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### Annual report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary-General

Promotion and protection of all human rights, civil,  
political, economic, social and cultural rights,  
including the right to development

## Report of the United Nations High Commissioner for Human Rights on the right of the child to the enjoyment of the highest attainable standard of health

### *Summary*

Despite progress, child health remains a significant concern throughout the world. The present report describes the main health issues that affect children. It contains an analysis of the obligations of States and other duty-bearers with regard to children's right to health, and recommendations to ensure the realization of that right. The report stresses that the survival, protection, growth and development of children in good physical and emotional health are the foundations of human dignity and human rights.

## Contents

	<i>Paragraphs</i>	<i>Page</i>
I. Introduction .....	1–2	3
II. Children’s health: a global priority .....	3–8	3
III. International legal framework .....	9–25	4
IV. Health issues relating to children requiring attention .....	26–66	7
A. Pregnancy, delivery and postnatal care .....	28–32	7
B. Child mortality .....	33–39	8
C. Malnutrition .....	40–45	9
D. Harmful practices .....	46–47	10
E. Sexual and reproductive health .....	48–53	10
F. Violence .....	54–56	11
G. Injuries, accidents and disabilities .....	57–59	12
H. Mental health .....	60–62	12
I. Substance use .....	63–66	13
V. Measures for implementation .....	67–88	13
A. Accountability .....	67–68	13
B. Health systems .....	69–77	14
C. Laws and policies .....	78–80	15
D. Birth registration .....	81–82	15
E. Parents and caregivers .....	83–84	16
F. Education .....	85–87	16
G. International cooperation .....	88	16
VI. Recommendations .....	89–109	17

## I. Introduction

1. The present report is submitted to the Human Rights Council pursuant to resolution 19/37, in which the Council invited the Office of the United Nations High Commissioner for Human Rights (OHCHR) to prepare a report on the right of the child to the enjoyment of the highest attainable standard of health, in close collaboration with relevant stakeholders, including States, the United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and other relevant United Nations bodies and agencies, relevant special procedures mandate holders, regional organizations and human rights bodies, civil society, national human rights institutions and children themselves, and to present it to the Council at its twenty-second session, to inform the annual day of discussion on children's rights.

2. A total of 112 contributions were received for the study from States, intergovernmental and non-governmental organizations, national human rights institutions and academia. On 30 and 31 October 2012, OHCHR organized an expert consultation to gather input from stakeholders. The wealth of information obtained from written submissions, a research document and the views of experts participating in the consultation were used in the preparation of the present report.<sup>1</sup>

## II. Children's health: a global priority

3. The right to health is a universal human right recognized by the Universal Declaration of Human Rights, article 12 of the International Covenant on Civil and Political Rights and article 24 of the Convention on the Rights of the Child. The realization of the right of the child to health is indispensable for the enjoyment of all other rights in the Convention. The survival, protection, growth and development of children in good physical and emotional health are the foundations of human dignity and human rights.

4. Childhood is a unique moment of growth and development, but also a time when the child may be affected by serious health problems. Risky forms of behaviour and experimentation associated with adolescence may also have serious health consequences.

5. It is important to look at child health through a life-course approach, consistent with a rights-based approach, starting from the neonatal stage to childhood through adolescence and into adulthood. Child mortality has been reduced, but remains unacceptably high; 6.9 million children die every year before they reach their fifth birthday. In addition, an estimated 2.6 million people aged between 10 and 24 years of age die every year. Most of these deaths are preventable.

6. The burden of morbidity among children is another important concern. Patterns of disease vary according to gender, age, geography and other categories. Furthermore, certain groups of children, particularly those in most difficult circumstances, warrant special attention. Recognizing these variations in disease patterns is critical to tailoring appropriate responses to children's needs.

7. Childhood illness can have sequelae well into adulthood, and behaviour patterns developed during childhood can continue in adulthood. Nearly two thirds of premature deaths and one third of the total disease burden in adults are associated with conditions or

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<sup>1</sup> For more information, see [www.ohchr.org/EN/Issues/Children/RightHealth/Pages/righttohealthindex.aspx](http://www.ohchr.org/EN/Issues/Children/RightHealth/Pages/righttohealthindex.aspx).

forms of behaviour initiated as young people, including tobacco use, unhealthy nutritional habits, lack of physical activity, unprotected sexual relations or exposure to violence. In addition, the dangers and risks of local environmental pollution for child health must also be borne in mind.

8. The submissions received and the discussions held during the expert consultation confirmed that, despite progress, child health remains a significant concern throughout the world. Some areas of common concern require special attention, including malnutrition, violence, injuries and accidents, mental health, substance use, adolescent sexual and reproductive health, and education for healthy behaviour. In resource-limited settings, additional attention to pneumonia, diarrhoea and other communicable diseases should also be prioritized.

### **III. International legal framework**

9. The Convention on the Rights of the Child, the main international instrument for the promotion and protection of the rights of the child, applies to children in all circumstances. Children everywhere, whether in the developed world, in developing countries or in countries in conflict, are entitled to the same protection of their rights, including the right to health. In conformity with article 1 of the Convention, the right of the child to health applies to any human being below the age of 18.

10. Beyond the Convention on the Rights of the Child and the Optional Protocols thereto, all other core human rights treaties with health-related provisions apply to both adults and children and, as such, constitute additional sources of guidance for fulfilling the right of the child to health. These include, inter alia, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Rights of Persons with Disabilities, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and the conventions of the International Labour Organization (ILO) relevant to child labour, namely the Minimum Age Convention, 1973 (No.138) and the Worst Forms of Child Labour Convention, 1999 (No. 182).

