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

Summary of the expert meeting on experiences in applying a human rights-based approach to address mortality and morbidity among newborns and children under 5 years of age

Report of the United Nations High Commissioner for Human Rights

Summary

The present report, prepared in accordance with Human Rights Council resolution 33/11, contains a summary of the expert meeting, held on 27 and 28 June 2017, to discuss experiences in preventing mortality and morbidity of children under 5 years of age, with a focus on challenges, best practices and lessons learned, and with consideration of the particular challenges in respect of the newborn child. The expert meeting was organized by the Office of the United Nations High Commissioner for Human Rights in partnership with the World Health Organization.

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I. Introduction

1. In its resolution 33/11, the Human Rights Council requested the United Nations High Commissioner for Human Rights to organize, prior to its thirty-ninth session and in close collaboration with the World Health Organization (WHO), an expert workshop to discuss experiences in preventing mortality and morbidity of children under 5 years of age, with a particular focus on the implementation of the technical guidance, including challenges, best practices and lessons learned, and including consideration of the particular challenges in respect of the newborn child.

2. The expert meeting, held on 27 and 28 June 2017 at the United Nations Office at Geneva, was attended by 36 participants from all regions, representing United Nations agencies, Governments and civil society organizations, as well as health sector policymakers and practitioners. A background document prepared to guide discussions at the meeting included case studies on how a human rights approach to addressing mortality and morbidity among children under 5 had been approached to date.[1]

3. The expert meeting built upon a body of existing work to address child mortality and morbidity from a human rights perspective undertaken on the basis of mandates given by the Human Rights Council and the World Health Assembly. In its resolution 22/32, the Council invited, inter alia, the Office of the High Commissioner (OHCHR) and WHO to prepare a study on mortality of children under 5 years of age as a human rights concern; in its resolution 24/11, it requested OHCHR and WHO to prepare technical guidance on a human rights-based approach to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31), as well as an initial report on the implementation of the technical guidance (A/HRC/33/23).

4. This substantive work complements the work done by the independent Expert Review Group on Accountability for Women's and Children's Health and the establishment of the Independent Accountability Panel and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030). In addition, the adoption of the Every Newborn Action Plan in 2014 by the World Health Assembly has been crucial in drawing attention to the particular needs of the newborn child. Furthermore, the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents, established in May 2016 by WHO and OHCHR, to secure political support for the implementation of the Global Strategy, presented a report of its findings and recommendations in May 2017.[2]

II. A human rights-based approach to child mortality and health care

A. Opening and expected outcomes

5. At the opening session on human rights in the future and the implications for child survival, the United Nations Deputy High Commissioner for Human Rights noted the substantial progress that has been made in recent decades in reducing child mortality; the global number of child deaths had declined from 12.7 million in 1990 to 5.9 million in 2016. Overall progress had been the result of many different factors, including improvements in medical services, technology, advances in immunization and the treatment of childhood infections, as well as the development of standards and respect for human rights. Human rights were intrinsically linked to the realization of the right to health, including the right to education, the right to information, water and sanitation, and the right to be free from violence and discrimination. She stressed that political leadership and commitment, and accountability, were essential to ensure the implementation of the right to

[1] Available at www.ohchr.org/Documents/Issues/Children/ReportExpertMeetingExperiences ApplyingAHumanNov2017.pdf.

[2] WHO and OHCHR, "Leading the Realization of Human Rights to Health and Through Health", 2017.

health. She also noted the importance of child-friendly medical services, and that the rights of the child were being integrated into paediatric standards of care. She welcomed the important contribution made by the High-level Working Group on the Health and Human Rights of Women, Children and Adolescents, and recognized the challenges posed by child marriage to upholding sexual and reproductive health and rights, and the impact of violence and exploitation on the right to health. Too much attention had been focused on the supply side of human rights; there should be greater focus on the voices of people on the demand side of rights, through freedom of expression, assembly and association. She expressed her deep concern at the increasing number of attacks on health workers in conflict situations. A human rights-based approach was fundamental to overcoming powerlessness.

6. The Director of the Department of Maternal, Newborn, Child and Adolescent Health at WHO pointed out the limited implementation of children's rights among health practitioners in spite of the evidence indicating that it improved health outcomes. He emphasized the importance of a human rights-based approach through equality and participation, highlighting the positive role of the 2030 Agenda for Sustainable Development and the Global Strategy for Women's, Children's and Adolescents' Health. He noted the imperative need to interpret certain health practices from a human rights perspective, for example, inadequate access to or overuse of caesarean sections, commercial malnutrition, the marketing of breast-milk substitutes and trade policies that affected health outcomes. He highlighted the broad trends and factors that had an impact on child mortality, such as climate change, lack of political voice, the implications of the global economic model and the failure to implement the Millennium Development Goal on sanitation. Scientific rigour, country leadership and local ownership, social accountability and health education were vital to progress.

