



Convention on the Rights of the Child

Distr.: General
14 March 2013
**ADVANCE UNEDITED
VERSION**
Original: English

Committee on the Rights of the Child

General comment No. 15 (2013)

**The right of the child to the enjoyment of the highest
attainable standard of health (Article. 24)**

Contents

	<i>Paragraphs</i>	<i>Page</i>
I. Introduction.....	1-6	3
II. Principles and premises for realising children’s right to health.....	7-22	4
A. The indivisibility and interdependence of children’s rights.....	7	4
B. Right to non-discrimination.....	8-11	4
C. The best interests of the child.....	12-15	5
D. Right to life, survival and development and the determinants of child health	16-18	6
E. The right of the child to be heard.....	19	6
F. Evolving capacities and the life-course of the child.....	20-22	7
III. Normative content.....	23-70	7
A. Article 24.1.....	23-31	7
B. Article 24.2.....	32-70	9
IV. Obligations and responsibilities.....	71-85	15
A. States parties’ obligations to respect, protect and fulfil	71-74	15
B. Responsibilities of non-states actors.....	75-85	16
1. Responsibilities of parents and other caregivers.....	78	16
2. Non-state service providers and other non-state actors.....	79-85	17
V. International cooperation.....	86-89	18
VI. Framework for implementation and accountability.....	90-120	18
A. Promoting knowledge of children’s right to health.....	93	19
B. Legislative measures.....	94-95	19
C. Governance and coordination.....	96-103	19
1. The role of parliaments in national accountability.....	102	20
2. The role of national human rights institutions in national accountability	103	20
D. Investing in children’s health.....	104-107	21
E. The action cycle: Planning, implementation, monitoring and evaluation.....	108-118	21
1. Planning.....	110-111	21
2. Criteria for performance and implementation.....	112-116	22
(a) Availability.....	113	22
(b) Accessibility.....	114	22
(c) Acceptability.....	115	22
(d) Quality.....	116	23
3. Monitoring and evaluation.....	117-118	23
F. Remedies for violations of the right to health.....	119-120	23
VII. Dissemination.....	120	23

I. Introduction

1. The present General Comment is based on the importance of approaching children's health from a Child Rights approach that all children have the right to opportunities, to survive, grow and develop, within the context of physical, emotional and social wellbeing, to each child's full potential. Throughout this General Comment, "child" refers to an individual below the age of 18 years, in accordance with Article 1 of the Convention on the Rights of the Child (hereinafter "the Convention" or "the CRC"). Despite the remarkable achievements towards fulfilling children's rights to health in recent years since the adoption of the Convention, significant challenges remain. The Committee on the Rights of the Child (hereinafter "the Committee") recognises that a majority of mortality, morbidity, and disabilities among children could be prevented if there were political commitment and sufficient allocation of resources directed towards the application of available knowledge and technologies for prevention, treatment and care. This General Comment was prepared with the aim of providing guidance and support to States parties and other duty bearers to support them to respect, protect and fulfil children's right to the enjoyment of the highest attainable standard of health (hereinafter "children's right to health").

2. The Committee interprets children's right to health as defined in Article 24 as an inclusive right extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also a right to grow and develop to their full potential, and live in conditions that enable them to attain the highest standard of health by implementing programmes that address the underlying determinants of health. A holistic approach to health places the realization of children's right to health within the broader framework of international human rights obligations.

3. The Committee directs this General Comment to a range of stakeholders working in the fields of children's rights and public health, including policy-makers, programme implementers and activists as well as parents and children themselves. It is explicitly generic in order to ensure its relevance to a wide range of children's health problems, health systems and varied contexts that exist in different countries and regions. It focuses primarily on Article 24.1 and 24.2, and additionally addresses Article 24.4.¹ Implementation of Article 24 must take into account all human rights principles, especially the guiding principles of the Convention, and must be shaped by evidence-based public health standards and best practices.

4. In the WHO Constitution, States have agreed to regard health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity.² This positive understanding of health provides the public health foundation for this General Comment. Article 24 explicitly mentions primary health care, an approach defined in the Declaration of Alma-Ata³ and reinforced by the World Health Assembly.⁴ This approach emphasizes the need to eliminate exclusion and reduce social disparities in health; organize health services around people's needs and expectations; integrate health into related sectors; pursue collaborative models of policy dialogue; and increase stakeholder participation, including the demand for and appropriate use of services.

¹ Article 24.3 is not covered because a General Comment on Harmful Practices is currently being developed.

² Preamble to the Constitution of the WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946.

³ Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978.

⁴ Primary Health Care Including Health Systems Strengthening, World Health Assembly, April 2009.

5. Children's health is affected by a variety of factors, many of which have changed during the past twenty years and are likely to continue to evolve in the future. This includes attention to new health problems and changing health priorities, such as: HIV/AIDS, pandemic influenza, non-communicable diseases, importance of mental health care, care of the new born, and neonatal and adolescent mortality; increased understanding of the factors that contribute to death, disease and disability in children, including structural determinants, such as the global economic and financial situation, poverty, unemployment, migration and population displacements, war and civil unrest, discrimination and marginalization. There is also a growing understanding of the impact of climate change and rapid urbanization on children's health; the development of new technologies, such as vaccines and pharmaceuticals; a stronger evidence base for effective biomedical, behavioural and structural interventions, as well as some cultural practices that relate to child rearing, and which have proved to have a positive impact on children.

6. Advances in information and communication technologies have created new opportunities and challenges to achieve children's right to health. Despite the additional resources and technologies that have now become available to the health sector, many countries still fail to provide universal access to basic children's health promotion, prevention and treatment services. A wide range of different duty-bearers needs to be involved if children's right to health is to be fully realized and the central role played by parents and other caregivers needs to be better recognised. Relevant stakeholders will need to be engaged, working at national, regional, district and community levels, including governmental and non-governmental partners, private sector and funding organizations. States have an obligation to ensure that all duty-bearers have sufficient awareness, knowledge and capacity to fulfil their obligations and responsibilities, and that children's capacity is sufficiently developed to enable them to claim their right to health.

II. Principles and premises for realising children's right to health

A. The indivisibility and interdependence of children's rights

7. The Convention recognizes the interdependence and equal importance of all rights (civil, political, economic, social and cultural) that enable all children to develop their mental and physical abilities, personalities and talents to the fullest extent possible. Not only is children's right to health important in and of itself, but also the realization of the right to health is indispensable for the enjoyment of all the other rights in the Convention. Moreover, achieving children's right to health is dependent on the realization of many other rights outlined in the Convention.

