



General Assembly

Distr.: General
9 September 2013

English only

Human Rights Council

Twenty-fourth session

Agenda item 3

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

Study by the World Health Organization on mortality among children under five years of age as a human rights concern*

Note by the Secretary-General

The Secretary-General has the honour to transmit to the Human Rights Council the study of the World Health Organization on mortality among children under five years of age as a human rights concern, submitted pursuant to Human Rights Council resolution 22/32.

* Reproduced as received from the World Health Organization.

Study by the World Health Organization on mortality among children under five years of age as a human rights concern

Summary

The present study is submitted pursuant to Human Rights Council resolution 22/32. It introduces the definition of under-five mortality, and provides an overview of its scale, its direct causes and underlying determinants, as well as the key interventions needed to avert child mortality and morbidity. The study identifies the human rights dimensions of under-five mortality in the existing international legal framework, and finally proposes concrete recommendations on how the Council can support the articulation and adoption of a human rights-based approach to eliminating preventable under-five mortality.

Contents

	<i>Paragraphs</i>	<i>Page</i>
I. Introduction	1–5	4
II. Under-five mortality: definition and scale	6–31	4
A. Defining under-five mortality	6–8	4
B. Levels of under-five mortality	9–13	5
C. Main causes of under-five mortality and associated risk factors	14–23	6
D. The need for an holistic approach to avoid preventable under-five mortality	24–31	8
III. Human-rights dimensions of under-five mortality: the international legal framework.....	32–78	10
A. Rights in focus	35–57	10
B. Key human rights principles to address under-five mortality	58–78	15
IV. Conclusions and recommendations	79–91	20

I. Introduction

1. The present report is submitted to the Human Rights Council (“the Council”) pursuant to resolution A/HRC/22/32, in which the Council invited the World Health Organization (WHO) to prepare, in collaboration with relevant United Nations agencies, in particular the Office of the United Nations High Commissioner for Human Rights (OHCHR), the United Nations Children’s Fund (UNICEF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), as well the special procedures mandate holders and the Special Representative of the Secretary-General on Violence against Children, a study on mortality of children under five years of age as a human rights concern.

2. The report was prepared by WHO, and supported by an external advisory group of human rights and child health experts. In addition, contributions were received from OHCHR, UNICEF, Save the Children and World Vision.

3. In its resolutions A/HRC/RES/19/37 and A/HRC/22/32, the Council expressed deep concern about the high rates of mortality among children under the age of five (also “under-five mortality” or “child mortality”). In resolution A/HRC/22/32, the Council affirmed “the importance of applying a human-rights-based approach to reducing and eliminating preventable maternal and child mortality and morbidity”, and requested all States “to renew their political commitment in that respect at all levels”. It also called upon States, “in adopting a human-rights-based approach, especially to scale up efforts to achieve integrated management of maternal, new-born and child health care and to take action to address the main causes of maternal and child mortality”. The concerns raised by the Council reaffirm that the annual death toll of close to 7 million children under five years of age is an urgent public health and human rights concern.

4. In spite of the significant progress made in recent years to reduce under-five mortality, significant inequities between and within countries continue to exist. These are not only driven by poverty, but are intrinsically linked to social exclusion and de jure and de facto discrimination. Therefore, efforts to eliminate under-five mortality require a comprehensive and holistic approach, which explicitly recognizes and integrates relevant human rights standards.

5. This study defines under-five mortality and provides an overview of its scale, direct causes and underlying determinants, as well as the key interventions needed to avert child mortality and morbidity. The study identifies the human rights dimensions of under-five mortality within the existing international legal framework, and recommends ways in which the Council can support the articulation and adoption of a human-rights-based approach to eliminating preventable under-five mortality.

II. Under-five mortality: definition and scale

A. Defining under-five mortality

6. The life-course approach to health care recognizes the continuum from birth through childhood, adolescence and adulthood. This approach reflects the principle that care given to children at birth, or even that given to their mothers prior to their birth, will affect their immediate well-being and will have an impact on their health and development in later years. Within the life-course, the period of life before adulthood is divided into three age subgroups, based on epidemiology and health-care needs: (1) the first five years (under-five children), (2) the next five years (older children), and (3) the second decade of life (adolescents). In order to address the specific health challenges and needs of young children

more effectively, the first five years of life are further subdivided into the neonatal period (the first 28 days of life), infancy (the first year of life) and pre-school years (1–5 years).

7. Deaths among children under the age of five years present one of the most serious challenges currently faced by the international community. To address this challenge, it is necessary to measure accurately the levels and causes of mortality among this population group. The most common measures of mortality among these children are:^{1,2}

(a) the under-five mortality rate (U5MR) – the probability of a child dying before reaching the age of five years;

(b) the infant mortality rate (IMR) – the probability of a child dying before his or her first birthday; and

(c) neonatal mortality rate (NNMR) – the probability of a child dying between 0 and 28 days of age.³

8. U5MR and IMR are broadly recognized as some of the most sensitive indicators of a country's socioeconomic situation and quality of life. Mortality among infants reflects both the specific problems affecting children under five years and the structural factors that affect the health of entire populations.

B. Levels of under-five mortality

9. Of the 136 million babies born into the world in 2011, nearly 5 million are estimated to have died before their first birthday and an additional 2 million are expected to die before reaching the age of five. These correspond to an U5MR of 51 per 1000 live births and an IMR of 37 per 1000 live births.⁴ At these levels of mortality, one in every 20 children dies before reaching his or her fifth birthday, and one in every 27 children does not survive until his or her first birthday.

10. Overall, substantial progress has been made over recent decades. The global number of under-five deaths has decreased by 42 per cent, from nearly 12 million in 1990 to an estimated 6.9 million in 2011.² However, levels, trends and progress in both IMR and U5MR are unequally distributed. Under-five mortality rates range from over 150 per 1000 live births in some of the poorest countries to less than 3 per 1000 live births in the richest countries.

11. Of the almost 7 million children under the age of five still dying every year in the world, more than 95 per cent are clustered in just two regions of the world: Africa and Asia.⁵ Although the African region has about 24 per cent of the world's under-five population, it accounts for nearly 50 per cent of global under-five deaths; in contrast, less than 1 per cent of under-five deaths take place in Europe. Similarly, most infant and

¹ World Health Organization, "Health status statistics: mortality". Available from <http://www.who.int/healthinfo/statistics/indunder5mortality/en/> (accessed 29 August 2013).

² J.L. Fleiss. *Statistical methods for rates and proportions*. New York, John Wiley & Sons, 1981.

³ All rates relate the number of deaths occurring among children of the specific age group to the size of the population at risk, and are expressed per 1000 live births. Relating the number of deaths to the size of the population at risk allows for comparison between different populations and gives an equity dimension to the measure.

⁴ United Nations Inter-agency Group for Child Mortality Estimation. *Levels & Trends in Child Mortality: Report 2012*. New York, United Nations Children's Fund, 2012. Available from http://www.who.int/maternal_child_adolescent/documents/levels_trends_child_mortality_2012/en/.

