The Convention on the rights of the child: implications for the health and well-being of Pacific children

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Introduction

In the past two years, seven Pacific Island Countries (Papua New Guinea, Fiji, the Federated States of Micronesia, Republic of Marshall Islands, Vanuatu, Western Samoa and Nauru) have become Party to the Convention on the Rights of the Child (CRC) and a number of others are about to. This reflects a growing public commitment to the needs of children, at least in principle. What is now urgently needed, is effective implementation of the Convention, which rests, in large part, in the hands of relevant government ministries and departments. Furthermore, within two years of ratifying the Convention, State Parties to the Treaty must prepare a comprehensive report for the International Review Committee. This report calls for an assessment of how well countries are truly responding to their commitment to children.

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The substance and process of enforcing the Convention, provide both the moral imperative and a practical framework for advocating, planning, implementing, monitoring and evaluating programmes aimed at promoting the health and well-being of children.

This paper will examine the Convention, and describe how a number of the specific Articles relate to child health. In so doing, it sets out the commitments countries have made to child health. In addition, it will demonstrate how the Convention presents a platform and framework for advocating and monitoring children's programmes.

Finally, it will examine the status of the Convention in the Pacific and discuss how the Convention can become the focal point for coordinated efforts to improve the situation of children in the Region.

Overview of the Convention

The CRC was unanimously adopted by the General Assembly of the United Nations on 20 November 1989.[1] By 2 September 1990, upon ratification of the Treaty by the necessary 20 States, the Convention entered into force, representing the fastest ever response by the international community to any human rights treaty. As of the writing of this article, at least 163 countries had signed or ratified the Convention, indicating their commitment to its principles. It is among the most widely accepted international treaties. More than 90% of the world's children are already protected by its provisions and the world community has targeted 1995 for ratification by all States. Signing a convention indicates a government's intention to ratify. Ratification means that the provisions become legally binding. Accession carries the same legal obligations as ratification, but is not preceded by signing. Unicef, WHO and governments have come to an agreemen on 10 priority "Mid-Decade Goals" for children. Ratification of the CRC is one of them.

In light of the diversity of nations' socio-economic, cultural and religious perceptions of childhood, and the role of the child in the family and society, some have questioned the relevance of a universal charter on children. Indeed, patterns of child rearing, socialization and child care services do vary from country to country. Nevertheless, the Convention represents a consensus that there are universally accepted norms and pre-requisites for any child's full development, in spite of the varied manner in which these pre-requisites are met in any given culture. There is, therefore, scope for locally appropriate strategies for the fulfillment of the obligations of the Treaty.

With the adoption of the Treaty, the world community took a major step towards recognizing and ensuring children's rights to survival, protection, development and participation, thus moving beyond the basic right to protection.The Convention is a short document consisting of only 54 Articles. Forty Articles deal with substantive rights while the remainder deal with procedural matters to facili-

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tate the implementation of the Convention. The Treaty is unique in that it treats civil, political, economic, social and cultural rights in an integrated manner. Muntarbhorn observes that the treaty "weaves an intricate tapestry of rights around the child in an inter-disciplinary perspective."[2] The holistic approach of the Convention can be illustrated as follows: although a child may be adequately nourished (a social and economic right), the right to develop fully is not adequately protected unless the child is provided with an education (a social and cultural right), allowed to participate in decision-making (a cultural, social and political right), is protected from arbitrary detention (a civil right) and exploitation in the work place (a social and economic right). This broad spectrum of rights reflects the multi-faceted nature of children's place in society.

Under the Convention, rights can be broadly grouped into those relating to survival, development, protection and participation. Adequate living standards and access to health services comprise survival rights. Development rights include such things as education, access to information, play, cultural activities, and freedom of thought etc. Protection rights cover the above, but more specifically, include exploitation, cruelty, arbitrary detention and separation from the family, and abuses in the justice system. Having the right to a say in matters affecting one's life and playing a role in society form the basis for participation rights. Underlying these rights is the notion that the child's best interests should be of paramount importance, and the child's opinion should be given due regard.

Parents retain the primary responsibility for creating an environment which fosters their children's physical, mental, spiritual, moral and social development, but governments are expected to provide the services and programmes to ensure that this responsibility can be fulfilled (Article 27). Many of the provisions of the CRC are reflected in the Goals set at the World Summit for Children in 1990. The twenty seven goals, for most of which measurable and specific indicators have been developed, are based on low-cost strategies and technologies which are readily "doable."At least 86 countries have drawn up National Programmes of Action for reaching these goals by the year 2000.[3] As such they are demonstrating a major commitment to meeting the broad spectrum of rights outlined in the Convention.

