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RIGHTS OF THE CHILD

Written statement* submitted by the International League for Human Rights, a non-governmental organization in special consultative status

The Secretary-General has received the following written statement which is circulated in accordance with Economic and Social Council resolution 1996/31.

[16 January 2002]

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*This written statement is issued, unedited, in the language(s) received from the submitting non-governmental organization(s).

1. The U.N. Convention on the Rights of the Child (CRC) secures to children the basic rights to food, shelter, healthcare, and education. It also instructs states that, to implement the CRC, states should be guided at all times by the "best interests of the child." Article 24 sets the "highest attainable standard of health" for children as a goal for states party to the CRC. In pursuit of this goal, the Convention requires states to take all available measures to diminish infant and child mortality; provide necessary health care to all children, and combat disease and malnutrition.1

2. The CRC recognizes that limitations on state resources make immediate and complete realization of its goals unrealistic.2 State claims of resource constraints, however, often mask decisions to place other political and economic priorities above health care. Given the CRC's goals and its near unanimous ratification, the welfare of the next generation is recognized as crucial. Common sense would dictate making children's health a top priority. At one end of the spectrum are countries like the United States, which, despite its enormous wealth, still does not ensure a medical safety net for all children. At the other end are developing countries that have made substantial economic progress over recent decades, which continue to prioritize economic growth over the welfare of children.

3. Tibet provides one example. A recent study on child healthcare in Tibet from the International Committee of Lawyers for Tibet found that in many areas, the provision of healthcare has improved in recent decades.3 Nonetheless, it finds some areas of concern. Information collected from this study provides evidence of both substandard healthcare and nutrition for Tibetan children, as well as a proven ability to do much better, were if not for political decisions to allocate resources almost exclusively to urban dwellers. In Tibet, such decisions satisfy the needs of the vast majority of Chinese cadres and settlers, and ignore 80% of Tibetan children.

4. First, Tibetan children face an absence of adequate healthcare facilities in rural areas. Tibetan children in Lhasa and a few other urban areas live near modern hospitals. More than eighty percent of Tibetans, however, live in rural and nomadic areas. Most Tibetans in those areas must travel hours or days to reach a modern medical clinic. In the event of an emergency, Tibetan children may be unable to reach an appropriate facility in time to avert fatality. One child, for example, who had been mauled by police dogs, had to travel two days by yak with his father to reach the nearest hospital.

5. Second, prohibitive costs pose a major barrier to medical treatment. The PRC claims "[t]he government provides free medical care for all Tibetans." 4 One medical aid worker in Tibet, however, described the healthcare system as "the most expensive free healthcare system in the world." The large hospitals charge excessive "security deposits," without which they refuse to treat patients. Larger hospitals generally require a 1,000-yuan security deposit for admission. The size of the deposit may vary depending on the hospital's location (urban or rural), as well as whether the patient has connections to the Chinese government. Security deposits

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1 CRC, art. 24.

2 *See* UNITED NATIONS CHILDRENS FUND, IMPLEMENTATION HANDBOOK FOR THE CONVENTION ON THE RIGHTS OF THE CHILD (1998) at 322.

3 International Committee of Lawyers for Tibet, A GENERATION IN PERIL: THE LIVES OF TIBETAN CHILDREN UNDER CHINESE RULE (2001).

4 *See* Information Office of the State Council of the People's Republic of China, *Tibet – Its Ownership and Human Rights Situation* (Sept. 1992).

range from 1,000 yuan at the village level to 2,000 yuan at the larger Chinese hospitals. (In Tibet, 1,000 yuan may represent 3-6 months' income.) Many families cannot afford required hospital care. One boy, for example, stated that his family had to sell all of its possessions to pay for his mother's four-month stay in the hospital.

6. A planned immunization program has been implemented in Tibet since 1986, with reports claiming over 85 percent of children have been inoculated.5 But other evidence suggests this number is not accurate. Several physicians reported that few children received vaccinations in remote villages because healthcare workers dislike serving in these regions. Urban Tibetan children typically can recall childhood shots, but those from rural regions often do not. Moreover, most refugee Tibetan children arrive in India without a "TB mark," which indicates the standard "BCG" vaccination for tuberculosis. Separate reports show that tuberculosis is a widespread problem among Tibetan children.

7. Most disturbing is the growing evidence that Tibetan children suffer from growth stunting as a result of severe malnutrition. A February 2001 study in the *New England Journal of Medicine* examined 2,078 Tibetan children under the age of seven.6 The study found that "stunting was linked to malnutrition . . . and was often accompanied by bone disorders, depigmented hair, skin disorders and other diseases of malnutrition." More than fifty-six percent of Tibetan children between the ages of two and seven manifested severe growth stunting.7 We emphasize here that early childhood malnutrition typically affects not only physical development, but mental development as well.