⁵ United Nations Population Division. *World Population Prospects: The 2012 Revision* (ST/ESA/SER.A/336).

neonatal deaths occur in these same regions. One in nine children under five years of age die every year in Sub-Saharan Africa, more than 16 times the average for developed regions, where one child in 152 dies before the age of five years.

12. Beyond regional and inter-country disparities, further critical inequities are present within countries, where children from the poorest families, living in rural areas and whose mothers are less educated, are those more likely to die. Data from the Demographic and Health Surveys (DHS) indicate a threefold increase in mortality rates among these children in some countries.^{6,7} Intracountry inequities are further exacerbated by additional factors, including exclusion and discrimination based on health status, ethnic or linguistic origin and race. These may result in higher mortality rates among particular groups of children, such as children with disabilities, orphaned children and children belonging to indigenous and ethnic minorities.

13. While global efforts to address this social injustice focus on the poorest regions, it is important to note that under-five mortality remains an issue even in developed regions, and hence must be given sustained attention by States, in conformity with their legal obligations under relevant international treaties. Under-five mortality in middle and high-income countries is associated with increasing socioeconomic inequity within their societies. The other factors influencing inequity in these countries are largely similar to those identified in developing countries, including discrimination and social exclusion, and must be systematically addressed by States.

C. Main causes of under-five mortality and associated risk factors

14. Most deaths of children under the age of five are due to a small number of diseases and conditions. Forty-three per cent of these deaths occur among babies aged 0–28 days (newborn babies)⁸ and are mainly due to preterm birth complications, birth asphyxia and trauma, and sepsis. After the first 28 days until the age of five years, the majority of deaths are attributable to infectious diseases such as pneumonia (22%), diarrhoeal diseases (15%), malaria (12%) and HIV/AIDS (3%).⁹

15. Although the major causes of under-five mortality remain the same globally, their relative importance varies across regions of the world. While, in low-income countries, infectious diseases account for a large proportion of under-five deaths, the main killers of children in high-income countries are noncommunicable diseases such as congenital anomalies (26%), prematurity (23%), injuries (13%) and birth asphyxia (6%).²

16. Poor nutritional status in a child¹⁰ is strongly correlated with vulnerability to diseases, to delayed physical and mental development, and to an increased risk of dying.¹¹

⁶ Central Statistical Agency, Ethiopia/ICF International. *Ethiopia Demographic and Health Survey 2011* (Addis Ababa, 2012).

⁷ National Institute of Statistics, Directorate General for Health/ICF Macro. *Cambodia Demographic and Health Survey 2010* (Phnom Penh/Calverton, Maryland, 2011).

⁸ United Nations Inter-agency Group for Child Mortality Estimation. *Levels & Trends in Child Mortality: Report 2012*. New York, United Nations Children's Fund, 2012.

⁹ World Health Organization Global Health Observatory. Available from <http://apps.who.int/gho/data/node.main.CODWORLD?lang=en> (accessed 29 August 2013).

¹⁰ The nutritional status of under-five children is usually assessed through three standard indicators: stunting, wasting and underweight. A stunted child is a child who is too short for his/her age. Stunting is usually a result of nutritional deprivation over a lengthy period of time. A child is considered wasted when the weight is too low for the child's height. Wasting usually reflects an acute nutritional deficiency, due either to reduced food consumption or to acute weight loss during an illness. Finally,

While, between 1990 and 2011, the proportion of children under the age of five who were underweight declined by 36 per cent, under-nutrition is still estimated to be associated with 45% of child deaths worldwide.⁴ In 2011, there were 165 million children under the age of five who were stunted, and 52 million who were wasted.¹²

17. At birth, low weight can be either the result of a birth that occurred too early (before 37 weeks of gestation) or of restricted growth during gestation, or both. Low birth weight (LBW) is closely associated with increased risks of neonatal mortality, cognitive problems and chronic diseases in later life. Every year, more than 20 million babies are born with LBW worldwide, the majority of them in Africa and South-East Asia.¹³

18. The risk factors associated with leading causes of death in children less than one month old – preterm birth, birth asphyxia and trauma, and neonatal sepsis – are multiple and complex, and include complications during pregnancy and childbirth, such as bleeding, hypertension, prolonged and obstructed labour and infections, and lack of timely access to quality skilled care during and after birth to prevent or manage newborn complications.

19. Key interventions to reduce newborn mortality associated with preterm birth include early recognition and care-seeking by women at risk of preterm birth, administration of antenatal corticosteroids to promote foetal lung maturity, skilled care during birth and essential newborn care, including drying of the baby, ensuring warmth through skin-to-skin contact, early and exclusive breastfeeding, and other interventions as necessary.

20. Care during labour and childbirth should be provided by a skilled attendant. Early recognition of slow progress in labour and timely interventions to prevent prolonged labour and intrapartum foetal distress can reduce mortality. Operative delivery and immediate newborn resuscitation, if required, will reduce mortality and morbidity due to asphyxia. Adherence to good infection prevention practices during and immediately after childbirth, avoiding prolonged labour and prolonged rupture of membranes, use of antibiotics for suspected sepsis during labour, early and exclusive breastfeeding, appropriate cord care and early diagnosis and treatment of the infant for suspected sepsis contribute to reductions in newborn mortality due to sepsis.

21. The main risk factors associated with the two leading causes of death in children aged between one month and five years – pneumonia and diarrhoea – include low birth weight, lack of breastfeeding, undernutrition, overcrowded conditions, indoor air pollution, unsafe drinking-water and food, and poor hygiene practices. In some regions, HIV infection and malaria are also significant risk factors.

22. Key evidence-based interventions to prevent pneumonia include immunization against specific pathogens, adequate nutrition (including exclusive breastfeeding for the first six months of life) and measures to reduce indoor air pollution (young children exposed to smoke from the use of household biomass fuel have an incidence of pneumonia

a child is said to be underweight if his/her weight is too low for his/her age, as a consequence of wasting, stunting, or both.

¹¹ R.E. Black and others, “Maternal and child undernutrition and overweight in low-income and middle-income countries”, *Lancet*, published online 6 June 2013. Available at [http://dx.doi.org/10.1016/S0140-6736\(13\)60937-X](http://dx.doi.org/10.1016/S0140-6736(13)60937-X).

¹² United Nations Children’s Fund/World Health Organization/World Bank. *Levels & Trends in Child Malnutrition: Report 2012*, 2012. Available from http://www.who.int/nutgrowthdb/jme_unicef_who_wb.pdf.

