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

Implementation of the technical guidance on the application of a human rights-based approach to policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age

Report of the United Nations High Commissioner for Human Rights

Summary

The present report, submitted pursuant to Human Rights Council resolution 27/14, provides an overview of activities undertaken to implement the technical guidance since its adoption. It analyses issues that require further attention from a human rights perspective, including in relation to the newborn child, the quality of care in the delivery of health services for children and the marketing of breast-milk substitutes. It makes a number of recommendations for the Council to remain seized of the matter.

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Contents

I. Background

1. The technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (see A/HRC/27/31) was requested by the Human Rights Council in its resolution 24/11 and was presented to the Council at its twenty-seventh session in September 2014.

2. In its resolution 27/14, the Council welcomed the technical guidance and urged States to disseminate and apply it as appropriate in the design, implementation, evaluation and monitoring of laws, policies, programmes, budgets and mechanisms for remedy and redress. It called on the United Nations High Commissioner for Human Rights, in close collaboration with the World Health Organization (WHO) and others, to continue the dialogue on the issue of preventable mortality and morbidity of children under 5 years of age and to prepare a report on the practical application of the technical guidance and its impact and present it to the Human Rights Council at its thirty-third session. The present report is submitted in accordance with that request.

3. The present report is the first follow-up report on prevention of child mortality and the implementation of the technical guidance. It is presented at the same time as the second follow-up report on maternal mortality, which focuses on the implementation of the Sustainable Development Goals (A/HRC/33/24). Given their close links, the reports should be read in conjunction with each other.

4. The technical guidance presented specific human rights guidance, organized according to the policy cycle of planning, budgeting, implementation, monitoring and evaluation, review, redress and international cooperation. The present report provides an overview of activities undertaken by the Office of the United Nations High Commissioner for Human Rights (OHCHR) and other partners, including WHO, to implement the technical guidance. It also highlights some of the areas that need further focus and support at international level.

II. Latest progress on child survival

5. The life of every child is unique — its loss is a tragedy. If that loss is preventable, the tragedy is even bigger, as an irreplaceable life could have been spared. Without the child surviving, no other rights have meaning.

6. Substantial progress has been achieved in the past decades in reducing child mortality. The global number of child deaths has declined from 12.7 million in 1990 to 5.9 million in 2015. At the country level, about a third of all countries have reduced child mortality by two thirds or more, including Cambodia, Ethiopia, Eritrea, Liberia, Madagascar, Malawi, Mozambique, Nepal, the Niger, Rwanda, Uganda and the United Republic of Tanzania. An additional 74 countries reduced their under-5 mortality rates by at least half and another 41 countries by at least 30 per cent.[1]

7. That overall progress has been the result of many different factors, including renewed political commitment and major newborn and child health initiatives in recent years. Advances in immunization and the treatment of childhood infections, improvements in health services and medical technology, and overall respect for human rights, including

[1] Inter-Agency Group for Child Mortality Estimation, “Levels and trends in child mortality: report 2015” (2015), p. 3.

the right to education, the right to freedom from violence, the right to water and sanitation and overall improvement of the economic situation, have been key.[2] International cooperation and support has played a critical role.

8. Yet, despite remarkable progress, inequality persists in many countries, hampering the further reduction of child mortality among some groups of children. Examples in that regard have been referred to in the 2016 report of Save the Children Every Last Child,[3] which reveals that disadvantaged regions in a number of countries are making slower progress. The report shows, however, that the opposite is also possible and refers to the example of the Niger, where regions that were lagging behind, such as Zinder and Maradi, have experienced a faster rate of progress than Niamey (ibid., p. 23). Progress in those deprived regions has benefited children who had low chances of survival. It is important to note that inequalities undermine progress in developed countries as well as low- and middle-income countries.

9. Under the 2030 Agenda for Sustainable Development, a commitment is made to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births. In the Agenda, it is recognized that human dignity is fundamental and that the goals and targets are to be met for all segments of society, endeavouring to reach the furthest behind first.

10. Human rights-based policies and programmes need to ensure that children in hard-to-reach regions are given further attention and that investment in health care be made in regions that are falling behind. Furthermore, investment in child survival must be viewed through the lens of the rights of the child rather than driven merely by development and assistance needs.

III. Human rights and prevention of child mortality: an unfinished agenda

11. Recognizing under-5 mortality as a human rights issue implies understanding that the death of a child is not an inevitable fact of life, but rather is often the result of discriminatory laws, practices and attitudes, as well as institutional arrangements that compound poverty, disempowerment and injustice. The ultimate goal of a human rights-based approach is to change the social power dynamics that lead to inequalities and discrimination in accessing health services and failures to establish and maintain health systems that are available, accessible, affordable, acceptable and of high quality.

12. Human rights-based approaches to health in general have long been the subject of discussion. In particular, maternal health and wider sexual and reproductive health issues have been analysed through a human rights lens for many years (see A/HRC/27/20, para. 5). On the other hand, while reducing the mortality and morbidity of children under 5 years of age has been a focus of the global health community for several decades, it is only recently that the issue has been recognized as a human rights concern and brought to the attention of child rights mechanisms and child rights experts. A number of reasons explain that, including: (a) for a very long time the child rights community had focused on child protection issues and considered the health system merely an element of child protection;

[2] See United Nations Children's Fund (UNICEF), *Committing to Child Survival: A Promise Renewed* (2014).