11. The right to health is a universal human right recognized by the Universal Declaration of Human Rights and by article 12 of the International Convention on Economic, Social and Cultural Rights. The interpretation of article 24 of the Convention on the Rights of the Child should take into account the guidance provided by the Committee on Economic, Social and Cultural Rights in its general comment No. 14, as some of the obligations of the State directed at fulfilling the right of the child to health coincide with general obligations stemming from the universal right to health. The right of the child to health is an inclusive right that is also informed by the Constitution of the World Health Organization, in which health is defined as a state of complete physical, mental and social well-being, rather than merely the absence of disease or infirmity.

12. In article 24 of the Convention on the Rights of the Child, State parties to the Convention recognize the right of the child to the enjoyment of the highest attainable standard of health and strive to ensure that no child is deprived of his or her right of access to health-care services. Moreover, States parties are required to take appropriate measures to diminish infant and child mortality, to ensure appropriate prenatal and postnatal health care for mothers, and to combat disease and malnutrition. State parties are also obliged 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. In addition, States parties are also required to take all effective and appropriate measures with a view to abolishing practices that are harmful to the health of children.

13. The Committee on the Rights of the Child regularly raises the issue of the right of the child to health in its dialogue with State parties, and makes recommendations for them in this regard. The Committee also refers specifically to this right in several of its general comments, including Nos.3 (HIV/AIDS), 4 (adolescent health), 7 (early childhood), 13 (the right of the child to freedom from all forms of violence), 12 (the right of the child to be heard) and 10 (children's rights in juvenile justice).

14. The Convention on the Rights of the Child recognizes the interdependence and indivisibility of all the rights contained therein; the realization of the right to health is therefore indispensable for the enjoyment of all the other rights, and achieving the right to health is dependent on the realization of many other rights in the Convention. If a child is ill and does not have access to health-care services, the child cannot go to school and his or her right to education (art.28) will be effectively denied. Similarly, if other rights outlined in the Convention, such as the right to be free from violence (art.19) are not realized, there will be an immediate and negative impact on the child's right to health. Other rights intrinsically linked to the realization of the right to health include the right to life and the right to non-discrimination, as well as the right to be protected from work that is likely to be harmful to the child's health (art.32), the right to be free from sexual exploitation and sexual abuse (art.34) and the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment (art.37). The right to play (art.31) also becomes crucial when discussing children's health, as play has been proven essential to the emotional and physical health and well-being of the child.

15. In accordance with general comment No. 14 of the Committee on Economic, Social and Cultural Rights, the right of the child to health should not be construed as the right to be healthy as such, but rather as the right to conditions and services that ensure the enjoyment of the best health standards attainable under existing circumstances. Such an approach to health situates the realization of the right to health within the broader framework of international human rights obligations. The notion of the "highest attainable standard of health" takes into account both the child's biological, social, cultural and economic preconditions and the resources available to the State, supplemented by resources made available by other sources, including non-governmental organizations, the international community and the private sector.

16. The right of the child to health comprises a constituent set of freedoms and entitlements. The freedoms, of increasing importance according to growing capacity and maturity, include the right to control one's health and body. The entitlements include access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health. In addition to the provision of health information and services, the right to the highest attainable standard of health includes, inter alia, ensuring access to the services and programmes necessary to address the underlying determinants of health.

17. In addition, the implementation of any of the rights of the Convention, including the right to health, must be guided by the four general principles that constitute the main pillars of the Convention on the Rights of the Child.

### **Equality and non-discrimination**

18. In order to achieve the full realization of the right to health for all children, States have an obligation to ensure that children's health is not undermined by discrimination. A number of grounds on which discrimination is proscribed are outlined in article 2 of the

Convention on the Rights of the Child, including the child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. These grounds also encompass sexual orientation and health status, including HIV/AIDS and mental health. Gender-based discrimination is particularly pervasive, affecting a wide range of outcomes, from sex ratio imbalances to gender stereotyping and access to child health-related services. Attention should be paid to the differing needs of girls and boys and the impact of gender-related social norms and values. In many countries, gender inequality and discrimination influence the girl child's access to nutrition and health care from a very early age, which has a long-lasting impact on her health and development. Similarly, discrimination on the basis of sexual orientation and gender identity has a negative impact on the implementation of the child's right to health.

19. Children are a heterogeneous population and their health priorities vary, depending on a range of factors. Beyond proscribed grounds for discrimination, it is important to recognize the disproportionate vulnerability and ill health of certain groups of children. There is a need to ensure that there is no discrimination against these groups of children, including, *inter alia*, children with disabilities or chronic illness; migrant children and children left behind; minority and indigenous children; children in street situations, an institution or without parental support; working children, including those performing work likely to be harmful to their health; child victims of violence, sexual exploitation and abuse; refugee children and children affected by conflict situations, foreign occupation and emergencies; children who have not had their births registered; children who are lesbian, gay, bisexual, transsexual or intersex; children living in families and communities where drug abuse is common; children subjected to harmful practices; and children living in remote areas, in socio-economically disadvantaged urban areas and in situations of extreme economic deprivation.