7. During the ensuing discussion, participants pointed out that the Sustainable Development Goals presented an opportunity to advance rights, and that good leadership could play a key role where resources were limited. With regard to developing the capacity of rights holders to claim their rights, the High-level Working Group for the Health and Human Rights of Women, Children and Adolescents should be supported, for instance by means of people's councils at the subnational level, given that change on the ground should be local and catalyzed by young people. Some participants asked whether the parameters for child mortality could be expanded beyond 5 years of age, and stressed the challenge posed by inequality, as evidenced by the relatively small drop in mortality for the most marginalized children, including newborns. The issue was closely associated with the fight against gender inequality through the empowerment of girls and women at all levels. Real change should come from citizens' voices and action to hold leaders accountable, and consideration should be given to broader factors, such as the role of fathers, adolescent mothers, the promotion of breastfeeding, commercial malnutrition, and health professionals who did not have a human rights focus. Legal approaches, including to combat marketing of breast-milk substitutes, could be supported by behavioural change programmes, as had been demonstrated in the implementation of anti-tobacco laws.

8. The Chief of the Right to Development Section at OHCHR stated that the central objective of the meeting was to learn from specific examples of how a human rights-based approach had an impact on the prevention of mortality and morbidity of newborns and children under the age of 5, with a view to strengthening the integration of this approach among practitioners and policymakers. The meeting provided a platform for the discussion of challenges, best practices and lessons learned among expert participants, and would explore how and to what effect the implementation of the technical guidance could have an impact on reducing child mortality.

B. A human rights-based approach to the prevention of child mortality

9. The Child Rights Adviser at OHCHR referred to the international framework for the protection of children's rights and the core elements of a human rights-based approach, namely, participation, accountability, non-discrimination and equality. The right to health was a universal right, enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights and article 24 of the Convention on the Rights of the Child. She

referred to the different elements of the right to health, including availability, accessibility, acceptability, affordability and quality, and underlined the importance of ensuring access to remedies to support the process of claiming the right to health. Article 24 of the Convention on the Rights of the Child referred not only to the obligation of States to take steps to reduce infant and child mortality, but also requested States parties to take all measures to abolish traditional practices that are prejudicial to children's health; these included child marriage and female genital mutilation. According to international human rights law, States were obliged to implement the right to health to the maximum of their available resources. The idea of securing human rights to health and through health should be pursued further. She outlined the core challenges that had an impact on child mortality with regard to birth registration, children in situations of migration, and the imperative to prioritize the rights of the newborn child.

10. Laura Ferguson from the Program on Global Health and Human Rights at the Institute for Global Health (University of Southern California) presented an overview of, and lessons emerging from, the case studies identified in her research, including case studies shared prior to the meeting by expert participants. She discussed the relationship between legal human rights obligations and the importance of evidence in paediatrics. While discussing the findings of the case studies, she highlighted the imperative of accountability, data and monitoring, and concluded that a human rights-based approach could be applied to mortality and morbidity of children in diverse ways, with highly positive results. Beyond the legal imperative to implement a child rights-based approach, such an approach was extremely promising and could contribute to better health outcomes. A stronger base of evidence to demonstrate this could increase the attention paid to rights-based approaches and support the realization of children's rights and their health.

11. According to some participants, health workers could be promoters of rights, and should be protected and supported by means of training and education, which would enable them to claim their own rights and deliver quality care. There was also a need to address social norms and the determinants of health; a holistic life cycle approach should be applied, including due attention to the role of women and violence against them, which had a major impact on rates of child survival. When considering how to realize rights through health, participants stated that it was essential to examine health inequities, and that rights could be realized through health in diverse ways, depending on the context, such as in cross-border and migration situations. Participants emphasized the ways in which power dynamics played a role in health outcomes, and called into question legalistic applications of human rights, noting that, in the case of South Africa, access to antiretroviral therapies had been won by pursuing legal rights also through political engagement.

