Global Child Survival: A Human Rights Priority

Case Studies of Child Mortality in Uganda, Mexico and the United States

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Founded in 1983, Minnesota Advocates for Human Rights is a volunteer-based, non-governmental, non-profit 501(c)(3) organization comprised of more than 1200 members dedicated to the promotion and protection of human rights worldwide. Minnesota Advocates for Human Rights impartially and independently investigates and exposes human rights violations; represents human rights victims; trains and assists groups that protect human rights; educates the public, policy-makers and children; and promotes the universal acceptance of international human rights standards.

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This report is dedicated to the world's children.

PROLOGUE

The needless death of children is among the most critical of global crises. Yet, it is also among the most preventable. In developing and developed countries alike, more than 12 million children under the age of five die each year as a result of inadequate health services, violence, malnutrition, unsafe water, and lack of other basic necessities. These deaths constitute an unspeakable tragedy and must be recognized as a gross violation of fundamental human rights.

The Minnesota Advocates for Human Rights report, *Global Child Survival: A Human Rights Priority,* is a milestone. This report represents the first time a U.S. non-governmental organization has tackled the serious issue of preventable child mortality as a violation of internationally recognized human rights obligations. The report emphasizes that all rights—civil, political, economic, social and cultural—are interdependent. To ensure the health and survival of children, all of these rights must be promoted and protected.

It is the failure of non-governmental organizations to investigate violations of economic, social, and cultural rights, and to develop a deeper understanding of those rights, which inspired this report. In 1994, Larry Cox, who later became Human Rights Program Officer at the Ford Foundation, and I were among those who critically discussed this subject during the Stanley Foundation's conference "Reconceptualizing Human Rights Strategy" in Washington, D.C. Following that conference, on May 16, 1995, I convened a meeting at the University of Minnesota Law School with several human rights organizations and scholars to discuss how we could work together to give greater meaning to and implement economic, social, and cultural rights. Among the individuals who were invited to participate in that meeting and a subsequent discussion on May 31, 1995 were:

Nancy Arnison, Deputy Director, Minnesota Advocates for Human Rights
Dr. Michael Cline, St. Paul Ramsey Medical Center
Kristin Dawkins, Institute for Agriculture and Trade Policy
Marti Erickson, Program Director, Children, Youth & Families,
Institute of Child Development, University of Minnesota
Arvonne Fraser, Former Ambassador to the U.N. Commission on the Status of Women
Donald Fraser, Former Congressman and Mayor
Barbara Frey, Executive Director, Minnesota Advocates for Human Rights
Marsha Freeman, Executive Director, International Womens' Rights Action Watch
Dr. Norbert Hirschhorn, University of Minnesota School of Public health
Michael Reed Hurtado, then law student, University of Minnesota
(now with the Andean Commission of Jurists)
Douglas Johnson, Executive Director, Center for Victims of Torture
Cynthia Myntti, Humphrey Institute of Public Affairs, University of Minnesota
Luanne Nyberg, Health Management and Policy, University of Minnesota
Professor Joe Oloka-Onyango, Human Rights and Peace Centre, Makerere University
Kristi Rudelius-Palmer, Co-Director, The Human Rights Center, University of Minnesota

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We are grateful to the Ford Foundation for its confidence in funding this important work. We acknowledge with special thanks Larry Cox, Program Officer, Human Rights and International Cooperation, Peace and Social Justice Program at the Ford Foundation for his continued interest and support.

Members of the core team of researchers, authors, and consultants included Nancy Arnison, Johanna Bond, Ross D'Emanuele, Janelle Diller, Cecie Goetz, Kathleen Graham, Nancy Leland, Alba Perez, Huy Pham, Cindy Phillips, Cheryl Robertson, Sosamma Samuel, and Alicia Ely Yamin. We are grateful to Robin Phillips, Janet S. (Jan) Karon, Kristi Rudelius-Palmer, and Jennifer Prestholdt for their editing contributions. The report also benefitted greatly from the notable participation in intellectual discussion and advice, literature reviews, background research, statistics, case-studies preparation, and other helpful contributions provided by our colleagues in and outside Minnesota Advocates, including Anne Bateson, Margaret R. Celebrezze, Diana DuBois, Jodi Eiesland, Kathy Fennelly, Jim Hilbert, Rhiddi Jani, Dana Mitchell, Vincent O. Orlu Nmehielle, Johanna Olson, Jay Ovsiovitch, Susan Pachikara, Julie Potyondy, Claudia Saavedra, Abbey Sidebottom, Patti Thompson, Betsy Van Hecke, and Michael Zumwinkle. Angela Hoeft and Gwen Willems provided tireless work with editing, formatting, and graphics.

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Uganda. We give special acknowledgment to Cheryl Robertson, whose years of experience in Uganda enriched the case-study. We are greatly indebted to Joe Oloka-Onyango, Dean of the Faculty of Law at Makarere University, Kampala, Uganda. His insights and advice were most relevant during the drafting of the overall framework and the Uganda section of the

Mark Ritchie, Executive Director, Institute for Agricultural and Trade Policy
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The participants considered various approaches to the relatively uncharted field of economic, social, and cultural rights. They considered which rights were among the most important, including the right to food and health. The meeting also tried to identify the worst violations of economic, social and cultural rights requiring primary attention in this path-breaking effort. Several participants noted that a considerable body of information exists about child mortality, but that data had never been evaluated and understood in human rights terms. No effort had been made to focus international human rights attention on the causes of child mortality and on the human rights violation committed when young children die.

The group suggested that Minnesota Advocates for Human Rights undertake a concerted, multidiciplinary investigation and campaign on child mortality. All the participants agreed that pursuing such a study would require the collaborative efforts of lawyers, public health practitioners, policy makers, development professionals and others. There was also a consensus that the study should compare the experiences of several countries and should include the United States, since the principal work would be done in this country.

Thereafter, based on these recommendations, Minnesota Advocates for Human Rights presented a proposal to the Ford Foundation. The major funding provided by the Ford Foundation allowed Minnesota Advocates to pursue this ground-breaking study of preventable mortality of children under age five as a gross human rights violation. Many of the participants of the early strategy sessions have continued to be involved in collecting information, writing, editing, and reviewing the report.

As the study developed, it became evident that the initially negative, or violations approach, to under-five child mortality should be transposed into the more positive task of pursuing global child survival. This careful study contributes much to our understanding of one domain of economic, social, and cultural rights. It also reflects how human rights and public health issues can be joined to gain a new perspective on the issue of global child survival. More importantly, the report is a significant step in protecting children's rights and saving children's lives.

David Weissbrodt
Fredrikson and Byron Professor of Law, University of Minnesota Law School
Legal Counsel, Minnesota Advocates for Human Rights.

report. Kathleen Graham participated in the fact-finding mission and provided significant input in the legal and policy analysis. Helena Collins expertly arranged the fact-finding mission to Uganda. Special thanks to Zachary A. Lomo, Catherine W. Bukeni Obokech, and Godber W. Tumushabe for the literature reviews and background research. We are also grateful to the officials of various Ugandan ministries and agencies, and to the representatives of UNICEF, USAID, the World Bank, other international and local non-governmental organizations—all of whom agreed to meet with us and provided useful information during our mission to Uganda.

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Finally, we are grateful for all the valuable comments, suggestions, and inputs that we received, and we assume full responsibility for all opinions and conclusions expressed in the report.

Nancy Arnison, Huy Pham, and Sosamma Samuel
Minnesota Advocates for Human Rights
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Edited by
Nancy D. Arnison, Huy Pham, and Sosamma Samuel

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FUNDAMENTAL HUMAN RIGHTS TO CHILD SURVIVAL AND HEALTH
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International Covenant on Economic, Social and Cultural Rights

Article 2

1. Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

2. The State Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

3. Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   (a) The provision for the reduction of stillbirth rate and of infant mortality and for the healthy development of the child;
   (b) The improvement of all aspects of environmental and industrial hygiene;
   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

International Covenant on Civil and Political Rights

Article 6

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

Article 26

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Convention on the Rights of the Child

Article 6

1. States Parties recognize that every child has the inherent right to life.

2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

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 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 prenatal and postnatal 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.

Convention on the Elimination of All Forms of Discrimination Against Women

Article 11

2. In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:

   (d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.

Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 14

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(b) To have access to adequate health care facilities, including information, counseling and services in family planning.

EXECUTIVE SUMMARY

We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the fountain of life. Many of the things we need can wait. The Child cannot. Right now is the time his bones are being formed, his blood is being made and his senses being developed. To him we cannot answer "Tomorrow." His name is "Today."

—Gabriela Mistral, Chilean Poet and Nobel Laureate

Summary and background

More than 12 million children under the age of five still die needlessly each year from "diseases of poverty," including immunizable childhood diseases, malaria, intestinal and respiratory infections, lack of food and clean water, violence, and lack of primary health care. These avoidable child deaths are unconscionable at a time when preventative and curative measures are available and remarkably cost-effective. Advances in child survival have reached only a portion of children around the world. Even within industrialized nations, significant disparities in infant and child mortality persist.

The continuing worldwide crisis of excessive child mortality is not only a tragedy, it is a human rights violation. Recent global efforts to reduce child mortality reflect both remarkable successes and dismal failures. Although dramatic improvements in child survival have occurred in the past 50 years, many innocent children are still denied the chance to live to see their fifth birthday. Without their most fundamental human right—the right to survive—no other human rights have meaning. The Convention on the Rights of the Child is the most widely ratified international human rights treaty in history. It recognizes the child's inherent right to life and articulates the obligation of governments to "ensure to the maximum extent possible the survival and development of the child." This obligation includes a guarantee to "a standard of living adequate for the child's physical, mental, spiritual, moral, and social development" regardless of the child's gender, race, or socioeconomic status. The Convention represents the minimum standards for children's rights. The failure of ratifying governments to provide all their infants and children conditions adequate for survival and healthy development violates these minimum standards.

This report outlines the interdependence between health and human rights. It analyzes the international standards that are breached by avoidable child deaths and defines the responsibilities of governments to protect the fundamental human rights of their children. A commitment to the protection of these rights by governments and the international community is critical to ensure that every child has an equal chance to live and develop.

High rates of child mortality worldwide are caused by the combined effects of biological,

behavioral, and socioeconomic factors. The immediate cause of a child's death is usually a biological event such as an infection. A behavioral factor on the part of the parent or care provider, such as delay in seeking health care for the child, may also contribute to the death. Most child deaths are accompanied by underlying structural or socioeconomic factors. In many cases, impoverishment, lack of basic necessities, prohibitive costs of health care, lack of social services, and the inferior status of women in a society all contribute to high levels of child mortality. An understanding of the interconnection of these causes is essential to the development of effective strategies to increase child survival.

This report describes the specific obligations under international human rights law for the protection of child survival and health. While sustainable social and economic development is indispensable to child survival, it may also prevent other human tragedies. A respect for the full range of human rights protected under international law will improve child survival and provide a clear mechanism to determine policy and programmatic priorities. In addition to increased child survival, a respect for human rights will improve the health and livelihood of women and enhance socioeconomic conditions for the entire population.

This report uses a case study approach to analyze the child survival situation in three countries of varying levels of development—Uganda, Mexico, and the United States. The report also sets forth the relevant obligations under international human rights law and makes recommendations for measures to increase child survival and health.

Findings of this report

Global child survival has improved since the 1950s but the benefits reach only a portion of the world's children. Children in developing countries are more likely to die before reaching age five than children in developed countries. Uganda's children under age five face a child mortality rate that is one of the world's worst at 147 deaths per 1000 live births. In Mexico, mortality rates of children under five have fallen considerably; however, these rates are still disproportionately high for its development level and comparatively higher than those of other middle income countries. In the United States, the overall rate of infant mortality ranks worse than 20 other developed countries. The death rate among U.S. Black infants is even higher than those of developing countries such as Costa Rica, Cuba, and Sri Lanka.

In both developing and developed countries, poor people, racial and ethnic minorities, and indigenous groups have disproportionately higher rates of child mortality. In Uganda, over 60 percent of the total population live in poverty and 90 percent of the people reside in rural areas. Across the country, one in six Ugandan children dies before reaching age five. In Mexico, the situation is equally compelling. Mexican children from poor and rural areas, where the incidence of poverty among indigenous populations exceeds 80 percent, are most susceptible to preventable deaths. The U.S. case example reveals that gross disparities in infant and child mortality rates persist among different population groups in the country. Poor children and Black children are the most vulnerable in the United States. Black infants die at more than twice

the rate of White infants. The mortality rate among U.S. infants from poor families is 60 percent higher than for infants above the poverty level.

Data on issues critical to child mortality are inadequate and are not disaggregated in a manner useful to developing effective policies and programs. In many countries, data are kept on the overall rate of child mortality while data on the specific circumstances of individual deaths or the regions where the deaths occur are not adequately recorded. Overall child mortality rates mask important variations among population groups within a country. In Mexico, data on child mortality collected by the government are unreliable. First, the information varies widely by sources within the country and is inconsistent with data collected by UNICEF. Second, government data on child mortality are lacking for regions where large numbers of indigenous people live. Similarly, in the United States significant discrepancies exist in the collection of data useful for understanding and preventing the underlying causes of disparities in infant mortality. For example, although vital records of births and deaths are the primary data sources for understanding patterns of infant mortality in the United States, information about the household income status of infants at the time of their birth or death is not included in these records.

Children under age five are dying primarily from preventable causes that include biological, behavioral, and socioeconomic determinants. In developing countries, child deaths are caused largely by the "diseases of poverty" such as immunizable childhood diseases and malnutrition. The low socioeconomic status of mothers, unsafe water, lack of nutritious food, and punitive government policies also contribute to excessive child deaths. In industrialized countries, children often die from low birth weight and preterm births, abuse and neglect, and accidental injuries. As in non-industrialized countries, socioeconomic factors impact child survival in industrialized countries.

Structural factors which contribute to child mortality include absolute poverty, lack of basic necessities, discrimination, unbalanced macroeconomic policies, and unsustainable external debts. Resource disparities among population groups generally parallel the disparities in child death rates in these groups. The Uganda case study illustrates the formidable constraints to improving child survival and health in a developing country. Uganda is one of the poorest and most heavily indebted countries in the world. Child and maternal mortality rates are among the world's highest, while access to essential health care and safe water lags far behind. The low social status and high illiteracy of women in Uganda undermine the health of children as well as women.

In Mexico, persistent socioeconomic inequities are exacerbated by economic and structural adjustment policies. Government economic policies have been biased toward urban centers at the expense of marginalized areas. In the past decade, the Mexican government has systematically pursued austerity and structural adjustment programs in accordance with World Bank and IMF specifications. This process has aggravated inequities in socioeconomic development between urban and rural areas. The Mexican government has treated issues such as

poverty and disparities in child mortality rates as acceptable consequences of the country's economic development, rather than violations of economic, social, and cultural rights. As a result, child mortality is viewed as inevitable rather than preventable.

The United States has seen dramatic changes in public benefits for health care and social welfare since the 1980s. U.S. strategies for reducing infant mortality have had mixed success in the last two decades. "Reforms" in the social and health delivery systems, if not carefully scrutinized, may undermine the improvements that have been made and increase infant and child health differentials between socioeconomic classes. This pattern is especially troubling in light of the projected increase in the percentage of disadvantaged children in the United States. The child poverty rate has already grown to nearly 22 percent and is now the highest in the industrialized world.