#### **Best interests of the child**

20. Article 3 of the Convention on the Rights of the Child places an obligation on public and private social welfare institutions, courts of law, administrative authorities and legislative bodies to ensure that the best interests of the child are a primary consideration in all actions affecting children. This includes decisions relating to the allocation of resources and the development and implementation of policies, interventions and services that affect the underlying determinants of their health. Individual children's best interests should be based on best public health practices grounded in evidence, children's ascertainable wishes and feelings (art.12), their physical, emotional and educational needs, age, sex, background, relationship with caregivers and other relevant characteristics.

#### **Right to life, survival and development**

21. Article 6 of the Convention not only recognizes the inherent right to life, but also asserts the duty of the State to ensure the survival and development of the child, including the physical, mental, spiritual and social dimensions of their development.

#### **Respect for the views of the child**

22. Article 12 of the Convention provides for children to express their views and to have such views seriously taken into account; this includes their views on all aspects of health provision. Children's evolving capacities have important implications for when they can take part in, and eventually make autonomous decisions about, health, including their access to health services, if necessary without parental consent. On the basis of their evolving capacities and maturity, children should have access to confidential counselling

and advice without parental or legal guardian consent, where this is in the child's best interests.

23. As described by the Committee on Economic, Social and Cultural Rights in its general comment No.14, health services and programmes, including for children, should comply with a number of criteria, including availability, accessibility, acceptability and quality. The realization of the right of the child to health requires the availability of functioning child health facilities, goods, services and programmes, in sufficient quantity. This includes sufficient hospitals, clinics, health practitioners, mobile teams and facilities, community health workers, equipment and essential drugs to provide all children within the State with health care. Sufficiency should be measured according to need, with particular attention given to underserved and hard-to-reach populations.

24. Accessibility has four dimensions:

(a) Non-discrimination: Health and related services, equipment and supplies must be accessible to all children, pregnant women and mothers, in law and in practice, without discrimination of any kind;

(b) Physical accessibility: Health facilities must be within an accessible distance for all children, pregnant women and mothers. It may require additional attention to the needs of children with disabilities;

(c) Economic accessibility: Lack of ability to pay for services, supplies or medicines should not result in the denial of access. States should create safety nets allowing poor populations access to services where and when critically needed, regardless of their ability to pay. This may include abolishing user fees and implementing health financing systems that do not discriminate against the poor for their inability to pay;

(d) Information accessibility: Information on health promotion, health status and treatment options should be provided to children and their caregivers in a language and format that is accessible and clearly understandable and culturally suited to them.

25. In the context of the child's right to health, acceptability implies that all health-related facilities, goods and services should be designed and used in a way that takes into full account and is respectful of medical ethics, as well as the child's needs, expectations, culture and language. Health-related facilities, goods and services should be scientifically and medically appropriate and of good quality.

#### **IV. Health issues relating to children requiring attention**

26. The health concerns of an ever-increasing population of people aged between 0 and 19 years, currently estimated at 2.5 billion worldwide, must be afforded appropriate attention.

27. According to ILO, 115 million children are engaged in work that is likely to harm their health, safety or morals and that should be prohibited for anyone under the age of 18. Children involved in hazardous work are highly exposed to work-related illnesses and injuries.

##### **A. Pregnancy, delivery and postnatal care**

28. Ensuring that children are healthy begins with promoting the health and well-being of women of reproductive age, and continues with care and services during pregnancy, delivery and the post-partum stage. A child whose mother dies within six weeks of their birth is less likely to survive to the age of 2 than a child whose mother survives. The need

for a human rights-based approach to preventable maternal mortality and morbidity has been recognized by the Human Rights Council.<sup>2</sup>

29. Maternal and child undernutrition, conditions that are inextricably linked, is estimated to be responsible for 35 per cent of child deaths and 11 per cent of the total global disease burden. Adequate nutrition and nutritional supplements for pregnant women are critical to ensure healthy foetal and infant development, and to reduce the child's susceptibility to infectious diseases in infancy and chronic diseases in adulthood.

30. In 2010, almost 2.8 million deaths were attributable to neonatal mortality (deaths in children aged from 0 to 27 days). Pre-term birth complications, intrapartum-related complications, infections, maternal hypertension, diabetes and foetal growth restriction are responsible for most cases of stillbirth and neonatal death. Improved pregnancy monitoring and the early prevention, detection and management of complications have a positive impact on the health and survival of women and newborn children.

31. More than 90 per cent of children with HIV have been infected through mother-to-child transmission, which can be prevented with antiretroviral drugs, as well as safer delivery and feeding practices. Voluntary HIV counselling and testing, coupled with links to infant HIV diagnosis services and long-term HIV care and treatment services for women and infants, as required, can reduce HIV transmission and promote access to needed services.

32. Increasing skilled attendance at birth and access to emergency obstetric care services can improve child survival by reducing stillbirths and saving maternal and newborn lives. Postnatal care should include, at a minimum, early and exclusive breastfeeding, keeping the baby warm, more frequent hand-washing and hygienic umbilical cord and skin care, identifying conditions requiring additional care, and counselling on when to take a newborn to a health facility. Furthermore, breastfeeding has a positive impact on many areas of child health since, in addition to its nutritional value, it strengthens the infant's immune system thus preventing a wide range of infections.

## **B. Child mortality**

33. In children aged from one to 59 months, the leading causes of death are pneumonia, diarrhoea and malaria; injuries and congenital abnormalities are also important causes of mortality.<sup>3</sup> The primary causes of child mortality also lead to sickness in millions of children every year. Almost half of the global burden of disease in children aged from 0 to 4 years is attributable to seven infectious diseases: lower respiratory infections (including pneumonia), diarrhoeal diseases, malaria, measles, pertussis, HIV/ AIDS and tetanus.