C. Legal and policy measures to promote rights-based health care

12. Haroon Saloojee of the University of the Witwatersrand, Johannesburg made a presentation on a landmark judgment in support of child rights in South Africa. He noted that arguments had been put forward against providing anti-retroviral drugs to prevent mother-to-child transmission of HIV, one of which was their cost. Political action had been taken at the grass-roots level, followed by legal action to force doctors to prescribe those drugs. Following a court case that found that failure to provide anti-retroviral drugs was a violation of the constitutional right to basic health care, the High Court ordered the Government to begin a countrywide mother-to-child transmission prevention programme. In the decade following the court case, half a million infants were saved and transmission rates dramatically decreased. This case demonstrated that successful litigation on human rights required respect for the rule of law, a Government willing to prioritize constitutional rights, and an active civil society willing to challenge the Government.

13. Suzanne Aho, member of the Committee on the Rights of the Child and former Minister for Health of Togo, discussed the legal and policy measures taken to combat newborn and child mortality in Togo. Despite the shortfalls in funds allocated to health, it remained a national policy priority. In the efforts made to reduce infant and maternal mortality, one ongoing challenge were the unofficial clinics that claimed to treat mothers and newborns but that neither followed medical procedures nor had adequate equipment. In

addition, medical professionals did not know which drugs should be provided free of charge, and public awareness programmes had been ineffective owing to their lack of local engagement. Despite the adoption of a law in 2012 on measures to prevent neonatal and maternal deaths, its implementation had been limited owing to the lack of access of pregnant women and newborns to health care and services, public scepticism with regard to vaccines, low rates of birth registration, and challenges in the regulation of drug markets.

14. Helia Molina of the University of Santiago stated that, in the 1950s, awareness that the rate of infant mortality was problematically high began to grow, and national action was taken to reduce it. Even though per capita income in Chile was low, the targeted national efforts made had led to a massive reduction in the child mortality rate by 2014. Public expenditure on health was still among the lowest (3.4 per cent of GDP against an average of 6.5 per cent in countries that are members of the Organization for Economic Cooperation and Development), which showed that there was no direct correlation with expenditure. What was important was the focus on primary health-care issues and targeted, long-term policy planning implemented through comprehensive approaches. Success also relied upon strong political will and the development of human resources and capacity.

15. David Sanders from the University of Western Cape (South Africa) addressed the evidence, experience and regulatory challenges in ensuring access to essential child health interventions. In South Africa, rates of child mortality were, considering the country's level of wealth and development, higher than they should be because of a lack of momentum, fragmentation, and inadequate resources. Immunization coverage for babies was also well below what it should be, given the country's income level, owing to a shortage in vaccine stocks, the sheer distance to clinics and low degree of awareness among mothers. Interest in the role of community health workers had, however, been renewed, and community case management had been introduced to address pneumonia, a major cause of child mortality. All countries that had managed to attain the targets of Millennium Development Goal 4 on child mortality had community health workers; in South Africa, however, there was still only one community health worker for every 250 households.

16. Marcus Stahlhofer of WHO discussed addressing inappropriate marketing of breast-milk substitutes and other foods for infants and young children, including through human rights frameworks. Improved breastfeeding rates worldwide could save the lives of as many as 823,000 children under 5 years of age, result in economic gains of more than $300 billion annually due to increased productivity, and lead to a 6 per cent reduction in the risk of invasive breast cancer. Women, however, lacked support to initiate and sustain breastfeeding, and investments in this regard fell far short. Global annual sales of breast-milk substitutes totalled $44.8 billion, and were expected to rise to $70.6 billion by 2019. Even though the International Code of Marketing of Breast-milk Substitutes, adopted by WHO in 1981, was a major instrument in protecting mothers and babies from inappropriate marketing of breast-milk substitutes, its implementation at the national level remained low: only 35 States had comprehensive Code-related legislation, and only 32 States had a functional monitoring and enforcement system in place for implementation of laws. Manufacturers of breast-milk substitutes continued to interfere in both law-making and policy development, while lack of political will, data and coordination posed problems too. Moreover, legislation, monitoring and enforcement were inadequately resourced. Such action (and lack of action) constituted a violation of mothers' and children's rights. International human rights institutions should be part of the solution.

17. During the discussion, participants considered the importance of the availability, accessibility, acceptability and quality of health services. They noted that litigation could be a catalyst in this respect, but that its effectiveness could be reduced by corruption and clientelism. They discussed the reasons for the delays in the progress made in the fight against child mortality, which in some cases included the late booking of pregnancies, inadequate postnatal follow-up, lack of household visits from health workers and lack of data, including on deaths outside health facilities. Mental health issues and substance abuse, neglected in most countries, also exacerbated the situation of child mortality. Participants agreed that greater efforts were needed to support breastfeeding, including through civil action to strengthen a culture of breastfeeding. They proposed that violators of the WHO

International Code of Marketing of Breast-milk Substitutes could be named on an annual list.