Ameliorative measures are available and affordable. A global strategy to promote "Health for All by the Year 2000," which was proposed at the 1978 Alma-Ata International Conference on Primary Health Care and adopted by the World Health Assembly in 1981, provides a practical framework for improving child health and survival worldwide. The 20:20 initiative suggests a strategy through which aid donors and governments can earmark 20 percent of their budgets towards meeting the social goal of universal access to primary health care and nutrition, reproductive health, water and sanitation, primary education, and other basic social services. U.N. agencies as UNICEF, UNFPA, WHO, UNDP, and UNESCO endorsed the 20:20 initiative in 1994. In spite of these global strategies, basic child survival strategies in Uganda remain under-funded. The government dedicates greater resources to defense spending, the debt burden, and low-impact, tertiary health care. Uganda has not succeeded in carrying out its plans to improve child survival by moving resources away from curative, hospital-based programs to primary and preventative health care.

The Mexican government's response to preventable child mortality in marginalized areas remains inadequate. While Mexico's domestic laws, institutions, and administrative programs appear consistent with the Alma-Ata primary health care approach, they do not support long-term solutions to the problem of preventable child mortality. Rather, government programs to reduce child mortality are framed in terms of short-term poverty alleviation or social assistance. Health and social programs are often politicized and do not adequately address the disparity in child survival nor the underlying socioeconomic conditions which threaten the health and survival of children.

In 1990, the United States government adopted its own national initiative called Healthy People 2000 which sets specific objectives for achieving health for all U.S. residents by the year 2000. Healthy People 2000 emphasizes the reduction of persistent disparities in health between certain groups who bear the disproportionate burdens of poor health and the population at large. The country's gross disparities in infant mortality are associated with the racial and ethnic background as well as the gender and socioeconomic status of various population groups. Although overall health has improved, health conditions for some disadvantaged groups have

deteriorated. The status of Black infants as compared to White infants is an apt illustration. Use of prenatal care has improved for both Blacks and Whites, but remains significantly higher for Whites. The incidence of low birth weight remains stable for Whites and has increased for Blacks. The disparity in Black and White infant deaths rates is *growing*. It now appears unlikely that the main objective in reducing racial disparities in U.S. infant health can be achieved by the target year.

Disparate levels of avoidable child deaths reflect a failure on the part of governments to respect and ensure the basic guarantees essential to child survival. Child survival is a predicate to the enjoyment of all other human rights. Of the three countries studied in this report, only the United States has not ratified the Convention on the Rights of the Child. The United States has, however, ratified the International Covenant on Civil and Political Rights and the Convention on the Elimination of Racial Discrimination, which require the government to protect its children against racial discrimination in health and development. The widening disparity in infant mortality and in the socioeconomic status of its citizens points to a general failure on the part of the U.S. government to meet international standards to protect and provide for the human rights of all its children.

Although the Mexican government has ratified and adopted international instruments relevant to child health and survival, Mexico has not effectively complied with its international obligations to protect the basic guarantees to life, health, and non-discrimination. Despite domestic laws and programs related to health, Mexico has not adequately protected the health and survival rights of poor, rural, or indigenous children. Increasing socioeconomic and child survival disparities in marginalized communities constitute discrimination, violating international law.

Uganda's domestic law places a priority on child welfare, however, legal and resource limitations hinder the protection of children's rights. The 1995 Constitution of Uganda recognizes and protects the right to life, but contains no explicit guarantee of the right to health. In addition, the enforcement provisions of the Constitution do not apply to the right to health. The Children's Statute of 1996 specifies children's rights and places shared responsibility for ensuring those rights on the nation, parents, extended families, and local authorities. In practice the country faces the enormous challenge of marshaling adequate human and financial resources to implement these guarantees.

General recommendations

To governments

- Take all necessary steps to assure basic and fundamental human rights, including:
  - right to non-discrimination;
  - right to life;

- take all necessary steps to fully comply with the Convention on the Elimination of All Forms of Discrimination Against Women;

- guarantee by law and practice that all women have universal access to health and education, economic opportunity, and improved standards of living;

- provide resources to ensure equality in gender relations within the family structure and the larger society.

- Accede to the United Nations' 20:20 initiative that calls for a prioritized resource allocation towards basic health and social development: a minimum allocation of 20 percent of governmental budgets and 20 percent of donor countries' official development assistance.

- Comply with obligations under international human rights law to assist poorer countries in realizing the rights essential to the survival and health of children.

- Develop an organized public education and advocacy program to heighten awareness of the need to improve maternal and infant health that should be directed toward the general public, women of childbearing age, families, teachers, and employers.

To international financial institutions

- Ensure that finance and economic development programs do not disadvantage poor, rural, and agrarian regions by focusing only on urban centers and the global market.

- Continue the joint initiative of debt relief and poverty reduction in development policy and program planning. A more progressive debt reduction plan must be considered for all poor countries, particularly indebted countries that have a demonstrated commitment to the social sector, institutional and human capacity building, poverty alleviation, and development of a democratic and civil society.

- Apply a social conditionality on future loans as a strategy to compel loan-recipient countries to mobilize greater national resources specifically for health and social development.

To U.N. specialized agencies and international health/development non-governmental organizations

- Emphasize ratification and observance of human rights treaties, especially those which guarantee rights related to child health and survival, including:

  - International Covenant on Political and Civil Rights;
  - International Covenant on Economic, Social, and Cultural Rights;
  - International Convention on the Elimination of All Forms of Discrimination;

- right to health;
- right to an adequate standard of living, which includes:
  - sufficient food
  - appropriate housing
  - safe water and sanitation
  - adequate medical services; and
- right to education.

- Fully comply with human rights treaties and instruments, in particular, the Convention on the Rights of the Child.

- Observe the Alma-Ata principles of primary health care by ensuring equity, universality, community participation, and intersectoral collaboration in health policies and programs. All segments of the population must be enabled to define and guide their own well-being.

- Adopt a cohesive strategy for child survival that promotes long-term investments and solutions, and de-emphasizes short-term measures. In particular:

  - operate child survival programs that include:
    - universal immunization
    - oral rehydration therapy
    - micronutrient supplemental and nutrition programs
    - breast-feeding promotion
    - reproductive health and family planning services
    - epidemic control and prevention;

  - improve environmental conditions such as access to good sanitation and safe water, instead of reliance on oral rehydration therapy alone;

  - enact equitable food policies (e.g., equitable distribution of income and food sources, famine prevention, targeted food supplementation, and stabilization of food prices), rather than targeted micronutrient/food supplementation alone;

  - monitor and evaluate the status of children through a permanent system for periodic collection of reliable disaggregated data; and,

  - fund on-going research on children's issues to shape policies and programs.

- Take legal and policy measures to ensure that the status and role of women will improve the quality of their life as well as the health and welfare of their children and family. In particular:

- Convention on the Rights of the Child; and
- Convention on the Elimination of All Forms of Discrimination Against Women.

- Continue active involvement in the monitoring of global child survival and health. Facilitate the work of the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women. Improve the selection and collection of appropriate (disaggregated) social and health indicators to measure more accurately the impacts of policies and programs.

- Facilitate and improve the linkages between U.N. specialized agencies, international health and development (non-governmental) organizations, governments, and international financial institutions to improve child survival through national planning and implementation.

- Promote primary health care objectives that are low-cost, high-impact, and appropriate to local situations.

- Support long-term, grass-roots development that improves social conditions and human capacity in a sustainable manner.

Country-specific recommendations

Uganda

- Comply with all human rights obligations under treaties and instruments to which Uganda is a party.

- Promote and protect children's rights, in particular those related to child health and survival, through adequate programs and funding.

- Continue legislative efforts as well as target social spending to promote the rights and status of women. Government funds should support the implementation of a massive women's literacy campaign.

- Repeal or update provisions of the Public Health Law that are inconsistent with the Local Governments Act. Increase the resources available to the Ministry of Health and Local Councils to guarantee the implementation of reasonable minimum health standards regardless of the wealth of the various districts. The cost sharing scheme for the health sector should be re-examined and modified to ensure accessibility to the poor.

- Provide funds to support high-impact primary health care strategies as a national priority, including the required human capacity resources outlined in the Uganda National Plan of Action for Children reform program. Funds made available from the current IMF and World Bank debt relief initiative provide an excellent opportunity to invest in the Uganda National Plan of Action for Children primary health care package.

- Use debt relief funds effectively and sustainably to increase child survival. After demonstrating the impact of debt relief on child survival, more IMF and World Bank debt should be forgiven.

- Target rural communities in the provision of health and social service funds.

Mexico

- Comply with all human rights obligations under treaties and instruments to which Mexico is a party.

- Promote and protect children's rights, in particular rights related to child health and survival, through adequate programs and funding.

- Combat preventable childhood deaths and diseases among all segments of the population as a national health priority to which the maximum available resources must be allocated.

- Adopt a cohesive strategy for child health and survival which promotes long-term investments and solutions to alleviate underlying socioeconomic disparities in marginalized areas, including:

  - *poverty*: reorient socioeconomic development policies to redress the devastating impacts in rural and poor communities resulting from World Bank/IMF austerity programs, and government biases and "reforms";

  - *malnutrition*: establish equitable food policies which promote self-sufficiency through food production and livable wages rather than dependency on micronutrient/food supplementation subsidies;

  - *lack of clean water, basic sanitation, and safe housing*: improve environmental conditions to prevent childhood diseases resulting from unsafe housing and water, and lack of basic sanitation systems; and

  - *lack of health and social services*: ensure affordable, accessible, and quality health and social services, especially for women and children, which take into account the socioeconomic and cultural concerns of marginalized, particularly indigenous, populations.

- Observe the Alma-Ata principles of primary health care by ensuring equity, universality, community participation, and intersectoral collaboration in health policies and programs. All segments of the population must be enabled to define and guide their own well-being.

- Improve the productive life and health of women, particularly rural women, as well as the welfare of their children and families.

- Target resources to poor and rural communities, and implement urgent measures to ensure balanced and equitable economic growth in both urban and rural areas.

- Correct inconsistencies in child health data, with particular attention to issues of validity and reliability, and utilize disaggregated indicators for vulnerable populations.

- Consult nongovernmental organizations and consider their information and recommendations in health policies and programs.

United States of America

- Ratify the Convention on the Rights of the Child, the International Covenant of Economic, Social and Cultural Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women.

- Ensure implementation and compliance with all human rights obligations under treaties and instruments to which the U.S. is a party.

- Promote and protect children's rights, in particular rights related to child health and survival, through adequate programs and funding.

- Achieve further reductions in the disparity in infant mortality and morbidity. Such reductions require changes in social and economic barriers to healthy pregnancy and birth outcome. Both the public and private sectors should increase their investment in health care coverage, child care, education, and training.

- Ensure that the changes in public benefits and health-care delivery do not further threaten child health and survival.

- Implement strategies that minimize the risks of unintentional injuries and violence toward children. Prevention of child abuse and neglect should focus on the millions of high-risk families who are living below the poverty line or are plagued by domestic violence and substance abuse—major risk factors for child ill-treatment.

- Adopt an integrated policy on children's health and well-being in both the federal and state governments, addressing not only the medical needs of all expectant mothers and newborns, but also investing in broad-based preventive approaches.

- Strengthen coordination between state and federal programs and social and health services for women and their children. A comprehensive service delivery system is needed, offering perinatal clinical services and linkages between community-based health care and social services.

- Increase funding at the state and federal level for monitoring, data collection, and research on the status of children's health and well-being.

The Child Survival Project of Minnesota Advocates for Human Rights invites and encourages comment on this report, which is part of an overall strategy to build support for promoting economic, social and cultural rights. This report is intended to serve as a catalyst for future research and advocacy.

Over the next two years, the Child Survival Project will bring together a coalition of new constituents and resources for promoting child survival through public education and advocacy. The Project will assist human rights and health advocates, educators, lawyers, parents, health and development professionals, and policy makers, to work collaboratively to protect the basic rights of vulnerable children and to lower the rates of child mortality. The process of implementing human rights guarantees invokes mechanisms that can promote child survival. At national and local levels, laws, policies, and programs can be assessed in light of a government's international human rights obligations. At the international level, advocates can use international and regional bodies, such as the Committee on the Rights of the Child and UNICEF, to present information about a country's compliance with its obligations under international law and advocate for corresponding international assistance and pressure.

I. INTRODUCTION

"[I]t is or ought to be a source of profound international shame [that] the deaths of almost 25,000 children every day from five causes for which we long ago discovered inexpensive means of prevention or cure are allowed to pass with barely a murmur. It is as though a cure for heart disease or cancer or AIDS had been discovered but not used. And if the comparison seems far-fetched, let it be remembered that diarrhoeal disease claims half as many lives as heart disease, respiratory infections more lives than cancer, measles more lives than AIDS. [T]hey are almost always the deaths of children from the least-regarded families in the world, families from the margins of life, families without political influence, without economic power, without media access."

—M. Sharma & J. Tulloch, UNICEF, THE PROGRESS OF NATIONS, 1996

A. Preventable child mortality: A human rights violation

Around the world, more than 12 million children under age five are expected to die this year.[1] Child mortality[2] is an enormous tragedy that afflicts every country. In the developing world, the deaths come largely from preventable childhood diseases and malnutrition. In industrialized societies, children die from low birth weight and premature births, abuse and neglect, and unintentional injuries.

Millions of children die each year who could be saved by available preventive and curative means. Evidence exists that both developing and industrialized nations can afford to meet the basic human needs of these children who die needlessly.[3]

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[1] UNICEF, THE STATE OF THE WORLD'S CHILDREN 10 (1996) [hereinafter UNICEF, WORLD'S CHILDREN 1996].

[2] The term "child mortality" lacks a uniform definition. U.N. DEP'T OF INT'L ECONOMICS & SOCIAL AFFAIRS, POPULATION STUDIES NO. 105, MORTALITY OF CHILDREN UNDER 5: WORLD ESTIMATES AND PROJECTIONS, 1950-2025, U.N. Doc. ST/ESA/SER.A/105, at 4 (1988). The term "under-5 mortality," or "child mortality," refers to death occurring between birth and the exact age of 5; the term "under-5-mortality rate," or "child mortality rate," refers to the *probability* of death between birth and 5 years of life, expressed per 1000 live births. Included in this age group are infants, which refers to live-born children. The term "infant mortality" refers to death within the first year of life; within this category are *neonatal mortality*, or death occurring from birth through the first 28 days of life, and *postneonatal mortality*, or death occurring from 29 days of life through the first year. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 86. *See also* CDC, PUBLIC HEALTH SURVEILLANCE FOR WOMEN, INFANTS AND CHILDREN, MONOGRAPH 3, 163 (1994) [hereinafter CDC, HEALTH SURVEILLANCE].

[3] A basic child survival package costs about $12 per person per year in the developing world. WHO, INVESTING IN HEALTH RESEARCH AND DEVELOPMENT 20 (1996) [hereinafter WHO, INVESTING IN HEALTH]. See *infra* note 27.

The right of children to live is the most fundamental of their human rights. Child survival is an obvious predicate to the enjoyment of all other internationally recognized human rights. Preventable child mortality violates both the civil and political rights[4] as well as economic, social and cultural rights of children.[5] Discrimination and other violations of the rights of women, indigenous peoples, and minorities also contribute to high rates of preventable child deaths.