34. Global figures nonetheless mask important regional differences, and national statistics hide subnational variations in health. The risk of a child dying before his or her fifth birthday in low-income countries is 18 times higher than in high-income countries; in all settings, this risk is higher in rural areas, less educated communities and poorer households.<sup>4</sup>

35. More than two thirds of cases of mortality among children under 5 years of age are due to diseases that are preventable and treatable through simple, affordable interventions.

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<sup>2</sup> See Human Rights Council resolutions 11/8, 15/17, 18/12 and 21/6.

<sup>3</sup> UNICEF. *A Promise Renewed*, 2012. Available from [www.apromiserenewed.org/files/APR\\_Brochure\\_September12.pdf](http://www.apromiserenewed.org/files/APR_Brochure_September12.pdf).

<sup>4</sup> See [www.who.int/maternal\\_child\\_adolescent/epidemiology/child/en/index.html](http://www.who.int/maternal_child_adolescent/epidemiology/child/en/index.html).



Health workers should deliver these interventions within communities and provide parents and caregivers with information on how to promote their child's health and survival.

36. Ensuring access to the full schedule of childhood immunizations recommended by WHO is critical to the prevention of an expanding array of childhood illnesses as well as to diseases that may emerge later in life.

37. Access to insecticide-treated nets and appropriate treatment for malaria, in accordance with WHO guidelines, can improve the likelihood of child survival in malaria endemic areas. Access to a sufficient supply of safe, potable water is essential for reducing child morbidity and mortality. Hand-washing with soap, access to improved sanitation facilities and anthelmintics can help reduce diarrhoea and pneumonia, as well as other infectious and parasitic diseases.

38. Measures should be taken to address the dangers and risks of local environmental pollution for child health, such as by reducing emissions from smoke producing cooking facilities, thereby reducing pneumonia and other respiratory infections, and by addressing climate change, which contributes to the infectious disease burden and exacerbates health inequalities.

39. Children affected by HIV require additional attention to ensure their healthy survival and development, continued access to care and support from appropriate adults, and protection of their rights, including to education, health and other social services, and inheritance.

### C. Malnutrition

40. Undernutrition, micronutrient deficiency and overnutrition are different dimensions of malnutrition that must be addressed together through a life-course approach.<sup>5</sup> Undernutrition is the underlying cause of the death of 2.6 million children every year, one third of the global total of children's deaths. In addition, the growth of one in four of the world's children is stunted; in developing countries, this figure is as high as one in three.<sup>6</sup>

41. In addition to the burden of disease and stunting attributable to undernutrition, overnutrition is becoming an increasingly important concern. In 2010, there were an estimated 42 million children under the age of 5 who were overweight, and these rates continue to rise owing to a lack of physical activity and unhealthy diets.<sup>7</sup>

42. The submissions received confirm the above finding, showing that this dual burden is beginning to affect developed and non-developed countries in equal measure. The replies received also reported on worrying trends concerning the stigmatization of obese children by medical personnel.

43. Ensuring adequate nutrition for infants and young children plays a key role. A number of measures could be taken to address child malnutrition, such as by providing parents with advice and food and nutritional supplements, promoting access to an adequate and culturally acceptable supply of safe food, and providing complementary and emergency food programmes where acute malnutrition threatens or is prevalent. Some caution against over-reliance on the use of supplements, therapeutic foods, fortificants and infant formulas,

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<sup>5</sup> A/HRC/19/59.

<sup>6</sup> Save the Children, *A Life free from Hunger*, 2012.

<sup>7</sup> WHO, *Population-based prevention strategies for childhood obesity: report of a WHO forum and technical meeting*, Geneva, 15-17 December 2009. Available from [www.who.int/dietphysicalactivity/childhood/child-obesity-eng.pdf](http://www.who.int/dietphysicalactivity/childhood/child-obesity-eng.pdf).

arguing that they may actually lead to malnutrition if applied where ecosystems are able to support sustainable diets. Meals provided at schools may help to ensure children's access to adequate food as well as increase their learning capacity and enrolment in schools.

44. Obesity in children can be addressed by promoting healthy eating habits and physical exercise. Together with parental education, regulating advertising and the promotion of unhealthy food and beverages can limit children's exposure to them.

45. The Special Rapporteur on the right to food underscores the importance of addressing undernutrition, micronutrient deficiency and overnutrition in a concurrent manner by reshaping whole food systems for the promotion of sustainable diets.<sup>8</sup>

#### **D. Harmful practices**

46. Certain practices condoned by parents, relatives, even religious and community leaders, may have a detrimental impact on the health of children, such as female genital mutilation and cutting, forced feeding, child marriage, acid attacks, "honour" killings, breast ironing, virginity testing, harmful initiation rites, son preference, sex selection, infanticide, dowry, bonded labour and sexual slavery. Measures should be taken to abolish them, in accordance with article 24.3 of the Convention on the Rights of the Child.

47. Harmful practices to children's health are in some cases induced by the media and private industry. Beauty stereotypes promoted by the media can lead to such unnecessary practices as cosmetic surgery. States should also take effective and appropriate measures to address them, if relevant.

#### **E. Sexual and reproductive health**

48. Approximately 16 million girls aged from 15 to 19 years give birth every year; adolescent girls run a particularly high risk of complications during pregnancy and delivery. Poor maternal health causes 7 per cent of female deaths in the 10 to 24 age group, and underlies a high proportion of global disability.