D. Ensuring maximum investment: budget monitoring and financial accountability

18. Bob Muchabaiwa of the United Nations Children's Fund (UNICEF), Ethiopia pointed out that investment in children was a rights issue, given that it was the means through which core challenges to child rights were targeted. There was a positive correlation between increased health expenditure and reductions in mortality rates, where fiscal policies supported access to and the availability, affordability and quality of health care. In this respect, the use of disaggregated data and statistics in defining budgets was fundamental to ensure responsiveness to key age and gender considerations. Corruption was a challenge, as it led to the wasting of large amounts of resources allocated to health, while low levels of financing in emergencies resulted in higher rates of mortality and morbidity. Health budgets could be buttressed by tackling inefficient expenditure and by ensuring cost-effective management of procurement, together with fiscal transparency, budget monitoring and greater social accountability. Focus should be strengthened on the political economy dimension, the links between policy plans and budgets on the basis of children's rights, a greater reliance on sustainable domestic resources, and investment in community health care.

19. Participants stated that an effective legal framework on health should be accompanied by corresponding financial plans. While policies were compliant in most countries, major shortfalls undermined implementation. Ensuring adequate resource allocations was a key factor in implementing laws and policies, and children should be able to give their opinion on these matters in appropriate forums. Trade-offs (though contentious) were sometimes made between the application of a purely economic model and of a rights-based model; Governments therefore had to find a balance between them. Private health care in poor countries undermined the overall quality of public health systems by serving as a refuge for those who could afford it.

III. Improving quality of care through monitoring and accountability

A. Child rights-based quality care

20. Andrew Clarke of Lancashire Care NHS Foundation Trust (United Kingdom of Great Britain and Northern Ireland) and Kidasha (United Kingdom and Nepal) discussed the development of tools and approaches to measure children's rights in health settings and to improve the quality of care. He explained that human rights were often violated in health-care settings, and elaborated on the lessons learned from projects in Nepal based on standards contained in the Convention on the Rights of the Child, which made children's rights part of daily health practices, including through support for health workers and by providing a framework to monitor and improve the quality of care. In Nepal and Chile, human rights were a greater concern in primary care than in most countries; in the *Hospital Amigable* ("Friendly Hospital") programme in Santiago, child rights had been adopted as the mission strategy of the hospital. This case demonstrated that a human rights-based approach could guide health planners and support health workers, improving the experience of care and reducing suffering. Pragmatic tools that could be integrated into routine health practices were needed, and health workers should be enabled to design rights-based improvements to quality of care through training and facilitation.

21. Ana Isabel Guerreiro, an independent consultant, presented her perspective on improving quality of care in hospitals through human rights-based standards. She explained that the Convention on the Rights of the Child could be used as a functional framework to guide the development and delivery of human rights-based health care to children, and pointed that equality, participation and accountability were key principles in this respect.

She stressed the need for a concurrent focus on the wider enabling environment; for example, in WHO pilot programmes to implement quality of care tools in health systems in Georgia, the Republic of Moldova and Tajikistan, a broader goal was to support reporting on the implementation of health-related and other rights under the Convention. She provided examples of standards for assessing and improving children's rights, for example by defining the best possible quality of care that could be delivered to all children, or developing plans to ensure equality and non-discrimination. The integration of child rights and quality of care standards into relevant undergraduate and graduate curricula was crucial.

22. Raul Mercer of the Program of Social Sciences and Health at the Latin American School of Social Sciences (FLACSO), Buenos Aires delivered a presentation on capacity-building and child rights training for health practitioners. He pointed out that the main determinants of health were only 10 per cent medical and 90 per cent due to social and environmental factors. In order to effect change, scientific evidence should be translated with a rights-based approach; a continuum of rights throughout life should be established through, inter alia, the promotion of human rights, the prevention of violations and the restitution of rights. With regard to training health professionals, epidemiological information could be used as the foundation of a national rights-based policy. Barriers in health systems and interventions, including bias, discrimination, omission, homophobia, prejudice and racism, ought to be addressed.