¹³ United Nations Children’s Fund/World Health Organization. *Low Birth Weight: Country, Regional, and Global Estimates* (UNICEF, New York, 2004).

twice that of children not so exposed^{14,15}). Treatment of pneumonia requires improved care-seeking, and case management by a trained health provider with antibiotics and oxygen for severe cases. Community case management of pneumonia with antibiotic treatment reduces mortality due to pneumonia by up to 35%.¹⁶

23. Poor sanitation, lack of accessible clean water and inadequate personal and domestic hygiene are responsible for an estimated 88 per cent of diarrhoea cases everywhere.¹⁷ Proven prevention measures that can significantly reduce the burden of diarrhoea include early and exclusive breastfeeding (a nonbreastfed child is 10 times more likely to die from diarrhoea in the first six months of life than an exclusively breastfed child¹⁸), rotavirus and measles vaccination and hand-washing with soap (hand-washing with soap reduces the risk of diarrhoea by an average of 48 per cent¹⁹). Treatment measures include fluid replacement to prevent dehydration (use of oral rehydration salts (ORS) reduces diarrhoea-specific mortality by 69 per cent²⁰) and zinc treatment.²¹ Improved safe water supply and community-wide sanitation are crucial interventions.

D. The need for an holistic approach to avoid preventable under-five mortality

24. The vast majority of conditions and diseases which lead to death among children under five years of age are preventable and treatable through cost-effective interventions. If universal coverage of such interventions were to be attained, 95 per cent of diarrhoea deaths and 67 per cent of pneumonia deaths in children under five years could be eliminated by 2025,²² and the total number of under-five deaths reduced by more than 1.4 million.

25. Rapid progress in increasing coverage of single interventions is possible.²³ But coverage must increase simultaneously across multiple interventions and across different segments of the population, including the most disadvantaged groups. Countries that have rapidly increased coverage for multiple interventions across the continuum of care have reaped significant benefits in terms of accelerating child survival gains.

¹⁴ M. Dherani and others, "Indoor pollution from unprocessed solid fuel use and pneumonia risk in children aged five years: a systematic review and meta-analysis", *Bulletin of the World Health Organization*, vol. 86 (2008), pp.390-398.

¹⁵ K.R. Smith and others, "Effect of reduction on household air pollution on childhood pneumonia in Guatemala (RESPIRE): a randomized controlled trial", *Lancet*, vol. 378 (2011), pp.1717-26.

¹⁶ E. Theodoratou and others, "The effect of case management on childhood pneumonia mortality in developing countries", *International Journal of Epidemiology*, vol. 39 (2010), pp.i155-i171.

¹⁷ World Health Organization. *Combating Waterborne Disease at the Household Level* (Geneva, 2007). Available from http://www.who.int/household_water/advocacy/combating_disease.pdf.

¹⁸ L. Lamberti and others, "Breastfeeding and the risk for diarrhea morbidity and mortality", *BMC Public Health*, vol. 11 (Suppl 3) (2011), p.S15.

¹⁹ S. Cairncross and others, "Water, sanitation and hygiene for the prevention of diarrhoea", *International Journal of Epidemiology*, vol. 39 (2010), pp.i193-i205.

²⁰ M.K. Munos, C.L. Walker and R.E. Black. "The effect of oral rehydration solution and recommended home fluids on diarrhoea mortality", *International Journal of Epidemiology*, 39(Suppl. 1) (2010), pp.i75-i87.

²¹ United Nations Children's Fund/World Health Organization. *Diarrhoea: Why Children Are Still Dying and What Can Be Done* (New York/Geneva, 2009).

²² A.B. Zulfiqar and others, "Interventions to address deaths from childhood pneumonia and diarrhoea equitably: what works and at what cost?" *Lancet*, vol. 381 (2013), pp.1417-29.

²³ World Health Organization. *Countdown to 2015. Accountability for Maternal, Newborn and Child Survival. An Update on Progress in Priority Countries* (Geneva, 2012).

26. However, in many low-income countries it is not possible to scale up child health interventions effectively without dealing with the challenges that affect health systems. Programmes to address newborn and child health are implemented through “complex public and private organizations that rely on systems to provide medicines, finance health services, assure quality and efficiency of care, manage the health workforce, and generate information needed for effective operational decisions”.²⁴

27. In addition, child health interventions will not be effective if the broader risk factors and determinants of under-five mortality are not simultaneously addressed. In rich and poor countries alike, the poorest and most disadvantaged children continue to miss out on life-saving interventions. Socioeconomic inequities exist in coverage of some of the key interventions across the continuum of care. Intervention coverage is consistently higher among women and children from the richest-20-per-cent stratum (although the gap in coverage between richest and poorest varies by intervention).²⁵

28. To accelerate progress and achieve improved health outcomes for all children, ensuring universal access to high-quality care, safe water and sanitation, safe and nutritious foods and safe housing is crucial, as is access to education, social security and other social services. In addition, investment in women’s health and education, and in the empowerment of women and the poorest and most disadvantaged population groups, is vital to ensure an effective response to under-five mortality.

29. There is an intrinsic link between under-five mortality and women’s status. Women’s comprehensive understanding of their sexual and reproductive health is imperative to ensuring their ability to protect their health and make informed decisions about sexuality and reproduction. Moreover, ensuring delay in sexual debut, preventing and treating sexually transmitted infections and guaranteeing optimal timing and spacing of pregnancies contribute to reductions in neonatal mortality. In addition, harmful practices such as child marriage and female genital mutilation need to be eliminated in order to improve both women’s health and child survival.

30. Low rates of literacy and education among women correlate strongly with high rates of under-five mortality. Hence, access to education allows women to understand and act for their own health and that of their children more effectively, and to seek care if needed. The impact of education and empowerment of women in reducing under-five mortality is even larger when their indirect effects are considered. The education of women leads to greater employment and decision-making power. There is evidence showing that, when women have more influence over household decisions, they are more likely to prioritize children’s nutrition, health care and education than men. The recognition of both parents’ role in child-rearing and the promotion of gender equality in pay and working conditions, including adequate maternity protection, is vital to the improvement of children’s health.²⁶

31. It is evident that the response to under-five mortality must be multi-faceted and must address the broader risk factors and determinants of child health and mortality. It must give sustained consideration to the needs of society’s most disadvantaged and vulnerable children and their families, if improved and more equitable child health outcomes are to be achieved. Empowering such communities, inter alia through meaningful participation and

²⁴ E. Cavagnero and others, “Assessment of the health system and policy environment as a critical complement to tracking intervention coverage for maternal, newborn and child health”, *Lancet*, vol. 371 (2008), pp.1284-93.

²⁵ A. Barros and others, “Equity in maternal, newborn and child health interventions in Countdown to 2015: a retrospective review of survey data from 54 countries”, *Lancet*, vol. 379 (2012), pp.1225-33.

²⁶ United Nations Children’s Fund. *State of the World’s Children Report 2007: The Double Dividend of Gender Equality* (New York, 2006).

enhanced accountability at all levels, is a key requirement, and can be facilitated by integrating practical human rights approaches into efforts to reduce under-five mortality.