49. The right to sexual and reproductive health is a fundamental part of the right to health. As noted by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, States must ensure that this aspect of the right to health is fully realized.<sup>9</sup> Ensuring the highest attainable standard of health and well-being of adolescents requires comprehensive sexuality education and full access to confidential youth-friendly and evidence-based sexual and reproductive health services. Adolescent-friendly comprehensive sexuality education can help to address the high rates of teenage pregnancy and the additional risks of associated morbidity and mortality.

50. The Committee on the Rights of the Child has urged State parties to take all necessary measures to reduce teenage pregnancies and to improve knowledge and the availability of family planning services, to develop education programmes on adolescent reproductive health, and to raise awareness about access to safe contraception methods. It has also stressed that the views of the child should always be heard and respected in abortion decisions, and that this be ensured by law and in practice.<sup>10</sup>

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<sup>8</sup> A/HRC/19/59, paras. 37-47,

<sup>9</sup> A/66/254.

<sup>10</sup> CRC/C/UKR/CO/3-4, para. 57.

51. The Committee has also noted its concerns about the impact of highly restrictive abortion laws on the right to health of adolescent girls,<sup>11</sup> and has urged States to ensure that girls are not subject to criminal sanctions for seeking or obtaining an abortion under any circumstance.<sup>12</sup> It has further requested States to review their legislation on abortion with a view to ensuring that it is in full compliance with the best interests of the child, including by ensuring that single adolescent mothers are allowed access to safe abortions and are adequately protected from the risks of illegal abortions.<sup>13</sup>

52. A continuum of adolescent-friendly HIV-related services should be made universally available, such as HIV prevention, voluntary counselling and testing, care, treatment and support services. Post-exposure prophylaxis should be available to victims of sexual assault. Due attention should be given to ensuring the confidentiality of HIV test results and other related information.

53. In some places, social and cultural values may limit access to information and services. For example, comprehensive sexuality education is considered inappropriate in some settings, where abstinence-only sexual education is provided. Where traditional views on sexuality prevail, access to sexual and reproductive health services can be limited for some segments of the populations, including adolescents. Parental and spousal consent laws may deny adolescents their right to have access to sexual and reproductive health information.

## **F. Violence**

54. The United Nations study on violence against children<sup>14</sup> brought to light the magnitude of the problem posed by violence, confirming that it exists in every country and takes place in different settings, including the family, school, institutions and the community. The burden of mortality and morbidity in children attributable to violence is high, particularly during early childhood and adolescence, a fact which highlights the need to create an environment that protects children from violence, to support parents and caregivers in healthy child-rearing, and to challenge attitudes that perpetuate tolerance and the condoning of violence in all forms and settings. The right of the child to be free from violence is reflected in article 19 of the Convention on the Rights of the Child.

55. Sexual violence can have serious short- and long-term physical, psychological and social consequences not only for girls and boys, but also for their families and communities. Robust and effective child protection systems, including the provision of comprehensive services to child victims, are required.

56. In the light of the impact of corporal punishment on children's health, including fatal and non-fatal injury, as well as psychological and emotional consequences, corporal punishment and other cruel or degrading forms of punishment in all settings should be eliminated.<sup>15</sup>

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<sup>11</sup> CRC/C/15/Add.107, para. 30; CRC/C/CHL/CO/3, paras. 55-56; CRC/C/URY/CO/2, para. 51.

<sup>12</sup> CRC/C/NIC/CO/4, para. 59 (b).

<sup>13</sup> CRC/C/KOR/CO/3-4, para. 11.

<sup>14</sup> A/61/299.

<sup>15</sup> CRC/C/GC/8.

## G. Injuries, accidents and disabilities

57. Among children aged between 5 and 9 years, injuries, road traffic accidents, falls and fires contribute significantly to the disease burden, and can lead to physical disabilities. The leading cause of mortality among people aged between 10 and 24 years is traffic accidents.

58. Reducing the burden of child injuries requires strategies and measures to reduce road traffic accidents, drowning, burns and other accidents in the home, such as appropriate legislation and enforcement, especially with regard to road safety; product and environmental modification; education, skills development and behaviour change; community-based projects; and pre-hospital and acute care, as well as rehabilitation.<sup>16</sup> The health system should enable early diagnosis of physical disabilities, including visual and auditory disabilities and, in the case of children with disabilities, the prompt application of appropriate rehabilitation and care services as close to the community as possible.

59. In addition, some of the submissions received raised concerns about the consequences of certain dangerous games, such as the “choking” or “fainting” game<sup>17</sup> on health. Although no figures are available, parents associations are being established in some countries to raise awareness of the consequences of such games. Prevention in schools is essential.

## H. Mental health

60. Mental health problems among adolescents are increasing, such as developmental and behavioural disorders, depression, anxiety, psychological trauma resulting from abuse, violence or exploitation, self-harm and suicide. The problems are often diagnosed late and inadequately addressed.

61. In its 2012 resolution on mental health (WHA65.4), the World Health Assembly noted that there was increasing evidence of the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents. Such interventions should be scaled up by mainstreaming them through a range of sectoral policies and programmes, including health, education and protection, with the involvement of families and communities. This should include interventions targeted at children at risk due to their family and social environments, in order to improve their coping skills and promote protective and supportive environments. Providing psychosocial support in schools and other community settings may help to promote the mental health of children.

62. There is growing recognition of the need for greater attention to the diseases and behavioural and social issues that undermine children’s mental health, psychosocial well-being and emotional development. Many mental health disorders can be prevented and treated more effectively by investing in primary-care approaches that facilitate the early detection and treatment of children’s psychosocial, emotional and mental problems.