B. The right to non-discrimination

8. In order to fully realize the right to health for all children, States parties have an obligation to ensure that children's health is not undermined as a result of discrimination, which is an important factor in creating vulnerability. A number of grounds on which discrimination is proscribed are outlined in Article 2 of the Convention, including the child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. These also include sexual orientation, gender identity and health status, for example HIV status and mental health.⁵ Attention should also be given to any other forms of discrimination that

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CRC General Comment No. 4 on Adolescent Health. CRC/GC/2003/4, para.6.

might undermine children's health, and implications of multiple forms of discrimination should also be addressed.

9. Gender-based discrimination is particularly pervasive, affecting a wide range of outcomes from female infanticide/foeticide to discriminatory infant and young child feeding practices, gender stereotyping and access to services. Attention should be given to the differing needs of girls and boys, and the impact of gender-related social norms and values on the health and development of boys and girls. Attention also needs to be given to harmful gender-based practices and norms of behaviour that are ingrained in traditions and customs and undermine the right to health of girls and boys.

10. All policies and programmes affecting children's health should be grounded in a broad approach to gender equality that ensures young women full political participation; social and economic empowerment; recognition of equal rights related to sexual and reproductive health; and equal access to information, education, justice and security, including the elimination of all forms of sexual and gender-based violence.

11. Children in disadvantaged situations and underserved areas should be a central focus of efforts to fulfil children's right to health. States should identify factors at national and sub-national levels that create vulnerabilities for children or that disadvantage certain groups of children. These factors should be addressed when developing laws, regulations, policies, programmes and services for children's health, and work towards ensuring equity.

C. The best interests of the child

12. Article 3 (1) of the Convention places an obligation on public and private social welfare institutions, courts of law, administrative authorities and legislative bodies to ensure that the best interests of the child are assessed and taken as a primary consideration in all actions affecting children. This principle must be observed in all health-related decisions concerning individual children or children as a group. Individual children's best interests should be based on their physical, emotional, social and educational needs, age, sex, relationship with parents and caregivers, and their family and social background, and after having heard their views according to Article 12 of the CRC.

13. The Committee urges States to place children's best interests at the centre of all decisions affecting their health and development, including the allocation of resources, and the development and implementation of policies and interventions that affect the underlying determinants of their health. For example, the best interests of the child should:

- guide treatment options, superseding economic considerations where feasible;
- aid the resolution of conflict of interest between parents and health workers; and
- influence the development of policies to regulate actions that impede the physical and social environments in which children live, grow and develop.

14. The Committee underscores the importance of the best interests of the child as a basis for all decision-making with regard to providing, withholding or terminating treatment for all children. States should develop procedures and criteria to provide guidance to health workers for assessing the best interests of the child in the area of health, in addition to other formal, binding processes that are in place for best interests determination. The Committee in its General Comment No 3 (2003)⁶ has underlined that adequate measures to address HIV/AIDS can be undertaken only if the rights of children and adolescents are fully respected. The principle of child's best interests should therefore

⁶ CRC General Comment No. 3 on HIV/AIDS and the Rights of the Child, CRC/GC/2003/3.

guide in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support.

15. In its General Comment No.4 (2003), the Committee has underlined the best interests of the child to have access to appropriate information on health issues.⁷ Special attention must be given to certain categories of children, including children and adolescents with psychosocial disabilities. Where hospitalization or placement in an institution is being considered, this decision should be made in accordance with the principle of the best interests of the child, with the primary understanding that it is in the best interests of all children with disabilities, to be cared for, as far as possible, in the community in a family setting and preferably within their own family with the necessary supports made available to the family and the child.

D. Right to life, survival and development and the determinants of children's health

16. Article 6 highlights States parties' obligations to ensure the survival, growth and development of the child, including the physical, mental, moral, spiritual and social dimensions of their development. The many risks and protective factors that underlie life, survival, growth and development of the child need to be systematically identified in order to design and implement evidence-informed interventions that address a wide range of determinants during the life-course.

17. The Committee recognizes that a number of determinants need to be considered for the realization of children's right to health, including individual factors such as age, sex, educational attainment, socio-economic status and domicile; determinants working at the immediate environment of families, peers, teachers and service providers, notably the violence that threatens the life and survival of children as part of the immediate environment; and structural determinants, including policies, administrative structures and systems, social and cultural values and norms.⁸

18. Among the key determinants of children's health, nutrition and development are the realization of the mother's right to health,⁹ and the role of parents and other caregivers. A significant number of infant deaths occur during the neonatal period, related to the poor health of the mother prior to, and during the pregnancy and the immediate post-partum period, and to sub-optimal breastfeeding practices. The health and health-related behaviours of parents and other significant adults have a major impact on children's health.

E. The right of the child to be heard

19. Article 12 highlights the importance of children's participation, providing for children to express their views and to have such views seriously taken into account, according to age and maturity.¹⁰ This includes their views on all aspects of health provisions, including, for example, what services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes

⁷ CRC General Comment No. 4 on Adolescent health and development in the context of the Convention on the Rights of the Child, CRC/GC/2003/4, para.32.

⁸ CRC General Comment No. 13 on The right of the child to be free from all forms of violence, CRC/C/GC/13, 2011.

⁹ CEDAW General Recommendation No.24 on Women and Health, 1999.

¹⁰ CRC General Comment No. 12 on the Right of the child to be heard, CRC/C/GC/12/2009.

of health professionals, how to strengthen children's capacities to take increasing levels of responsibility for their own health and development, and how to involve them more effectively in the provision of services, as peer educators. States are encouraged to conduct regular participatory consultations, which are adapted to the age and maturity of the child, and research with children, and to do this separately with their parents, in order to learn about their health challenges, developmental needs and expectations as a contribution to the design of effective interventions and health programmes.

F. Evolving capacities and the life-course of the child

20. Childhood is a period of continuous growth from birth to infancy, through the pre-school age to adolescence. Each phase is significant as important developmental changes occur in terms of physical, psychological, emotional and social development, expectations and norms. The stages of the child's development are cumulative and each stage has an impact on subsequent phases, influencing the children's health, potential, risks and opportunities. Understanding the life course is essential in order to appreciate how health problems in childhood affect public health in general.