III. Human-rights dimensions of under-five mortality: the international legal framework

32. There has been an increasing understanding at the international and regional levels that reducing under-five mortality is not solely an issue of health and development, but a matter of human rights.²⁷

33. In resolution A/HRC/22/32, the Human Rights Council identified a range of human rights which have a direct bearing on under-five mortality. These include the rights to nondiscrimination, to an identity, to health, to education, to safe and nutritious foods, to safe drinking-water and sanitation, and to protection from harmful traditional practices. These rights are enshrined in various international and regional human rights treaties and have been reaffirmed in numerous general comments, concluding observations and recommendations by treaty monitoring bodies.^{28,29}

34. As the analysis in the previous chapter emphasizes, under-five mortality is influenced by a variety of factors. In order to eliminate preventable under-five mortality, States must fulfil their international legal obligations to respect, protect and fulfil the full range of rights necessary for ensuring children's survival, health and development.

A. Rights in focus

35. International human rights law includes fundamental commitments by States to address under-five mortality as part of their work to ensure the right to the highest attainable standard of health for the child. Sound public health practice, which includes broader measures to address the health of children, such as combating disease and malnutrition, providing clean drinking-water and improved sanitation and ensuring safe pregnancy and childbirth, is crucial in order to enable States to fulfil this right.

36. Children under the age of five may die as a result of violations of the right to life, the right to the highest attainable standard of physical and mental health, the right to an adequate standard of living, the rights to water and sanitation and to food, and others. Importantly, under-five mortality is also linked to women's rights and the ability of women to survive pregnancy and childbirth and to exercise autonomy over decisions relating to their reproductive lives and optimal feeding practices. These rights are indivisible, interdependent, interrelated and all of equal importance for human dignity. They are identified on the basis of their direct relationship with under-five mortality. Other human

²⁷ See www.bayefsky.com; Brazil, ICCPR, A/51/40 vol. I (1996) 44; Mali, ICESCR, E/1995/22 (1994) 64; Morocco, ICESCR, E/2001/22 (2000) 82; Paraguay, ICESCR, E/1997/22 (1996) 22; Peru, ICESCR, E/1998/22 (1997) 33; Portugal, CRC, CRC/C/111 (2001) 48; Romania, ICCPR, A/49/40 vol. I (1994) 28; Senegal, ICESCR, E/2002/22 (2001) 61; Solomon Islands, ICESCR, E/2000/22 (1999) 40. See also A/HRC/17/25/Add. 3.

²⁸ In particular, CRC General Comments No. 4 and No. 15, CESCR General Comment No. 14, CEDAW General Recommendation No. 24 and Human Rights Committee General Comment No. 6.

²⁹ Office of the United Nations High Commissioner for Human Rights. *The right of the child to the enjoyment of the highest attainable standard of health* (Geneva, 2013). Available from http://www.ohchr.org/Documents/Issues/Children/Study/RightHealth/OHCR_Brochure_Report%20Health_2012_Eng.pdf.

rights also influence under-five mortality indirectly, such as freedom of expression and the rights to information, to social security, to work and to birth registration.

1. Right to life

37. Every human being has the inherent right to life.³⁰ The Human Rights Committee (the group of experts which oversees the implementation of the International Covenant on Civil and Political Rights – ICCPR) has emphasized that: “...the expression ‘inherent right to life’ cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy”.³¹ This has been further reaffirmed in the Convention on the Rights of the Child, which recognizes that “...every child has the inherent right to life.”³²

38. The number of preventable deaths among children under five suggests a systematic failure to provide access to high-quality services needed by children, and may constitute a violation of the right to life.¹ According to the Committee on the Rights of the Child (CRC), the many risks and protective factors that underlie the life, survival, growth and development of the child need to be systematically identified in order to design and implement evidence-informed interventions that address a wide range of determinants of health.³³

39. In the context of under-five mortality, the right to life is connected with a range of additional human rights, as discussed in the subsequent paragraphs.

2. Right to the highest attainable standard of health

40. Article 24 of the Convention on the Rights of the Child recognizes the right of the child to the enjoyment of the highest attainable standard of health. It explicitly states that its States parties shall take appropriate measures to reduce infant and under-five mortality. This has been reaffirmed in other conventions as well, most notably Article 12(2)(a) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which provides for the reduction of infant mortality and the healthy development of the child.^{34,35} Article 24 of the Convention on the Rights of the Child further requires States parties to take appropriate measures to ensure the provision of necessary medical assistance and health care for all children, with emphasis on the development of primary health care; to combat disease and malnutrition through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, and to ensure the provision of information and education on child health and nutrition.³⁶

41. Non-fulfilment of the right to health accounts for a major part of preventable under-five mortality. The right to the highest attainable standard of health creates a specific obligation on States to address under-five mortality and ensure that child-friendly health

³⁰ International Covenant on Civil and Political Rights, Art. 6.

³¹ Human Rights Committee General Comment No. 6 (1982), para. 5.

³² Convention on the Rights of the Child, Art. 6.

³³ CRC General Comment No. 15 (2013).

³⁴ International Covenant on Economic, Social and Cultural Rights.

³⁵ Organization of African Unity. *African Charter on Human and Peoples' Rights* (Nairobi, 1981).

³⁶ Convention on the Rights of the Child, Art. 24.

services, goods and facilities that are needed are available, accessible, acceptable and of high quality.³⁷

42. The response needed to avoid under-five deaths due to diarrhoea illustrates the importance of this obligation. While it is critical that oral rehydration salts and zinc be made available as key interventions to treat diarrhoea, States are also required to ensure the dissemination of appropriate information regarding breastfeeding practices, provide preventive vaccination against rotavirus and measles, and address water- and sanitation-related needs to try to reduce the burden of diarrhoea.

43. States must ensure that information and services are accessible to the entire population, especially those who are most marginalized.³⁸ Hence, measures must be taken to identify and address the underlying reasons why access to services remains constrained for some populations, e.g. gender inequality and discrimination, and ensure targeted responses, which may include measures such as social insurance or waiver schemes to guarantee financial accessibility. Attention to the functioning of any such scheme as well as attention to mechanisms for redress in case of breakdown is vital. Also encompassed within the principle of accessibility is access to health-related information to promote healthy behaviour and appropriate care-seeking. Parents and other caregivers should be informed about how best to prevent diarrhoeal disease and other childhood illnesses, as well as when to seek care if their child is ill.

44. The acceptability of child health services to clients is critical. For instance, oral rehydration salts are increasingly offered in flavoured varieties and smaller sachets for children, and new distribution mechanisms are being promoted to improve the acceptability and uptake of this life-saving product.³⁹

45. To ensure the quality of health services, States are required to train and equip an appropriate mix of health workers to address diarrhoea prevention and treatment and ensure adequate geographical coverage throughout the country. In addition, ensuring the quality and accuracy of health information can require regulation of the private sector or other interested parties: for instance, the promotion of exclusive breastfeeding may require regulation of the marketing of breast-milk substitutes and promotion of workplace policies that support breastfeeding as well as the provision of health information for new mothers.