[3] Save the Children, *Every Last Child* (London, 2016).

and (b) given the lack of autonomy of the small child, his or her rights tend to be associated with the mother and tend to be included in discussions of sexual, reproductive and maternal health. Continuum of care is critical and attention to the mother before, during and after birth is essential to improve the chances of survival for the child. Nevertheless, the interdependence between the mother and the child should not lead to a conflation of their rights and needs.

13. As explained in the technical guidance, a human rights-based approach to reducing under-5 mortality requires the identification of relevant duty-bearers and rights holders and building the capacity of the former to fulfil their obligations and of the latter to claim their rights related to child health and survival. Yet, in the case of newborns, infants and under-5 children, that becomes highly complex, because the young child is not autonomous and depends on others for the realization of his or her rights. Often the rights of newborns and infants are not explicitly taken into consideration, as they are not perceived as active agents. A human rights-based approach requires recognition that the newborn, infant and under-5 child is not merely a passive receiver of care, but is a rights holder and thereby entitled to quality health services without discrimination.

14. Collaboration between the communities working on rights and health is emerging in the area of child health and prevention of mortality. Clear examples are the annual day of discussion of the Human Rights Council on the right of the child to health in 2013, followed by a number of reports by OHCHR and WHO, and expert meetings on child mortality and human rights, as well as the development of the technical guidance. General comment No. 15 (2013) of the Committee on the Rights of the Child on the right of the child to the enjoyment of the highest attainable standard of health, as well as the recent report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on early childhood (A/70/213), demonstrate the increasing interest of, and attention paid, by United Nations human rights mechanisms.

15. The work of the independent Expert Review Group on Accountability for Women's and Children's Health placed the issue of human rights at the top of the health agenda and called for the establishment of a global commission on health and human rights of women and children to propose ways to protect, augment and sustain their health and well-being. The establishment of the Independent Accountability Panel and the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) will be key in bringing both areas of work closer. When leading a sub-working group on human rights in the context of the development of the Global Strategy, OHCHR re-emphasized the need not to leave anyone behind, with a focus on non-discrimination and accountability.

16. From a child rights perspective, it is critical that all the various global initiatives give the appropriate space to the young child and that the child be at the centre of the discussion, including through participatory approaches for children and their caregivers, in accordance with the Convention on the Rights of the Child.

17. During the past two years, a key question that has come up in the discussions of the technical guidance by those outside the human rights field has been: does a human rights-based approach reduce child mortality? While there is no straightforward answer to that question, evidence is starting to emerge that using a human rights-based approach has a positive impact on children's health,[4] which supports the case for human rights to be fully integrated into efforts to improve child health, survival and development.

[4] See Flavia Bustreo, Paul Hunt and others, *Women's and Children's Health: Evidence of Impact of Human Rights* (Geneva, WHO, 2013).

18. Furthermore, the issue is not so much how many children a human rights-based approach saves, but more specifically if international human rights law allows for dignity, equality, participation and accountability not to be placed at the centre of policy and programme development. Given that States have ratified the Convention of the Rights of the Child and assumed obligations vis-à-vis children on a voluntary basis, the inclusion of human rights principles in the development of policies and programmes is not a choice but rather an obligation: a legal and a moral obligation that the State has towards the smallest of its citizens.[5]

19. Through the work undertaken since the finalization of the technical guidance, it has become clear that the area of human rights-based approaches to newborn, infant and under-5 health has many dimensions in addition to prevention of mortality of children, and that a specific child rights and child health dialogue is needed. That has also been signalled by the Special Rapporteur on the right to health in his report on early childhood (A/70/213).

20. In the context of the discussions on the technical guidance, OHCHR has been approached by different stakeholders raising child health issues requiring urgent attention from a rights perspective, including: pain management for the newborn child; palliative care for children; consent issues regarding surgeries, including for intersex children; paediatric medicines; children born with severe impairments and life-threatening health conditions, including severely premature babies; abandonment of the newborn; and the role of health personnel in assessing violence against children, including shaken baby syndrome and sexual violence. Stakeholders also raised the inequitable access of infants and young children to HIV testing, treatment and care, especially in sub-Saharan Africa, contributing to disproportionately high AIDS-related mortality rates among children.

21. The technical guidance has made a great contribution to promoting the dialogue between human rights experts and mechanisms with obstetricians, neonatologists and paediatricians, but there is still a long way to go before that area of work is fully developed.

IV. Implementing the technical guidance at the country level

A. Dissemination

22. Efforts have been made to ensure the dissemination of the technical guidance by OHCHR and United Nations system agencies, including WHO, as well as civil society partners, national human rights institutions and other stakeholders.

23. Following its launch in September 2014 by the High Commissioner for Human Rights and the WHO Assistant Director-General for Family, Women's and Children's Health, the technical guidance was widely disseminated. In addition to coverage of the launch by OHCHR, WHO and the Partnership for Maternal, Newborn and Child Health, as well as United Nations Information Centres, the technical guidance was distributed via the Child Rights Information Network and the African Child Information Hub. Furthermore, it was disseminated via patient information websites, including those of the International Alliance of Patients' Organizations and the European Association for Children in Hospitals, and by international advocacy groups, such as the International Baby Food Action Network.

[5] Statement of the High Commissioner for Human Rights on the occasion of the launch of the technical guidance.