In practice, the denial of the rights essential to child survival takes place on a massive scale around the world, affecting literally hundreds of millions of people. The right to survive implicates a host of related rights; governments and government officials must act to meet their corresponding responsibilities. Human rights laws hold governments accountable for complying with internationally recognized standards. The process of breaking down the large social and economic problems involved into component human rights highlights the incremental steps that states and others must take to bring about the full realization of those rights. As one commentator has noted:

> The human rights framework describes the essential preconditions for health better than any conceptual model or analysis thus far proposed from within bio-medicine or public health. A society in which human rights are promoted and protected and in which human dignity is respected is a healthy society; that is, a society in which people can best achieve physical, mental and social well-being.[6]

In addition, human rights enforcement mechanisms can promote child survival. At national and local levels, laws, policies, and programs can be assessed in light of a state's international human rights obligations. At the international level, advocates can use international and regional bodies such as the Committee on the Rights of the child and UNICEF in two ways. Advocates can present information about a country's compliance with its obligations under international law and they can propose corresponding international assistance and intervention.

This report outlines the human rights standards violated by preventable child mortality and links its causes with the legal obligations of governments to respect and ensure the rights

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[4] The civil and political rights implicated in child mortality include the rights to life; equality and equal protection; freedom from cruel, inhuman or degrading treatment; and the right to non-discrimination in the enjoyment of such rights. *See infra* ch. III, part B.1-2.

[5] The economic, social and cultural rights implicated in child mortality include rights to the highest attainable standard of health, adequate standard of living, special measures of protection and assistance for all children, enjoyment of the benefits of scientific progress, and non-discrimination in the enjoyment of such rights. *See infra* ch. III, parts B.3-4.

[6] Jonathan Mann, *Human Rights and the New Public Health*, 1 HEALTH & HUM. RTS. 3, 230-31 (1995).

essential to child survival.[7] The report also issues recommendations for governments and private actors to protect the essential rights of children and improve child survival.

B. A case study approach to child mortality

This report uses a case study approach to illustrate the complex relationship between child mortality and human rights. The report documents child mortality in three countries with differing levels of development: Uganda, the United Mexican States (Mexico), and the United States of America (U.S.).[8] It reviews the international human rights obligations of each of the three countries, and then examines whether and how those obligations have been implemented. The report includes an analysis of traditional sources of law (e.g., constitutions, legislation, and regulations) as well as governmental policies and programs. The premise of the methodology is that the rights essential to child survival and health are only enforceable in the context of specific problems in specific places. The following questions guide the case studies:

- *What rights are essential to child survival?*
- *What are the corresponding governmental obligations?*
- *What are the roles of private actors in contributing to child mortality and child survival?*
- *What mechanisms are available to implement and realize these rights?*

The case studies use documentary and testimonial information, including statistical and census data and interviews with government officials, health and development professionals, local civic leaders, and others. The studies demonstrate the impact of the laws, policies, and programs on child survival. Sources for statistics on public health and economic issues include governments as well as international agencies such as the United Nations Development Program (UNDP), UNICEF, and the World Health Organization (WHO). For each of the three case studies, the report provides specific findings and recommendations. General findings and recommendations addressing the global situation of child mortality are found in the executive summary and at the end of this chapter.

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[7] Until recently, child mortality was rarely addressed as a human rights problem. There are few notable exceptions. *See generally* Rebecca J. Cook, *Human Rights and Infant Survival: A Case for Priorities*, 18 COLUM. HUM. RTS. L. REV. 1 (1986); Cynthia P. Cohen, *The Developing Jurisprudence of the Rights of the Child*, 6 ST. THOM. L. REV. 1, (1993); Sanford J. Fox & Diony Young, *International Protection of Children's Right to Health: The Medical Screening of Newborns*, 11 B.C. THIRD WORLD L.J. 1 (1991).

[8] The three countries for case studies were selected because they represent different histories, socioeconomic stories, and experiences. The U.S. case study incorporates examples from five Midwestern cities: Chicago, Detroit, Indianapolis, Milwaukee, and Minneapolis.

The research team is comprised of Minnesota Advocates for Human Rights project staff and colleagues with expertise in international health, human rights, public policy and law. The research for the case studies and global sections of the report is based on child health and survival situation analyses drawn from literature reviews and statistical data provided by government agencies and international organizations. The analyses were limited by the availability, reliability, and comparability of data sources on factors and trends influencing child mortality.[9]

A team from Minnesota Advocates, including international health and human rights law experts, conducted fact-finding missions in Mexico and Uganda. The team carried out field observations and interviews, involving a wide range of sectors and actors including women's groups, provincial/rural health workers, in-country and indigenous human rights groups, activists, international non-governmental organizations, local U.N. agencies, and government representatives. For the U.S. case study, Minnesota Advocates conducted information requests and interviews via telephone, facsimile, and electronic mail. Information was compiled from recognized sources such as the Centers for Disease Control and Prevention (CDC), the National Center for Health Statistics (NCHS), the Bureau of Census, state health departments, the Children's Defense Fund (CDF), and CityMatCH (a national consortium of urban maternal and child health departments). Primary data sources for U.S. infant mortality rates were derived from vital records and the national maternal and infant health survey.

The assessments in this report are drawn from many quantitative and qualitative sources of information and provide a representative picture of child survival in the context of international human rights obligations. This report outlines the systematic violations of human rights that cause excessive, preventable child mortality and calls on the governments of Uganda, Mexico, and the United States to urgently consider ameliorative measures to protect their most vulnerable children.

C. General findings and recommendations

1. Findings

- A high incidence of child mortality is a result of the violation of the following, and other, basic human rights:
  - right to non-discrimination;
  - right to life;

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[9] National mortality data are available for all countries in the world; however, these data are typically incomplete and less reliable in developing countries with high mortality levels, due largely to dysfunctions within national vital registration systems and incomplete information from censuses and surveys. W. Henry Mosley & Peter Cowley, *The Challenge of the World Health*, 46 POPULATION BULL. 4, 5 (Dec. 1991). *See also* discussion on sources and limitations of data for Mexico and the United States, *infra* chs. V & VI.

- right to health;
- right to an adequate standard of living, which includes:
  - sufficient food
  - appropriate housing
  - safe water and sanitation
  - adequate medical services; and
- right to education.

- High and disparate levels of preventable child deaths reflect a failure on the part of governments to respect and ensure the rights essential to child survival. Child survival is a predicate to the enjoyment of all other human rights.

- Global child survival has improved since the 1950s but the advances reach only a portion of the world's children. Those most likely to die before reaching age five are in developing countries.

- Within both developing and developed countries, the poor, racial and ethnic minorities and indigenous groups have disproportionately higher rates of child mortality.

- Data on issues critical to child mortality are inadequate and are not disaggregated in a way that is helpful to policy making and programming. Overall child mortality rates mask important variations within a country.

- Children under-five are primarily dying from preventable causes that include biological, behavioral, and socioeconomic determinants. In developing countries, child deaths are caused largely by the "diseases of poverty" such as immunizable childhood diseases and malnutrition. The low socioeconomic status of mothers, unsafe water, lack of nutritious food, and punitive government policies also contribute to excessive child deaths. In industrialized countries, children often die from low birth weight and preterm births, abuse and neglect, and accidental injuries. As in non-industrialized countries, socioeconomic factors impact child survival in industrialized countries. The disparities in these factors among population groups generally parallel the disparities in the child death rates.

- Structural factors which have had a damaging effect on child mortality include absolute poverty, lack of satisfaction of basic human needs, gender and other forms of discrimination, unbalanced macroeconomic policies, and unsustainable external debts.

Ameliorative measures are available and affordable. A global strategy to promote "Health for All by the Year 2000," which was proposed at the 1978 Alma-Ata International Conference on Primary Health Care and adopted by the World Health Assembly in 1981, provides a practical framework for improving child health and survival worldwide. The 20:20 initiative endorsed by such U.N. agencies as UNICEF, UNFPA, WHO, UNDP, and UNESCO suggests a strategy through which aid donors and governments can earmark 20 percent of their budgets towards meeting the social goal of universal access to primary health care and nutrition, reproductive health, water and sanitation, primary education, and other basic social services.

2. Recommendations

2.1. To governments

- Take all necessary steps to assure basic and fundamental human rights, including:
  - right to non-discrimination;
  - right to life;
  - right to health;
  - right to an adequate standard of living, which includes:
    - sufficient food
    - appropriate housing
    - safe water and sanitation
    - adequate medical services; and
  - right to education.

- Fully comply with human rights treaties and instruments, in particular, the Convention on the Rights of the Child.

- Observe the Alma-Ata principles of primary health care by ensuring equity, universality, community participation, and intersectoral collaboration in health policies and programs. All segments of the population must be enabled to define and guide their own well-being.

- Adopt a cohesive strategy for child survival that promotes long-term investments and solutions, and de-emphasizes short-term measures. In particular:
  - operate child survival programs that include:
    - universal immunization
    - oral rehydration therapy
    - micronutrient supplemental and nutrition programs
    - breast-feeding promotion
    - reproductive health and family planning services
    - epidemic control and prevention;

- improve environmental conditions such as access to good sanitation and safe water, instead of reliance on oral rehydration therapy alone;

- enact equitable food policies (e.g., equitable distribution of income and food sources, famine prevention, targeted food supplementation, and stabilization of food prices), rather than targeted micronutrient/food supplementation alone;

- monitor and evaluate the status of children through a permanent system for periodic collection of reliable disaggregated data; and,

- fund on-going research on children's issues to shape policies and programs.

- Take legal and policy measures to ensure that the status and role of women will improve the quality of their life as well as the health and welfare of their children and family. In particular:

  - take all necessary steps to fully comply with the Convention on the Elimination of All Forms of Discrimination Against Women;

  - guarantee by law and practice that all women have universal access to health and education, economic opportunity, and improved standards of living;

  - provide resources to ensure equality in gender relations within the family structure and the larger society.

- Accede to the United Nations' 20:20 initiative that calls for a prioritized resource allocation towards basic health and social development: a minimum allocation of 20 percent of governmental budgets and 20 percent of donor countries' official development assistance.

- Comply with obligations under international human rights law to assist poorer countries in realizing the rights essential to the survival and health of children.

- Develop an organized public education and advocacy program to heighten awareness of the need to improve maternal and infant health that should be directed toward the general public, women of childbearing age, families, teachers, and employers.

2.2 To international financial institutions

- Ensure that finance and economic development programs do not disadvantage poor, rural, and agrarian regions by focusing only on urban centers and the global market.

- Continue the joint initiative of debt relief and poverty reduction in development policy and program planning. A more progressive debt reduction plan must be considered for all poor countries, particularly indebted countries that have a demonstrated commitment to the social sector, institutional and human capacity building, poverty alleviation, and development of a democratic and civil society.

- Apply a social conditionality on future loans as a strategy to compel loan-recipient countries to mobilize greater national resources specifically for health and social development.

2.3 To U.N. specialized agencies and international health/development non-governmental organizations

- Emphasize ratification and observance of human rights treaties, especially those which guarantee rights related to child health and survival, including:

  - International Covenant on Political and Civil Rights;
  - International Covenant on Economic, Social, and Cultural Rights;
  - International Convention on the Elimination of All Forms of Discrimination;
  - Convention on the Rights of the Child; and
  - Convention on the Elimination of All Forms of Discrimination Against Women.

- Continue active involvement in the monitoring of global child survival and health. Facilitate the work of the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women. Improve the selection and collection of appropriate (disaggregated) social and health indicators to measure more accurately the impacts of policies and programs.

- Facilitate and improve the linkages between U.N. specialized agencies, international health and development (non-governmental) organizations, governments, and international financial institutions to improve child survival through national planning and implementation.

- Promote primary health care objectives that are low-cost, high-impact, and appropriate to local situations.

- Support long-term, grass-roots development that improves social conditions and human capacity in a sustainable manner.

II. GLOBAL CHILD MORTALITY, RESPONSES AND STRATEGIES

A. Global situation of child mortality

At the advent of the twenty-first century, unacceptably high levels of preventable early death still plague the world's most vulnerable population—children under five years of age. This chapter discusses the magnitude of the child mortality problem, the causes of child mortality, and its avoidability.

1. Magnitude of the problem

Every year, an estimated 12.5 million children under age five die unnecessarily from vaccine-preventable diseases, diarrheal and respiratory diseases, malaria, and malnutrition.[10] Box 2.1 illustrates the global trends in the "under-five mortality rate" (U5MR), which measures the number of deaths among children under the age of five per 1000 live births.

Certain populations of children are far more vulnerable to early death than others. The highest child mortality rates are found in the world's low-income populations. Dramatic advances have reduced child mortality in recent years,[11] but the progress has benefitted only a select portion of children around the world. Within both developed and developing countries, under-five child mortality rates are higher for poor, rural, and inner-city children, and for children of ethnic, racial, and indigenous minorities.

Children in the developing world[12] disproportionately bear the burden of high child mortality. The child mortality rate in developing countries is six times greater than that in industrialized countries.[13] Up to 98 percent of deaths among children under age five occur in

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[10] This annual total number of deaths is approximately 2 percent of the global population of children under the age of 5, estimated at 631 million, of which 87 percent are in developing countries (549 million). UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 98.

[11] Advances in health knowledge and technology, coupled with socioeconomic improvements, have reduced under-age-five child mortality by 50 percent globally in the last 50 years. The progress marks a steep decline from 25 million deaths to 12.5 million deaths per year. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 10.

[12] Nearly 80 percent of the global population resides in developing nations and more than 88 percent of all births occur there. Mosley & Cowley, *supra* note 9, at 8.

[13] The overall child mortality rate in developing countries is 97 per 1000 live births. U.N. DEV. PROGRAMME (UNDP), HUMAN DEVELOPMENT REPORT 20 (1996).