46. The CRC emphasizes that children's right to health is dependent on the realization of many other rights, including the rights to nutrition, water and sanitation, an adequate standard of living, nondiscrimination and equality.⁴⁰ Similarly, realization of the right to health is crucial for realization of other human rights.⁴¹

47. The right to the highest attainable standard of health, like other economic, social and cultural rights, is subject to the principles of progressive realization and resource availability. States are required to fulfil these rights to the maximum extent of their available resources and, where needed, within the framework of international cooperation.⁴² While recognizing the principle of progressive realization and acknowledging constraints

³⁷ CESCR General Comment No. 14 (2000).

³⁸ Office of the United Nations High Commissioner for Human Rights. *The right of the child to the enjoyment of the highest attainable standard of health* (Geneva, 2013).

³⁹ S. Isanaka and others, "Bridging the gap from knowledge to delivery in the control of childhood diarrhoea", *Bulletin of the World Health Organization*, vol. 90, no. 9 (2012), pp. 635-635A.

⁴⁰ CRC General Comment No. 15 (2013).

⁴¹ Office of the United Nations High Commissioner for Human Rights. *Right of the child to the highest attainable standard of health* (Geneva, 2013).

⁴² See Convention on the Rights of the Child Art. 4 and CRC General Comment No. 15 (2013), paras. 71-72.

due to the limits of available resources, treaty monitoring bodies have emphasized that there are certain obligations which are of immediate effect. For example, according to the ICESCR, States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (Art. 2.2) and the obligation to take steps (Art. 2.1) towards the full realization of Article 12 on the achievement of the highest attainable standard of health. Such steps must be deliberate, concrete and targeted towards the full realization of the right to health.⁴³

48. CESCR has stated that the provision of child health care is comparable with a core obligation, and that States parties have the immediate obligation to take “deliberate, concrete and targeted steps” towards fulfilling the child’s right to health. For instance, this requires States parties to ensure access to essential health services for the child and his or her family, including prenatal and postnatal care for mothers. In all policies and programmes aimed at guaranteeing the right to health of children, their best interests shall be a primary consideration.^{44,45} Further, Article 24(3) of the Convention on the Rights of the Child obliges States parties to take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children, including such harmful practices as child marriage, which impair women’s and girls’ ability to make decisions about their sexual and reproductive lives and have negative effects on child survival.

3. Right to an adequate standard of living

49. Article 27 of the Convention on the Rights of the Child recognizes “the right of every child to a standard of living adequate for the child’s physical, mental, spiritual, moral and social development” and that States parties must “take the appropriate measures to assist parents and others responsible for the child to implement this right and shall ... provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing”. This has also been emphasized in Article 11 of the ICESCR, which recognizes the “right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions”.

50. The right to an adequate standard of living is essential for preventing under-five deaths and promoting the healthy development of the child. Adequate housing, including safe cooking facilities, adequate space and protection from overcrowding, a smoke-free environment, appropriate ventilation, effective management of waste and the disposal of rubbish from living quarters and the immediate surroundings, the absence of mould and other toxic substances, and a good standard of family hygiene, are core requirements for a healthy upbringing and development. The absence of these guarantees has direct implications for under-five mortality and morbidity, especially as many of these factors have a direct relationship with pneumonia and diarrhoea, which are leading causes of under-five mortality.⁴⁶

4. Right to water and sanitation

51. Numerous United Nations resolutions recognize the right to safe and clean drinking-water and sanitation as a human right that is essential for the full enjoyment of life and all human rights.⁴⁷ Access to a sufficient supply of safe, potable water is essential for reducing

⁴³ CESCR General Comment No. 14 (2000).

⁴⁴ Convention on the Rights of the Child, Art. 3(1).

⁴⁵ CRC General Comment No. 5 (2003).

⁴⁶ CRC General Comment No. 15 (2013), para. 49.

⁴⁷ Human Rights Council Resolution HRC/RES/15/9.

child morbidity and mortality, since hand-washing with soap and access to improved sanitation facilities can help reduce diarrhoea and pneumonia, as well as other infectious and parasitic diseases.⁴⁸

52. The CRC has repeatedly expressed concern regarding high infant and under-five mortality rates due to poor water supply, hygiene and sanitation practices.⁴⁹ It has called on governments to ensure that departments and local authorities actively consider indicators relating to malnutrition, diarrhoea and other water-related diseases in children when planning water services. States are not exempt from their obligations, even if they have privatized water and sanitation services.⁵⁰

5. Right to food and nutrition

53. Article 24(c) of the Convention on the Rights of the Child requires States parties “to combat disease and malnutrition”. The Convention emphasizes that States parties shall ensure the provision of adequate nutritious food. This has been reaffirmed in Article 11 of the ICESCR, which requires States parties to ensure access to nutritionally adequate, culturally appropriate and safe food and to combat malnutrition.⁵¹

54. The CRC and other treaty monitoring bodies have repeatedly expressed concern about high rates of infant mortality and levels of malnutrition, especially in rural and remote areas and among children belonging to indigenous groups.⁵² Undernutrition remains an urgent human rights challenge. The CRC emphasizes the importance of ensuring the provision of information and education about child health and nutrition, including the advantages of breastfeeding,⁵³ the risks of not breastfeeding, and the obligation to protect parents from misinformation, which includes the promotion of breast-milk substitutes. Hence, States parties must introduce into domestic law, implement and enforce the International Code of Marketing of Breast-milk Substitutes⁵⁴ and the relevant subsequent World Health Assembly resolutions, so as to minimize the negative impact of the marketing of such products on optimal feeding practices.

6. Women’s rights

55. Addressing gender inequality and ensuring that women’s rights are respected, protected and fulfilled are necessary conditions for making sustained progress in reducing child deaths.⁵⁵ A mother’s education has a direct impact on her children’s health. The children of mothers with no education are 2.7 times more likely to die than children of mothers who have more than 12 years of education.⁵⁶ Early marriage and pregnancy also

⁴⁸ General Assembly Resolution A/RES/64/292.

⁴⁹ CRC/C/69, paras. 131, 134 and 149.

⁵⁰ CRC General Comment No. 15 (2013), para. 48.

⁵¹ See: International Covenant on Economic, Social and Cultural Rights, Art. 11; CESCR General Comment No. 12; E/2011/22, Supplement 2, Annex V.

⁵² See www.bayefsky.com: Gabon, CRC, CRC/C/114 (2002) 47 at paras. 217-220; India, CRC, CRC/C/137 (2004) 75; Senegal, ICESCR, E/2002/22 (2001) 61 at para. 354; Uganda, CRC, CRC/C/69 (1997) 21.

⁵³ Convention on the Rights of the Child, Art. 24; CRC General Comment No. 15, para. 48.

⁵⁴ http://www.who.int/nutrition/publications/code_english.pdf, accessed 29 August 2013.

⁵⁵ Committee on the Rights of the Child. *Technical guidance on the application of a human rights based approach to maternal mortality and morbidity*. Geneva, 2012.

