit from the advances in science and technology; the international agencies may play an important role in making those advances generally known and accessible. States Parties should also utilize the extensive information and advisory services of WHO with regard to data collection, disaggregation, and the development of right to health indicators and benchmarks.

115. The incidence of HIV/AIDS, tuberculosis and other infectious diseases is higher in Africa than in any other part of the world. This fact is connected to Africa's many other problems. Africans are vulnerable to these diseases

[78] Article 45 (a) of the CRC.
[79] Article 45 (b) of the CRC.

because most of them are poor and undernourished. They are too often uninformed of basic precautions, or unwilling to take them. Many of them have no access to basic health care, and they are particularly vulnerable because they do not have safe drinking water or sanitation. There is therefore a particular importance to provide assistance to African countries.

To address some of the most serious problems, a 'Global Fund to Fight AIDS, Tuberculosis and Malaria' was set up in 2002, based on a recommendation to that effect by a Special Session of the United Nations in 2001 to address the problem of HIV/AIDS. Several initiatives have since been launched in regard to these illnesses which severely endangers the health of the African child.

One example is a project by the Measles Initiative – a partnership between a range of international agencies and national organisations – to combine mass immunisation against measles, which is one of the major causes of child mortality in Africa, with the distribution of insecticide-treated bednets (ITNs) to fight death and disease due to malaria, especially in Africa south of the Sahara, which accounts for 90% of deaths due to malaria worldwide. Those most at risk of death due to malaria are young children and pregnant women. This could be substantially reduced if they could sleep under insecticide-treated bednets. Unfortunately, people who are most in need of these bednets do not know about them, do not have access to them, or cannot afford them. Their unit cost of $5 is high for a rural African family. Through international assistance, this simple tool could significantly protect the health both of pregnant women and of children.[80] Globally, the GAVI — Global Alliance for Vaccines and Immunization — was formed in 2000 as a public-private partnership "to harness the strengths and experience of multiple partners in immunization", committed to saving children's lives and protecting people's health through the widespread use of vaccines. As an alliance of major leaders in international health and development GAVI has a potential to influence decision making among policy makers and donors on the value of vaccination for reducing poverty and infant mortality in the developing world.[81]

116. In his reform program to the United Nations presented on March 21, 2005, the Secretary General called on member States to launch, in 2005, an International Financial Facility to support an immediate front-loading of

[80] Reported in the American Red Cross publication 'In the News', 27 September 2004.

[81] See further at http://www.vaccinealliance.org/General_Information/About_alliance/index.php.

official development assistance, underpinned by commitments to achieve the 0.7 per cent ODA target no later than 2015, and also to consider other innovative sources of finance for development to supplement the Facility in the longer term. Furthermore, to launch a series of 'quick win' initiatives so as to realize major immediate progress towards the Millennium Development Goals through such measures as the free distribution of malaria bednets and effective antimalaria medicines, the expansion of home-grown school meals programmes using locally produced foods and the elimination of user fees for primary education and health services. Additionally, the Secretary-General has called on States to ensure that the international community urgently provide the resources needed for an expanded and comprehensive response to HIV/AIDS, as identified by UNAIDS and its partners, and full funding for the Global Fund to fight AIDS, tuberculosis and malaria.[82]

117. The international financial institutions, notably the World Bank and the International Monetary Fund, should pay greater attention to the protection of the right to health in their lending policies, credit agreements and structural adjustment programmes.[83]

118. As pointed out in General Comment No. 14 of the CESCR Committee, the role of the WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as international non-governmental organisations is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population. It should be added that special attention should be given to children and pregnant or breastfeeding women.

[82] UN Secretary-General, *In larger freedom: towards development, security and human rights for all. Report of the Secretary-General* (annex to UN Doc. A/59/2005, 2005).

[83] A recent report of the World Bank: "Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action" argues for greater invesment in nutrition and broader interventions by countries in nutrition programmes: "While world hunger gets more political attention, addressing malnutrition is in fact a key of poverty reduction in developing nations. Poor nutrition reflects the non-income face of poverty and has substantive long-term impacts on economies in developing countries." A rights-based approach to such action could well be a test-case whether the World Bank is ready to explicitly incorporate principles of human rights into its portfolio.