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<sup>16</sup> WHO, *World report on child injury prevention: summary*, Geneva, 2008. Available from [http://whqlibdoc.who.int/hq/2008/WHO\\_NMH\\_VIP08.01\\_eng.pdf](http://whqlibdoc.who.int/hq/2008/WHO_NMH_VIP08.01_eng.pdf).

<sup>17</sup> A voluntary strangulation game with the aim of experiencing new sensations provoked by cutting off the oxygen supply to the brain.

## I. Substance use

63. An estimated 150 million young people, primarily in low- and middle-income countries, use tobacco, and alcohol consumption among young people, especially young males, is increasing;<sup>18</sup> both tobacco use and alcohol consumption contribute to cardiovascular and other diseases in adulthood. Patterns of substance use established during adolescence tend to develop into chronic patterns of use, mortality and morbidity in later life. Children should be protected from solvents, alcohol, tobacco and illicit substances.

64. The ratification of the WHO Framework Convention on Tobacco Control<sup>19</sup> is an important step in controlling the use of tobacco among children. Interventions to ban tobacco advertising, to raise the price of tobacco products and to enact laws prohibiting smoking in schools and other public places reduce the number of people who start using tobacco products. Banning alcohol advertising, regulating access to it and providing counselling when alcohol use is detected are effective strategies to reduce alcohol use by young people.

65. Although in children the use of alcohol, cannabis, solvents and “club” drugs remain much more prevalent than injecting drug use, the latter is a serious concern. Children who inject drugs are often those in most difficult circumstances, including children in street situations and without parental care. Children who inject drugs are more likely than adults to share equipment with others and less likely to have access to needle and syringe exchange services. Sharing injecting equipment can lead to the transmission of blood-borne viruses, including HIV. Children and young people who inject drugs are also at greater risk of other preventable diseases and death from overdose.<sup>20</sup>

66. A rights-based, comprehensive approach to substance use should be adopted, and include harm reduction strategies to minimize the negative health impacts of substance abuse.

## V. Measures for implementation

### A. Accountability

67. Although States are the primary duty-bearers with obligations for realizing the right of the child to health, the engagement of a number of stakeholders is required, working at different levels, including public and private, governmental and non-governmental, development partners and funding organizations. The central role played by parents and other caregivers, including teachers, doctors, social workers and all those working with children, is critical. States have an obligation to ensure that all duty-bearers have sufficient capacity to fulfil their obligations and responsibilities, and that the capacity of children is sufficiently developed to enable them to claim their right to health.

68. Accountability is a key component for ensuring the enjoyment of the right of the child to health, and national accountability mechanisms must be effective and transparent. Adequate accountability mechanisms include complaint systems, judicial remedies and independent monitoring bodies. With the active engagement of the Government, communities, civil society and children, national accountability mechanisms must aim to

<sup>18</sup> WHO, Global status report on alcohol and health, Geneva, 2011.

<sup>19</sup> Available from <http://apps.who.int/iris/bitstream/10665/42811/1/9241591013.pdf>.

<sup>20</sup> Submission by Harm Reduction International, available from [www.ohchr.org/EN/Issues/Children/RightHealth/Pages/Contributionsreceived.aspx](http://www.ohchr.org/EN/Issues/Children/RightHealth/Pages/Contributionsreceived.aspx).

hold all actors responsible for their actions. They should also pay attention to the structural factors affecting child health, such as laws, policies and budgets. The participatory tracking of financial resources and of the impact on children's health is essential for State accountability mechanisms.

## **B. Health systems**

69. Investing in strong health systems is a key factor in the prevention and delivery of quality care; an effective, transparent and responsive health system is essential to fulfilling the right of the child to health. A rights-based approach must ensure that health systems are designed to reach everyone, including the most disadvantaged groups of children, that they are transparent, and that there are systems in place to ensure the accountability of all duty-bearers.

70. While the universal right to health entails access to health services for everyone, the right of the child to health requires health systems to be adequate to children's health needs. The right to health highlights the need for comprehensive primary health-care programmes, delivered alongside proven community-based efforts, such as preventive care, the treatment of specific diseases and nutritional interventions. Delivering health services and technologies through a combination of health facilities and mobile arrangements can substantially reduce some risks, and should be universally adopted. While strengthening national health systems should be the long-term aim, community-based initiatives can extend the delivery of interventions in areas where health services are hard to obtain.

71. Prevention and health promotion are central to primary health care. Interventions should address communicable and non-communicable diseases, as well as such other health challenges as accidents, violence, substance abuse, and psycho-social and mental health problems, and incorporate a combination of biomedical, behavioural and structural interventions.

72. Equality and non-discrimination must be promoted to address the range of disparities that affect children's access to and use of health services. Targeting the most deprived communities with a focus on primary health care and community-based interventions can result in sharper reductions in child mortality and greater cost-effectiveness than strategies not specifically designed to address health inequalities.

73. Child-sensitive health approaches throughout different periods of childhood, such as the WHO/UNICEF Baby-Friendly Hospital Initiative,<sup>21</sup> child-friendly health policies and adolescent-friendly health services can increase acceptability and the uptake of health services.

74. The realization of the right of the child to health requires particular attention to increasing interaction with children, and their participation at all stages of health system design and operation to improve the acceptability and, by extension, the uptake and use of services.