⁵⁶ S. Karlsen and others, “The relationship between maternal education and mortality among women giving birth in health care institutions: Analysis of the cross sectional WHO Global Survey on Maternal and Perinatal Health”, *BMC Public Health*, vol. 11 (2011) 606. Available from doi: 10.1186/1471-2458-11-606.

have a direct impact on the health and mortality of children. Millions of young girls around the world are forced into marriage, resulting in high-risk pregnancies and childbirth.⁵⁷

56. Various treaty monitoring bodies and Special Rapporteurs have emphasized the importance of realizing women's rights in relation to under-five mortality. They have called on States parties to address harmful practices, such as child marriage, and ensure access to the information and services needed by women and girls to make informed decisions about their sexual and reproductive lives.⁵⁸

57. Article 24 of the Convention on the Rights of the Child emphasizes the need for States parties to take appropriate measures to ensure prenatal and postnatal health care for mothers.⁵⁹ Women's reproductive rights include "the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth".⁶⁰ The Convention on the Elimination of All Forms of Discrimination Against Women requires States parties to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (Art. 12.2).⁶¹ Furthermore, the CRC's General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health states that "special measures should be taken to promote community and workplace support for mothers in relation to pregnancy and breastfeeding, and feasible and affordable childcare services, and compliance with the International Labour Organization Convention No. 183 (2000) concerning the revision of the Maternity Protection Convention (Revised), 1952."⁶²

B. Key human rights principles to address under-five mortality

58. International human rights law and standards identify certain principles that must lie at the heart of State efforts to address under-five mortality. These principles include the following.

1. Equality and non-discrimination:

59. States have an obligation to ensure equality and protect children against discrimination. International human rights law specifies that all human beings must be able to enjoy and exercise their human rights on a basis of equality and free from discrimination.⁶³

⁵⁷ United Nations Population Fund. *Marrying too young*. New York, 2012. Available from <http://unfpa.org/endchildmarriage>.

⁵⁸ See www.bayefsky.com: India, CRC, CRC/C/137 (2004) 75.

⁵⁹ Convention on the Rights of the Child, Art. 24.

⁶⁰ United Nations Population Fund. *Programme of Action of the International Conference on Population and Development*, para. 7.2 (New York, 1995). Available from <http://www.unfpa.org/public/home/sitemap/icpd/International-Conference-on-Population-and-Development/ICPD-Programme>.

⁶¹ United Nations. Convention on the Elimination of All Forms of Discrimination against Women. New York, 1979. Available from <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>.

⁶² CRC General Comment No. 15.

⁶³ See: ICCPR, Art. 3; ICESCR, Art. 3; Convention on the Elimination of All Forms of Discrimination against Women, Arts. 1 and 2; Human Rights Committee General Comment No. 28 (2000); CESCR, General Comment No. 16 (2005); CESCR, General Comment No. 20 (2009).

60. Discrimination is a significant factor contributing to vulnerability and has adverse effects on children's health.⁶⁴ Article 2 of the Convention on the Rights of the Child, alongside various other human rights documents, outlines a number of grounds on which discrimination is prohibited, 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.⁶⁵ Stigma and discrimination often hamper access by affected people and their children to essential health and related support services. Studies have shown that child survival inequities are shaped by ethnicity and geographical location,⁶⁶ which draws attention to the need for the collection and use of appropriately disaggregated routine health information to help to target areas or populations that are underserved or that have particularly poor health outcomes. An approach to under-five mortality that applies the human rights principles of equality and nondiscrimination can facilitate the identification of high-risk groups, enable analysis of the complex gaps in protection, participation and accountability they are facing, and promote the identification of comprehensive and sustainable solutions. For instance, identifying the areas and population groups which experience a disproportionately high burden of diarrhoea can help focus investments on improving access to effective interventions, through participatory processes and other means, and will accelerate the rate of decrease in under-five mortality, helping to bridge the equity gap in under-five mortality.^{67,68}

61. Treaty monitoring bodies require that particular attention be paid to gender-based discrimination, which has various manifestations relevant to under-five mortality, ranging from female infanticide/feticide to discriminatory infant and young child feeding practices, gender stereotyping and access to services. States should identify factors at national and subnational levels that create vulnerabilities for children or that disadvantage certain groups of children.

62. These factors should be addressed when developing laws, regulations, policies, programmes and services for children's health and working towards ensuring equality. Attention should also be paid to the implications of multiple and intersecting forms of discrimination.⁶⁹

2. Participation

63. The Declaration of Alma Ata, signed by 134 States and 67 international organizations in 1978, states that "the people have the right and duty to participate

⁶⁴ CRC General Comment No. 4 (2003), para. 6.

⁶⁵ ICCPR, Art. 2, para. 1; ICESCR, Art. 2, para. 2; Convention on the Rights of the Child, Art. 2, para. 1; Human Rights Committee, General Comment No. 18 (1989); CESCR General Comment No. 20 (2009); CESCR General Comment No. 16 (2005), para. 18.

⁶⁶ E.K. Mulholland and others, "Equity and child survival strategies", *WHO Bulletin*, vol. 86 (2008), pp. 399-407.

⁶⁷ Program on Global Health and Human Rights/World Health Organization. *Child rights situation analysis tool for child survival strategic planning* (forthcoming 2013).

⁶⁸ M. Chopra and others, "Ending of preventable deaths from pneumonia and diarrhoea: an achievable goal", *Lancet*, vol. 381, no. 9876 (2013), pp. 1499-1506.

⁶⁹ CEDAW General Recommendation No. 25, para. 12; CESCR General Comment No. 16 (2005), para. 5; CESCR General Comment No. 20 (2009), para. 17; CESCR General Comment No. 20 (2009); Human Rights Committee General Comment No. 28 (2000), para. 30; Committee on the Elimination of Racial Discrimination General Comment No. 25 (2000), para. 1; Durban Declaration (preamble, para. 69) and Programme of Action (paras. 18, 31, 50, 54(a), 176). Available from <http://www.un.org/WCAR/durban.pdf>, accessed 4 September 2013.

individually and collectively in the planning and implementation of their health care”.⁷⁰ The CESCR has stated that the participation of the population in all health-related decision-making at the community, national and international levels is an important aspect of the right to health.

64. Participation in the context of under-five mortality means granting parents of children, or other representatives, access to all relevant and necessary information to ensure an informed opinion, and including them in the decision-making processes which affect their children’s survival and health. Participation also requires empowerment of parents or other representatives to claim their rights and those of their children, and requires them to be able to participate in policy discussions and in processes that allow them to hold service providers to account.

65. Numerous studies have found that involving communities in health-related activities, including strengthening women’s organizations, developing women’s skills in problem identification and prioritization, training community members in safe birthing techniques and mobilizing women’s groups to recognize and treat malaria effectively at home can reduce under-five mortality.^{71,72} Furthermore, nongovernmental organizations working on child health have found across a range of settings that community participation can help to ensure that interventions are appropriate and effective.⁷³

66. The United Nations Special Rapporteur on the right to health has emphasized that participation in decision-making is an essential element of the right-to-health framework, and is of great importance in achieving long-term gains in core areas, and in particular in further lowering maternal and under-five mortality rates.⁷⁴ Community participation can also contribute to effective monitoring and accountability.