21. The Committee recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality.

22. To respond and understand children's evolving capacities and the different health priorities along the life cycle, data and information that are collected and analysed should be disaggregated by age, sex, disability, socio-economic status and socio-cultural aspects and geographic location, in accordance with international standards. This makes it possible to plan, develop, implement and monitor appropriate policies and interventions that take into consideration the changing capacities and needs of children over time, and that help to provide relevant health services for all children.

III. Normative content of article 24

A. Article 24.1

“States parties recognize the right of the child to the enjoyment of the highest attainable standard of health...”

23. The notion of "the highest attainable standard of health" takes into account both the child's biological, social, cultural and economic preconditions and the State's available resources, supplemented by resources made available by other sources, including non-governmental organisations, the international community and the private sector.

24. Children's right to health contains a set of freedoms and entitlements. The freedoms, which are of increasing importance in accordance with growing capacity and maturity, include the right to control one's health and body, including sexual and reproductive freedom to make responsible choices. The entitlements include access to a range of facilities, goods, services and conditions that provide equality of opportunity for every child to enjoy the highest attainable standard of health.

“... and to facilities for the treatment of illness and rehabilitation of health”

25. Children are entitled to quality health services, including prevention, promotion, treatment, rehabilitation and palliative care services. At the primary level, these services must be available in sufficient quantity and quality, functional, within the physical and financial reach of all sections of the child population, and acceptable to all. The healthcare system should not only provide health care support but also report the information to relevant authorities for cases of rights violations and injustice. Secondary and tertiary level care should also be made available, to the extent possible, with functional referral systems linking communities and families at all levels of the health system.

26. Comprehensive primary health care programs should be delivered alongside proven community-based efforts including preventive care, treatment of specific diseases and nutritional interventions. Interventions at the community level should include the provision of information, services and commodities as well as prevention of illness and injury through e.g. investment in safe public spaces, road safety, and education on injury, accident and violence prevention.

27. States should ensure an appropriately trained workforce of sufficient size to support health services for all children. Adequate regulation, supervision, remuneration and conditions of service are also required, including for community health workers. Capacity development activities should ensure that service providers work in a child-sensitive manner and do not deny children any services they are entitled to by law. Accountability mechanisms should be incorporated to ensure that quality assurance standards are maintained.

“States parties shall strive to ensure that no child is deprived of his or her right of access to such health care services”

28. Article 24.1 imposes a strong duty of action by States parties to ensure that health and other relevant services are available and accessible to all children, with special attention to underserved areas and populations. It requires a comprehensive primary health care system, an adequate legal framework, and sustained attention to the underlying determinants of children’s health.

29. Barriers to children’s access to health services, including financial, institutional and cultural barriers, should be identified and eliminated. Universal free birth registration is a prerequisite and social protection interventions, including social security such as child grants or subsidies, cash transfers, and paid parental leave, should be implemented and seen as complementary investments.

30. Health-seeking behaviour is shaped by the environment in which it takes place, including, inter alia, the availability of services, levels of health knowledge, life skills and values. States should seek to ensure an enabling environment to encourage appropriate health-seeking behaviour by parents and children.

31. In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child’s best interests. States should clarify the legislative procedures for designation of appropriate caregivers for children without parents or legal guardians, who can consent on the child’s behalf or assist the child in consenting, depending on the child’s age and maturity. States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.

B. Article 24.2

32. In accordance with article 24.2, States should put in place a process for identifying and addressing other issues relevant to children's right to health. This requires, inter alia, an in-depth analysis of the current situation in terms of priority health problems and responses, and the identification and implementation of evidence-informed interventions and policies that respond to key determinants and health problems, in consultation with children when appropriate.

Article 24.2(a). "To diminish infant and child mortality"

33. States have an obligation to reduce child mortality. The Committee urges particular attention to neonatal mortality, which constitutes an increasing proportion of under-five mortality. Additionally, States parties should also address adolescent morbidity and mortality, which is generally under-prioritised.

34. Interventions should include attention to, inter alia, still births, preterm birth complications, birth asphyxia, low birth weight, mother-to-child transmission of HIV and other STIs, neonatal infections, pneumonia, diarrhoea, measles, under- and malnutrition, malaria, accidents, violence, suicide, and adolescent maternal morbidity and mortality. Strengthening health systems to provide such interventions to all children in the context of the continuum of care for reproductive, maternal, newborn and children's health, including screening for birth defects, safe delivery services, and care for the newborn are recommended. Maternal and perinatal mortality audits should be conducted regularly for the purposes of prevention and accountability.

35. States should put particular emphasis on scaling up simple, safe and inexpensive interventions that have proven to be effective, such as community-based treatments for pneumonia, diarrhoeal disease and malaria, and pay particular attention to ensuring full protection and promotion of breastfeeding practices.

Article 24.2(b). "To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care"

36. States should prioritise universal access for children to primary health care services provided as close as possible to where children and their families live particularly in community settings. While the exact configuration and content of services will vary from country to country, in all cases effective health systems will be required including: a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics systems to deliver quality medicines and technologies; and strong leadership and governance. Health service provision within schools provides an important opportunity for health promotion, to screen for illness, and increases the accessibility of health services for in-school children.

37. Recommended packages of services should be used, for example the Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Children's health.¹¹ States have an obligation to make all essential medicines on the WHO Model Lists of Essential Medicines including the list for children (in paediatric formulations where possible) available, accessible, and affordable.

38. The Committee is concerned by the increase in mental ill-health among adolescents, including developmental and behavioural disorders; depression; eating disorders; anxiety; psychological trauma resulting from abuse, neglect, violence or exploitation; alcohol,

¹¹

The Partnership for Maternal, Newborn & Child Health, A Global Review of the Key Interventions Related to Reproductive, Maternal, Newborn and Child Health, Geneva, 2011.

tobacco and drug use; obsessive behaviour such as excessive use of and the addiction to the internet and other technologies; and self-harm and suicide. There is growing recognition of the need for increased attention to behavioural and social issues that undermine children's mental health, psychosocial wellbeing and emotional development. The Committee cautions against over medicalization and institutionalization, and urges to undertake a public health and psychosocial support approach in addressing mental ill-health among children and adolescents and to invest in primary care approaches that facilitate the early detection and treatment of children's psychosocial, emotional and mental problems.

39. States have the obligation to provide adequate treatment and rehabilitation for children with mental health and psychosocial disorders while abstaining from unnecessary medication. The 2012 WHA Resolution on Mental Health¹² notes that there is increasing evidence of the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children. The Committee strongly encourages States to scale up these interventions by mainstreaming them through a range of sectoral policies and programmes, including health, education and protection (criminal justice), with the involvement of families and communities. Children at risk because of their family and social environments, require special attention in order to enhance their coping and life skills and promote protective and supportive environments.