8. Poor diet and the absence of a clean water supply play a major role in malnutrition. Official data issued in 1998 shows that in 1997, among China's rural populations, the Tibet Autonomous Region (TAR) ranked last in improved access to clean drinking water with only an eighteen percent improvement. The next-lowest ranked province in China, Chongqing, improved by almost forty-two percent.8 Research does indicate that some Tibetan children suffer from the absence of a stable clean water supply. Contaminated water leads to chronic gastrointestinal infections and malabsorption syndromes, which contribute to the severe growth stunting.

9. We note, for example, that dysentery — which can be caused by parasites, a poor water supply or spoiled food — is one of the most common ailments for Tibetan children. In fact, dysentery is the single greatest cause of infant mortality in rural regions of Tibet. Tragically, the World Health Organization has noted that to prevent most deaths caused by "diarrheal disease, there exists a simple, inexpensive and effective intervention: oral rehydration therapy."9

10. The scarcity of data makes it difficult to assess the state of Tibetan children's healthcare and nutrition. This results primarily from the difficult barriers erected to conducting independent studies and monitoring of conditions within Tibet. Foreign charities and humanitarian aid projects operate in Tibet, but the government tightly regulates the scope of their activity. These restrictions make it difficult to ascertain fully the health and nutritional issues faced by

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5 Information Office of the State Council of the People's Republic of China, *Tibet – Its Ownership and Human Rights Situation* (Sept. 1992).
6 *Nutritional and Health Status of Tibetan Children Living at High Altitudes*, 344 N. ENGL. J. MED. 341 (No. 5) (2001).
7 *See id*.
8 PEOPLE'S REPUBLIC OF CHINA, YEAR BOOK OF HEALTH IN THE PEOPLE'S REPUBLIC OF CHINA (1998).
9 WORLD HEALTH ORGANIZATION, WORLD HEALTH REPORT 1999: MAKING A DIFFERENCE 20 (1999).

Tibetan children and thus impede progress towards their resolution.

11. We also emphasize that government restrictions on the ability of outside organizations to study and publicize the health conditions prevailing in Tibet violate Tibetan children's rights. Under the CRC, states parties agree to pursue economic, social and cultural rights "where needed, *within the framework of international cooperation.*"10 By restricting monitoring and access to information, the government inhibits international cooperation, limiting the ability of international organizations to help children in Tibet.

12. At the same time, China's decision to focus its healthcare resources on urban areas that serve principally Chinese settlers indicates undue neglect of the health and nutritional needs of Tibetan children. In addition, it appears that health and nutritional conditions for Tibetan children are in several respects inferior to those prevailing elsewhere in the PRC. In 1990, the infant mortality rate of the Tibetan nationality was 92.46 per 1,000 live births, roughly triple the national average for China.11 In contrast to Tibetan children, who suffer from growth stunting caused by malnutrition, another study published in 1996 by the *New England Journal of Medicine* found that in China (excluding Tibet) children in rural areas are continuing to grow, though at a pace slower than urban children. The Tibetan life expectancy (59.7 years) ranks lowest among China's eighteen "major nationalities."12 Official statistics provided by the PRC indicate that the ratio of doctors and medical aides per village in the TAR is only .61, compared with a 1.8 average for the PRC as a whole. The TAR, in fact, ranks the lowest of all provinces in the PRC in the number of medical personnel per village.13 Whereas China has roughly 85-95 beds per 1,000 people, the TAR has only 6-22 beds per 1000 people.14

13. Tibet, then, contrasts deep concerns about healthcare and nutrition for the vast majority of Tibetan children, with plentiful resources for urban Chinese settlers and cadres in Tibet and for urban Chinese throughout China. We therefore urge the Committee to scrutinize carefully situations such as Tibet, where some evidence of progress on healthcare for children, combined with claims that resource constraints prevent more being done, may mask political decisions that ignore the best interests of children. We urge the Committee to adopt a resolution addressing this, as well as other, human rights issues in Tibet at this session.

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10 CRC, art. 4 (emphasis added).

11 Jin Yangsun, et al. *A Study on Patterns in the Average Life Expectancies and Mortality Rates of 56 Nationalities in China in 1990*, 6 CHINESE J. OF POPULATION SCIENCE 263, 268 (1994).

12 Yangsun, *supra* note 9.

13 PEOPLE'S REPUBLIC OF CHINA, YEAR BOOK OF HEALTH IN THE PEOPLE'S REPUBLIC OF CHINA (1998).

14 World Food Program, *China Province Reference Database for Vulnerability Analysis*, (June 1998, as revised).