23. Armida Fernandez of the Society for Nutrition, Education and Health Action (SNEHA), Mumbai (India) discussed ways of tackling challenges to quality care in low-income areas, such as ensuring sustainability. Her work focused on women and children, given that they were the most vulnerable groups in slums. The application of a life-cycle approach to the prevention of violence against women was essential. Almost half of the 16 million inhabitants of Mumbai lived in slums, where many women gave birth in their home. Gaining the trust of communities and changing health-seeking behaviour while accounting for diverse cultures and traditions had posed a real challenge. To bring about changes to behaviour, SNEHA had implemented a capacity-building and monitoring programme for community health workers. India had a mixed public and private health-care system, where partnerships had played a key role, including with private companies, public institutions and the global academic community. An appreciative approach to inquiry had been taken in order to share the strengths of successful approaches identified in workshops held with administrators, doctors, nurses and others. Access to the poorest had been improved by installing neonatal clinics at local health posts, where a referral system to peripheral and maternity hospitals had been developed. Improving the quality of care required partnerships, perseverance and a participatory approach.

24. Tarek Meguid of the Mnazi Mmoja Hospital and the State University of Zanzibar presented his perspective on the feasibility of high-quality maternal and child health care in hospitals in Zanzibar. He described a project designed to assess the readiness of local hospitals to integrate a human rights-based approach to quality of care on the basis of WHO standards. At the largest hospital in Zanzibar, which delivers 13,000 babies every year, infrastructure and services were scarce owing to problems with supplies, staffing and poor standards of care. Health workers were uninformed about rights; training and capacity-building were therefore needed to implement quality care standards. Men should be more involved during and after deliveries, but were prevented from doing so. Patients deserved dignity, and could play a key role if empowered to voice their needs. He emphasized the importance of addressing determinants to strengthen health-care systems, and of addressing the political context to bring about justice.

25. Sanjay Atreya of the Asha Health Care programme (Child Welfare Scheme Nepal) made a presentation on integrating children's rights into the design and delivery of primary care services in western Nepal. He explained that primary care was a key opportunity to integrate human rights, and highlighted its shortfall among the urban poor, leading to, inter alia, violations of rights and hospital services that were unaffordable, and consequently little used or delayed. Many private providers were unregulated, their services just as unaffordable and associated with low quality care. A network had been created to improve primary health care and to make it more accessible, with a view to designing systems and

delivery based on human rights, and to increase the use of services by the poor, the socially excluded and disadvantaged castes. Efforts had led to major improvements in health-seeking behaviour, as confirmed by quality indicators. Care delivery was focused on values, behavioural change, training, protocols and monitoring. The approaches taken in this initiative had been adopted in the local municipal health-care systems in 2016.

26. During the discussion, participants considered how rights could be employed from the perspective of (a) legal frameworks and institutions that support the delivery of care through requirements enabling human rights input to health systems; and (b) accountability through the use of quality care benchmarks demonstrating the user's perspective. They stressed that the issue of discrimination deserved greater attention, given that discriminatory barriers to health care were a central challenge that led to adverse health outcomes. They reiterated that the rights of health service providers should be addressed, and not only the rights of patients, given that, in many cases, the conditions of health-care workers amounted to a violation of human rights. "On the ground" mechanisms were imperative; changes should be accompanied by corresponding protocols. Education and training played a key role, also for health-care professionals on health-related laws. There was in addition a need for a greater focus on care and education provided to women, to ensure that mothers were empowered by relevant knowledge and information.

27. While some participants advocated for the expanded use of randomized controlled trials, others pointed out that they were costly and might not be an appropriate research methodology to gather evidence on the human rights dimension; they proposed that such funds could be used instead for alternative types of research, such as implementation research, including how to better implement effective measures that already existed, and how to develop additional tools and metrics to improve human rights-based approaches to child mortality. The right to privacy starts from the very outset; there was evidence that showed that the prognosis for newborns improved when the right to privacy was respected in intensive care units for newborns.

B. Monitoring, evaluation and data to strengthen accountability and quality of care

28. Dinesh Poudyal of the Namuna Integrated Development Council (Nepal) discussed human rights in public health and social approaches for improving child health and accountability. He explained that gender and social discrimination were barriers to improving health in Nepal, exacerbated by lack of knowledge and information, poverty, difficulty in gaining access to health care and a lack of local accountability. In a three-year project encompassing caste-disadvantaged communities experiencing the highest rates of child mortality, progress had been made by addressing the infrequent use of maternal, newborn and child services by marginalized groups and negative gender norms and by promoting the empowerment of pregnant women. Positive change had been eventually made in the district health system, particularly by embedding local accountability systems and emphasizing a rights-based approach to health care.