Box 2.1. Under-five child mortality rates among nations, 1960 and 1995

	Country	Under 5 Mortality Rate 1960	1995		Country	Under 5 Mortality Rate 1960	1995		Country	Under 5 Mortality Rate 1960	1995
1	Niger	320	320	51	Tajikistan	*	79	101	Venezuela	70	24
2	Angola	345	292	52	Namibia	206	78	102	Yugoslavia	120	23
3	Sierra Leone	385	284	53	Indonesia	216	75	103	Mauritius	84	23
4	Mozambique	331	275	54	Morocco	215	75	1	tonia	*	22
5	Afghanistan	360	257	55	Mongolia	185	74	1	guay	47	21
6	Guinea-Bissau	336	227	56	Zimbabwe	181	74	1	arus	*	20
7	Guinea	337	219	57	Iraq	171	71	10	Panama	104	20
8	Malawi	365	219	58	Guatemala	205	67	108	Bulgaria	70	19
9	Liberia	288	216	59	South Africa	126	67	109	Lithuania	*	19
10	Somalia	294	211	60	Libyan Arab Jamahiriya	269	63	110	Sri Lanka	130	19
11	Mali	400	210	61	Uzbekistan	*	62	111	Ut.d. Arab Emirates	240	19
12	Zambia	220	203	62	Algeria	243	61	112	Trinidad / Tobago	73	18
13	Eritrea	294	195	63	Brazil	181	60	113	Bosnia / Herzegovina	155	17
14	Ethiopia	294	195	64	Nicaragua	209	60	114	Poland	70	16
15	Mauritania	321	195	65	Peru	236	55	115	Costa Rica	112	16
16	Nigeria	204	191	66	Kyrgyzstan	*	54	116	Slovakia	*	15
17	Bhutan	324	189	67	Philippines	102	53	117	Chile	138	15
18	Uganda	218	185	68	Botswana	170	52	118	Croatia	98	14
19	Zaire	286	185	69	Egypt	258	51	119	Hungary	57	14
20	Burundi	255	176	70	Azerbaijan	*	50	120	Kuwait	128	14
21	Cambodia	217	174	71	Turkey	217	50	121	Jamaica	76	13
22	Central African Rep.	294	165	72	China	209	47	122	Malaysia	105	13
23	Burkina Faso	318	164	73	Kazakstan	*	47	123	Portugal	112	11
24	Madagascar	364	164	74	Viet Nam	219	45	124	Cuba	5(	10
25	Tanzania, U. Rep. of	249	160	75	Dominican Republic	152	44	125	United States	3	10
26	Lesotho	204	154	76	Albania	151	40	126	Czech Republic		10
27	Chad	325	152	77	Ecuador	180	40	127	Belgium	35	10
28	Côte d'Ivoire	300	150	78	El Salvador	210	40	128	Greece	64	10
29	Myanmar	237	150	79	Iran, Islamic Rep. of	233	40	129	Spain	57	9
30	Gabon	287	148	80	Lebanon	85	40	130	Korea, Republic of	124	9
31	Benin	310	142	81	Honduras	203	38	131	France	34	9
32	Rwanda	191	139	82	Tunisia	244	37	132	Israel	39	9
33	Pakistan	221	137	83	Colombia	132	36	133	New Zealand	26	9
34	Lao Peoples Dem.Rep.	233	134	84	Syrian Arab Rep.	201	36	134	Slovenia	45	8
35	Ghana	213	130	85	Moldova	*	34	135	Australia	24	8
36	Togo	264	128	86	Paraguay	90	34	136	Italy	50	8
37	Haiti	260	124	87	Saudi Arabia	292	34	137	Netherlands	22	8
38	Bangladesh	247	115	88	Mexico	148	32	137	Norway	23	8
39	India	236	115	89	Thailand	146	32	139	Canada	33	8
40	Sudan	292	115	90	Armenia	*	31	140	Austria	43	7
41	Nepal	290	114	91	TFYR Macedonia	177	31	141	United Kingdom	27	7
42	Gambia	375	110	92	Korea, Dem. Peo. Rep.	120	30	142	Switzerland	27	7
43	Senegal	303	110	93	Russian Federation	*	30	143	Ireland	36	7
44	Yemen	340	110	94	Romania	82	29	144	Germany	40	7
45	Congo	220	108	95	Argentina	68	27	145	Denmark	25	7
46	Cameroon	264	106	96	Georgia	*	26	146	Japan	40	6
47	Bolivia	252	105	97	Latvia	*	26	147	Hong Kong	52	6
48	Papua New Guinea	248	95	98	Jordan	149	25	148	Singapore	40	6
49	Kenya	202	90	99	Oman	300	25	149	Finland	28	5
50	Turkmenistan	*	85	100	Ukraine	*	24	150	Sweden	20	5

Source: UNICEF, *The State of the World's Children 1997*, Table 1, pg. 80-81. Note: Countries are listed in descending order of their under-five mortality rates for 1995, expressed as deaths per 1000 live births.

poor countries of the Southern Hemisphere.[14] Today in the developing world, seven out of ten babies are born without a trained birth attendant. Over 1.3 billion people live in absolute poverty in developing countries with basic nutritional needs unmet; more than 1.5 billion have no access to safe water; more than 2 billion live without appropriate sanitation.[15]

Socioeconomically disadvantaged children in both industrialized and developing countries suffer high mortality rates. Striking disparities among populations within individual countries are associated with varying socioeconomic, race/ethnicity, and geographical backgrounds. Studies in Brazil and Kenya have linked high child mortality with populations of poor socioeconomic conditions and lack of education.[16] Infant mortality in Porto Alegre, Brazil, was 76 deaths per 1000 live births among shanty town residents as compared to 34 in non-shanty town residents.[17] In Uganda, substantial rate differentials in child survival persist between the urban and rural areas; the capital city of Kampala has the lowest child mortality rate at 129, while in the rural northern district of Gulu the rate is more than double at 299.[18] In Mexico, impoverished, rural states with large indigenous populations have significantly higher death rates than do the largely non-indigenous populations in urban areas.[19]

Socioeconomic status and race are associated with child mortality in countries of the Northern Hemisphere as well. Several studies have linked mortality differentials for different racial/ethnic and socioeconomic groups to increased child poverty attributable in part to rising

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[14] Mosley & Cowley, *supra* note 9, at 8. A child's risk of dying before age five in Sub-Saharan Africa, at 18 percent in 1993, is still the highest in the world and appears to be rising. In South Asia, where one quarter of the world's children live, one in eight children die by age five. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 46, 50.

[15] UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13, at 20; J. Yunes, C. Chelala, & N. Blaistein, *Children's Health in the Developing World: Much Remains to be Done*, WORLD HEALTH FORUM 15, 73-76 (1994).

[16] WORLD BANK, WORLD DEVELOPMENT REPORT: INVESTING IN HEALTH 21 (1993) [hereinafter WORLD BANK, INVESTING IN HEALTH].

[17] G. Lima & A. Fischmann, *Inequalities in 1980 Infant Mortality Among Shanty Town Residents and Non-Shanty Town Residents in the Municipality of Porto Alegre, Rio Grande do Sul, Brazil*, 19 BULL. PAHO 235-51 (1985).

[18] UNICEF, CHILD HEALTH SITUATION ANALYSIS: UGANDA (1994). *See also* discussion *infra* ch. IV, part B.2.

[19] *See generally* COLECTIVO MEXICANO DE APOYO A LA NIÑEZ (COMEXANI), LOS NIÑOS DEL OTRO MÉXICO [CHILDREN OF THE OTHER MEXICO] (1995) (Third Report on the Rights and Status of Children in Mexico, 1994) [hereinafter COMEXANI, LOS NIÑOS]; MEXICO MINISTRY OF HEALTH & UNICEF, MEXICO AND THE WORLD SUMMIT FOR CHILDREN: ADVANCES IN MATERNAL AND CHILD HEALTH 1980-1994, (Oct. 1995) [hereinafter MEXICO & UNICEF, WORLD SUMMIT FOR CHILDREN]. *See* discussion *infra* ch. V, part B.2.

social inequities in Canada, Germany, the United Kingdom, and the United States.[20] In the United States, for example, the mortality rate for infants whose mothers live below the poverty level is 60 percent higher than those above the poverty level,[21] and the mortality rate for Black infants is double that of White infants.[22] In one study evidencing that the disparity is widening, the mortality rate differentials between U.S. Black and White infants have been increasing over time, while the risk of dying is higher for Black than for White infants with respect to nearly all leading causes of infant death.[23] Similarly in the United Kingdom, the progressive impoverishment of the social underclass and the corresponding increase in mortality and morbidity differentials have been documented.[24]

2. Avoidability of child deaths

Millions of children who die each year could be saved by preventive and curative measures that are readily available and remarkably cost-effective.[25] UNICEF estimates that 95 percent of infant and child deaths in developing countries of the South today are preventable, as are 60 percent in the industrialized countries of the North, including the "countries in transition" of the former Soviet Union and Eastern Europe.[26] Evidence exists that shows most countries can afford to meet basic human health and social needs.[27] Many preventive and curative means, including life-saving immunizations and oral rehydration therapy, cost little and are very

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[20] P. TOWNSEND & N. DAVIDSON, INEQUALITIES IN HEALTH—THE BLACK REPORT (1980); G.D. Smith, M. Bartley, & D. Blane, *The Black Report on Socioeconomic Inequalities in Health: 10 Years On*, 301 BRIT. MED. J. 373-77 (1990); L.A. Aday, *Health Status of Vulnerable Populations*, 15 ANN. REV. PUB. HEALTH 487-509 (1994).

[21] U.S. Center for Disease Control and Prevention (CDC), *Poverty and Infant Mortality-United States, 1988*, 44 MORTALITY & MORBIDITY WKLY. REP., 922-28 (Dec. 15, 1995) [hereinafter CDC, *Poverty and Infant Mortality*].

[22] In 1994, the mortality rate for Black infants (15.8 deaths per 1000 live births) remained more than twice that for White infants (6.6 per 1000 live births). G.K. Singh, K.D. Kochanek, & M.F. MacDorman, *Advance Report of Final Mortality Statistics, 1994*. 45 MONTHLY VITAL STAT. REP. 1-76 (Sept. 30, 1996).

[23] *Id.* at 10.

[24] *See generally* Smith et al., *supra* note 20.

[25] See discussion on country-level and global responses, *infra* part B, and discussion on comprehensive strategies, *infra* part C.

[26] Mosley & Cowley, *supra* note 9, at 8 (citing UNICEF, THE STATE OF THE WORLD'S CHILDREN 1990).

[27] A basic child survival package costs about $12 per person per year in the developing world. WHO, INVESTING IN HEALTH, *supra* note 3, at 20. WHO and UNICEF estimate that the training and support of the 850,000 health workers needed in the developing world today would cost approximately $200 million, which is only about 0.2 percent of current health expenditures by governments in the South. The average cost for essential drugs for every child in the developing world is 15 cents per annum. UNICEF, THE PROGRESS OF NATIONS 1996, at 25. *See also* discussion on comprehensive strategies, *infra* part C.

effective. Focus on primary health care and improvement in the socioeconomic status of women is essential. Methods for reducing high U5MR (26-200 deaths per 1000 live births) to lower rates (25 or below) are relatively affordable and effective, including safe water and sanitation, breast-feeding, ante- and perinatal care, and vaccinations against common childhood communicable diseases.

3. Causes of child mortality

Biological, behavioral, and socioeconomic factors all contribute to the deaths of infants and children under age five.[28] The immediate cause of a child's death is usually attributed to a biological event such as an infection. A behavioral factor on the part of the parent or care giver, however, may contribute to the death, such as delay in seeking health care for the child.[29] Moreover, most preventable child deaths are accompanied by detrimental socioeconomic and cultural factors. In many cases, for example, impoverishment, lack of basic necessities, prohibitive costs of health care and social services, and inferior status of women in a society, combine to negatively affect child survival.[30]

An effective strategy to combat child mortality at the global and local levels must address

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[28] The status of child health and survival worldwide can be linked to numerous synergistic factors such as scarcity of resources (i.e., poverty), maternal health and survival, war and non-war related violence and neglect, drug-resistant pathogens, economic policies, and social investments and so forth. *See, e.g.*, WHO, *An Unfinished Agenda: Improving Maternal and Child Health*, *in* WHO, INVESTING IN HEALTH, *supra* note 3; CDC, *Poverty and Infant Mortality*, *supra* note 21, at 19; UNICEF, *The Poverty-Population-Environment Spiral*, *in* UNICEF, THE STATE OF THE WORLD'S CHILDREN 1994, at 23 (1994) [hereinafter UNICEF, WORLD'S CHILDREN 1994]; UNICEF, *Children in War*, *in* UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 12; N. Kanji, N. Kanji, & F. Manji, *From Development to Sustained Crisis: Structural Adjustment, Equity and Health* 33 SOC. SC. MED. 985 (1991).

[29] For an epidemiologic analysis of the etiology of child mortality, see Ann V. Millard, *A Causal Model of High Rates of Child Mortality*, 38 SOC. SC. MED. 253-68 (1994); S. DESAI, HEALTH AND EQUITY: REFOCUSING ON BASIC NEEDS AND LIVELIHOOD STRATEGIES 1-32 (The Population Council Working Paper 56, 1993).

[30] In a 1984 study of child survival, various macro-level factors were highlighted, including problems in the health delivery system, adverse environmental conditions, and factors in the political economy such as income inequality, deficient food policies, lack of social investment, and lack of productive assets. *See* W. Henry Mosley & L.C. Chen, *An Analytical Framework for the Study of Child Survival in Developing Countries*, 10 POPULATION & DEV. REV. (Supp.) 25-45 (1984). The prevalence of negative structural factors cannot be overstated. The declarations of the 1995 World Summit for Social Development and the 1995 Fourth World Conference on Women reported, respectively, that more than 1 billion people in the world live in abject poverty, most of whom go hungry every day; communicable diseases constitute a serious health problem in all countries and are a major cause of death globally; households headed by women, which constitute one fourth of all households worldwide, are among the poorest because of wage discrimination, occupational segregation patterns and other gender-based barriers; and poverty has increased in both absolute and relative terms, along with the number of women living in poverty in most regions.

the interconnected chain of causes.[31] Scholars have identified three primary interactive levels of causation:[32]

- **Biological causes**. The immediate or *proximate causes* of death are biological factors such as malnutrition, diarrhea, and acute respiratory infections which account for the majority of child deaths in the developing world.[33]

- **Behavioral factors**. Behavioral factors such as deficient child care practices are *intermediate factors* aggravating the child's exposure to the biological causes of death.

- **Structural factors**. Social, economic, and cultural determinants, also known as *fundamental factors,* are at the root of the biological and behavioral factors affecting child health. Such determinants typically entail, among other factors: scarcity of basic resources such as food, housing, and sanitation;[34] parental literacy;[35] inadequate delivery of primary health care;[36] racial or class discrimination;[37] and macroeconomic policies with adverse impact on low income populations.[38]

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[31] Notable conceptualizations of the causal chain in childhood diseases and conditions have been guided largely by empirical evidence drawn from research in social epidemiology and medical sociology and anthropology. *See generally* Mosley & Chen, *supra* note 30; Millard, *supra* note 29; DESAI, *supra* note 29.

[32] *See, e.g.*, Millard, *supra* note 29.

[33] *See, e.g.*, D.L. Pelletier, D.G. Schroeder, & J.P. Habicht, *The Effects of Malnutrition on Child Mortality in Developing Countries*, 73 BULL. WHO 443-48 (1995); J. Tulloch & L. Richards, *Childhood Diarrhea and Acute Respiratory Infections in Developing Countries*, 159 MED. J. AUSTRAL. 46-51 (1993).

[34] Millard, *supra* note 29; K. Kim & P.M. Moody, *More Resources Better Health? A Cross-National Perspective* 34 SOC. SC.. MED. 837-40 (1992).

[35] Ingrid E. Swensen, Nguyen Minh Thang, Pham Bich San, Vu Qui Nham, & Vu Duy Man, *Factors Influencing Infant Mortality in Vietnam*, 25 J. BIOSOCIAL SCI. 285-302 (1993); Abate Mammo, *Factors Responsible for Childhood Mortality Variation in Rural Ethiopia*, 25 J. BIOSOCIAL SCI. 223-38 (1993).

[36] D. Koch-Weser & A. Yankauer, *What Makes Infant Mortality Rates Fall in Developing Countries?* 81 AM. J. PUB. HEALTH 12 (1991); N. Hirschhorn, M. Grabowsky, R. Houston, & R. Steinglass, *Are We Ignoring Different Levels of Mortality in the Primary Health Care Debate?* 4 HEALTH CARE PLAN. & POL'Y 343-46 (1989).

[37] *See generally* A.T. Geronimus, *Black/White Differences in the Relationship of Maternal Age to Birthweight: A Population-Based Test of the Weathering Hypothesis*, 42 SOC. SC. MED. 589-97 (1996); I. Emanuel, H. Filakti, E. Alberman & S.J.W. Evans, *Intergenerational Studies of Human Birthweight from the 1958 Birth Cohort: Evidence for a Multigenerational Effect*, 99 BRIT. J. OBSTET. GYNAECOL. 67-74 (1992); J.W. Collins & R.J. David, *Bad Outcomes in Black Babies: Race or Racism?* 1 ETHNICITY & DISEASE 236-44 (1991); Lima & Fischmann, *supra* note 17.