24. The technical guidance was shared in various meetings, including the One Asia Breastfeeding Partners Forum in Malaysia, and was brought to the attention of participants at different forums, including the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases, the African Child Policy Forum in South Africa and the Social Forum on access to medicines. It was also presented to an expert meeting on the right to health in early childhood, as well as to the Seventh Europediatrics Conference in Florence, Italy. The Partnership for Maternal, Newborn and Child Health also promoted the technical guidance among its network of over 500 members. It was also discussed in a number of stakeholder meetings for women's and children's health, including in India and South Africa.

25. Working-level discussions on the technical guidance were held between OHCHR and WHO, and the Office of the Secretary-General as part of Every Woman Every Child, and the United Nations Children's Fund (UNICEF) Health Section staff in New York. Furthermore, the High Commissioner for Human Rights met with the Executive Director of UNICEF to discuss the implementation of the technical guidance at the country level.

26. WHO and OHCHR produced an information leaflet on "Preventable deaths among the world's youngest children", which was also widely disseminated. Other tools, including a knowledge summary on operationalizing human rights in efforts to improve health, were developed by WHO and the Partnership for Maternal, Newborn and Child Health. With other partners, OHCHR produced a number of guides on maternal and child health for health policymakers, health workers, the judiciary and national human rights institutions. WHO uses the technical guidance as a basis for integration of human and child rights standards in its ongoing work in developing global standards of facility-based care for young children.

27 Following the distribution of the technical guidance among permanent missions in Geneva, Cyprus reported that the technical guidance had been distributed to all the departments of the Ministry of Health involved in providing services to children, health-care providers involved in the provision of health care to newborns and children and professionals in charge of collecting data related to mortality of children working in the health monitoring unit of the Ministry of Health. It further reported the consideration of the technical guidance in the development of the country's national strategy on the promotion, protection and support of the rights of children related to health. Mozambique informed OHCHR that the technical guidance had been disseminated to the Ministry of Health, health-care providers and the National Child Council, which coordinates issues related to children's rights. The technical guidance is being used to build health programmes and ensure better coordination between health-care providers and communities.

28. Human rights mechanisms have been key in promoting the use of the technical guidance by recommending its implementation at the national level to Member States. Those mechanisms will therefore play a key role in ensuring accountability for human rights-based approaches to preventing child mortality in their follow-up dialogue with States.

29. The Committee on the Rights of the Child has recommended the implementation of the technical guidance in its concluding observations for Benin, Colombia, the Dominican Republic, Eritrea, Ethiopia, the Gambia, Ghana, Haiti, Kenya, Mexico, Peru, Senegal, Turkmenistan, the United Republic of Tanzania, the Bolivarian Republic of Venezuela, Zambia and Zimbabwe. Equally, as part of the universal periodic review, various States have recommended taking action at all levels to address the interlinked root causes of preventable mortality and morbidity of children under 5 and consider applying the technical guidance to Angola, the Gambia, Guyana, Lesotho, Liberia and the Marshall Islands. In addition, the Special Rapporteur on the right to health has recommended its implementation in his missions to Malaysia and Paraguay.

30. OHCHR is supporting the establishment and strengthening of national mechanisms for reporting to and follow-up on recommendations from regional and international human rights mechanisms, including treaty bodies, special procedure mandate holders and the universal periodic review.

B. Country-level activities

1. Dominican Republic

31. Following a UNICEF initiative in the Dominican Republic in 2014, OHCHR, WHO and the Pan American Health Organization were invited to discuss with the United Nations country team and civil society organizations how a human rights-based approach could contribute to national efforts to reduce preventable deaths of newborn, infant and under-5 children. The human rights discussions with the United Nations country team were used in the development of an inter-agency initiative to prevent and reduce child, infant, newborn and maternal mortality. The process and discussions demonstrate how initiatives within the Human Rights Council can complement efforts undertaken at the national level to effect positive change, in accordance with the human rights obligations undertaken by the State.

32. The right to health and comprehensive health care is enshrined in the Constitution of the Dominican Republic. Furthermore, in the country's National Development Strategy 2030, a view is expressed of a society with equal rights and opportunities for all, where basic services and rights, including the right to health, are guaranteed to all without discrimination. It states that all plans, programmes, projects and public policies must be informed by a human rights-based approach.

33. The Dominican Republic has achieved significant progress in advancing children's rights and has shown strong political willingness to improve infant and under-5 health. The Ministry of Health has incorporated into the national immunization schedule the rotavirus and pneumococcal vaccines, which will have a strong impact on reducing infant deaths from diarrhoea, pneumonia and meningitis. The country has strategies, plans and programmes in the health sector, in addition to specific projects aimed at reducing child, infant, newborn and maternal mortality. Despite many efforts, there has been no improvement in the neonatal mortality rates over the past decade, which are above the regional average for Latin America and the Caribbean.

34. During discussions, it became clear that there are complex social dynamics that impact on health service users and that there is an urgent need to strengthen the capacity of public hospitals with adequately trained health professionals, including by re-establishing the function of the midwife. It is also necessary to ensure the humane and dignified treatment of users of health services, change health workers' attitudes and empower patients to claim their rights. The importance of strengthening reporting mechanisms and oversight by civil society was also highlighted. Furthermore, reference was made to the need to strictly follow standards for prevention and infection control in health facilities, which are essential in controlling sepsis — the primary cause of newborn deaths in the Dominican Republic. Ensuring accountability and reinforcing the investigation capacity of the Committee of Medical Audits in cases of newborn and infant deaths was strongly emphasized.