29. Prasanta Tripathy of Ekjut India addressed the role of monitoring to strengthen community-based newborn health strategies. His organization implemented participatory learning and action through community mobilization and capacity-building workshops to improve maternal and newborn health, in accordance with WHO recommendations. After 10 to 12 group meetings, women felt confident to take on society and government officials in seeking support to improve outcomes. Although the change process had been difficult owing to established, hierarchical ways of working within the health system, the evidence gathered through a monitoring system reflected major reductions in mortality by the second year of implementation. Looking at the data from the perspective of inequality, participatory groups generated the greatest impact for the poorest, as they addressed social determinants and were conducted in local dialects. They had found that neonatal mortality could only be reduced if the poorest rural homes were reached by community health workers. The impact of participatory learning and action interventions had been sustained over time, even though the specific pathways to results had changed over time.

30. Nand Wadhwani from the Mother and Child Health and Education Trust (India) delivered a presentation on the opportunity provided by new technologies to increase access to health-care knowledge. He highlighted the fact that most deaths of infants under 5 years of age were from treatable and preventable causes, and that a lack of basic health-care knowledge cost lives. He stressed the need to ensure that mothers knew about basic health care; currently, pregnant women received little to no health information. Despite the inadequacy of health-care budgets, the advent of smartphones and mobile technology today allowed health knowledge to be brought directly to those who need it most, bypassing complex administrative structures. The vision of the Mother and Child Health and Education Trust was to give every woman, when she registers her pregnancy, access to a video library, in her own language, containing information on the importance of the first 1,000 days of pregnancy, starting from pregnancy. The library could serve as an instruction manual for the entire pregnancy and help mothers to be in contact with health-care professionals.

31. Laura Ferguson of the Program on Global Health and Human Rights, Institute for Global Health, University of Southern California, presented her perspective on using routinely collected child health data for monitoring human rights and on ensuring sustainable approaches to collecting human rights data. She provided an overview of a human rights-based approach, and emphasized the importance of relying on data, and in particular disaggregated data, to strengthen the implementation of a human rights-based approach in health systems. She pointed out that human rights evaluations were complex; there was therefore a need for interim indicators to help to identify specific pathways and theories of change. She outlined a framework for assessing the extent to which existing child health indicators could shed light on the realization of human rights, and highlighted how findings could be used to inform national and subnational data-collection efforts. She underscored the need to ensure the local relevance of all data to help to ensure that they were used to inform improved service delivery with a view to improving child health and the realization of children's rights.

32. Participants discussed how monitoring and measuring progress was central to addressing discrimination and inequalities, and debated the role and limitations of randomized controlled trials. Some stressed the importance of community-based monitoring and of data that captured elements absent from routine hospital data, which were easy to collect but uninformative on human rights indicators, such as accessibility and acceptability. One participant pointed out that data were usually not disaggregated and could be subject to double counting, such as on immunization coverage in South Africa. Routinely collected household survey data also did not generate qualitative human rights data, and there were limits to what could be collected through household surveys. Participants added that special monitoring methods and disaggregated data collection were necessary in health facilities alongside qualitative research to reflect human rights dimensions. Primary and secondary health-care facilities should be integrated, and more investment made in community health interventions and their assessment. In this context, engaging men to combat gender barriers and monitoring pregnant women correctly were essential.

IV. Strengthening measures for children at heightened risk

A. Addressing newborn and child mortality in situations of conflict and humanitarian crisis

33. Roberta Petrucci of Médecins sans Frontières (Switzerland) gave an overview of the impact of conflict and emergencies on children's health. She explained that one in six children lived in countries affected by conflict, that more than a third of child deaths were in countries affected by conflict and emergencies, and that 50 per cent of all refugees were children. Displaced children had a greatly heightened risk of mortality, and children were disproportionately affected by terrorist attacks and actively recruited into armed groups. Complex factors beyond the medical realm led to high rates of child mortality in conflict and humanitarian crises, such as lack of access to water and sanitation, exposure to malaria

or other illnesses, and lack of access to food or health-care facilities. The response necessary was therefore not only medical. As seen recently in the Syrian Arab Republic and Yemen, health-care facilities, hospitals and humanitarian convoys were increasingly targeted to destabilize areas, and children faced the long-term consequences of trauma, including post-traumatic stress disorder, anxiety and depression, even after the conflict had ended.