[38] Kanji et al., *supra* note 28, at 985-91; Rene Loewenson, *Structural Adjustment and Health Policy in Africa*, 23 INT'L J. HEALTH SERVICES 717-30 (1993).

Each level of causation, together with the corresponding determinants for child health and survival, is examined below.

3.1. Major biological causes

Worldwide the five leading causes of death of children under age five are malnutrition, pneumonia, diarrhea, measles, and malaria. These conditions are largely preventable. The World Health Organization (WHO) has identified child mortality as one of four key health challenges on a global scale, requiring renewed international investment and action.[39] Box 2.2 illustrates the major causes of death for children around the world.

Box 2.2. Estimated annual deaths among the world's under-five children by major causes

Chronic malnutrition ▸ An estimated 200 million children under five are chronically malnourished. Poor nutritional health is a major factor in perhaps 1/3 of all under-five deaths each year. The World Food Program estimates that 11,000 children die every day from "malnutrition"–one every 8 seconds.	4.1 million
Pneumonia	3.1 million
Diarrheal diseases	2.9 million
Measles	1.1 million
Malaria	1.0 million
Neonatal tetanus	0.6 million
Whooping cough	0.4 million
AIDS ▸ The WHO estimates that HIV has infected about 1 million children; over 60 percent of whom have developed AIDS. It is estimated that over 80 percent of infected babies will die before their fifth birthday. In addition, during the 1990s nearly 10 million children will have been orphaned by AIDS.	0.6 million

Sources: UNICEF, THE STATE OF THE WORLD'S CHILDREN (1991 & 1994); UNICEF, AIDS: THE SECOND DECADE–A FOCUS ON YOUTH AND WOMEN (1993); FAO/WFP statistics, *in* C. Bohlen, *Conference on food aid starts in Rome*, N.Y. TIMES, Nov. 13, 1996, at A5.

Along with threats of malnutrition and ordinary childhood diseases, the world's children also face the recent resurgence of infectious diseases.[40] At the global level, three major

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[39] WHO, INVESTING IN HEALTH, *supra* note 3, at 19-34.

[40] The resurgence of four major communicable diseases (malaria, pneumonia, sexually transmitted infections including HIV/AIDS, and tuberculosis) is fueled by the following contributing factors: (1) widespread use and misuse of antimicrobial drugs since the 1940s which has led to increasing numbers of drug-resistant pathogens; (2) rapid and massive demographic changes through urbanization and population growth, population shifts due to conflicts or economic reasons, and the "globalization" of trade and intercontinental travel; (3) inadequate public health infrastructures and health care systems, which have compromised disease surveillance and control efforts.

communicable diseases that constitute serious health threats are major killers of children under five: malaria, pneumonia, and HIV/AIDS. Malaria kills about 1 million children under five each year, the majority of whom live in Sub-Saharan Africa.[41] The persistence of pneumonia is due in part to poor access to existing, effective treatment. The disease overwhelmingly kills poor, malnourished children; fatality differentials are 10 to 50 times higher in poor nations as compared to wealthier nations. The HIV/AIDS global epidemic has now reached all populated regions of the world and its impact on women and children is profound.[42] Of the current total of HIV/AIDS infected people, 85 percent are in Africa and Asia, of whom over 1 million are children. According to a recent study in Central and East Africa, HIV/AIDS will cause the child mortality rate to rise to between 159 to 189 deaths per 1000 births by the year 2000, from the current projections of 78 to 132, respectively.[43] Yet, the AIDS epidemic has been slowed in certain countries such as Thailand and Uganda where positive individual behavioral strategies are strengthened by affirmative societal attitudes and commitment of political and fiscal resources.[44] Equally tragic is the estimated 10 million AIDS orphans whose lives are severely compromised by the loss of one or both parents.[45]

The impact of these major diseases on child health is likely to worsen significantly in the coming decades if: (1) existing effective interventions continue to fail to be delivered to vulnerable populations, particularly in developing countries; and (2) low priority is given to further innovation of public health and prophylactic measures to keep pace with the development of pathogen resistance.[46]

For details, see WHO, INVESTING IN HEALTH, *supra* note 3, at 35-53; InterAction, *Infectious Diseases . . . A Growing Threat to Everybody's Health* (visited Dec. 4, 1996) <http://www.interaction.org/ia/alliance/print2.html>.

[41] WHO, INVESTING IN HEALTH, *supra* note 3, at 35.

[42] Today, an estimated 25 million people worldwide are infected with HIV/AIDS, and WHO estimates that total numbers of infected will reach 30-40 million by the year 2000. UNICEF, AIDS: THE SECOND DECADE--A FOCUS ON YOUTH AND WOMEN (1993); *Some Hope on Third-World AIDS*, N.Y. TIMES, Oct. 10, 1996, at A18.

[43] E. Preble, *Impact of HIV/AIDS on African Children*, 31 SOC. SCI. MED. 671-80 (1990). The infection rate among women of child-bearing age is rising steeply; in Uganda, the HIV prevalence among women receiving prenatal care is an astounding 15 percent. One of three children born to these women is HIV-infected. Among the 1 million infected children, most will develop AIDS and die before reaching their fifth birthday. *See also infra* notes 314-18 and accompanying text.ch. IV, part B.3.5.

[44] *Some Hope on Third-World AIDS*, *supra* note 42.

[45] *See also infra* notes 314-18 and accompanying text.ch. IV, part B.3.5.

[46] WHO, INVESTING IN HEALTH, *supra* note 3, at 35-53.

3.2. Behavioral factors

A range of behavioral factors interact with biological and structural factors to affect child survival. These factors include child care practices, maternal health and behaviors affecting health, and violence against children or care-givers. Although many practices affecting women's health and social status can be considered behavioral, this report discusses those practices in the following section on structural factors.

- **Child care practices**

Child care practices interact with childhood malnutrition and infectious and diarrheal diseases to affect child mortality. Relevant practices include the degree of maintenance and consistency of proper feeding, hygiene, and emotional care as well as health care.

> [I]f two children begin life with the same birth weight and are exposed to the same frequency of infectious diseases, but one is better fed and cared for, the better-fed one will suffer shorter overall periods of illness and will recover and regain weight more rapidly afterwards. The less well-fed and less cared-for child will be ill for longer periods, lose more weight, and will take longer to regain it. This child is more and more likely to die.[47]

- **Maternal health and mortality**

In many cases, the health of the mother is key to the survival of her children. Maternal deaths and injuries result in immediate suffering for millions of infants and children, whose loss of their primary care givers can be life endangering.[48] Women who suffer from malnutrition or disease during pregnancy have a much greater risk of giving birth to an underweight infant. Studies worldwide have confirmed the importance of low birth weight as a cause of infant and child mortality.[49] Most low birth weight infants born in the developing world suffer from intrauterine growth retardation (IUGR), which is often the result of maternal malnutrition during pregnancy coupled with excessively heavy work.[50] An estimated 7 million or more newborns die annually throughout the world as a result of maternal health problems and their mismanagement.[51]

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[47] *Id.* at 24.

[48] *See, e.g.*, A. Tinker & M.A. Koblinsky et al., *Making Motherhood Safe* 4 (World Bank Discussion Papers 202).

[49] *See generally* Mosley & Cowley, *supra* note 9.

[50] *Id.*

[51] Tinker & Koblinsky et al., *supra* note 48.

In infant mortality, the interrelationship between survival and care is particularly notable and implicates prenatal care, safe childbirth, and maternal and infant survival. As noted by UNICEF,

> [a]bout half of infant deaths occur in the first month of life—and most of those in the first week. Those lives can only be saved by clean and safe births, maintenance of body temperature, initiation of spontaneous breathing, and an almost immediate beginning of breast-feeding. This comes down to the availability of the right skills and care in pregnancy and childbirth. There is therefore a significant overlap between the action needed to protect women and the action needed to protect newborns.[52]

A growing understanding of this interconnection has resulted in health and development strategies targeting "maternal attributes,"[53] including breast-feeding promotion, effective family planning, and improvement in female literacy. In addition, structural strategies such as the adequacy of obstetric care and increased access to safe water and sanitation are being addressed.[54]

- **Family violence**

Violence against children in the form of abuse or neglect has a significant impact on child survival and health in many countries. The United States keeps several statistics that illustrate this phenomenon. The number of U.S. child victims of abuse and neglect increased 105 percent, from 1.4 million in 1986 to nearly 3 million in 1993; almost 50 percent of the victims are children under age 6. From 1990 to 1994, 5400 children died as a result of abuse and neglect; those children seriously injured jumped to over 570,000 cases.[55] Many incidents of life-threatening violence against children, particularly rape of girls, still go unreported.[56] In turn, violence perpetrated against women who serve as children's primary care givers indirectly affect child welfare. According to a recent World Bank discussion paper, "at a global level, the health

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[52] P. Adamson, *A Failure of Imagination*, *in* UNICEF, THE PROGRESS OF NATIONS 1996, *supra* note 27, at 6.

[53] For further discussion regarding emphasizing structural issues over maternal attirubutes, see sub-section 2.2.

[54] For further discussion of excessive maternal mortality and morbidity in the context of global health threats for women *as women*, not simply in their roles as mothers or primary care givers of children, see Adamson, *supra* note 52; UNITED NATIONS (UN), FROM NAIROBI TO BEIJING: REPORT OF THE SECRETARY-GENERAL, U.N. Sales No. E.95.IV.5 (1995); D. DuBois, Primary Factors that Impact Women's Mortality and Morbidity: A Life-Cycle Approach (1997) (unpublished manuscript, on file with Minnesota Advocates for Human Rights).

[55] USDHHS, *Child Maltreatment 1994: Reports from the States to the National Center on Child Abuse and Neglect* (visited Dec. 2, 1996) <http://www.acf.dhhs.gov/programs/NCCAN/abuse/statfact.htm>.

[56] *Id.* at 1.

burden from gender-based victimization among women age 15 to 44 is comparable to that posed by other risk factors and diseases already high on the world agenda, including HIV, tuberculosis, sepsis during childbirth, cancer, and cardiovascular disease."[57]

3.3. Structural factors

Structural factors tend to operate in combination with biological and behavioral factors to cause child mortality. Structural factors involve both macrolevel and household level determinants. As discussed below, these factors include poverty, lack of education, lack of adequate housing, the socioeconomic status of women, armed conflict and social disruption, and displacement and urbanization. Additional structural factors include macroeconomic conditions and policies, particularly the debt crisis, increasing inequities, and structural adjustment policies.[58] Attention to such factors results in policies and programs that target health by facilitating greater access to productive resources such as income generation, housing, infrastructure development, and primary health care.[59]

- **Poverty**

There is a gross disparity in child mortality between wealthy and poor populations, whether in the North or South.[60] This disparity reflects the interdependence of social development and health. Poverty leads to poor health, and poor health perpetuates poverty.[61] Conversely, higher social development improves health and well-being; in turn, a healthy population contributes to social development.[62] WHO has noted that:

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[57] LORI HEISE, JACQUELINE PITANGUY, & ADRIENNE GERMAIN, VIOLENCE AGAINST WOMEN: THE HIDDEN HEALTH BURDEN (World Bank Discussion Paper 255, 1994).

[58] *See, e.g.*, WHO, *An Unfinished Agenda: Improving Maternal and Child Health*, *in* WHO, INVESTING IN HEALTH, *supra* note 3; UNICEF, *The Poverty-Population- Environment Spiral*, *in* UNICEF, WORLD'S CHILDREN 1994, *supra* note 28, at 23-38; Kanji et al., *supra* note 28.

[59] *See, e.g.*, B. Link & J. Phelan, *Social Conditions as Fundamental Causes of Disease*, J. HEALTH & SOC. BEHAV. 80-94 (extra issue, 1995).

[60] *See supra* part A.1.

[61] WHO, INVESTING IN HEALTH, *supra* note 3, at 19-20; WFPHA, POSITION PAPER NO. 96-1, RESOLUTIONS: HEALTH, ECONOMICS, AND DEVELOPMENT: A PEOPLE–CENTERED APPROACH (May 30, 1996), *in* WFPHA REP., Aug. 1996, at 7-10. There are notable examples of poor countries or communities with low child mortality rates (e.g., Cuba, the State of Kerala in India), which point to issues of equity in health and distributive justice. *See infra* part B.1.

[62] WORLD BANK, INVESTING IN HEALTH, *supra* note 16. For a definition of the term *social development*, see Glossary.

> [p]overty increases people's vulnerability to diseases . . . The childhood infections, malnutrition, and maternal and perinatal conditions are borne almost exclusively by poor populations. Not only is poverty a predisposing factor for these conditions, it is also a consequence of them . . . As long as they persist, hundreds of millions will be trapped in a cycle of underdevelopment, prevented from reaching their potential at school, in the workplace, in the household and thus in the economy.[63]

While the social determinants of health and survival are not definitively understood, studies indicate that poor children and women experience worse health outcomes than their wealthier counterparts.[64] Sub-Saharan Africa, with a GNP per capita of $519 and a deepening economic crisis, has a strikingly high child mortality rate of 177 per 1000 live births. At the other extreme, the industrialized countries' GNP per capita is $23,195, while their average child mortality rate is 9 per 1000 live births.[65] Gross disparities between the poor and their wealthier counterparts are indicated by gaps in rates of child and maternal mortality, female literacy, nutritional status, and access to primary education and health services. Those social indicators reflect the excess burden and vulnerability facing poor populations and highlight potential intervention points.

During the critical early childhood period (within the first three years of life), children develop rapidly and require essential food, clean water, shelter and health care in order to survive and thrive. Unfortunately, these basic needs are largely unmet for hundreds of millions of impoverished children in the world today.[66]

At the household level in developing countries, poor health results from a combination of poor nutrition, inadequate housing, and lack of access to safe drinking water, which in turn reduces productive capacity (e.g., income-generating activities both in the formal and informal sectors; subsistence food crop farming). The loss of household income threatens food security, and curtails household access to basic services in health and education. Overall, these conditions exacerbate susceptibility to disease, deprive children of full physical and social development

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[63] WHO, INVESTING IN HEALTH, *supra* note 3, at 19-20.

[64] *See,* e.g., CDC, *Poverty and Infant Mortality*, *supra* note 21; TOWNSEND & DAVIDSON, *supra* note 20.

[65] UNICEF, *Regional Summaries*, annex, *in* UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 98-9.

[66] Conditions of poverty that threaten the life and health of the world's children affect a quarter of the world's population living in poverty; 43 percent of the world's poor are children. UNICEF, THE STATE OF THE WORLD'S CHILDREN 1992 [hereinafter UNICEF, WORLD'S CHILDREN 1992]. In developing countries, nearly half of children under age five live in absolute poverty, their basic needs unmet. For a definition of absolute poverty, see Glossary. Every year an estimated 200 million children are malnourished. UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13, at 21-2; *World Food Summit–Nov. 13-17, 1996*, CHILD HEALTH FOUND. NEWS, Issue 3, 1996, at 5; UNICEF, WORLD'S CHILDREN 1994, *supra* note 28, at 12; J. Biddulph, *Child Health in the Third World*, 159 MED. J. AUSTRAL. 41-45 (July 5, 1993).

during their critical childhood years, and ultimately threaten their chance of survival.[67]

At the macrolevel, general economic decline, population growth, and a lack of socio-political support for basic needs contribute to the further demise of the impoverished. In many cases, deteriorating national economies prompt poor governments and their lenders to implement social and economic adjustment policies; the operation and impact of those policies are discussed in the following subsection on the debt crisis and structural adjustment programs.