The CRC recognizes the challenges confronting poorer countries as they seek to realize the rights inherent in the document. In particular, Article 4 obliges Parties to the Convention, to "undertake such measures (legislative and administrative) to the maximum extent of their available resources" to ensure compliance. While the treaty compels Parties to do all they can, it does suggest three strategies to deal with implementation in the context of resource scarcity.

First, countries are advised that they strive to achieve these rights "progressively" (*Article 24 on Health and 28 on Education*). Second, in the case of some Articles, the "highest attainable standard" is called for (*Article 24 on Health*) which is left to subjective assessment. Finally, the document makes clear the obligations of the donor community to respond with assistance where required. The preamble of the Convention recognizes the necessity of international cooperation in "improving the living conditions of children in every country, in particular developing countries." No less than 10 articles refer to the need for international cooperation in meeting the needs of children as specified in the Convention.

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While a full discussion is beyond the scope of this paper, Parker[4] suggests that the CRC can be implemented in resource-poor countries through budget restructuring, mobilizing non-traditional resources, enhancing efficiency and improving targeting. While economists can deliberate over the particular financing and delivery options, what is important about the Convention is that it provides child advocates, under all economic circumstances, the moral authority to demand that resource allocations be made with the best interests of the child in mind.

Nevertheless, as the above caveats make clear, there can be various interpretations as to what constitutes the "highest attainable standard" and "the maximum extent of available resources." To assist child advocates, Unicef has developed one approach with respect to standard setting and compliance with the provisions of the Convention.

The method compares a country's actual level of progress on essential child well-being indicators with the expected level for its per capita GNP. In *The Progress of Nations*, Unicef lists these as "national performance gaps" for those countries for which all relevant data are available.[5] In those countries with large gaps, it is clear that the "highest attainable levels" of child welfare are not being achieved and in particular that resources could be better allocated.

But again, irrespective of which criteria of assessment is used, what is important is that the Convention provides legal ammunition to those who champion for the rights of children irrespective of the economic context. Ratification provides the public, the media and non-governmental organizations an agreed upon framework to remind political leaders of their commitments to children in good times and bad. The following section examines what those commitments consist of in terms of child health.

Select articles of the Convention and how they relate to child health and well-being

The aim of the Convention is the improvement of children's welfare, hence the entirety of the document concerns child well-being. In this section, we draw attention to seven Articles which relate directly to health. Summaries of the Articles are provided in italicised text.

Article 24: Health and Health Services

The entire text of Article 24 on "Health and Health Services" is included as it is central to the paper (See sidebar).

Of all of the Articles in the Convention, Article 24 is most directly related to child health. The Article draws attention to a number of principles and strategies which are integral to health sector reform in the Pacific.

The Convention stipulates that governments must do all they can to ensure that children enjoy the "highest possible standard of health" and health facilities. While this elusive standard will be subject to debate, two observations deserve to be made. First, using methods such as that to derive the "national performance gaps" discussed earlier, it is possible to determine how well Pacific Island governments are doing in achieving the highest possible standards. Such analysis needs to be undertaken. Second, given existing data, it is clear that more can be done. For example, there have been declines in the real value of health budgets of Pacific Island countries during the 1980s. These trends need to be reversed.

Article 24 obliges States Parties to the Convention to guarantee all children access to health services. Countries in the Pacific face special constraints in complying with this provision. While services are generally available in urban centres, many children do not have effective access as a function of their geographic isolation. Greater effort needs to be placed on the provision of a first tier of services to outer islands. In addition to geographic access, service providers need to consider other constraints to utilization of services such as the direct and indirect costs of obtaining health care (eg. transportation costs and the opportunity cost incurred by mothers accompanying children to clinics). Moreover, a number of cultural and professional barriers prevent utilization. Many adolescents might not be offered nor take up family planning services, for instance, because the manner of service delivery conflicts with the cultural norms concerning sexual activity and reproductive health. There remains much to be done to ensure universal access to health facilities by Pacific Island children.

Special measures need to be taken to diminish infant and child mortality. While rates in the region are favourable when compared with other regions in the developing world, rates remain high in some countries and the pace of decline has been sluggish, except with some notable exceptions (eg. Kiribati). Declining finance plays a large role in the lack of progress in this area, as do the orientation and organization of health services.