35. Campaigns on radio and television are being conducted, with the support of the Ministry of Health and UNICEF, to ensure an increase in the registration of children at birth in public hospitals. UNICEF fostered dialogue to incorporate birth registration of newborns in maternity hospitals as one of the new certification criteria of the Expanded Baby-Friendly Hospital Initiative. An alliance with the Ministry of Health allowed primary

health-care units to become key partners, as they inform mothers about the importance of registration and help them in applying for identity cards.

36. The inter-agency initiative is a clear example of the integration of human rights-based approaches in reducing newborn, infant and under-5 mortality and demonstrates the important role of the United Nations country team in that regard.

2. United Republic of Tanzania

37. On 29 and 30 June 2015, OHCHR, in conjunction with WHO, the Ministry of Health, the Commission for Human Rights and Good Governance and the United Nations country team in Dar es Salaam organized a consultation on the role of human rights mechanisms in improving newborn, infant and under-5 health. Participants were from the health and human rights fields, including United Nations agencies, the Government and civil society. There were representatives from medical hospitals, including Amana Hospital, the Bugando Medical Centre, the Kilimanjaro Christian Medical Centre, the Mbeya Referral Hospital, the Mnazi Mmoja Hospital, the Muhimbili National Hospital and the Mwananyamala Hospital.

38. The United Republic of Tanzania has made substantial advances in improving child survival, but the reduction in newborn mortality has been much slower, as it still accounts for 40 per cent of deaths of Tanzanian children younger than 5 years. Much of the progress has been due to prenatal and postnatal care, vaccinations, nutritional supplements and overall improvement of health services.

39. The discussions during the consultation highlighted the importance of enhancing the quality of health services, particularly for newborn children, and ensuring access to medication for children affected by infections, including pneumonia, diarrhoea, measles, malaria and HIV/AIDS. Improving the nutrition of small children was also raised as a requirement to ensuring the implementation of the rights of the child to survival and development. Particular emphasis was paid to the health situation and the rights of children affected by albinism and refugee children. Other elements of the discussion referred to capacity and funding gaps in the health sector, the unavailability of essential medicines and the need to improve health governance. Integration of human rights principles into health service delivery, enhancement of partnerships and strengthened social accountability were recommended, as well as further investment in disadvantaged regions.

40. Following the meeting's recommendation that human rights principles be integrated in the delivery of health services and quality of care, particularly for newborn children, OHCHR, in consultation with WHO, commissioned an assessment of the state of newborn health in a number of selected hospitals. At the time of preparation of the present report, the assessment was under way in Zanzibar.

41. The assessment comes at an important moment for Zanzibar, since in 2015 it received the Future Policy Award for its Children's Act. That piece of legislation earned the award for its balanced coverage of child abuse and violence against children and for its promotion of children's rights. It lays the foundation for the establishment of a comprehensive national child protection system to deal with cases of children in need of care and protection. In the Act, it is stipulated that the child has the right to medical care and immunization and should not be denied medical care for reasons of religion or other beliefs. It is stated that every child shall be registered upon birth and that health authorities shall cooperate to secure the registration of all births. Any person who performs professional or official duties with respect to a child, including a doctor, medical officer or traditional health practitioner, who has a reasonable belief that a child's rights are being significantly infringed has the duty to report it. A chapter of the Act is devoted to consent to medical interventions and surgical operations, as well as HIV testing.

C. Work by civil society partners

42. Civil society actors have a key role in promoting human rights-based approaches to prevention of child mortality and in implementing the technical guidance. For example, both the "Child Health Now" campaign by World Vision and "Every One" campaign by Save the Children have focused on preventing deaths of children under 5 and supported human rights-based approaches by addressing determinants of child health, social and community-based accountability mechanisms and citizen's empowerment. They also opened up spaces for children and caregivers to participate in the decision-making processes that affect children's survival and health.

43. In the Niger, World Vision initiated and led a coalition to ensure accountability for effective implementation of the free health-care policy, which grants all children under 5 access to free health care. Through the Child Friendly National Budget Initiative in Zimbabwe, Save the Children, the National Association of Non-Governmental Organizations and UNICEF supported child-led groups in eight provinces to engage in pre-budget consultations, resulting in increased budget allocations for children's health and education.

44. Much work has been undertaken by civil society to enhance social and community-based accountability mechanisms, a core element of a human rights-based approach, to monitor health services and ensure children's engagement in decision-making processes. Examples of social and community accountability mechanisms include the "Citizen Voice and Action" and "Citizens' hearings" methodologies.

45. "Citizen Voice and Action" is a local-level advocacy methodology that aims to advance essential services, such as health, by improving the relationship between communities and government. This methodology has been used by World Vision and other partners to strengthen governments' commitments to child survival. For example, in Armenia, the Government responded to "Citizen Voice and Action" by creating new incentives for doctors to visit the most vulnerable people in rural areas.

46. Citizens' hearings are open and constructive dialogues that give communities the possibility to share recommendations for improved health services with local and national leaders. That form of social accountability serves the double purpose of empowering citizens to know their rights and to hold their leaders to account on commitments made to end the preventable deaths of women and children. The International Planned Parenthood Federation, Save the Children, White Ribbon Alliance and World Vision International have been working with local and national partners to organize Citizens' hearings on health around the world, including Afghanistan, Bangladesh, Burkina Faso, the Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Malawi, Mali, Nepal, the Niger, Nigeria, Pakistan, Uganda, the United Republic of Tanzania and Yemen.[6]

47. In 2015, a number of civil society organizations held the Global Citizens' Dialogue in Geneva during the World Health Assembly. A key objective of the citizens' hearings movement is to strengthen the feedback loop between global processes and local and national decision-making processes.