In many industrialized countries, child poverty rates have increased since the 1980s as a result of a new set of social and economic problems, including increasing unemployment, worsening income distribution, single parenthood, and erosion of community. The United States has the highest level of child poverty of any industrialized country; one in five U.S. children lives in poverty today.[68]

- **Lack of education**

Women, girls, and vulnerable populations, such as children who are poor or indigenous, face issues of access to and adequacy of education. A strong link exists between educational levels of girls and women on the one hand, and child survival on the other. As little as three years of basic education for women is associated with decreases of 20 to 30 percent in child mortality.[69] The majority of primary care givers of children are female. Women with basic writing and reading skills are more likely to have the resources necessary to ensure their children's survival. Specifically, those women have better knowledge of birth spacing, adequate diets and hygiene. They more readily use maternal and child health services—specifically antenatal and obstetrics care, nutrition, immunization, and oral rehydration treatment for diarrhea. In general, literate women are more likely to be able to provide structural conditions important to child survival, including income-generation and safe housing. Nonetheless, basic education is still not accessible to 130 million children, a majority of whom are girls. Over 600 million women worldwide are illiterate, of whom 540 million reside in the developing world.[70]

- **Inadequate housing**

Adequate housing is highly correlated with progress in health, literacy, longevity, and informal employment such as gardening and dressmaking; the UNDP estimates that worldwide

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[67] Save the Children Fund/UK, *Toward a Children's Agenda: New Challenges for Social Development* (visited July 20, 1996) <http://www.oneworld.org/scf/scf_agenda.html>.

[68] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 67.

[69] Mosley & Cowley, *supra* note 9, at 10.

[70] HUMAN DEVELOPMENT REPORT, *supra* note 13, at 20, 147.

more than 1 billion people live in inadequate shelter, a large percentage of whom are young children, while another 100 million are homeless.[71] Worldwide, more than 30 million children live on the streets, exposing themselves to extreme hardship and conditions adverse to health, including increased susceptibility to disease.[72]

- **Lack of comprehensive reproductive health services**

Lack of access to comprehensive reproductive health services has profound repercussions on child survival. If women do not have access to family planning and other essential services, they are more likely to have children at close intervals; in addition, infants are at a higher risk of death if born to adolescent mothers, mothers over age 40, and women who have had more than seven births.[73] The risk of delivering a low birth weight baby increases after a woman has had four children.[74] In most cases, however, the lack of reproductive choice (i.e., the ability of a woman to control her own fertility) results in high rates of infant mortality among women of intermediate reproductive age and among those who have had fewer than four children.

- **Gender-based socioeconomic and cultural status**

Child mortality is directly affected by the socioeconomic and cultural status of girl-children and women. The practice of aborting female fetuses and female infanticide constitutes discrimination against girl children.[75] This discrimination continues in infancy and early childhood. Although girls are more biologically resistant than boys at birth, data show that girls are at higher risk of dying before age five because as infants and young children they receive less food and medical care.[76] According to a World Bank report, "deaths of young girls in India exceed those of young boys by almost a third of a million every year. Every sixth infant death is

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[71] *Id.* at 24.

[72] UNICEF, TOWARD AN OPERATIONAL STRATEGY FOR CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES (1989).

[73] Children born after intervals of less than two years between births are 80 percent more likely to die than children born after birth intervals of two to three years. Mosley & Cowley, *supra* note 9, at 10.

[74] UNICEF, FACTS FOR LIFE: A COMMUNICATION CHALLENGE 1 (1993).

[75] HEISE ET AL., *supra* note 57, at 11-12.

[76] UN, FROM NAIROBI TO BEIJING, *supra* note 54, at 112; UNICEF, STATISTICAL REVIEW OF THE SITUATION OF CHILDREN OF THE WORLD (1986) (noting that in 45 developing countries all but two experienced mortality rates among girls age 1 to 4 higher than boys in the same age group). *See also supra* notes 69-70 and accompanying text.

specifically due to gender discrimination."[77]

Women often bear a disproportionate burden with respect to domestic work. In developing countries, in particular, the demands of excessive domestic labor during pregnancy often combine with other health problems to endanger both women and their infants. This factor, acting together with a lack of reproductive choice and the restricted access to relevant women's health and related services, often leaves women unable to adequately address their own health needs and those of their children, thereby perpetuating a pattern of high maternal and child mortality.

Up to 80 percent of maternal deaths in developing countries are a consequence of obstetric complications such as hemorrhage, complications from illegal abortion, hypertension, obstructed labor, and infection. An overwhelming number of women experience these pregnancy-related complications each year with tragic, often deadly consequences. Each year, 585,000 women die from pregnancy-related causes.[78] Because women are often the primary care givers of children and the elderly, high rates of maternal mortality can endanger the lives of children and the elderly.

Female genital mutilation (FGM) also leads to health complications. In severe cases, women and girls can die from FGM or from complications in pregnancy and childbirth as a result of the practice.[79] During childbirth, FGM poses risks to infants due to the potential for obstructed labor that deprives the baby of oxygen. The practice in varying forms is still widespread in 28 African countries and among some communities in Asia, Europe, and North America.[80] Other forms of gender-based violence against women threaten both girl children and mothers; a discussion of such practices in the context of behavioral factors, which typically arise as a result of the cultural and socioeconomic status of women, is found in the previous subsection.

- **Armed conflict and social disruption**

Armed conflict exacts an appalling toll on child survival, especially among those under the age of five. Violent conflicts not only destroy lives but also devastate social infrastructures,

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[77] MEERA CHATTERJEE, INDIAN WOMEN: THEIR HEALTH AND ECONOMIC PRODUCTIVITY (World Bank Discussion Paper 109, Washington, D.C., 1990).

[78] WHO & UNICEF, REVISED 1990 ESTIMATES OF MATERNAL MORTALITY: A NEW APPROACH BY WHO AND UNICEF (Apr. 1996). In addition, over 15 million women sustain pregnancy-related injuries each year. Adamson, *supra* note 52.

[79] N. TOUBIA, FEMALE GENITAL MUTILATION: A CALL FOR GLOBAL ACTION 10-15 (2d ed. 1995).

[80] *Id.* at 5 (reporting an estimated 30 to 130 million victims of FGM). *See also* UN, FROM NAIROBI TO BEIJING, *supra* note 54, at 114.

basic services, and food and water supplies. Some of the highest rates of child mortality today, averaging well above 200 child deaths per 1000 births, are recorded in countries with internal conflict, including Afghanistan, Liberia, and Somalia.[81] In the last decade alone, an estimated 1.5 million children have been killed in armed conflicts, while 12 million more have been displaced from their homes.[82] UNICEF estimates that as a direct result of armed conflicts during the last few decades alone, child deaths have numbered more than two million.[83]

An indirect effect of armed conflict is the diversion of national resources away from health and social needs and toward military spending. Table 2.1 shows a comparison of government expenditures among the health, education, and defense sectors in poor African countries with extremely high child mortality. Many of these African countries recently experienced, or are still experiencing, internal armed conflicts. The industrialized world must share the responsibility for the distorted military expenditures by developing nations since the principal arms exporters to the developing world are the five permanent members of the U.N. Security Council.[84]

It is estimated that the equivalent of US$60 billion in annual spending would pay for the basic health packages in all developing countries.[85] Compared to the $121 billion of annual military expenditures by developing countries, this would be a small price to pay for activities that would protect the world's children from the worst effects of disease, poverty, and underdevelopment.[86] Indeed, the United Nations Development Programme (UNDP) estimates that the re-allocation of just one quarter of developing countries' military spending would provide sufficient resources to implement most of the Year 2000 programme proposed by UNICEF: immunization of all children, primary health care for all, eradication of severe malnutrition, provision of safe water for all, universal primary education, reduction of illiteracy, and family planning.[87]

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[81] UNICEF, *Children in War*, *in* UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 12-41.

[82] *Id.*

[83] Another four to five million children have been disabled, 12 million displaced, and some 10 million traumatized. *Id.* at 12-41.

[84] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 25.

[85] WORLD BANK, INVESTING IN HEALTH, *supra* note 16, at 11.

[86] R.L. SIVARD, WORLD MILITARY AND SOCIAL EXPENDITURES 20 (1993).

[87] The Year 2000 programme comprise specific goals for the survival, protection, and development of children. These goals were adopted by almost all of the world's nations subsequent to the 1990 World Summit for Children. For details, see *World Declaration on the Survival, Protection and Development of Children, Plan of Action for Implementing the Declaration in the 1990s*, and the *Convention on the Rights of the Child*, *in* UNICEF, THE STATE OF THE WORLD'S CHILDREN 1991, annexes at 51-75. See *infra* part B.2.

Table 2.1. Government expenditure allocated to health, education and defense in selected African countries, 1986-1993

Country	Child mortality (per 1000 live births)	Health (%)	Education (%)	Defense (%)
Angola	292	6	15	34
Mozambique	277	5	10	35
Guinea	223	3	11	29
Somalia	211	1	2	38
Ethiopia	200	3	10	39
Zaire	186	0	0	27
Uganda	185	2	15	26

Source: UNICEF, THE STATE OF THE WORLD'S CHILDREN 1996.

- **Displacement and urbanization**

Rural poverty and an increasing loss of productive land resulting from desertification, land "reform" policies, or other conditions often compel people to migrate to urban areas. As UNDP has observed, "while cities are centres of deprivation, they are also centres of opportunity."[88] Such migration leads to increasing urbanization; indeed, urban populations in the South are growing at an astonishing rate of one million a week. As urban areas expand, an already chronic shortage of adequate housing is intensified. Urban slums, not unlike rural villages, suffer from poverty, overcrowding, lack of clean drinking water, and inadequate waste disposal—all conditions that create an environment conducive to disease and ill health. Overcrowded and substandard housing is a significant predisposing factor for the spread of childhood pneumonia, which kills over 3 million children each year.[89]

- **Macroeconomic conditions and policies**

Macroeconomic policies impact the interaction of socioeconomic conditions with biological and behavioral factors that affect the survival and healthy development of children. Over the past 15 years, worsening terms of trade and overwhelming external debts have led to general economic decline in more than 100 countries, of which at least 71 are in Africa and Latin America.[90] Figure 2.1 illustrates the debt trends in developing countries over this period.[91]

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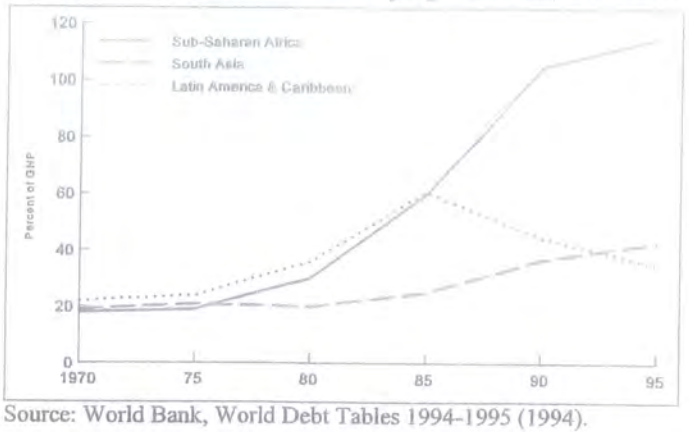
[88] UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13, at 25.

[89] WHO, INVESTING IN HEALTH, *supra* note 3, at 20.

[90] UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13, at 1-3. Between 1980 and 1995, the total debt of the developing world soared from $650 billion to more than $2 trillion. Debt levels in South Asia and Sub-Saharan Africa have experienced a dramatic upward trend since the mid-1980s. In Sub-Saharan Africa, the region's total debt levels have surpassed its GNP. Latin America's high external debt reached approximately 60 percent of its

Figure 2.1. Debt trends of developing countries, 1970-1995



Source: World Bank, World Debt Tables 1994-1995 (1994).

Under present trends, widening economic disparities among and within countries have resulted in deepening levels of poverty that have negatively affected the health of the most vulnerable populations.[92] Table 2.2 shows current external debt trends of the developing regions.

GNP by the mid-1980s—three times more than its total export earnings by 1987. But overall debt in the Latin American region has since fallen by half. World Bank, World debt tables 94-95, *in* UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 53. That seeming success, however, disguises the costs of economic growth without equity: the incidence of poverty in the Latin American region during the 1985-1990 period climbed from 23 percent to 28 percent; 18 countries have per capita income levels below that of 10 years ago, while the poor in many "growing economies" of the region (e.g., in Brazil, Chile, Mexico) have become even more marginal. UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13, at 2, 59-60.

[91] Governments of the developing world must share some of the responsibility for the crippling debt crisis in their countries. The recent collapse of the Asian economies revealed starkly the ill effects of "crony capitalism," which for many years benefitted the ruling elites in these countries, while the poor majority saw only marginal improvements in their standard of living.

[92] In 1993, 20 percent of the world's population represented by the industrialized countries held $18 trillion (78 percent) of the total share of global production, compared with only $5 trillion shared by the remaining 80 percent of the world's population in developing countries. From 1960 to 1993, the gap in per capita income between the developing and industrialized worlds tripled from $5700 to $15,400. UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13, at 2.

Table 2.2. Rising external debt of developing countries, 1981-1995

Year	Total debt (billion US$)
1981	749
1983	890
1985	992
1987	1,080
1991	1,300
1995	2,000

Sources: Murkherjee (1987); UNICEF, STATE OF THE WORLD'S CHILDREN 1991; Bread for the World (1996).

The poorest 20 percent of the world's people in both industrialized and developing countries have become more economically marginalized.[93] This era of economic decline has resulted in drastic cutbacks in health and social expenditures in many affected countries. The growing gaps in health and nutritional status threaten to undermine recent gains in global health improvements.[94]

Historically, international financial institutions have contributed to the deterioration in health conditions. Traditional structural adjustment programs imposed by the IMF and World Bank in the 1980s required social spending retrenchments and debt service obligations.[95] The

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[93] In the United States, for example, per capita income of the poorest 20 percent is less than a fourth of the country's average per capita income ($5814 as compared to $24,240); in Brazil it is only a tenth ($564 to $5370). In more than 100 countries, the failure to achieve economic growth has resulted in current income levels lower than those of the 1960s and 1970s. *Id.* at 13.

[94] B. Mukherjee, *External Debt Limits Health Interventions,* 3 PARASITOLOGY TODAY 228-30 (1987); G. CORNIA ET AL, ADJUSTMENT WITH A HUMAN FACE (1987); Kanji et al. *supra* note 28, at 985; Loewenson, *supra* note 38.

[95] Debt service is the sum of interest payments and repayments of principal on external long-term debts. The macroeconomic policies and programs of the World Bank (WB) and International Monetary Fund (IMF) were aimed initially at helping poor countries respond to their declining economic situations through stabilization of national budgets and trade deficits. Ensuing structural adjustment programs were implemented to address long-term economic recovery, promote a shift toward privatization, and reduce the government's role and influence. The *Human Development Report* 1996 published by UNDP offers this critical perspective:

> Restoring growth, an objective on paper, was rarely achieved in practice. Although these [stabilization] policies reduced deficits in some countries, they often did so at the cost of inducing recession. In short, they often balanced budgets by unbalancing people's lives . . . During this whole process of liberalization, adjustment and privatization, concern for the poor was pushed into the background. Policy-makers assumed that even if poverty increased in the short-term, this was a price that had to be paid for long-term stability and growth.