3. Best interests of the child

67. The CRC emphasizes that the best interests of the child must be taken as a primary consideration in all actions affecting children. This principle must be observed in all health-related decisions concerning individual children or children as a group.

68. The CRC has called on States to place children’s best interests at the centre of all decisions affecting their health and development, including the allocation of resources and the development and implementation of policies and interventions that affect the underlying determinants of their health.

69. The CRC underscores the importance of the best interests of the child as the basis for all decision-making with regard to providing, withholding or terminating treatment for all children. States should develop procedures and criteria to provide guidance to health

⁷⁰ World Health Organization. *Declaration of Alma Ata*, para. IV. Geneva, 1978. Available from http://www.who.int/publications/almaata_declaration_en.pdf.

⁷¹ M. Rosato and others, “Community participation: lessons for maternal, newborn, and child health”, *Lancet*, vol. 372, no. 9642 (2008), pp. 962–971.

⁷² D.S. Manandhar and others, “Effect of a participatory intervention with women’s groups on birth outcomes in Nepal: cluster-randomised controlled trial”, *Lancet*, vol. 364, no. 9438 (2004), pp. 970–979.

⁷³ Save the Children India/Public Interest Foundation. *Communities for children: selected good practices in improving children’s well-being through community participation*. New Delhi, 2009. Available from http://www.savethechildren.in/custom/recent-publication/communities_for_children.pdf.

⁷⁴ A/HRC/17/25/Add.3.

workers for assessing the best interests of the child in the area of health, in addition to other formal, binding processes that are in place for determining the child's best interests.⁷⁵

4. International cooperation and assistance

70. Human rights obligations in the context of the promotion of global health call for shared approaches and systems of collective responsibility, together with a global development agenda that centrally reflects issues of human rights.⁷⁶ Human rights bodies have emphasized the need for international cooperation and assistance to develop a multifaceted approach to improve the situation of children and prevent and combat infant and under-five mortality and malnutrition.⁷⁷

71. In this connection, the Special Rapporteur on the right to health has emphasized that: "the right to health gives rise to a responsibility of international assistance and cooperation on developed States to assist developing States to realize the right to health".⁷⁸ Thus, donor countries have a responsibility to provide international cooperation and assistance focused on realizing the right to health.

5. Accountability

72. Ensuring effective monitoring and accountability is at the core of any response to under-five mortality. Monitoring and accountability require multiple forms of review, oversight and redress – administrative, social, political and legal. The Commission on Information and Accountability for Women's and Children's Health (convened under the Global Strategy for Women's and Children's Health) reiterated these multiple dimensions of accountability by adopting a framework built on three pillars: monitoring, review and action (including redress). The independent Expert Review Group (iERG), established to monitor and assess progress in implementation of recommendations made by the Commission, has stated that accountability needs to be based on certain core principles — clarity about stakeholder responsibility for action; accurate measurement; independent verification; impartial, transparent, and participatory review; and clear recommendations for future action.⁷⁹ The CRC and other treaty monitoring bodies have reminded States parties of their obligations to ensure that relevant government authorities and service providers are held accountable for maintaining the highest possible standards of children's health and health care. This means, for instance, ensuring that health-service users are able to report essential medicine stock-outs, in addition to procedures for investigating every preventable death.

73. Accountability in the context of human rights is understood as States' obligation to prevent, investigate or redress harm caused by acts of private persons or entities.⁸⁰ Such accountability must aim towards addressing both the individual and the structural nature of harm caused by discrimination in the enjoyment of rights.⁸¹

⁷⁵ CRC General Comment No. 15 (2013), para. 14.

⁷⁶ See Paris Declaration on Aid Effectiveness, 2005 and Accra Agenda for Action, 2008. Available from <http://www.oecd.org/dac/effectiveness/parisdeclarationandaccraagendaforaction.htm>.

⁷⁷ A/HRC/7/11/Add.2.

⁷⁸ A/61/338, para. 20.

⁷⁹ World Health Organization. *iERG. Every woman every child: from commitments to action. The first report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health*. Geneva, 2012.

⁸⁰ Human Rights Committee General Comment No. 31(2004), para. 8.

⁸¹ CESCR General Comment No. 20 (2009), para. 40.

74. Treaty monitoring bodies have called on States to ensure a regulatory framework within which all actors should operate and can be monitored, inter alia by mobilizing political and financial support for children's health-related issues and building the capacity of duty-bearers to fulfil their obligations. Without monitoring, systemic failures in reducing under-five mortality cannot be corrected. When States adopt and implement a national public health strategy and plan of action, they should also develop "appropriate indicators to monitor progress made, and to highlight where policy adjustments may be needed".⁸²

75. Treaty monitoring bodies also require States to ensure, effective national accountability mechanisms, which are transparent and hold all actors responsible for their actions. National accountability mechanisms should monitor, review and act on their findings.⁸³ Access to national justice systems should be expanded, as well as legal literacy and empowerment. States should also devote attention to the structural factors affecting children's health, including laws, policies and budgets.⁸⁴

76. Article 4 of the Convention on the Rights of the Child stipulates the requirement to "take all necessary legislative measures for the implementation of rights recognized" in the Convention. Taking all necessary legislative measures includes regulating services and medications to ensure that they are of good quality and cause no harm, ensuring that they are available at appropriate levels of the health system to maximize safe uptake, ensuring nondiscrimination in access to health-related information and services and removing impediments to realizing the child's right to health. In addition, legislation should define the scope of the right to health and recognize children as rights-holders; clarify the roles and obligations of all duty-bearers; and identify the services which children, pregnant women and mothers are entitled to claim.⁸⁵

77. Furthermore, the CRC has determined that one of the core obligations under the child's right to health is "reviewing the national and sub-national legal and policy environment and, where necessary, amending it".⁸⁶

78. One example of this core obligation is the identification and subsequent elimination of legal restrictions on the administration of antibiotic drugs for pneumonia in children by community health workers. These restrictions, present in a significant number of countries, ultimately deny children their right to access to life-saving interventions. Legislative reforms aimed at eliminating such legal barriers must be coupled with appropriate training for community health workers to ensure that they have sufficient capacity to deliver the necessary interventions safely, and empowerment of parents or other caregivers to claim their right to access said interventions, through legal or non-legal remedies. Hence, functional accountability mechanisms that are enforceable through the courts, as well as through quasi- and non-judicial mechanisms such as national human rights institutions and subnational complaints mechanisms, are a vital element in creating an enabling and supportive legal and regulatory environment for child health.

⁸² CESCR General Comment No. 14 (2000), para. 43(f).

⁸³ CRC General Comment No. 15 (2013), para. 118.