40. There is a need to recognise the particular challenges to children's health for children affected by humanitarian emergencies, including those resulting in large-scale displacements due to natural or man-made disasters. All possible measures should be taken to ensure that children have uninterrupted access to health services, to (re)unite them with their families, and to protect them not only with physical support such as food and clean water but also to encourage special parental or other psycho-social care to prevent or address fear and traumas.

Article 24.2(c). "To combat disease and malnutrition, including within the framework of primary health care through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution"

The application of readily available technology

41. As new, proven technologies in children's health, including drugs, equipment and interventions, become available, States should introduce them into policies and services. Mobile arrangements and community-based efforts can substantially reduce some risks and should be made universally available including: immunisation against the common childhood diseases; growth and developmental monitoring, especially in early childhood; vaccination against human papillomavirus for girls; tetanus toxoid injections for pregnant women; access to oral rehydration therapy and zinc supplementation for the management of diarrhoea; essential antibiotics and antiviral drugs; micronutrient supplements such as Vitamins A and D, iodised salt and iron supplements; and condoms. Health workers should advise parents how they can access and administer these simple technologies as required.

42. The private sector which includes business enterprises as well as not for profit organizations that impact on health, is taking an increasingly important role in the development and refinement of technology, drugs, equipment, interventions and processes that can contribute to significant advances in children's health. States should ensure that benefits reach all children who need them. States can also encourage public-private

¹²

The global burden of mental health disorders and the need for a comprehensive coordinated response from health and social sectors at the country level, Sixty-fifth World Health Assembly, 2012.

partnerships and sustainability initiatives that can increase access and affordability of health technology.

The provision of adequate nutritious foods

43. Measures for fulfilling State's obligations to ensure access to nutritionally adequate, culturally appropriate and safe food¹³ and to combat malnutrition will need to be adopted according to the specific context. Effective direct nutrition interventions for pregnant women, including addressing anaemia and folic acid and iodine deficiency, as well as providing calcium supplementation. Prevention and management of pre-eclampsia and eclampsia, should be ensured for all women of reproductive age to benefit their health, ensure healthy foetal and infant development.

44. Exclusive breastfeeding for infants up to 6 months should be protected and promoted and breastfeeding should continue together with appropriate complementary foods preferably until two years of age as feasible. States' obligations in this area are defined in the "*protect, promote and support framework*", adopted unanimously by the World Health Assembly.¹⁴ States are required to introduce into national law, implement and enforce internationally agreed standards concerning children's right to health, including the International Code on Marketing of Breast-milk Substitutes, as well as the WHO Framework Convention on Tobacco Control. Special measures should be taken to promote community and workplace support to mothers in relation to pregnancy and lactation, and feasible and affordable child-care services, and compliance to the ILO Maternity Protection Convention 2000 (No. 183).

45. Adequate nutrition and growth monitoring in early childhood are particularly important. Where necessary, integrated management of severe acute malnutrition should be expanded through facility and community-based interventions, as well as treatment of moderate acute malnutrition, including therapeutic feeding interventions.

46. School feeding is desirable to ensure all pupils have access to a full meal every day, which can also enhance attention to learning and increase school enrolment. The Committee recommends that this be combined with nutrition and health education including setting up school gardens and training teachers to improve children's nutrition and healthy eating habits.

47. States should also address obesity in children as it is associated with hypertension, early markers of cardiovascular disease, insulin resistance, psychological effects, a higher likelihood of adult obesity, and premature death. Children's exposure to 'fast' foods that are high in fat, sugar or salt, energy-dense and micronutrient-poor, and drinks containing high levels of caffeine or other potentially harmful substances should be limited. The marketing of these substances especially focused on children should be regulated and their availability in schools and other services controlled.

The provision of clean drinking water

48. Safe and clean drinking water and sanitation are essential for the full enjoyment of life and all other human rights.¹⁵ Government departments and local authorities responsible for water and sanitation should recognise their obligation to contribute to realising children's right to health, and actively consider child indicators on malnutrition, diarrhoea

¹³ ICESCR Article 11, and CESCR General Comment No. 12 on the right to adequate food, 1999.

¹⁴ WHO, Global Strategy for Infant and Young Child Feeding, 2003.

¹⁵ General Assembly, Resolution 64/292: "The human right to water and sanitation". 2010.

and other water-related diseases and household size when planning and implementing water services infrastructure expansion and maintenance, and when making decisions on free minimum allocation amounts and service disconnections. States are not exempted from their obligations even when they have privatized water and sanitation.

Environmental pollution

49. States should take measures to address the dangers and risks of local environmental pollution for children's health in all settings. Adequate housing that includes non-dangerous cooking facilities, smoke free environment, appropriate ventilation, effective management of waste and litter disposal in living quarters and the immediate surroundings, freedom from mould and other toxic substances, and family hygiene are core requirements to a healthy upbringing and development. States should regulate and monitor the environmental impact of business activities which can compromise children's right to health, food security, and access to safe drinking water and to sanitation.

50. The Committee draws attention to the relevance of the environment, beyond environmental pollution, to children's health. Environmental interventions should include addressing climate change as this is one of the biggest threats to children's health and to exacerbating health disparities. States should, therefore, put children's health concerns at the centre of their climate change adaptation and mitigation strategies.

Article 24.2(d). "To ensure appropriate pre-natal and post-natal health care for mothers"

51. The Committee notes that preventable maternal mortality and morbidity constitute grave violations of the human rights of women and girls and pose serious threats to their own and their children's right to health. Pregnancy and child birth are natural processes, with known health risks that are amenable to both prevention and therapeutic responses, if identified early. Such risk situations can occur during pregnancy, delivery, as well as in the antenatal and post natal periods and can have both short term and long term impact on the health and well-being of both mother and child.

52. The Committee encourages States to adopt child-sensitive health approaches throughout different periods of childhood such as (i) the Baby-Friendly Hospital Initiative¹⁶ which protects, promotes and supports rooming-in and breastfeeding; (ii) child-friendly health policies focused on training health workers to provide quality services in a way that minimises fear, anxiety and suffering of children and their families; and (iii) adolescent-friendly health services which require health practitioners and facilities to be welcoming and sensitive to adolescents, to respect confidentiality, and to deliver services that are acceptable to adolescents.