48. Involving children in these forms of social accountability is crucial to bringing their views to the attention of key stakeholders including communities, civil society, journalists

[6] See http://static1.squarespace.com/static/54d0f2c0e4b081a66404a5fb/t/560273e3e4b03fc4a33c4c80/1443001714114/FULL_REPORT_WEB.pdf.

and government representatives and to inform policies and implementation priorities at local, national and international levels.[7]

V. Synergies with other initiatives

49. A number of major initiatives at global level are aimed at saving and improving the lives of women and children. Every Woman Every Child is a global movement that mobilizes and intensifies international and national action to address the major health challenges facing women, children and adolescents everywhere. At its inception, the movement put into action the Global Strategy for Women's and Children's Health (2010-2015). Building on its success, an updated Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), fully aligned with the Sustainable Development Goals was launched by the Secretary-General in September 2015. A key strategic priority for the Global Strategy is the development of an updated accountability framework to ensure strong implementation of the Sustainable Development Goals. To that end, the Independent Accountability Panel was established in 2015 to provide independent assessment of progress and challenges to help strengthen the response from the international health community and countries.

50. Other important initiatives at global level are also key to saving and improving children's lives and their right to health. For example, the adoption of the Every Newborn Action Plan in 2014 at the World Health Assembly has been critical in centring attention on health interventions on the newborn child and reinvigorated the resolve for action in that regard. The Global Breastfeeding Advocacy Initiative established by UNICEF, WHO and other partners aims at increasing political commitment to, and investment in, breastfeeding as the cornerstone of child nutrition, health and development.

51. In 2012, the Comprehensive Implementation Plan on Maternal Infant and Young Child Nutrition called for strengthening legislative, regulatory and/or other measures to control the marketing of breast-milk substitutes. During the Second International Conference on Nutrition in 2014, ministers and representatives of countries agreed that governments should protect consumers, especially pregnant women, mothers and children, from marketing and promotion of foods and called for the implementation of the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions. In 2014, WHO, in close collaboration with UNICEF, established the Network for Global Monitoring and Support for Implementation of the International Code of Marketing of Breast-milk Substitutes and Subsequent relevant World Health Assembly Resolutions (NetCode). NetCode assists countries and civil society in strengthening capacity to monitor the Code and all relevant subsequent World Health Assembly resolutions, and in ensuring effective enforcement and monitoring of national legislation and regulations related to the Code. Key non-governmental organizations, including the International Baby Food Action Network, Helen Keller International and Save the Children, academic centres and selected countries have joined this network.

52. Efforts are ongoing to ensure that the technical guidance and human rights principles are integrated within the different current initiatives.

[7] Ibid.

VI. Issues in focus

A. Mortality projections

53. Estimating child mortality is challenging for most developing countries. Only about 60 countries worldwide have fully functioning and complete civil registration systems that can be relied on as a single source to produce reliable mortality estimates. Where there are no well-functioning civil registration systems, modelling exercises are usually required to generate reliable child mortality estimates. The challenges become even greater in the context of conflict and humanitarian crisis.

54. The Inter-Agency Group for Child Mortality Estimation noted a wide variation in how European countries define infant mortality, owing to differences in birth and death registration practices — that is, "differences in the cut-off points for acceptable weight or estimated gestation period to be registered as a birth and subsequent death".[8] This is the case for some of the Eastern European countries.[9] The Committee on the Rights of the Child in its concluding observations on Uzbekistan (CRC/C/OPSC/UZB/CO/1) raised that issue and indicated that the State party's definition of a live birth was not consistent with the internationally recognized WHO definition, thus hindering an objective assessment of the actual rates of neonatal infant mortality and the effective implementation of approaches for addressing it (CRC/C/UZB/CO/3-4).

55. Scenario-based projections by WHO indicate that, between 2016 and 2030, 94.4 million children are projected to die before the age of 5 years if the 2015 mortality rate remains constant in each country, and 68.8 million would die if each country continues to reduce its mortality rate at the pace estimated from 2000 to 2015. If all countries achieve the relevant target of the Sustainable Development Goals, the projections would stand at 56 million deaths by 2030.[10]

56. Sub-Saharan Africa will face unique challenges in reducing the number of child deaths. If current trends continue, 37 million children in sub-Saharan Africa will die in the next 15 years.[11] Extensive efforts will be required to provide the services and interventions necessary to meet the additional demand generated by a growing number of live births and chid population in the region. There is a 95 per cent probability that the number of children under 5 years will grow by an extra 26 to 57 million, going from 157 million in 2015 to 183-214 million in 2030.[12] In South Asia, reducing child mortality must also be urgently accelerated. Two out of the 8 countries in the region, Afghanistan and Pakistan, will need to accelerate progress to achieve the target of the Sustainable Development Goals. Further support is to be given to those countries to ensure that the right of the child to survival is implemented on equal basis with other regions.