34. Jérôme Pfaffmann, a child health specialist at UNICEF, delivered a presentation on community health in emergencies. He explained that emergencies, conflict and humanitarian crises were among the greatest threats to realizing children's right to health. There was a need for a detailed understanding of the challenges in each emergency to ensure an appropriate response. He stressed the importance of community health workers embedded in the local population, and of integrated primary health-care systems. He referred to UNICEF case studies from experience in Guinea, Liberia and South Sudan, highlighting how community health workers had been able to continue their work even when formal health system services had been disrupted. Community health workers needed ongoing support in order to operate effectively throughout crises and emergency situations. Greater investment was needed in predicting crises and in planning effective responses, including tools for applying a human rights-based approach.

35. David Southall of Maternal Child Health Advocacy International (United Kingdom of Great Britain and Northern Ireland) delivered a presentation on the topic of protecting children from the health consequences of armed conflict. He stated that the nexus of security, insecurity and health must take precedence in crisis settings; international law was, however, ignored in conflict, and the situation was worsening globally. Attacks against health facilities and health workers were endemic (as in for example Somalia); the Security Council, in its resolution 2286 (2016), urged States to address such attacks and to take action to ensure accountability for perpetrators. He noted that, in May 2017, the Safeguarding Health in Conflict Coalition published a report documenting the current situation and showing that such attacks were continuing globally, not only in the Syrian Arab Republic and Yemen, but also in Afghanistan and elsewhere. The proliferation of arms — including those manufactured by States Members of the Security Council — was a primary contributing factor to conflict, and proposed the development of a targeted global health protection system, funded and managed by the United Nations.

36. Nour Alnirabia of the Syrian American Medical Society Foundation in Aleppo made a presentation on her experience of addressing newborn and child mortality in the Syrian Arab Republic. She stated that children in conflict zones had heightened needs owing to displacement, injuries and lack of health care due to the destruction of medical centres and the lack of adequate personnel, facilities and equipment to cover the population. In the Syrian Arab Republic, for each physician there were 6,000 children needing care. Newborns, particularly premature babies, were at greatest risk of mortality; nonetheless, 300 babies were delivered daily in areas where hospitals did not have the means to provide care. Patients had no access to facilities being targeted by bombings and from which children were removed for safety reasons, even though they needed treatment. Chemical attacks were committed in areas where children could not be treated, and a lack of vaccination coverage in Syrian conflict areas had recently led to a polio epidemic. Children needed support through education, orphanages and centres to recover from the psychological trauma and stress of living through conflict, and also safe schools, which could help to build the next generation.

37. During the discussion, participants pointed out that attacks on health facilities in conflict were one of the six grave violations of children's rights that the Human Rights Council had been mandated to address. While minimum standards existed for humanitarian responses, they did not exist for children in emergency situations. There was a need to address how children's health was prioritized in humanitarian response planning; an inter-agency subcluster could be considered. More detailed understanding was needed in order to respond to non-medical factors, including underlying determinants, such as malnutrition. Participants noted the large number of abortions and premature births due to the exposure of pregnant women to conflict situations, and that conflicts of interests of States were an obstacle to bringing about effective responses to conflict.

B. Underlying determinants of child mortality

38. The Special Rapporteur on the right to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, stated that although remarkable achievements had been made in the right to survival globally, the right to holistic health and development was equally important. Healthy and responsible adults, including parents, were instrumental to breaking the cycles of violence and hopelessness. He pointed at asymmetries in health-related policies and approaches that were often too medicalized, adding that greater attention to underlying social determinants was needed in order to realize the right to health. He pointed out that non-biomedical interventions, such as psychosocial interventions, were also very effective, and highlighted a thematic report addressing the human rights of infants and newborns, who were also equal rights-holders deserving of dignity. Retrogressive measures globally with respect to women's rights were cause for great concern. The Special Rapporteur then stressed the importance of implementing the right to health while also realizing rights as a means of attaining health outcomes.

39. The Special Rapporteur on the human rights to safe drinking water and sanitation, Léo Heller underscored how underlying determinants were key factors in addressing child mortality, and the well-documented relationship between improving water and sanitation and child health. If water, sanitation and hygiene measures were improved, the incidence of diarrhoea could be reduced by 25 per cent, and child mortality by up to 65 per cent. Initiatives to improve the supply of water and sanitation services that were based on the human rights framework had the greatest impact. Hand-washing with soap could reduce cases of diarrhoea by up to 50 per cent. Regular access to safe drinking water prevented unsafe storage practices, and its supply to schools and health facilities was a key to child health. The Special Rapporteur had observed in several countries unaffordable systems for providing water and sanitation in urban areas. For successful outcomes, affordability was therefore essential.