⁸⁴ CRC General Comment No. 15 (2013), paras. 104-108.

⁸⁵ Committee on the Rights of the Child. *The right of the child to the enjoyment of the highest attainable standard of health*. Geneva, 2013.

⁸⁶ CRC General Comment No. 15 (2013), para. 73(i).

IV. Conclusions and recommendations

79. The annual death toll of close to 7 million children under five years of age remains not only an acute public health emergency, but must be recognized as a matter of great social injustice and as a grave human rights concern.

80. While international efforts to address mortality among children under the age of five have resulted in significant reductions globally, persistent inequities between and within countries exist. These are not only driven by poverty, but are intrinsically linked to social exclusion and discrimination. Therefore, continued efforts to eliminate under-five mortality must take into consideration both direct causes and underlying determinants. This requires a comprehensive and holistic approach, which must explicitly recognize human rights standards as essential integrated elements of the approach.

81. It is clear that bringing together human rights and public health is a critical step towards developing effective approaches to addressing this global problem. Over the past few years, significant progress has been made in further articulating the importance of human rights as a foundation for improving the health of children.

82. There is ample recognition within human rights treaties that human rights are vital to successfully addressing under-five mortality. The United Nations human rights mechanisms, including the Human Rights Council and treaty monitoring bodies, have progressively elaborated on the human rights dimensions of under-five mortality, as well as on the human rights violations that need to be addressed, prevented or remedied in this area. In February 2013, the CRC adopted its General Comment No. 15 on the child's right to the highest attainable standard of health. In its resolution A/HRC/22/32, the Human Rights Council affirmed the importance of applying a human-rights-based approach to reducing and eliminating preventable under-five mortality and morbidity, and requested States to renew their political commitment in that respect and to take action to address the main causes of under-five mortality.

83. The report by OHCHR on the right of the child to the enjoyment of the highest attainable standard of health⁸⁷ clearly outlines the importance of adopting a human-rights-based approach to children's health, as does the recently completed WHO study on the evidence of impact of human-rights-based approaches to improve the health of women and children.⁸⁸ The WHO study finds that applying human rights to women's and children's health policies, programmes and other interventions not only helps governments comply with their binding national and international obligations, but also contributes to improving the health of women and children.

84. The current report draws attention to a number of steps that are essential in order to address under-five mortality effectively and are also essential for a human-rights-based approach to health interventions. These include: ensuring a supportive legal and policy environment; increasing access to preventive health interventions and life-saving drugs; increasing access to services for the integrated management of childhood illnesses (at community level and elsewhere); and establishing accessible, transparent and effective mechanisms of monitoring and accountability. Related State

⁸⁷ Office of the United Nations High Commissioner for Human Rights. *The right of the child to the enjoyment of the highest attainable standard of health*. Geneva, 2013.

⁸⁸ World Health Organization. *Women's and children's health: evidence of impact of human rights*. Geneva, 2013.

obligations, including procedural obligations, are underpinned by several specific human rights principles: equality and nondiscrimination, participation, the best interests of the child, international cooperation and accountability. Giving effect to these principles is the core of a human-rights-based approach to the reduction of preventable under-five mortality. While under-five mortality is global in nature, States and other actors giving international assistance and technical cooperation need also to approach their work to address under-five mortality from a human-rights-based perspective.

85. The Human Rights Council can make a variety of constructive and effective contributions to the global effort to reduce under-five mortality. Such steps would be consistent with the Council's mandate as "the inter-governmental body within the United Nations system responsible for strengthening the promotion and protection of human rights around the globe and for addressing situations of human rights violations and making recommendations on them".⁸⁹

86. The Council could take important steps to promote the effective operationalization of a human-rights-based approach to under-five mortality. First and foremost, it could call for technical guidance on the practical application of a human-rights-based approach in a resolution on under-five mortality as a human rights concern.

87. Such technical guidance could help promote a more standardized approach to guide States in their human-rights-based efforts to address under-five mortality. In addition, it could seek to address many of the currently unanswered questions relating to applying human rights to the reduction of under-five mortality, such as: What are specific and practical steps that can be taken by States and other duty-bearers to implement/adopt a human-rights-based approach to eliminating preventable under-five mortality? How can legal, political and social environments that protect against under-five mortality be created? How can access to life-saving drugs and services be ensured for all children without discrimination of any kind? What is the range of constructive accountability mechanisms that are consistent with human rights principles and can be used to ensure effective reduction of under-five mortality?

88. In addition, the proposed technical guidance could contain specific practical steps and recommendations for the inclusion of such an approach in ongoing global initiatives. Significant progress has been made towards achieving MDG4, but additional efforts are required if the goal is to be reached and current inequities reduced. It is imperative that current global initiatives aimed at accelerating efforts to achieve MDG4 fully integrate a human rights dimension into their activities. In particular, implementation of the recommendations made by the Commission on Information and Accountability must be guided by human rights principles. The Council could reiterate the recommendation made by the iERG and call upon States, United Nations agencies and other partners to "strengthen human rights tools and accountability frameworks to achieve better health and accountability for women and children".⁹⁰

⁸⁹ Office of the United Nations High Commissioner for Human Rights, "Background information on the Human Rights Council". Available from <http://www.ohchr.org/EN/HRBodies/HRC/Pages/AboutCouncil.aspx>, accessed 4 September 2013.

⁹⁰ World Health Organization. *iERG. Every woman every child: from commitments to action. The first report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health*. Geneva, 2012.

89. Looking beyond the timeframe of the MDGs, the Council can take a leadership role in ensuring that a human-rights-based approach to addressing under-five mortality remains central to the post-2015 development agenda. In the short term, this could include advocating for such an approach at the MDG review summit, to be held in September 2013. Thereafter it will be important to ensure that human rights remain fully integrated in the design, implementation, monitoring and evaluation of the post-2015 agenda.

90. The Council could also consider requesting increased use of existing accountability mechanisms for monitoring State efforts to reduce under-five mortality. Opportunities for requesting information on State action in this regard include the Universal Periodic Review mechanism, as well as periodic State party reporting under the Convention on the Rights of the Child, ICESCR and the Convention on the Elimination of All Forms of Discrimination against Women. Another important element would be for the Council to invite United Nations agencies, funds and programmes that are undertaking initiatives and activities in relation to under-five mortality systematically to contribute information for consideration through all these mechanisms. As the discussion above shows, the issue of under-five mortality is not only a matter of the right to health, but cuts across a number of rights and thematic human rights issues. Thus, the Council could also encourage its special procedures to integrate consideration of the human rights dimensions of preventable under-five mortality into their respective mandates.

91. The Council might also consider encouraging national human rights institutions to contribute to efforts to reduce under-five mortality. This could include routinely addressing under-five mortality in their annual reports, instigating enquiries into under-five mortality, reviewing and promoting accountability, identifying remedial actions for violations of children's right to health, and advocating for systemic change towards the realization of this and other related rights.