Article 24 suggests that preventive services, primary health care and the application of readily available technologies are the preferred strategies for obtaining the highest

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
   (a) To diminish infant and child mortality;
   (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   (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;
   (d) To ensure appropriate pre-natal and post-natal health care for mothers;
   (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 child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
   (f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

possible health standards for children. In spite of official pronouncements in favour of the primary health care approach, data suggests that the principle is not adopted in practice in many Pacific Island countries. While the data must be used with caution, curative health care absorbs anywhere between 80 and 90% of public health care expenditure in the Pacific.[6] These levels of expenditure on curative care are not in the best interest of children.

Health information and the provision of support to children and care givers in the application of basic health and nutrition knowledge is stressed in Article 24. Such information can enable families to protect and maintain their health, and to meet many of the health related needs of their children. Substantial resource savings would thereby be realized for allocation to appropriate services. More resources need to be devoted to health education and communication programmes.

In addition to Article 24 which specifically defines child health concerns, various other Articles of the Convention address the health of the child by calling for States Parties to ensure the survival and development (Article 6), protection (Article 19) and the overall "best interests" of the child (Article 3). Although these complementary articles call on governments to respond to children's needs, the State is clearly seen in a supporting role to the family. The family is recognized throughout the Convention as the child's primary caregiver.

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The Article on health calls on governments to take measures to abolish traditional practices which are detrimental to child health. It should be noted that many "traditional practices" are actually conducive to the health of children. For example, breast feeding, maternal seclusion and extended family support, to mention but a few, have demonstrated a positive impact on child health. Beneficial practices need to be protected and encouraged. Nevertheless, some traditional practices need to be examined in light of their potential impact on child health. For example, intra-familial allocations of food might be of concern in some countries, while food taboos during pregnancy and weaning might pose problems elsewhere. There is a need to look critically at traditional customs, support those that are beneficial to child health and take measures to curb those that are harmful.

This Article, as do others in the Convention, encourages international cooperation in achieving the implementation of its provisions. In the Pacific, a number of United Nations and bi-lateral agencies, as well as NGOs, are active in the health sector. There is a clear role for these actors in assisting countries in the region to achieve the health goals specified in the Article. In particular, they should ensure that their support is directed to the development of coherent policies and coordinated programmes which support the provisions of the Convention, and that technical and material assistance fills identified gaps while governments make the necessary adjustments to ensure that they can meet their commitments to child health.

Article 3: Health and the "Best Interests" of the Child

All actions concerning the child shall take full account of his or her best interests. The State shall provide the child with adequate care when parents, or others charged with that responsibility fail to.

Article 18 specifically addresses parental responsibilities, noting that "Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child." When parents or legal guardians are unable or unwilling to take care of their children, or, furthermore, abuse their children, then the Convention underlines the State's responsibility to assume responsibility for the child's survival and healthy development to whatever extent possible.

Article 19: Protection from abuse and neglect

The State shall protect the child from all forms of maltreatment by parents or others responsible for the care of the child and establish appropriate social programmes for the prevention of abuse and the treatment of victims.

Article 6: Survival and Development of the Child

Every child has the inherent right to life, and the State has an obligation to ensure the child's survival and development

In most Pacific Island Countries, survival is not the most pressing right as healthy development is more at risk than life itself. Nevertheless, in certain countries, survival is by no means guaranteed. No less than fifty Pacific Island children under the age of five die each day, approximately 19,000 per year.[7] Moreover, the Under Five Mortality Rates estimated 77 per 1,000 in Papua New Guinea,[8] 88 per 1,000 in Kiribati and 92 in 1,000 in the Marshall Islands.[9] Thus the most fundamental right, that of survival, is presently not enjoyed by over 7% of children in each of these countries.

Article 6 specifies that "States Parties shall ensure to the maximum extent possible the survival and development of the child." As Bryant demonstrates,[10] the leading causes of infant and child death in the Pacific are primarily preventable through the use of low cost technologies. While data are

incomplete, public health expenditure as a percentage of Gross National Product range from 1.3% in PNG to 10% in Marshall Islands.[11] This wide range warns of the dangers in generalizing across the region, nevertheless two trends have been observed. First, the limited data which are available suggest that real expenditure for health care services in most Pacific Island Countries declined during the 1980s.[12]

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Second, in spite of rhetoric in favour of primary health care, health sector budgetary allocations were disportionally directed towards curative hospital-based care, a model which has proven extremely cost-inefficient with respect to health outcomes.[13] These trends indicate that governments have not been doing all they can in regard to child survival. On the positive side, if governments were to reverse the erosion of per capita health outlays and spend what health sector funds are available on appropriate, low-cost, high-impact interventions, the right to survival could be guaranteed almost universally to children throughout the region. The Convention gives governments the obligation to effect these policy changes.