HUMAN DEVELOPMENT REPORT, supra note 13, at 48. For an in-depth discussion of the international debt crisis and

adjustment "blue print" typically included the following measures:[96]

- Currency devaluations to discourage imports and encourage exports;
- Reduction of government expenditure, particularly in the social sectors;
- Withdrawal of subsidies on food and other commodities;
- Introduction of user fees for social services;
- Trade liberalization and other incentives for foreign investment;
- Privatization of public enterprises;
- Abolition of price controls; and,
- Retrenchment of workers, wage freezes, and deregulation of laws protecting job security.

The overall negative effects of structural adjustment programs on health services, disease control, and food security for impoverished children are well documented.[97] Studies suggest a direct correlation between rising child mortality and traditional structural adjustment programs, particularly in African countries (see Table 2.3).[98] Without appropriate safety nets, the structural adjustment measures further destabilized already volatile political, social, and environmental

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the conceptual framework and application of the IMF/WB stabilization and adjustment policies, see Kanji et al., *supra* note 28; THE IMF AND THE SOUTH: THE SOCIAL IMPACT OF CRISIS AND ADJUSTMENT (D. Ghai ed., 1991); C. PAYER, CAUSES OF THE DEBT CRISIS (1989). *See also* KATHY SELVAGGIO, HUNGER: THE PRICE OF POOR-COUNTRY DEBT (Bread For the World Background Paper 137, Nov. 1996) (noting that the massive debt of least developed countries is no longer payable); L. BRYDON & K. LEGGE, ADJUSTING SOCIETY: THE WORLD BANK, THE IMF AND GHANA (1996).

[96] Loewenson, *supra* note 38, at 717; Kanji et al., *supra* note 28, at 985.

[97] D.E. Weil, A.P. Alicbusan, J.F. Wilson, M.R. Reich, & D.J. Bradley, *The Impact of Development Policies on Health: A Review of the Literature*, *in* WHO, Chapter 7, 152-65 (1990). Cutbacks in public expenditures resulted in rising health care costs, shortages of essential medicines and supplies, and erosion of health infrastructure, including facilities (equipment, clinics) and trained personnel. The removal of food subsidies and a shift toward cash crop production resulted in, among other effects, higher malnutrition levels and increased morbidity and mortality. Loewenson, *supra* note 38.

[98] Deterioration in child survival and nutrition was preceded by decreased per capita GDP, increasing poverty and severe reduction in government social spending. CORNIA ET AL., *supra* note 94. In many of the 40 African countries implementing structural adjustment programs, mounting evidence illustrated worsening social and health conditions preceding rising malnutrition, morbidity, and mortality among children. Loewenson, *supra* note 38. These conditions include reduced food security in both quality and quantity; neglect and defunding of health and social service sectors, including cutbacks in immunization and disease prevention programs and weakened standards of living (which reduced household capacity to provide essential needs) among the poor due to wage cuts, unemployment, and rising costs of living. A ten-nation study by UNICEF of the impacts of adjustment on health documented worsened child nutritional status in eight countries, while three showed an increase in child mortality. CORNIA ET AL., *supra* note 94; Kanji et al., *supra* note 28. During Zambia's structural adjustment period between 1980 and 1984, hospital deaths due to malnutrition rose from 38 percent to 62 percent in the 1 to 4 age group, and from 2 percent to 6 percent in the infant group. J. CLARK & D. KEEN, DEBT AND POVERTY—A CASE STUDY OF ZAMBIA (1988).

conditions within many countries of the South.[99] In Sub-Saharan Africa, per capita incomes plummeted by 25 percent over the structural adjustment period. Unemployment rates rose in many implementing countries.[100] Furthermore, cutbacks in government health spending and the introduction of user fees as a form of "cost-recovery" resulted in prohibitive costs of health care among the poor.[101] In many countries, health expenditure per capita fell after the introduction of adjustment programs.[102] Significant declines in literacy and increases in school drop-out rates were documented, particularly for girl-children.[103]

Table 2.3. The negative effects of structural adjustment programs on infant mortality in selected African countries, 1980-1985

Country	Infant mortality rates			% change 1980-85
	1960	1980	1985	
Madagascar	n/a	71	109	-53.5
Mali	200	154	174	-26.5
Ethiopia	165	146	168	-15.1
Uganda	121	97	108	-11.3
Tanzania	138	103	110	-6.8
Somalia	165	146	152	-4.1

Source: Adapted from Commonwealth Secretariat, 1989, *in* Loewenson (1993).

The negative relationship between structural adjustment policies and health does not appear to have improved substantially in the 1990s. While maintaining that structural adjustment policies are necessary, international financial institutions and lending countries have introduced targeted, short-term "social safety nets" programs to mitigate *short-term "transitional costs"* on

[99] Loewenson, *supra* note 38; Kanji et al., *supra* note 28. Food self-sufficiency, for example, is undermined by emphasis on export (cash) crops (e.g., cotton, cocoa, coffee), and dramatic increases in food prices due to the removal of food subsidies. Food ration systems were introduced in some countries as a last recourse for the poorest. Food crop production plummeted by up to 30 percent in several African countries.

[100] Unemployment rose to 16 percent in Chile and 25 percent in Jamaica. CORNIA ET AL., *supra* note 94.

[101] Cost sharing in health through user fees often did not provide for adequate exemption or protection for the poor. A.V. ADAMS & T. HARTNETT, COST SHARING IN THE SOCIAL SECTORS OF SUB-SAHARAN AFRICA 1-44 (World Bank Discussion Paper 338, 1996).

[102] The decrease was 23 percent in Ghana and 40 percent in Jamaica. CORNIA ET AL., *supra* note 94.

[103] INTERNATIONAL PEOPLE'S HEALTH COUNCIL (IPHC) & THE THIRD WORLD NETWORK (TWN), ECONOMIC RECESSION, STRUCTURAL ADJUSTMENT AND HEALTH 1-4 (1994). *See also* Kanji et al., *supra* note 28.

the poor. The social safety nets of the IMF/WB typically comprise the following:[104]

- Targeted subsidies and cash compensation in lieu of subsidies (e.g., food, health care);
- Improved distribution of essential commodities such as medicines;
- Temporary price controls for essential commodities;
- Severance pay and retraining for retrenched public sector employees;
- Employment through public works (e.g., labor-intensive, low-wage projects in rural or urban areas); and
- Adaptation of permanent social security arrangements to protect the poorest.

Social safety measures arguably may help in the short term but the evidence is inconclusive. The ultimate focus of the reform programs remains "the cost-effectiveness and financial viability of social policy options."[105] In addition, the programmatic emphasis of both the IMF and World Bank is increasingly on *long-term poverty reduction*.[106] The IMF's own assessment of difficulties in identifying and targeting vulnerable populations in adjusting countries because of "a lack of household data" appears undercut by the fact that more than half of the population in some of those countries live in poverty.[107] While current IMF/WB measures may be effective in addressing acute social and health needs, the longer-term effects of these measures may be marginal because the fundamental problems of poverty and ill-health (e.g., equitable distribution of social resources; dependency on external financing) remain unresolved.[108]

The direct effects of structural adjustment programs on child mortality, although not definitively understood, continue to pose concerns.[109] For some of the most indebted countries,

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[104] IMF, PAMPHLET SERIES 47, SOCIAL DIMENSIONS OF THE IMF'S POLICY DIALOGUE, *available in* International Monetary Fund (visited Feb. 13, 1997) <http://www.imf.org/external/pubs/ft/pam/pam47/pam4703.htm#p5>.

[105] *Id.*

[106] In the 1990s, the World Bank articulated sustainable poverty reduction as its central mission, with expanded lending for improved investments in education, the environment, economic opportunities for women, population planning, health and nutrition services, and the development of the private sector. *See* LAWYERS COMMITTEE FOR HUMAN RIGHTS (LCHR), THE WORLD BANK: GOVERNANCE AND HUMAN RIGHTS (World Bank Annual Report 1991, 2d ed. Aug. 1995). The two-pronged approach of poverty reduction promoted by the Bank entails sustained and broad-based economic growth, which necessitates ongoing implementation of structural adjustment policies, and improvements in the level and quality of government spending on social services, which focus on reforms of public expenditures and the poor's access to these services. IMF, *supra* note 104.

[107] *See generally* Loewenson, *supra* note 38.

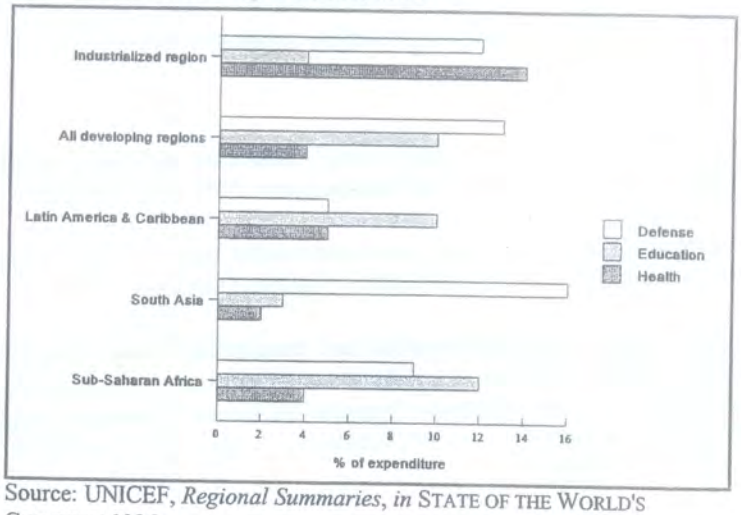
[108] Weil et al., *supra* note 97.

[109] *Id.* at 158. ("[D]ebate continues on the degree or, in some cases, even the direction of the impact [of negative health effects of structural adjustment]. Evidence from country studies is conflicting, and many effects

infant mortality rates have stagnated or worsened since the 1980s.[110] Health spending remains comparatively low, although it is encouraging to note that education spending has surpassed defense in some developing countries in Sub-Saharan Africa and Latin America (see Figure 2.2).[111]

There is strong evidence that retrenchments in the health sectors have severely compromised efforts to prevent and control diseases.[112] Consequently, immunizable and communicable diseases including malaria, respiratory infections, and cholera have experienced a resurgence.[113]

Figure 2.2. Regional comparisons of social investments in relation to defense expenditure, 1994



Source: UNICEF, *Regional Summaries*, *in* STATE OF THE WORLD'S CHILDREN 1996.

B. Country-level and global responses

Since the 1950s, advances in knowledge and technology, combined with improvements in communication and outreach capacity, particularly in many developing countries, have

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may not be apparent in the short run.")

[110] By 1995, infant mortality rates in Uganda and Madagascar remain much higher than those in 1980. In Tanzania, today's infant mortality rate is unchanged from 1980. *See supra* Table 6. *See also* UNICEF, STATE OF THE WORLD'S CHILDREN 1997 [hereinafter UNICEF, WORLD'S CHILDREN 1997], at 80.

[111] UNICEF, *Regional Summaries*, *in* UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 99.

[112] *See supra* notes 98, 101-02 and accompanying text.

[113] IPHC & TWN, *supra* note 103, at 1-4. For example, in the last several years the deterioration in water-sanitation infrastructure in Peru and other Latin American countries has resulted in a reemerging cholera epidemic.

contributed to a steady global decline in child mortality. As a result, measurable improvement in reducing child deaths worldwide has occurred.[114] Since 1980, oral rehydration therapy (ORT) has prevented 1 million dehydration deaths each year.[115] Basic immunization has saved the lives of about 20 million children during the past decade.[116] The level of access to safe water is at 70 percent, and safe sanitation has reached more than half of all families in developing countries, representing essential conditions to controlling intestinal infections and diarrhea.[117] In addition, over the past three decades, global fertility rates—the average number of children born per woman—affecting the health and socioeconomic status of women have fallen from 6.0 to 3.7, thereby lowering the levels of child mortality.[118]

Some leveraging of host country health expenditures has come from foreign assistance although, in many cases, the external assistance allocated directly to health sectors appears negligible.[119] Aid from relatively wealthy countries is provided at the bilateral level,[120]

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[114] Since the 1950s, overall child mortality rates have declined dramatically by about 50 percent, resulting in approximately 12.5 million fewer child deaths a year. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 10.

[115] About half of all diarrheal cases in the poorest nations are now treated with ORT. UNICEF, WORLD'S CHILDREN 1994, *supra* note 28, at 6; UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 58.

[116] In ten years, deaths from measles have been reduced from 2.5 to over 1 million annually. In addition, with global immunization levels reaching more than 80 percent by the early 1990s, a steady decline in such major immunizable diseases as polio, diphtheria, neonatal tetanus and whooping cough has been recorded. Given current trends, WHO projects that by the year 2000 polio can be eradicated from the face of the earth. UNICEF, WORLD'S CHILDREN 1994, *supra* note 28, at 7.

[117] WHO, THE INTERNATIONAL DRINKING WATER SUPPLY AND SANITATION DECADE: END OF DECADE REVIEW (1992); WHO & UNICEF, WATER AND SANITATION SECTOR MONITORING REPORT (1993).

[118] The introduction of family planning has been an important contributing factor, especially as knowledge and means of family planning services have become more widely accessible. UNITED NATIONS, WORLD POPULATION PROSPECTS: THE 1992 REVISION (1993). UNICEF offers the following perspective:

> [F]amily planning is one of the most important of all contributions to social and economic development: it reduces the number of maternal deaths; it lowers under-five mortality rates; it improves the nutritional health of both women and children; it gives women more health, more time, and more opportunity; it has a positive impact on the care and education of children; and it slows population growth.

UNICEF, WORLD'S CHILDREN 1994, *supra* note 28, at 8.

[119] One study estimated that, in the health sector, external aid to developing countries was US$4.8 billion in 1990, an amount less than 3 percent of the total health expenditures of those countries. C. Michaud & C.J.L. Murray, *External Assistance to the Health Sector in Developing Countries: A Detailed Analysis, 1972-90*, 72 BULL. WHO 639-51 (1994). By contrast, foreign aid to health sectors in some countries in Sub-Saharan Africa has reached 20 percent of those countries' health budgets. *Id.* at 641.

[120] Although the dollar amount of bilateral assistance from the Organization for Economic Cooperation and Development (OECD) member countries has increased across the years, the measurement of total assistance as a

sometimes through the work of private voluntary agencies (or international non-governmental organizations),[121] and at the multilateral level through agencies affiliated with the UN and multilateral development banks.[122] Even contributions from the for-profit business sector, either locally or internationally, are significant. However, "[t]here is no clear relationship between external assistance per capita and GDP per capita or measures of health status including child . . . mortality levels."[123] In other words, a mere accounting of money spent on health care does not explain whether and how the money is spent and what benefits to child survival may be procured.

1. Country-level developments

Since the 1970s, primary health care programs implemented by a number of developing countries have demonstrated encouraging but mixed results in attaining better health and survival. Progress in child survival has occurred even in countries with low per capita incomes, notably Costa Rica, Cuba, Jamaica, and Sri Lanka.[124] Child mortality rates in these countries, with per capita income in the range of $500 to $2000, are among the lowest in the developing world (see Table 2.4). A common predictive characteristic shared by all these countries is a significant level of political commitment to and investment in social progress and equity; for example, all have high literacy levels and low fertility rates among women.