57. In order to monitor effectively the number of children dying, the development of civil registrations systems to gather accurate, timely, disaggregated data that can inform decision-making, programming and planning is required. In that respect, well-functioning civil registration systems are essential to bring about accountability for the implementation of the 2030 Agenda for Sustainable Development, as they provide the most reliable basis

[8] Inter-Agency Group for Child Mortality Estimation, "Report 2015", p. 13.

[9] Ibid., p. 14.

[10] "Global, regional and national levels and trends in under-5 mortality between 1990 and 2015, with scenario-based projections to 2030: a systematic analysis by the Inter-Agency Group for Child Mortality Estimation" (WHO, 2015).

[11] Ibid.

[12] Ibid.

for monitoring multiple targets of the Sustainable Development Goals, including those requiring accurate, disaggregated data on mortality rates and causes.

B. The newborn child

58. The neonatal period, the first 28 days of life, is the most vulnerable time for a child. Despite the substantive progress on reduction of child mortality, deaths of newborn babies are falling slower than deaths occurring in other periods of childhood. According to the Inter-Agency Group for Child Mortality Estimation, if current trends continue, the share of neonatal deaths is projected to increase from 45 per cent of under-5 deaths in 2015 to 52 per cent in 2030.[13]

59. Some countries have achieved enormous progress in reducing newborn deaths. For example, between 1990 and 2012, China saw a decline of over 80 per cent and Cambodia of more than 60 per cent, showing that progress is possible. However, unless further efforts are made globally to tackle deaths of newborn children, there is a risk that child mortality will stall.[14]

60. Focusing on the newborn child is urgent from both medical and human rights perspectives. While human rights mechanisms, including the Committee on the Rights of the Child, have devoted some attention to the newborn child, including through that Committee's development of general comment No. 7 (2005) on implementing child rights in early childhood, a focused discussion at international level on the application of the Convention on the Rights of the Child to the newborn child could accelerate political will and ensure progress. That is critical given the vulnerability, lack of autonomy and full dependency on his or her caregivers of the newborn child. An urgent shift is required at all levels to give the newborn and his/her rights due attention. The application of the Convention on the Rights of the Child to the newborn child must be further discussed, understood and specified, and dialogue in that regard should be initiated in health and human rights forums.

61. Particularly inspiring is a text developed by a group of obstetricians, neonatologists and paediatricians on the newborn child.[15] In it, the authors recognize that no one is entitled to put at risk the health or physical integrity of a newborn child irrespective of racial, geographic or cultural origin or sexual discrimination and that every live newborn is entitled to appropriate assistance during delivery. It focuses on the right of every newborn to be born in the most suitable place, considering his or her foreseeable care requirements, especially if she or he suffers from or is at risk of an illness, and the right of the newborn child to be with his or her parents. It also raises the complex situation of newborns with health problems.

62. Complications from childbirth can have a significant impact on newborns and their development. Around 10 per cent of all newborns in every country need assistance to begin breathing.[16] If that assistance is not provided, the newborn may die of asphyxia or suffer consequences such as cerebral palsy and developmental delay. Yet, in developing countries, many health facilities do not have the equipment to resuscitate newborns. UNICEF has reported that quality of care for the newborn child is grossly lacking and, in regions with the highest newborn mortality rates, access to postnatal care is abysmally low.[17] This

[13] Inter-Agency Group for Child Mortality Estimation, "Report 2015", p. 7.
[14] Save the Children, *Ending Newborn Deaths: Ensuring Every Baby Survives* (London, 2014).
[15] See www.uenps.com.
[16] Save the Children, *Ending Newborn Deaths*.
[17] UNICEF, *Committing to Child Survival*, p. 7.

reflects again the crisis of inequality between children born in some regions and others, and the huge difference within countries with poor and marginalized communities receiving the poorest quality of care.

63. Of particular concern is the situation of premature and severely ill newborns and children born with severe impairments and/or life-threating health conditions. While there is a paucity of data in that regard, a human rights-based approach must ensure that those newborn children have access to the quality care they need, including psychosocial support for the families and the full complement of medical services.

64. Training on newborn care is essential to improve the child's chance of survival. In that context, enforcing laws and policies that promote access to newborn care is a key component of a human rights-based approach to preventing mortality of the newborn child.

65. In the context of the Zika virus outbreak, the situation of children affected by the virus merits special attention. The High Commissioner for Human Rights called for all public health responses to the Zika virus to fully integrate human rights, reiterating the importance of focusing on women's right to health and sexual and reproductive rights and at the same time urging States to prepare to provide proper support and care for children with Zika-related impairments. Media attention on children affected by Zika has focused on images and at times descriptive language that is pejorative, treating them as an oddity and undermining their dignity. Such portrayals reinforce and may exacerbate stigma and discrimination against children with disabilities. Reports show that children with microcephaly are at higher risk of abandonment by their parents, and suggest that the rates of abandonment of children may rise rapidly over the next years.[18] It is essential that sufficient resources be allocated to programmes to empower families of children with Zika-related impairments to care for the children and minimize risks of abandonment.

C. Quality of care

66. All children's health services and programmes must comply with the criteria of availability, accessibility, acceptability and quality, which are essential components of the right of the child to health. Quality requirements include skilled health professionals, scientifically approved and unexpired drugs and hospital equipment.[19] In the context of newborn, infant and under-5 health, that means that health professionals must be trained in obstetrics and newborn and paediatric care and that children have access to paediatric drugs and hospital equipment adapted to them. It also implies supportive supervision, monitoring and data analysis for quality improvement.