The Convention also covers the development prospects of child survivors. As noted above, these cover a range of rights including, *inter alia*, access to education and other resources that enable children and their care-givers to take decisions and advantage of services which will promote their health.

Article 23: Disabled children

A disabled child has the right to special care, education and training to help him or her enjoy a full and decent life in dignity and achieve the greatest degree of self-reliance and social integration possible.

Article 23 specifies that a disabled child should enjoy a full and decent life, in conditions which promote self-reliance and facilitate full integration into the community. As such, the child has a right to education, training, health and rehabilitation services. The Convention stipulates that these services should be provided free of charge.

A paucity of data surrounds childhood disability in the Pacific region. In large part, this derives from the fact that for the most part, service providers have been non-governmental groups, which do not have the capacity nor mandate to compile national statistics. If States Parties to the Convention are to fulfill their obligations to disabled children, they will first have to take stock of the situation. WHO and Unicef recommend, that at a minimum, States collect data on the total number of persons with disability, specifying the number having serious difficulty in seeing, hearing, speaking, moving, learning/comprehending. In addition, it has been suggested that data are collected on other disabilities that last more than six months or are of an irreversible nature. This would enable the quantification of "total disability rates." Data dissagregated by age would be more specifically useful for monitoring implementation of the Convention. The above data are essential to developing intervention programmes. The Convention specifies that intervention programmes should be preventive, curative and rehabilitative.

Article 34: Sexual exploitation of the child

The State shall protect children from sexual exploitation and abuse, including prostitution and involvement in pornography.

The exploitation of children through prostitution and pornography is a global industry of immense proportions. Less subtle forms of exploitation are by definition less visible. Data in the Pacific on child sexual exploitation are not readily available.

The power of the Convention, is that it has the capacity to open the eyes of child health workers to problems which may have been hidden or neglected and which do require action. A *Letter to the Editor* in this issue is an inducement and guide to clinicians for heightened awareness of sexual abuse.

The Convention as a tool for advocacy, planning, implementing, monitoring and evaluating programmes for children

Advocacy

The Convention represents a visionary view of society. Once adopted, the Convention serves as an authoritative guide to the issues which need to be addressed with respect to child well-being. As such, it forms the basis for advocacy on behalf of children. As the above analysis has indicated, a number of Articles relate directly to health. Health advocates need to become familiar with the provisions of the Convention as they relate to health so that they can remind decision-makers of the obligation that the country has towards its children and the programmes for which resources should be allocated. The power of the Convention is that it supports a broad range of commitments to the health of children with legally enforceable rights and responsibilities. However, as Madinger reminds us "the Convention is a tool, not a weapon."[14] There is a need to use the Convention in a positive and constructive manner to obtain the best deal for children's health.

In addition to the advocacy value of the Convention among policy-makers, a greater public understanding of the

Convention is critical to its effective implementation and monitoring. As health professionals and advocates we can help to de-mystify the Convention by first increasing our own understanding of its content and by referring to relevant Articles in the course of our work with colleagues as well as at a community level. Bringing attention to the Convention in radio and television programmes and through the press can also facilitate a public awareness of the Convention. Given the breadth of the Convention, it is often more meaningful to focus media efforts on specific aspects of the Convention rather than on all of the Articles at one time. Relating Articles of the Convention to the local situation is also a valuable means to bring a context to the Convention.

Planning

The Convention has been described as a "blue print for society." While this refers to the utopian nature of the document, it also relates to the utility of the Treaty with respect to its use as a planning tool. The Convention provides a useful framework for planning programmes to meet the health needs of children. The above discussion has demonstrated the health related commitments that governments have made to children through ratification. Planning can assist member States to achieve "to the maximum extent" the provisions of the Convention. This they can do by setting time-bound objectives, in relation to the health goals of the Treaty, together with strategies, programmes, budgets and verifiable indicators through which to measure achievement. National Programmes of Action for Children provide one such vehicle for planning based on the Convention.