53. The care that women receive before, during and after their pregnancy has profound implications for the health and development of their children. The obligation to ensure universal access to a comprehensive package of sexual and reproductive health interventions should be based on the concept of a continuum of care from pre-pregnancy, through pregnancy, childbirth, and throughout the post-partum period. Timely and good quality care throughout these periods provides important opportunities to prevent the inter-generational transmission of ill-health and has a high impact on the health of the child throughout the life course.

54. The interventions that should be made available across this continuum include but are not limited to: essential health prevention and promotion, and curative care including, inter alia, the prevention of neonatal tetanus, malaria in pregnancy and congenital syphilis;

¹⁶

UNICEF/WHO, The Baby-Friendly Hospital Initiative, 1991.

nutritional care; access to sexual and reproductive health education, information and services; health behaviour education (e.g. relating to smoking and substance use); birth preparedness; early recognition and management of complications; safe abortion services and post-abortion care; essential care at childbirth; and prevention of mother-to-child HIV transmission, and care and treatment of HIV-infected women and infants. Maternal and newborn care following delivery should ensure no unnecessary separation of the mother from her child.

55. The Committee recommends that social protection interventions include ensuring universal coverage or financial access to care, paid parental leave and other social security benefits, and legislation to restrict the inappropriate marketing and promotion of breast-milk substitutes.

56. Given the high rates of pregnancy among adolescents globally and the additional risks of associated morbidity and mortality, States should ensure that health systems and services are able to meet the specific sexual and reproductive health needs of adolescents, including family planning and safe abortion services. States should work to ensure that girls can make autonomous and informed decisions on their reproductive health. Discrimination based on adolescent pregnancy, such as expulsion from schools, should be prohibited, and opportunities for continuous education should be ensured.

57. Taking into account that boys and men are crucial to planning and ensuring healthy pregnancies and deliveries, States should integrate education, awareness and dialogue opportunities for boys and men in their policies and plans for sexual, reproductive, and children's health services.

Article 24.2(e). “To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of children’s health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents”

58. The obligations under this provision include providing health-related information and support in the use of this information. Health related information should be physically accessible, understandable, and appropriate to children's age and educational level.

59. Children require information and education on all aspects of health to enable them to make informed choices in relation to lifestyle and access to health services. Information and life skills education should address a broad range of health issues including, inter alia, healthy eating and promotion of physical activity, sports, and recreation, accident and injury prevention, sanitation, hand washing and other personal hygiene practices, and the dangers of alcohol, tobacco and psychoactive substance use. It should encompass appropriate information about children's right to health, the obligations of governments, and how and where to access health information and services and should be provided as a core part of school curriculum, as well as through health services and in other settings targeting children who are not in school. Materials providing information about health should be designed in collaboration with children and disseminated in a wide range of public settings.

60. Sexual and reproductive health education should include self-awareness and knowledge about the body, including anatomical, physiological and emotional aspects, and should be accessible to all children, girls and boys. It should include content related to sexual health and well-being, including information about body changes and maturation processes and designed in a manner through which children are able to gain knowledge regarding reproductive health, the prevention of gender-based violence, and adopt responsible sexual behaviour.

61. Information about children's health should be provided to all parents individually, or in groups, extended family, and other caregivers through different methods including health clinics, parenting classes, public information leaflets, professional bodies, community organisations and the media.

Article 24.2(f). "To develop preventive health care, guidance for parents and family planning education and services"

Preventive health care

62. Prevention and health promotion should address the main health challenges facing children within the community and the country as a whole. These challenges include diseases as well as other health challenges such as accidents, violence, substance abuse, and psychosocial and mental health problems. Preventive health should address communicable and non-communicable diseases, and incorporate a combination of bio-medical, behavioural and structural interventions. Preventing non-communicable diseases should start early in life through the promotion and support of healthy and non-violent lifestyles for pregnant women, their spouses/partners, and young children.

63. Reducing the burden of child injuries requires strategies and measures to reduce drowning, burns and other accidents. This should include legislation and enforcement; product and environmental modification; supportive home visits and promotion of safety features; education, skills development and behaviour change; community-based projects; and pre-hospital and acute care as well as rehabilitation. Efforts to reduce road traffic accidents should include legislating the use of seat-belts and other safety devices, ensuring access to safe transport for children, and according them due consideration in road planning and traffic control. The support of related industry and of the media is essential in this respect.

64. Recognising violence as a significant cause of mortality and morbidity in children, particularly adolescents, the Committee emphasises the need to create an environment that protects children from violence and encourages their participation in attitudinal and behavioural changes at home, in schools and in public spaces; to support parents and caregivers in healthy child-rearing; and to challenge attitudes which perpetuate the tolerance and condoning of violence in all forms, including by regulating the depiction of violence by mass media.

65. States should protect children from solvents, alcohol, tobacco and illicit substances, increase the collection of relevant evidence, and take appropriate measures to reduce the use of such substances among children. Regulation of advertising and sale of substances harmful to children's health and of promotion of such items in places where children congregate, as well as in media channels and publications that are accessed by children are recommended.

66. The Committee encourages States parties that have not yet done so to ratify the UN International Drug Control Conventions,¹⁷ and the WHO Framework Convention on Tobacco Control.¹⁸ The Committee underscores the importance of adopting a rights-based approach to substance use and recommends that, where appropriate, harm reduction strategies should be employed to minimize negative health impacts of substance abuse.

¹⁷ UN Single Convention on Narcotic Drugs, 2916; UN Convention on Psychotropic Substances, 1971; UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

¹⁸ WHO, Framework Convention on Tobacco Control, 2003.

Guidance for parents

67. Parents are the most important source of early diagnosis and primary care in small children, and the most important protective factor against high-risk behaviours in adolescents such as substance use and unsafe sex. Parents also play a central role in promoting healthy child development, protecting children from harm due to accidents, injuries and violence, and mitigating the negative effects of risk behaviours. Children's socialisation processes, which are crucial for understanding and adjusting to the world in which they grow up, are strongly influenced by their parents, extended family, and other caregivers. States should adopt evidence-based interventions to support good parenting, including parenting skills education, support groups and family counselling, especially for families experiencing children's health and other social challenges.