75. Many countries report shortages in human resources for health, particularly in times of crisis. In order to support health services for all children, however, an appropriately deployed workforce of sufficient size is required, as are adequate training, regulation, supervision, remuneration and conditions of service.

76. In support of a national coordinating framework on child health to facilitate cooperation between ministries and other level of Government, a well-structured and

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<sup>21</sup> See [www.unicef.org/nutrition/index\\_24806.html](http://www.unicef.org/nutrition/index_24806.html).

appropriately disaggregated set of indicators and assessment tools should be established. In addition, health information systems should respect children's right to privacy when personal data are collected and disseminated. Regular monitoring and review of appropriately disaggregated data on the national health system and the underlying determinants of health affecting children is a component critical to understanding and addressing child health and rights, globally and locally. States should regularly review their health information systems, including vital registration and surveillance systems, with a view to their improvement.

77. The links between poverty and poor health are well documented. Interventions to address poverty should be implemented alongside health education and services to mitigate potential financial barriers to the realization of the right of the child to health. Promoting women's control over family resources can also contribute to the improvement of child health through the prioritization of child nutrition and access to health services. User fees and associated health expenditures can constitute an insurmountable barrier in access to health services. Social protection interventions, including such social security mechanisms as child grants or subsidies, cash transfers, and paid parental leave, are complementary investments that increase the financial accessibility of health services for children.

### **C. Laws and policies**

78. National laws should place an obligation on the State to provide the services, programmes, resources and infrastructure necessary to realize the right of the child to health, and providing also a statutory entitlement to essential health and related services for pregnant women and children, irrespective of their ability to pay. In addition, national legislation should also include a comprehensive prohibition of practices that are harmful to children. Legal provisions justifying or allowing consent to harmful practices against children should be removed from national legislation. Legislation should also provide for adequate complaint mechanisms and remedies.

79. Legislation should fulfil a number of additional functions in the realization of the right of the child to health, by, inter alia, defining the scope of the right and recognizing children as rights-holders; clarifying the roles and responsibilities of all duty-bearers; clarifying what services children, pregnant women and mothers are entitled to claim; and regulating services to ensure that they are of good quality.

80. Laws, regulations and policies can also constitute barriers to the realization of the right of the child to health, such as, inter alia, requirements for parental and/or spousal consent for access to health information and/or services; restriction on access to services by migrant children and their parents; and restrictions on the provision of comprehensive sexuality education.

### **D. Birth registration**

81. Article 7 of the Convention on the Rights of the Child recognizes the right of the child to birth registration. Birth registration is crucial for establishing minimum ages for work, conscription and marriage and, during emergencies, for providing a basis for tracing separated and unaccompanied children. There is a confluence between children who are registered and those who are fully vaccinated, receive vitamin A supplements, and/or are taken to health-care professionals when ill.

82. Health systems are required to ensure that children whose births have not been registered may still claim the services and protections due to them on a full and equal basis

with other children. The effective registration of deaths is also essential for tracking population size and causes of mortality and for planning health interventions.

## **E. Parents and caregivers**

83. Parents and caregivers have an essential role in the upbringing of children, and States should support them in their responsibilities. Parents and other caregivers are the most important parties in the early diagnosis and primary care of small children, and the most important protective factor against high-risk behaviours in adolescents, such as substance use and unsafe sexual relations. Parents and caregivers also play a central role in promoting healthy child development, protecting children from harm due to accidents, dangerous games, injuries and violence, and mitigating the negative effects of risk behaviours. Children's socialization processes, which are crucial for understanding and adjusting to the world in which they grow up, are deeply influenced by parents and caregivers.

84. Taking the child's evolving capacity into account, parents should nurture, protect and help the child to grow and develop in a healthy manner. The responsibilities of parents and caregivers include the adoption of non-violent child-rearing practices, the promotion of healthy forms of behaviour and appropriate health-care-seeking, and support for children in making decisions, including those relating to their health. Information about child health should be provided to all parents and caregivers in accordance with article 24 of the Convention on the Rights of the Child.

## **F. Education**

85. There are strong links between the right to education and the right to health. Good health promotes better educational attainment; conversely, higher levels of education have a positive impact on the child's health. Improvements in girls' and women's education improve child survival, especially when implemented with poverty reduction programmes.

86. Article 24 of the Convention on the Rights of the Child highlights children's need for information on all aspects of health education to realize their right to health and to enable them to make informed choices in relation to lifestyle and access to health services. Information and life skills education should address, inter alia, comprehensive sexuality education, healthy eating and the promotion of physical activity, accident and injury prevention, sanitation, and the dangers of tobacco and psychoactive substance use. It should encompass appropriate information about the right of the child to health, the obligations of Governments, and how and where to obtain access to health information and services.

87. Schools have an essential role to play in health promotion. Information should be provided as a core part of school curricula, through health services and in other settings targeting children who are not in school. Health information materials should be designed in collaboration with children and disseminated in a wide range of public settings and social media.

## **G. International cooperation**

88. States have obligations not only to implement the right of the child to health within their own territory but also to contribute through international cooperation to global implementation. Article 24.4 of the Convention on the Rights of the Child requires States and inter-State agencies to pay particular attention to child health priorities in the poorest parts of the population and in developing States. States have a responsibility to cooperate in



providing disaster relief and humanitarian assistance in times of emergency. In such cases, all measures possible should be taken to ensure that children have uninterrupted access to health services, to (re)unite them with their families and to protect them not only with physical support (such as food and clean water) but also to encourage special parental or other psychosocial care to prevent or address fear and traumas.