A National Programme of Action (NPA) for Children is typically preceded by a base line situation analysis. The Convention serves in the situation analysis to alert planners to the issues confronting children. Hence, health planners would, for example, try to get a picture of sexual exploitation in the country, or assess the situation with respect to disabled children, issues which have hitherto remained outside of the planners purview.

In light of the situation of children with respect to the areas of concern noted in the Convention, a National Programme of Action would be developed to respond to existent needs. According to guidelines provided in *The Plan of Action for Implementing the World Declaration in the 1990s*, the National Programme of Action sets goals, outlines the principle strategies and programmes to be implemented, assigns institutional responsibilities, determines the costs of the programmes and explores mechanisms for financing them. In addition, it establishes verifiable indicators for measuring progress towards achievement. A good plan would include a strategy for mobilizing the requisite resources. The role of the Convention in this process, is twofold. First, it draws attention to health related concerns, and second, it reaffirms the legal obligation to work towards addressing the issues.

In a review of recently developed National Programmes of Action (NPA), Ledogar,[15] discusses at length the relationship between the Convention and NPAs. While all NPAs deal with the basic issues of survival (for example immunization programmes) he notes that substantial progress at inclusion of more sensitive Convention related issues. Of the 105 NPAs examined, 47 had programmes dealing with child abuse, 26 with child neglect, 21 with exploitation, and 18 with prostitution. In addition, a number of countries were found to include legislative reform in their NPAs (at least 25 countries). It would appear that the NPA shows great promise in terms of planning for the implementation of the CRC.

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Implementation

Mobilizing the requisite political support for ratification of the Convention is much less of a challenge than implementing its provisions. Implementation, or enforcement, of the Convention relates to ensuring "that children get what the Convention says that they should get and not have happen to them or be deprived of what it says should not."[16] It is incumbent upon States Parties to the Convention to ensure that measures are taken to harmonize national laws and policies with the provisions of the Convention. Most governments will establish mechanisms at both the national and local levels for coordinating policies relating to children. Implementation also requires that line ministries are made aware of their respective roles in implementing sectoral programmes in response to the Convention.

Monitoring and Reporting

Monitoring the Convention should not be confused with policing, but should rather be seen as a process of contributing to beneficial change. An essential element is the creation of national institutions to promote rights and monitoring. Thereafter, there is the need to improve mechanisms for the collection of statistical data and other information on the status of children.

Based on a review of the literature, Finau concludes that the data and information provided by health information systems in the Pacific are "incomplete, unreliable, obsolete and of poor quality."[17] He suggests that what data is collected is often "untouched by human thought." If the health components of the Convention are to be monitored, there is a need to improve the health information systems.

Monitoring, however, needs to go beyond the collection of aggregate data, there is a need to disaggregate and analyze what is collected. Article 2, on discrimination, is an invitation to undertake a different approach to monitoring. It begs the question, which groups of children in society are generally least well off, or suffer from infringement upon any one of the rights. With respect to child health, the monitoring of the Convention will demand social group analysis (or data disaggregation) on the child health indicators of working children, abused and neglected children, institutionalized children, and children in disasters.

Monitoring the Convention in the health realm, should go beyond an assessment of child health indicators and examine the broad reforms which allow more priority to be placed on children. This will include an assessment of the political bodies which advocate on behalf of children, as well as such tangible indicators as the proportion of the budget allocated to health, and an assessment of priority child health interventions.

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Conclusions

The Convention has been ratified by seven Pacific Island countries. Nevertheless, the majority of non-ratifying countries in the world are still in the Pacific. Most remaining Pacific island countries seem committed to the principles of the Convention. They are now in varying stages of reviewing their existing legislation in order to feel confident that there are no major discrepancies between their existing laws and the Articles in the Convention. Furthermore, some countries have expressed concern that, due to limited resources, they are not in a position to truly enforce the Convention. Ratification of the Convention is not a statement that a country has already achieved the objectives set forth in the Convention. Ratification, instead, reflects a country's commitment to work towards the objectives outlined in the Convention's Articles. In many cases, the substance of the Convention is not calling for allocation of new resources for children. On the contrary, it urges a rethinking of the current allocation of resources to, for instance, prioritize primary and preventive health care services over costly curative or rehabilitative interventions for children.

The Pacific is in a position to take on the Convention on the Rights of the Child and mobilize its enforcement at a political, community and family level to improve the situation of Pacific children. Child health professionals and advocates can start now to demonstrate the relevance and feasibility of the Convention by using it as a framework for action.

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