68. In light of the children's health impacts of corporal punishment, including fatal and non-fatal injury, as well as psychological and emotional consequences, the Committee reminds States of their obligation to take all appropriate legislative, administrative, social and educational measures to eliminate corporal punishment and other cruel or degrading forms of punishment in all settings, including the home.¹⁹

Family planning

69. Family planning services should be situated within comprehensive sexual and reproductive health services and should encompass sexuality education, including counselling. They can be considered part of the continuum of services described in Article 24.2(d) and should be designed to enable all couples and individuals to make sexual and reproductive decisions freely and responsibly, including the number, spacing and timing of their children, and to have the information and means to do so. Attention should be given to ensuring confidential, universal access to goods and services for both married and unmarried female and male adolescents. States should ensure that adolescents are not deprived of any sexual and reproductive health information or services due to providers' conscientious objection.

70. Short-term contraceptive methods such as condoms, hormonal methods and emergency contraception should be made easily and readily available to sexually active adolescents. Long-term and permanent contraceptive methods should also be provided. The Committee recommends that States ensure access to safe abortion and post-abortion care services, irrespective of whether abortion itself is legal.

IV. Obligations and responsibilities

A. State party's obligations to respect, protect, fulfil

71. States have three types of obligations relating to human rights, including children's right to health: to respect the freedoms and the entitlements, to protect both freedoms and entitlements against third parties or against social or environmental threats, and to fulfil the entitlements through facilitation or direct provision. In accordance with Article 4 of the Convention, States parties shall fulfil the entitlements contained in children's right to health to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

72. All States, regardless of their level of development, are required to take immediate action to implement these obligations as a matter of priority and without discrimination of

¹⁹

CRC General Comment No.8 on the Right of the child to protection from corporal punishment and other cruel or degrading forms of punishment, CRC/C/GC/8, 2006.

any kind. Where the available resources are demonstrably inadequate, States are still required to undertake targeted measures to move as expeditiously and effectively as possible towards the full realization of children's right to health. Irrespective of resources, States have the obligation to not take any retrogressive steps that could hamper the enjoyment of children's right to health.

73. The core obligations, under children's right to health, include:

- (i) Reviewing the national and sub-national legal and policy environment and, where necessary, amending it;
- (ii) Ensuring universal coverage of quality primary health services, including prevention, health promotion, care and treatment services, and essential drugs;
- (iii) Providing adequate response to the underlying determinants of children's health; and
- (iv) Developing, implementing, monitoring and evaluating policies and budgeted plans of actions that constitute a human rights-based approach to fulfilling children's right to health.

74. States should demonstrate their commitment to progressive fulfilment of all obligations under Article 24, prioritizing this even in the context of political or economic crisis or emergency situations. This requires that children's health and related policies, programmes and services be planned, designed, financed and implemented in a sustainable manner.

B. Responsibilities of non-state actors

75. The State is responsible for realising children's right to health regardless of whether or not it delegates the provision of services to non-state actors. In addition to the State, a wide range of non-state actors who provide information and services related to children's health and its underlying determinants have specific responsibilities and impact in this regard.

76. States' obligations include a duty to promote awareness of non-state actors' responsibilities and to ensure that all non-state actors recognize, respect and fulfil their responsibilities to the child, applying due diligence procedures where necessary.

77. The Committee calls on all non-State actors engaged in health promotion and services, especially the private sector including the pharmaceutical and health-technology industry as well as the mass media and health service providers to act in compliance with the provisions of the Convention and to ensure compliance by any partners who deliver services on their behalf. This encompasses international organizations, banks, regional financial institutions, global partnerships, the private sector (private foundations and funds), donors, and any other entities providing services or financial support to children's health, particularly in humanitarian emergencies or politically unstable situations.

1. Responsibilities of parents and other caregivers

78. The responsibilities of parents and other caregivers are expressly referred to in several provisions of the Convention. Parents should fulfil their responsibilities always acting in the best interests of the child, if necessary with the support of the State. Taking the child's evolving capacity into account, parents and caregivers should nurture, protect and support children to grow and develop in a healthy manner. Although not explicit in Article 24.2(f), the Committee understands any reference to parents to also include other caregivers.

2. Non-state service providers and other non-state actors

Non-state service providers

79. All health service providers, including non-state actors, must incorporate and apply to the design, implementation and evaluation of their programmes and services all relevant provisions of the Convention, as well as the criteria of availability, accessibility, acceptability and quality, as described later in this General Comment.

Private sector

80. All business enterprises have an obligation of due diligence with respect to human rights which include all rights enshrined under the Convention. States should require businesses to undertake children's rights due diligence. This will ensure that business enterprises identify, prevent and mitigate their negative impact on children's right to health including across their business relationships and within any global operations. Large business enterprises should be encouraged and where appropriate required to make public their efforts towards addressing their impact on children's rights.

81. Among other responsibilities and in all contexts, private companies should: refrain from engaging children in hazardous labour while ensuring they comply with the minimum age for child labour; comply with the International Code of Marketing of Breast-milk Substitutes; limit advertisement of energy-dense, micronutrient-poor foods, and drinks containing high levels of caffeine or other substances potentially harmful to children; and refrain from the advertisement, marketing and sale to children of tobacco, alcohol and other toxic substances or the use of child images.

82. The Committee acknowledges the profound impact of the pharmaceutical sector on the health of children and calls on pharmaceutical companies to adopt measures towards enhancing access to medicines for children, paying particular attention to the Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines.²⁰ At the same time, States should ensure that pharmaceutical companies to monitor the use and refrain from promoting excessive prescription and use of drugs and medicines on children. Intellectual property rights should not be applied in ways that cause necessary medicines or goods to be unaffordable for the poor.

83. Private health insurance companies should ensure that they do not discriminate against pregnant women, children or mothers on any prohibited grounds and that they promote equality through partnerships with State health insurance schemes based on the principle of solidarity and ensuring that inability to pay does not restrict access to services.

Mass and social media

84. Article 17 of the Convention delineates the responsibilities of mass media organisations. In the context of health, these can be further expanded to include promoting health and healthy life styles among children; providing free advertising space for health promotion; ensuring the privacy and confidentiality of children and adolescents; promoting access to information; not producing communication programmes and material that are harmful to child and general health; and not perpetuating health-related stigma.

²⁰

UN General Assembly, Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines, Report of the Special Rapporteur on the Right to Health, 11 August 2008, A/63/263; Human Rights Council Resolution 15/22, 6 October 2010, A/HRC/RES/15/22.

Researchers

85. The Committee underscores the responsibility of entities, including academics, private companies, and others, undertaking research involving children to respect the principles and provisions of the Convention and the International Ethical Guidelines for Biomedical Research Involving Human Subjects.²¹ The Committee reminds researchers that the best interests of the child shall always prevail over the interest of general society or scientific advancement.