40. According to the Special Rapporteur on the implications for human rights of the environmentally sound management and disposal of hazardous substances and wastes, Baskut Tuncak, there was currently a human rights crisis due to exposure to toxic chemicals and wastes, responsible for substantial mortality rates of children under 5 years of age, with serious effects for their development. Paediatricians had referred to a silent pandemic that started before babies were born. Childhood diabetes, cancer, impaired neurological development and asthma all pointed back to exposure to hazardous substances and waste. In his report on trends in this regard (A/HRC/33/41), the Special Rapporteur had explained that States had a duty to prevent childhood exposure, which violated different rights at multiple levels. Children could be irreversibly affected by exposure from very early in life. As policymakers could not pinpoint the risk factors causing high disease rates, no rights violations were identified, so no action was taken. The poorest were discriminated against because they were subjected to the greatest degree of exposure, but had no access to their rights. A new policy perspective was required, beyond risk assessment, where States could (a) assess toxic threats and prevent exposure; (b) require that businesses conduct human rights due diligence assessment; and (c) implement an effective global framework of treaties on hazardous substances and wastes.

41. The discussion focused on cross-cutting issues affecting underlying determinants, including behavioural change through access to information. All people, including children, had a right to be properly informed through health education and information. Rights relating to essential resources and a healthy environment were a question of equality and non-discrimination; States therefore had to provide effective protection to children in this regard. Participants asked how the value of human rights could be demonstrated through relevant data, tools and arguments, and noted that general comment No. 24 (2017) of the Committee on Economic, Social and Cultural Rights on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities would be informative on the obligations of States and the responsibilities of private companies.

V. Conclusions and recommendations

42. **Most child deaths are witnessed in the most marginalized communities and regions. Preventing child mortality therefore requires effectively tackling health inequality and overcoming the barriers and multiple forms of discrimination that exist in health systems and communities. Children face heightened risk in certain circumstances, such as migration or displacement, and at critical life-stages, particularly when they are newborn. Child mortality increases sharply in situations of conflict and humanitarian crisis, and underlying determinants — such as exposure to hazardous substances and waste, or lack of access to clean water and sanitation — can cause mortality rates to rise substantially.**

43. **There is growing evidence that a human rights-based approach to health care, as well as being an obligation of States under international law, contributes to improved child mortality outcomes. The case studies presented at the meeting indicated that such an approach can guide health planners and support health workers in improving the quality of care. Awareness of human rights or their implementation by health practitioners is, however, limited. A strengthened evidence base is required to convey the value of a human rights-based approach to preventing child mortality. There is a need for monitoring health outcomes on the basis of disaggregated data, including qualitative data on human rights indicators, such as the accessibility and acceptability of care. A life-cycle approach in which women are engaged and empowered at all stages and gender-based violence is tackled as a priority is critical.**

44. **The links between legal frameworks and policy plans should be strengthened, alongside greater investment in children's health. Existing health resources can be maximized by tackling corruption and supporting social accountability. As political will, incentives and power structures — including commercial interests — are key factors, legal and political action should be pursued in parallel in order to bring about transformative results.**

45. **Taking concrete measures to ensure accountability and participation improves the quality of care. Quality of care benchmarks in health systems, greater participation of patients, particularly women, and accessible and effective mechanisms for redress all contribute to accountability. Quality improvement tools for maternal, newborn and paediatric care recently developed by WHO integrate principles and standards relating to children's rights; their application is expected to provide a greater insight into how human and child rights can make a positive contribution to respectful and dignified care for children and their caregivers.**

46. **Any attack on health facilities in conflict is a grave violation of child rights, and the increase in such attacks violates the right to life and the right to health for children. An international protection system should be established for health workers and facilities in conflict and situations of humanitarian crisis.**

47. **Non-medical factors can have a major impact in exacerbating child mortality rates; a focus on the underlying determinants of health, including social norms, is therefore crucial. In certain circumstances, addressing underlying determinants requires challenging practices adopted by the private sector, for example, in the marketing of breast-milk substitutes, the privatization of access to clean water and the management of hazardous substances and toxic waste. In this respect, States have an obligation to ensure that private actors fulfil their responsibility to respect children's rights.**

48. **States could consider establishing a United Nations inter-agency working group to take forward the key recommendations made at the meeting with respect to the application of a human rights-based approach to address mortality and morbidity among newborns and children under 5 years of age.**