67. The Committee on the Rights of the Child has encouraged States to adopt child-sensitive health approaches throughout different periods of childhood, such as the Expanded Baby-Friendly Hospital Initiative, which protects, promotes and supports rooming-in and breastfeeding, and child-friendly health policies focused on training health workers to provide quality services in a way that minimizes pain, fear, anxiety and suffering of children and their families.[20]

[18] Women Enabled International, "Talking Points: Zika, Microcephaly, Women's Rights, and Disability Rights". Available from womenenabled.org/publications.html.

[19] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of health.

[20] Committee on the Rights of the Child, general comment No. 15 (2013) on the right of the child to the highest attainable standard of health.

68. During the discussions concerning the technical guidance, allegations emerged concerning mistreatment of women during labour, including being slapped, yelled at, insulted and denied pain medicine. Such attitudes are unacceptable and contribute to women not returning to health facilities to seek attention at the time of birth or for their children. Quality must therefore be redefined in such a way that the dignity and worth of the patient is central.[21] Factors that dehumanize health care must be removed, including understaffing and the deterioration of health facilities.[22] Health workers must be supported to ensure that they have appropriate conditions of work to provide adequate care to patients in accordance with human rights principles. Training and capacity-building on human rights and child rights principles for health workers can have a positive impact in that regard.

69. There is now broad recognition that health care must be organized around people's needs and expectations, including the small child. In the case of children, that requires implementing the right of the child to express their views and be consulted in all matters that affect him or her and that this be implemented from the earliest stages in ways appropriate to the child's capacities, best interests and right to be protected from harmful experiences. As rights holders, even the youngest children are entitled to express their views. The ongoing work by WHO in that area, including efforts to develop and adopt a WHO global strategy on people-centred and integrated health services and the preparation of human rights-based global frameworks for quality of care for maternal and newborn health and child health, respectively, are testimony to this growing recognition. Those frameworks address both the provision of care and experience of care, and require systematic integration of human and child rights principles and standards in guiding how health care must be constructed, implemented, monitored and evaluated. Participation and accountability are key components of the frameworks.

D. Inappropriate marketing of breast-milk substitutes

70. One of the key ways to reduce newborn, infant and under-5 mortality and morbidity is breastfeeding. According to research published in *The Lancet* in 2016,[23] increasing breastfeeding to near-universal levels could save the lives of more than 820,000 children under the age of 5 each year. In addition, boosting rates of exclusive breastfeeding for infants under 6 months of age would significantly reduce costs for treatment of childhood illnesses such as pneumonia, diarrhoea and asthma.

71. In spite of those advantages, globally nearly two out of three infants under 6 months are not exclusively breastfed — a rate that has not improved in two decades. Fewer than 1 in 5 infants are breastfed for 12 months in high-income countries and only two out of three children between 6 months and 2 years of age receive any breast milk in low- and middle-income countries.[24]

72. A significant barrier to improved breastfeeding rates in many countries remains the aggressive marketing of breast-milk substitutes. Global sales of breast-milk substitutes total US$ 44.8 billion, and are expected to rise to US$ 70.6 billion by 2019.[25] Aggressive and inappropriate marketing of breast-milk substitutes and other food products that compete

[21] Tarek Meguid, "(Re)Humanising Health Care-Placing Dignity and Agency of the Patient at the Center", *Nordic Journal of Human Rights*, vol. 34, No. 1 (2016).

[22] Ibid.

[23] WHO, *Marketing of Breast-milk Substitutes: National Implementation of the International Code — Status report 2016*.

[24] Ibid.

[25] Ibid.

with breastfeeding continues to undermine efforts to improve breastfeeding rates. Such marketing practices often negatively affect the choice and ability of mothers to breastfeed their infants optimally. The International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions are vital to regulate and reduce inappropriate marketing. Furthermore, in the Guiding Principles on Business and Human Rights, it is stipulated that all business enterprises should operate with respect for human rights. In the context of the marketing of breast-milk substitutes, the responsibility to respect human rights requires undertaking effective human rights due diligence to identify any risk that marketing of breast-milk substitutes may have an adverse impact on human rights, including the right of the child to health, and to take all necessary steps to prevent and mitigate such risks.

73. The national implementation report of the international code 2016 shows that too few countries have adopted strong legislation to reduce and eliminate inappropriate marketing of breast-milk substitutes, and that only a handful of countries that have legal measures in place and have established operational monitoring and enforcement mechanisms.

74. The report makes direct reference to the technical guidance and the recommendation therein to countries to regulate private actors, such as pharmaceutical companies, commodities and device manufacturers, producers and marketers of breast-milk substitutes in order to prevent violations of child health-related rights and ensure accountability, including remedy and redress if violations occur. The Committee on the Rights of the Child has further stated that countries are required to introduce into domestic law and implement and enforce the International Code on Marketing of Breast-milk Substitutes.

75. Since 2011, a number of countries have adopted or amended strong legal measures incorporating all of the Code's provisions. In 2012 and 2014, Viet Nam and Armenia, respectively, successfully amended their regulations to ensure full adherence to the Code.

76. In May 2016, the World Health Assembly welcomed WHO guidance and recommendations on ending inappropriate promotion of foods for infants and young children aged between 6 months and 3 years. In the recommendations, it is stated that all milk products specifically marketed for children between 6 and 36 months are de facto breast-milk substitutes and must be regulated under the scope of the International Code.