## **VI. Recommendations**

89. **Despite progress in many areas, child health remains an issue of concern throughout the world. The issues described in the present report pose enormous and complex challenges requiring joint efforts by a wide range of actors, including States, the international community, civil society, communities and families, as well as the private sector. A determined, enduring commitment to promote and protect the rights of all children, including their right to health, is needed so that all children everywhere grow and thrive in the full realization of all their rights.**

90. **In order to ensure the realization of the child right to health, OHCHR recommends that States that have not yet ratified and implemented the Convention on the Rights of the Child, the Optional Protocols thereto and other international human rights instruments relevant to child health to do so as a matter of priority. States are encouraged to review and withdraw reservations to article 24 of the Convention and other rights that might infringe on children's ability to realize the right to health.**

91. **OHCHR recommends that States report regularly on the implementation of the right of the child to health in their periodic reports submitted to the Committee on the Rights of the Child and in the context of their review under the universal periodic review mechanism of the Human Rights Council.**

92. **States are encouraged to adopt a holistic approach to the realization of the right of the child to health, which includes attention to other rights that might affect the realization of this right. The right of the child to health should be recognized in national legislation. In order to ensure access to health services and programmes, States should ensure that free, accessible, simple and expeditious birth registration is available to all children.**

93. **States should take appropriate legislative and other measures to fulfil the right of the child to health "to the maximum extent of their available resources", ensuring the availability, accessibility, acceptability and quality of essential health services for all children, without discrimination.**

94. **States are encouraged to review national laws and policies and, where necessary, amend them to ensure consonance with fulfilling the right of the child to health. To that end, comprehensive prohibition of all forms of violence against children, including practices that harm children's health, should be included in legislation. Barriers relating to comprehensive sexual and reproductive information and services should be removed.**

95. **States are also encouraged to establish and make use of a comprehensive and cohesive national coordinating framework on child health, built upon the principles of the Convention on the Rights of the Child, to facilitate cooperation between ministries and different levels of Government, as well as interaction with civil society.**

96. **States should engage all sectors of society, including children, in the implementation of the right of the child to health. Children's opinions should inform the policies, plans and interventions designed to address them.**

97. States should ensure universal coverage of quality primary health services, including in the area of sexual and reproductive health.
98. In order to ensure equality and non-discrimination, States should identify and address factors that create vulnerabilities for children or that disadvantage certain groups of children. Positive action or temporary special measures should be taken to ensure equality for particular groups of children, such as priority in the delivery of health services or the allocation of resources to previously neglected areas of child health or to groups of underserved children.
99. States are encouraged to prioritize issues that have received little attention to date, such as adolescent mortality in low- and middle-income countries, and issues concerning mental health and adolescent suicide. They should ensure adequate attention to the underlying determinants of child health, including, inter alia, access to minimum safe and nutritionally adequate food, basic shelter, housing, sanitation, safe and potable water and a healthy and safe environment.
100. States should support parents and caregivers to enable them to fulfil their responsibilities in the right to health and other related rights, including with financial support, where required.
101. Child-sensitive counselling, complaint and reporting mechanisms should be established, strengthened and implemented so that children have access to effective remedies for violations of their right to health or other related rights.
102. States should promote health education in formal and informal settings, including comprehensive sexuality education, and ensure that health promotion, including healthy eating and physical activity, is included in school curricula.
103. States should develop comprehensive and coordinated systems for the collection of data on children's health, disaggregated on the basis of the life course of the child, with due attention paid to gender and vulnerable groups. They should also be focused on health problems, including new and neglected causes of mortality and morbidity and violence, and capture the key determinants of child health.
104. States should allocate a sufficient proportion of public health expenditure to children and create an accompanying mechanism that allows for systematic, independent evaluation of this expenditure. States are encouraged to implement rights-based budget monitoring and analysis, as well as child impact assessments on how investments, particularly in the health sector, may serve the best interests of the child.
105. International cooperation should support State-led health systems and national health plans. Donors should identify the major health problems affecting children in recipient countries, and address them in accordance with the priorities and principles established by article 24 of the Convention on the Rights of the Child.
106. In accordance with the Guiding Principles on Business and Human Rights, private sector enterprises providing services or financial support that affect child health have a responsibility to respect children's rights, including their right to health, through their operations. Private sector enterprises are therefore required to avoid causing or contributing to any adverse impact on child health through their own activities.
107. In particular, food and beverage industries should limit the advertisement of food and drinks detrimental to children's health and development and, where relevant, comply with the International Code of Marketing of Breast-milk Substitutes. Similarly, the tobacco and alcohol industries should refrain from the advertisement,

marketing and sale of their products to children. Tobacco industries should comply with the WHO Framework Convention on Tobacco Control. Private health insurance companies should ensure they do not discriminate against pregnant women, children or mothers.

108. Media organizations are encouraged to promote health and healthy life styles among children; provide free advertising space for health promotion; ensure the privacy and confidentiality of children; not produce communication programmes and material that are harmful to children; and not perpetuate health-related stigma.

109. Researchers, including private companies, undertaking health-related research involving children must respect the principles and articles of the Convention on the Rights of the Child and, where appropriate, the International Ethical Guidelines for Biomedical Research Involving Human Subjects.<sup>22</sup> Research should be supported to ensure the availability of safe and appropriate paediatric drug formulations.

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<sup>22</sup> See [www.cioms.ch/publications/layout\\_guide2002.pdf](http://www.cioms.ch/publications/layout_guide2002.pdf).