V. International cooperation

86. States parties to the Convention have obligations not only to implement children's right to health within their own jurisdiction, but also to contribute through international cooperation to global implementation. Article 24.4 requires States and inter-state agencies to pay particular attention to the children's health priorities among the poorest parts of the population and in developing States.

87. The Convention should guide all international activities and programmes of donor and recipient States related directly or indirectly to children's health. It requires partner States to identify the major health problems affecting children, pregnant women and mothers in recipient countries and to address them in accordance with the priorities and principles established by Article 24. International cooperation should support state-led health systems and national health plans.

88. States have individual and joint responsibility, including through UN mechanisms, to cooperate in providing disaster relief and humanitarian assistance in times of emergency. In these cases, States should consider prioritizing efforts to realise children's right to health, including through appropriate international medical aid; distribution and management of resources, such as safe and potable water, food and medical supplies; and financial aid to the most vulnerable or marginalized children.

89. The Committee reminds States to meet the United Nations target of 0.7% of GNI for international development assistance, as these resources have important implications for the realisation of children's right to health in resource-limited States. In order to ensure the highest impact, States and inter-state agencies are encouraged to apply the Paris Principles on Aid Effectiveness and the principles of the Accra Agenda for Action.²²

VI. Framework for implementation and accountability

90. Accountability is at the core of the enjoyment of children's right to health. The Committee reminds the State Party of their obligations to ensure that relevant government authorities and service providers are held accountable for maintaining the highest possible standards of children's health and health care until they reach 18 years of age.

91. States should provide an environment that facilitates the discharge of all duty-bearers' obligations and responsibilities with respect to children's right to health, and a regulatory framework within which all actors should operate and can be monitored. This includes mobilizing political and financial support for children's health-related issues, and

²¹ CIOMS/WHO, "International ethical guidelines for biomedical research involving human subjects", Geneva, 1993.

²² OECD, The Paris Declaration on Aid Effectiveness, 2 March 2005; OECD The Accra Agenda For Action, 3rd High Level Forum on Aid Effectiveness 4 September 2008.

building the capacity of duty-bearers to fulfil their obligations and children to claim their right to health.

92. With the active engagement of the government, parliament, communities, civil society and children, national accountability mechanisms must be effective and transparent, and aim to hold all actors responsible for their actions. They should include attention to the structural factors affecting children's health including laws, policies and budgets. Participatory tracking of financial resources and impact on children's health is essential for state accountability mechanisms.

A. Promoting knowledge of children's right to health (Art.42)

93. The Committee encourages States to adopt and implement a comprehensive strategy to educate children, their caregivers, policy-makers, politicians, and professionals working with children, and about children's right to health, and the contributions they can make to its realisation.

B. Legislative measures

94. The Convention requires States Parties to adopt all appropriate legislative, administrative and other measures for the implementation of children's right to health without discrimination. National laws should place a statutory obligation on the State to provide the services, programmes, human resources, and infrastructure needed to realise children's right to health and to provide a statutory entitlement to essential, child sensitive, quality health and related services for pregnant women and children irrespective of their ability to pay. Laws should be reviewed to assess any potential discriminatory effect or impediment to realising children's right to health and repealed where required. Where necessary, international agencies and donors should provide development aid and technical assistance for such legal reforms.

95. Legislation should fulfil a number of additional functions in the realisation of children's right to health by defining the scope of this right and recognising children as rights-holders; clarifying the roles and responsibilities of all duty-bearers; clarifying what services children, pregnant women and mothers are entitled to claim; and regulating services and medications to ensure that they are of good quality and cause no harm. States must ensure that adequate legislative and other safeguards exist to protect and promote the work of human rights defenders working on children's right to health.

C. Governance and coordination

96. States are encouraged to ratify and implement international and regional human rights instruments relevant to children's health and to report on all aspects of children's health accordingly.

97. Sustainability in children's health policy and practice requires a long-term national plan that is supported and entrenched as a national priority. The Committee recommends that States establish and make use of a comprehensive and cohesive national coordinating framework on children's health, built upon the principles of the Convention, to facilitate cooperation between Government ministries and different levels of government as well as interaction with civil society stakeholders, including children. Given the high number of government agencies, legislative branches and Ministries working on children's health-related policies and services at different levels, the Committee recommends that the roles and responsibilities of each of these be clarified in the legal and regulatory framework.

98. Particular attention must be given to identifying and prioritizing marginalized and disadvantaged groups of children, as well as children who are at risk of any form of violence and discrimination. All activities should be fully costed, financed and made visible within the national budget.

99. A "Child Health in All Policies" strategy should be used, highlighting the links between children's health and its underlying determinants. Every effort should be made to remove bottlenecks that obstruct transparency, coordination, partnership and accountability in the provision of services affecting children's health.

100. While decentralization is required to meet the particular needs of localities and sectors, this does not reduce the direct responsibility of the central or national government to fulfil its obligations to all children within its jurisdiction. Decisions about allocations to the various levels of services and geographical areas should reflect the core elements of the primary health care approach.

101. States should engage all sectors of society, including children, in implementation of children's right to health. The Committee recommends that this include: creation of conditions conducive to the continual growth, development and sustainability of civil society organisations, including grass-roots and community-level groups; active facilitation of their involvement in the development, implementation and evaluation of children's health policy and services; and provision of appropriate financial support or assistance in obtaining financial support.

1. The role of parliaments in national accountability

102. In children's health related issues, parliaments have the responsibility to legislate, ensuring transparency and inclusiveness, and encourage continued public debate and a culture of accountability. They should create a public platform for reporting and debating performance and promoting public participation in independent review mechanisms. They should also hold the executive accountable for implementing the recommendations emerging from independent reviews and ensure that the results of the reviews inform subsequent national plans, laws, policies, budgets and further accountability measures.

2. The role of national human rights institutions in national accountability

103. National Human Rights Institutions (NHRIs) have an important role to play in reviewing and promoting accountability, providing children with relief for violations of their right to health, and advocating for systemic change towards the realisation of this right. The Committee recalls its General Comment No 2, and reminds States that the right to health should be included in the mandate of Children's Commissioners or Children's Ombudsmen and they are well-resourced and independent from the government.²³

D. Investing in children's health

104. In their decisions about budget allocation and spending, States should strive to ensure availability, accessibility, acceptability and quality of essential children's health services for all, without discrimination.