E. Impact on children of attacks on health facilities

77. Attacks on hospitals and medical personnel in conflict compromise the right of the child to health at many levels. The destruction in April 2016 of the Médecins sans frontières-supported Al Quds Hospital in Aleppo, killing civilians, children and medical personnel, including one of the last remaining paediatricians in the area, is a clear example. Attacks on hospitals limit access to medical care and can annihilate the long-term efforts to reduce child mortality, improve maternal health and fight disease.[26]

78. Attacks on hospitals and medical personnel are one of the six grave violations against children during armed conflict. In its resolution 1998 (2011), the Security Council highlighted the impact of attacks on hospitals on children during armed conflict and requested the Secretary-General to include in his reports on children and armed conflict those parties to armed conflict that engage in that category of violations. In its resolution 2286 (2016), the Security Council strongly condemned attacks on medical personnel in conflict situations, demanding an end to impunity for those responsible. Attacks against

[26] See www.un.org/press/en/2016/sc12347.doc.htm.

hospitals contravene well-established norms international humanitarian law, including customary norms, and may amount to war crimes and crimes against humanity.

79. Attacks on health workers, particularly those conducting vaccination campaigns can have a direct impact on child mortality, because immunization continues to be one of the best ways to ensure child survival. As noted in the 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 (A/HRC/22/31 and Corr.1), ensuring access to the full schedule of childhood immunizations recommended by WHO is critical to the prevention of an expanding array of illnesses, as well as to diseases that may emerge later in life.

80. According to the United Nations Assistance Mission in Afghanistan,[27] a total of 89,873 children could not be vaccinated during the December 2015 sub-national immunization days in Afghanistan. Over the past decade, the Taliban released several statements in support of the polio eradication programme. For example, on 13 May 2013, the Taliban issued a public statement expressing support for polio vaccination campaigns with a caveat that campaigns must be led by Afghan personnel and respect Islamic values. In 2015, however, the United Nations Assistance Mission in Afghanistan, WHO and UNICEF documented 22 incidents directly affecting vaccination campaigns attributed mainly to anti-government elements including the Taliban. The reported incidents included killing, maiming and abduction of vaccinators, threats and intimidation against them, as well as destruction of vaccination kits. Attacks on polio vaccinators have also been documented in Pakistan and Nigeria. The Global Polio Eradication Initiative warns that persistent attacks against polio vaccinators put an enormous strain on efforts to halt transmission rates.

VII. Next steps

81. While every newborn, infant and under-5 death can be attributed to a medical cause, the underlying reasons why children die cannot be explained from a medical perspective only. Many factors increase the risk of a child dying, including marginalization, poverty, discrimination, inequalities and a lack of education and health-care knowledge of caregivers. Children also die because of failures to maintain health systems that are accessible, available, affordable, acceptable and of quality and because of violence, conflict and insecurity.

82. Child deaths will only be eradicated if the root causes leading to inequalities are targeted. Hence, the importance and added value of a human rights-based approach. The technical guidance has made a major contribution to bringing human rights perspectives to the centre of public health discussions related to newborn, infant and under-5 health. Yet, implementing human rights-based approaches requires extensive and sustained engagement, commitment and adequate resources. Legislative, policy and programme reforms, behaviour change among duty bearers and empowerment of rights holders are long-term processes.

83. Dialogue and capacity-building with different stakeholders in the area of prevention of child mortality has been initiated but needs further strengthening and resources. That work should continue, in cooperation with Member States, on the understanding that realization of the right of the child to health is a shared responsibility of both developed and non-developed countries. Next steps include documenting good practices on the practical

[27] United Nations Assistance Mission in Afghanistan, “Education and Health Care at Risk”, April 2016. See http://unama.unmissions.org/un-chief-afghanistan-do-more-now-protect-civilians-unama-releases-civilian-casualty-data-first.

application of the technical guidance in law and policy development, and in delivery of high-quality care for children under 5, as well as providing operational guidance to various stakeholders, from health policymakers to health practitioners, on the value and application of human rights. Given that OHCHR resources for child rights are severely constrained, that can only be undertaken with full support from Member States.

84. Bearing in mind that around 40 per cent of the deaths of under-5 children concern the newborn child, further attention must be given to that stage of childhood. An expert dialogue on how human rights instruments, particularly the Convention on the Rights of the Child, apply to the newborn child could provide high-level visibility and contribute to accelerating and deepening political will to achieve the Sustainable Development Goals, with a particular focus on target 3.2 aimed at reducing neonatal mortality to at least as low as 12 per 1,000 live births. That could feed into the work of the Independent Panel on Accountability and the follow-up and review of the Sustainable Development Goals under the high-level political forum on sustainable development. Such expert discussion could build on the work already initiated by a group of obstetricians, neonatologists and paediatricians (see para. 62 above) and include human rights mechanisms such as the Special Rapporteur on the right to health, the Committee on the Rights of the Child, the Committee on the Rights of Persons with Disabilities and the Special Representative of the Secretary-General on Violence against Children. The results of the expert discussion could be presented to the Human Rights Council as part of the follow-up process on implementation of the technical guidance.

85. Investing in child survival continues to be the most important step in ensuring a future for all children, independent of the country they are born in. All efforts must be made by States, the international community and other stakeholders to uphold the right of the child to survive. Member States should report on the implementation of the technical guidance through existing international human rights mechanisms, as well as in the context of the monitoring and accountability framework of the Sustainable Development Goals.