105. States should continually assess the impact of macro-economic policy decisions on children's right to health, particularly children in vulnerable situations, prevent any decisions that may compromise children's rights, and to apply the best interests principle when making such decisions. States should also consider obligations under article 24 in all

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CRC General Comment No. 2 on The role of independent national human rights institutions in the promotion and protection of the rights of the child. CRC/GC/2002/2.

aspects of their negotiations with international financial institutions and other donors, to ensure that children's right to health is given adequate consideration in international cooperation.

106. The Committee recommends that States parties:

(a) legislate for a specific proportion of public expenditure to be allocated to children's health, and create an accompanying mechanism that allows for systematic independent evaluation of this expenditure,

(b) meet WHO's recommended minimum health expenditure per capita, and prioritize children's health in budgetary allocations,

(c) make investment in children visible in the State budget through detailed compilation of resources allocated to them and expended, and

(d) implement rights-based budget monitoring and analysis, as well as child impact assessments on how investments, particularly in the health sector, may serve the best interests of the child.

107. The Committee underlines the importance of assessment tools in the use of resources and recognizes the need to develop measurable indicators to assist States parties in monitoring and evaluating progress in the implementation of children's right to health.

E. The action cycle

108. States parties' fulfilment of their obligations under Article 24 requires engagement in a cyclical process of planning, implementation, monitoring and evaluation to then inform further planning, modified implementation and renewed monitoring and evaluation efforts. States should ensure the meaningful participation of children and incorporate feedback mechanisms to facilitate necessary adjustments throughout the cycle.

109. At the heart of the development, implementation and monitoring of policies, programmes and services that aim to realise children's right to health, is the availability of relevant and reliable data. This should include: appropriately disaggregated data across the life course of the child, with due attention to vulnerable groups; data on priority health problems, including new and neglected causes of mortality and morbidity; and data on the key determinants of children's health. Strategic information requires data collected through routine health information systems, special surveys, and research, and should include both quantitative and qualitative data. These data should be collected, analysed, disseminated and used to inform national and sub-national policies and programmes.

1. Planning

110. The Committee notes that, in order to inform implementation, monitoring, and evaluation of activities to fulfil obligations under Article 24, States should carry out situation analyses of existing problems, issues, and infrastructure for delivery of services. The analysis should assess the institutional capacity, and the availability of human, financial, and technical resources. Based on the outcome of the analysis, a strategy should be developed involving all stakeholders, both state and non-state actors, and children.

111. The situation analysis will provide a clear idea of national and sub-national priorities as well as strategies for their achievement. Benchmarks and targets, budgeted action plans and operational strategies should be established along with a framework for monitoring and evaluating policies, programmes and services, and promoting accountability for children's health. This will highlight how to build and strengthen existing structures and systems to be consonant with the Convention.

2. Criteria for performance and implementation

112. States should ensure that all children's health services and programs comply with the criteria of availability, accessibility, acceptability and quality.

(a) Availability

113. States should ensure that there are functioning children's health facilities, goods, services and programmes in sufficient quantity. States need to ensure that they have sufficient hospitals, clinics, health practitioners, mobile teams and facilities, community health workers, equipment and essential drugs to provide health care to all children, pregnant women and mothers within the State. Sufficiency should be measured according to need with particular attention given to underserved and hard to reach populations.

(b) Accessibility

114. The element of accessibility has four dimensions:

- *Non-discrimination:* Health and related services as well as equipment and supplies must be accessible to all children, pregnant women and mothers, in law and in practice, without discrimination of any kind.

- *Physical accessibility:* Health facilities must be within accessible distance for all children, pregnant women and mothers. Physical accessibility may require additional attention to the needs of children and women with disabilities. The Committee encourages States to prioritise the establishment of facilities and services in underserved areas and to invest in mobile outreach approaches, innovative technologies, and well-trained and supported community health workers as ways of reaching especially vulnerable groups of children.

- *Economic accessibility/affordability:* Lack of ability to pay for services, supplies or medicines should not result in the denial of access. The Committee calls on States to abolish user fees and to implement health-financing systems that do not discriminate against women and children on the basis of their inability to pay. Risk-pooling mechanisms such as tax and insurance should be implemented on the basis of equitable, means-based contributions.

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

(c) Acceptability

115. In the context of children's right to health, the Committee defines acceptability as the obligation to design and implement all health-related facilities, goods and services in a way that takes full account of and is respectful of medical ethics as well as children's needs, expectations, cultures, views and languages, paying special attention to certain groups, where necessary.

(d) Quality

116. Health-related facilities, goods and services should be scientifically and medically appropriate and of good quality. Ensuring quality requires, inter alia, that (i) treatments, interventions and medicines are based on the best available evidence; (ii) medical personnel are skilled and provided with adequate training on maternal and children's health, and the principles and provisions of the Convention; (iii) hospital equipment is scientifically approved and appropriate for children; (iv) drugs are scientifically approved, unexpired, child-specific when necessary, and monitored for adverse reactions; and (v) regular quality of care assessments of health institutions are conducted.

3. Monitoring and evaluation

117. A well-structured and appropriately disaggregated set of indicators should be established for monitoring and evaluation to meet the requirements under the performance criteria above. The data should be used to redesign and improve policies, programmes and services in support of fulfilment of children's right to health. Health information systems should ensure that data should be reliable, transparent, and consistent, while protecting the right to privacy for individuals. States should regularly review their health information system, including vital registration and disease surveillance, with a view to its improvement.

118. National accountability mechanisms should monitor, review and act on their findings. Monitoring means providing data on the health status of children, regularly reviewing the quality of children's health services, and how much is spent, where, on what and on whom. This should include both routine monitoring and periodic, in-depth evaluations. Reviewing means analysing the data and consulting children, families, other caregivers and civil society to determine whether children's health has improved and whether governments and other actors have fulfilled their commitments. Acting means using evidence emerging from these processes to repeat and expand what is working and to remedy and reform what is not.

F. Remedies for violations of the right to health

119. The Committee strongly encourages States to put in place functional and accessible complaints mechanisms for children that are community based and possible for children to seek and obtain reparations when their right to health is violated or at risk. States should also provide for broad rights of legal standing, including class actions.

120. States should ensure and facilitate access to courts for individual children and their caregivers and take steps to remove any barriers to access remedies for violations of children's right to health. NHRIs, Children's Ombudspersons, health-related professional associations, consumers' associations can play an important role in this regard.

VII. Dissemination

121. The Committee recommends that States widely disseminate this General Comment with parliament and across government, including within ministries, departments and municipal and local level bodies working in children's health issues.