Many country-level programs continue to face daunting obstacles inimical to health, including poor or deteriorating infrastructural and administrative capacity in health and basic

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percentage of GNP reflects a sharp decrease from 0.09 percent in 1984-85 to 0.06 percent in 1995. OECD, Development Assistance Committee, *Development Cooperation Report* (visited Nov. 10, 1997) <http://www.oecd.org/dac/htm/>. With respect to foreign assistance to all recipients, the data show a sharp dip in 1990 and 1992 from 0.73 percent in 1984, but a recovery to 0.76 percent in 1995, as a percentage of GNP. While the dollar amount of assistance has increased, it has remained largely static as a percentage of GNP (and in some years substantially less than that level). In 1994, the proportion of such assistance reported to be provided for basic health alone was only 0.5 percent of total OECD bilateral assistance; aid to both health and population sectors in the same year was 4.9 percent of total assistance. *Id.* Other categories of assistance included water supply and sanitation at 4.9 percent; agriculture at 7.5 percent; and food aid at 3.5 percent of the total. U.S. Agency for International Development (USAID), *Saving Lives Today and Tomorrow: A Decade Report on USAID's Child Survival Program* (Dec. 1996). Of particular note at the bilateral level is the Child Survival Program operated by the USAID. *Id.*

[121] Organizations such as CARE, Catholic Relief Services, Doctors without Borders, OXFAM, the Red Crescent and Red Cross, and Save the Children are important actors in health assistance to developing countries. These organizations are supported by private donors and volunteers but a large part of their budgets is funded by governments, notably the DAC countries of the OECD noted *supra* note 120.

[122] For a discussion of UNICEF and WHO's programs, see *infra* part B.2.

[123] Michaud & Murray, *supra* note 119, at 647.

[124] Mosley & Cowley, *supra* note 9, at 31.

service sectors (e.g., clean water, sanitation, health delivery systems, and roads), and entrenched socioeconomic norms (such as gender disparity in education, economic status, and decision-making at the household level).[125]

Table 2.4. Selected developing countries with low child mortality relative to GNP per capita, 1994

Country	GNP/capita (US$)	Child mortality (/1000 live births)	Fertility rate*	Female literacy** (%)
Sri Lanka	600	19	2.4	85
Cuba	1,170	10	1.8	94
Jamaica	1,440	13	2.3	87
Costa Rica	2,150	16	3.1	94

* Average total number of children born per woman.

** Percentage of women aged 15 and over who can read and write.

Source: UNICEF, Statistical Tables, STATE OF THE WORLD'S CHILDREN 1996.

2. Global responses

Child mortality appears to be slowing down as a result of global health intervention efforts by UNICEF, WHO, non-governmental entities, and others. The programs include the Health for All by the Year 2000 ("HFA2000") joint strategy of WHO and UNICEF, UNICEF's now-expanded GOBI-FFF package, and WHO's monitoring framework based on HFA2000. Those global strategies and programs, discussed below, have responded in varying degrees to the biological, behavioral, and socioeconomic determinants of high child mortality.

2.1 Health for All by the Year 2000 (HFA2000)

A global strategy known as "Health for All by the Year 2000" ("HFA2000" or "Health for All"), officially adopted in 1981 by the World Health Assembly, provides an international framework for the promotion of child health worldwide. Pursuant to the 1978 Alma-Ata International Conference, the primary health care approach (PHC) was developed by UNICEF and WHO as an instrument by which to attain HFA2000.[126] The Alma-Ata Conference, co-sponsored by WHO and UNICEF and attended by representatives of more than 140 countries and 60 U.N. agencies and non-governmental organizations (NGOs), marked the most significant, concerted global effort to date to comprehensively define health for the world's inhabitants. The conference agreed to the Alma-Ata Declaration on Primary Health Care, which recognized the

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[125] *See* H.R. Green, *Politics, Power and Poverty: Health for All in 2000 in the Third World?* 32 SOC. SCI. MED. 745-55 (1991); P.F. Basch, *Primary Health Care, in* TEXTBOOK OF INTERNATIONAL HEALTH 200 (1990). As Basch notes, "to evaluate these [primary health care] programs realistically in their worldwide setting requires background, experience, and judgment possessed by few, and only the passage of time until and beyond the year 2000 will provide the ultimate evaluation of their true utility." *Id.* at 211-12.

[126] For an in-depth discussion of the conceptual framework and utility of primary health care and Health for All by the Year 2000, see Green, *supra* note 125; Basch, *supra* note 125.

interdependent challenges concerning health rights, social development, economic progress, and political commitment:

> Health, which is a state of complete physical, mental and social well-being, and not merely an absence of disease and infirmity, is a fundamental right of all people and the attainment of the highest possible level of health is a most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.[127]

The Alma-Ata Declaration highlighted key components in the integration of primary health care with social and economic development (see Box 2.3).[128] Based on those components, the HFA2000 strategy reflects a people-centered approach to health and development.[129] It emphasizes preventive measures through full participation, equal access, reallocation of resources, and priorities on vulnerable women and children. The emerging perspective recognizes the significant interplay between the health and socioeconomic environments, and identifies the existing barriers to health as essentially political, social, and economic.

Box 2.3. Key components of the Alma-Ata Declaration on Primary Health Care

- Education concerning prevailing health problems
- Promotion of food supply and proper nutrition
- Adequate supply of safe water and basic sanitation
- Maternal and child health care, including family planning and immunization
- Prevention and control of endemic diseases
- Appropriate treatment of common diseases and injuries, including provision of essential drugs
- Coordinated participation of all related sectors and aspects of development, including agriculture, food, industry, education, housing, public works and communications
- Promotion of community participation and self-reliance
- Priority to those most in need, such as children and women
- Employment of local health workers, and traditional practitioners as needed

Source: Alma-Ata Declaration, section VII.

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[127] Declaration of Alma-Ata, Alma-Ata International Conference on Primary Health Care (1978), *reprinted in* Basch, *supra* note 125, at 226.

[128] *See also* discussion of the Alma-Ata International Conference on Primary Health Care in Appendix B.

[129] The global strategy for "Health for All by the Year 2000" is the major policy and programmatic aim of WHO and UNICEF. *See* WFPHA, *supra* note 61. For a general discussion of people-centered development, see PEOPLE CENTERED DEVELOPMENT: CONTRIBUTIONS TOWARD THEORY AND PLANNING FRAMEWORKS (D.C. Korten & R. Klauss, eds., 1984).

Participating governments and non-governmental organizations concerned with health and development generally have endorsed the Health for All global strategy. However, the reality has been that PHC and HFA2000 have been adopted and implemented mainly by the developing countries of the world.[130] The HFA2000 global campaign has faced challenges as to its attainability and sustainability. In general, challenges to primary health care objectives continue to stem from the following factors: the lack of financial and political commitment of governments that contend with competing political priorities and concerns; the tendency of the biomedical and pharmaceutical establishments to favor high-cost, low-access curative measures; diverse macrolevel events such as internal armed conflict and economic decline that diminish community resources and participation; and endemic poverty at both the household and national levels that decrease resource allocations for health and development.[131] The worldwide experience of increasing poverty and inequity over the past decade and a half [132] has prompted WHO to call for a "comprehensive re-evaluation of the principles and strategies of Health for All."[133]

2.2. GOBI-FFF

Since the early 1980s, UNICEF has promoted a package of basic child survival and health services generally considered to be effective in addressing factors at all three levels of the causal chain.[134] Known by the acronym GOBI-FFF, the package originally focused narrowly on a few selective low-cost health interventions and on improvement of selected maternal attributes. The original GOBI-FFF included the following techniques:

- **G**rowth monitoring as a regular check on child well-being;
- **O**ral RehydrationTherapy to reduce incidences of childhood diarrhea;
- **B**reast-feeding to promote a nutritional start in life;
- **I**mmunization against the major childhood diseases;
- **F**ood supplementation to minimize the effects of malnutrition and micronutrient deficiencies;
- **F**amily planning to promote reproductive health; and,

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[130] For discussion on national programs established based on the PHC and HFA2000 global strategy, see Basch, *supra* note 125, at 212 (discussing "case studies" in Haiti, Nicaragua, Indonesia, China, Tanzania, and Nigeria).

[131] Green, *supra* note 125, at 745.

[132] For a discussion of trends toward increased economic disparities and their impact on child mortality, see *supra* notes 90-100 and accompanying text.

[133] WHO, RENEWING THE HEALTH-FOR-ALL STRATEGY: ELABORATION OF A POLICY FOR EQUITY, SOLIDARITY, AND HEALTH–CONSULTATION DOCUMENT, 1995, *reprinted in* WFPHA REP., *supra* note 61, at 8.

[134] The objectives of GOBI-FFF are now primarily guided by the PHC/HFA2000 global strategy.

- Female education as a means to increase women's social and economic status.

Although the original GOBI-FFF strategy saved many children's lives, the initiative failed to directly address the underlying inadequacies of social structures such as unsafe water, poor sanitation, and food insecurity.[135] Subsequent UNICEF initiatives in the 1990s, pursuant to the Alma-Ata Declaration and PHC and HFA2000 strategy, have begun to address key social factors and the situation of women and children in especially difficult circumstances, such as armed conflict and socioeconomic neglect.[136] Along with the elements listed above, the GOBI-FFF package today includes:

- Provision of safe water and sanitation;
- Maternal health and survival;
- Elimination of micronutrient deficiencies;
- Control of acute respiratory infections and local epidemics such as AIDS, malaria and Guinea worm disease; and,
- Protection of children in especially difficult circumstances, such as in time of war, at work, and on the streets.

The current UNICEF package addresses certain proximate behavioral and structural variables as well as biological causes of child death (e.g., breast-feeding, education in child care and nutrition practices, family planning, provision of safe water, effective fertility control) in a manner that can improve women's health and household economic status as well as directly benefit children. The package also emphasizes cultural appropriateness and cost.[137] For details of UNICEF's current approach, see Box 2.4, World Summit for Children: Year 2000 Goals.[138] Progress toward the year 2000 goals for the survival, protection, and development of children is tracked and reported annually (since 1992) by UNICEF/WHO joint monitoring programs and other monitoring efforts of U.N. specialized agencies.[139] Critics of the UNICEF package argue

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[135] Kanji et al., *supra* note 28; DESAI, *supra* note 29. For example, the growth monitoring component of GOBI requires mothers to "monitor" the development of their infants through regular weighing by community health workers. However, the process becomes meaningless when such ameliorative measures as nutritious foods are not available or are unaffordable. Solving the problem of food security would implicate broader programs in the agricultural and economic sectors, and policies involving food production and distribution.

[136] The broadening of the GOBI-FFF package occurred in the context of HFA2000, discussed *infra* notes 138-39 and accompanying text.

[137] Millard, *supra* note 29.

[138] These goals were adopted by the World Summit for Children in 1990. UNICEF, WORLD'S CHILDREN 1991, *supra* note 87, at 2.

[139] Pursuant to the 1990 Convention on the Rights of the Child, state parties are required to submit country reports two years after ratification and every five years thereafter. Statistics by governments, in addition to those by international organizations and UN agencies, are analyzed and published by UNICEF in *The Progress of Nations*

that individual (maternal) attributes, such as female education, and selective health interventions, such as food supplementation, are highlighted to the detriment of adequate emphasis on structural factors such as the political economy and the health system.[140]

Box 2.4. Summit for Children Year 2000 Social Goals

Overall goals 1990-2000
- A reduction in under-five death rates by one-third (or to 70 per 1000 live births).
- A 50 percent reduction in maternal mortality rates.
- A halving of malnutrition rates among the world's under-fives.
- Provision of safe water and sanitation for all communities.
- Basic education for all children and completion of primary education by at least 80 percent--girls as well as boys.
- A 50 percent reduction in the adult illiteracy rate and the achievement of equal educational opportunity for females and males.
- Acceptance by all countries of the *Convention on the Rights of the Child*, including the protection of children in especially difficult circumstances (i.e., special protection for children in time of war, at work, and on the streets).

Nutrition
- A reduction in incidence of low birth weight (2.5 kg or less) to less than 10 percent.
- Elimination of vitamin A deficiency and iodine deficiency disorders.
- Promotion of exclusive breast-feeding for the first six months of a child's life and of meeting the special feeding needs through a child's vulnerable years.
- A one-third reduction in iron deficiency disorders among women.
- Institutionalization of growth monitoring and promotion.
- Enabling all families to ensure household food security.

Child health
- Achievement of immunization coverage of 90 percent among under-ones and universal tetanus immunization for women in child-bearing years.
- Eradication of polio.
- Elimination of neonatal tetanus.
- A 90 percent reduction in measles cases and a 95 percent reduction in measles deaths.
- A halving of child deaths caused by diarrhea.
- A one-third reduction in child deaths caused by acute respiratory infections.

Protection of girls and women
- Universal access to high-quality family planning information and services in order to prevent unwanted pregnancies and births that are too many and too closely spaced and to women who are too young or too old.
- All women to have access to prenatal care and trained birth attendants, and to referral for high-risk pregnancies and obstetric problems.
- Universal recognition of the special health and nutritional needs of women during early childhood, adolescence, pregnancy, and lactation.

Education
- In addition to the expansion of basic/primary education, essential knowledge and life skills can reach millions of families and communities by means of a vastly improved and increased communications capacity.

Source: UNICEF, THE STATE OF THE WORLD'S CHILDREN 1991, at 2.

2.3. WHO monitoring framework

Based on the Alma-Ata Declaration and HFA2000 strategy, WHO developed a set of monitoring indicators of health status on a population level for HFA2000 and a framework for evaluating the implementation of Health for All strategies.[141] The monitoring framework provided WHO member countries with guidelines for monitoring and evaluating progress in their

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annual report, which tracks advances and declines in child health and survival of the world's nations. *See* UNICEF, THE PROGRESS OF NATIONS 1997.

[140] DESAI, *supra* note 29; Kanji et al., *supra* note 28.

[141] WHO, DEVELOPMENT OF INDICATORS FOR MONITORING PROGRESS TOWARDS HFA2000 (1981); WHO, THIRD MONITORING OF PROGRESS, COMMON FRAMEWORK CFM3, IMPLEMENTATION OF STRATEGIES FOR HFA2000 (1993).

Health for All national programs. The global indicators developed by WHO comprise three broad categories: (1) health status indicators (e.g., infant and child mortality rates); (2) indicators of primary health care coverage (e.g., percentage of the population covered); and (3) socioeconomic indicators (e.g., expenditure on health as a percent of GNP). Members of WHO are obligated under the organization's constitution to report annually on the action and progress in improving the health status of their people based on the prescribed indicators.[142]

C. Comprehensive strategies

Basic means to reduce child mortality are now both available and affordable.[143] Comprehensive strategies that address the range of socioeconomic determinants as well as biomedical and public health factors are necessary to *sustain* reduced child mortality.[144] Given the relatively small levels of foreign assistance and domestic resources made available for health, it is important that resources be targeted to deliver results that materially reduce child mortality. Nonetheless, the biomedical approach to ameliorating high levels of child mortality continues to receive greater attention from policy makers than other approaches. As a result, the socioeconomic determinants of child survival are often overlooked or understated in policies and programs.[145] Indeed, a deficiency of research exists on socioeconomic strategies to address the problem.[146] Recently, health care policies and programs have shifted from public investment toward measures emphasizing individual responsibility and action, such as individually-based health interventions, and privatization or decentralization of the health sector.[147]

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[142] Constitution of the World Health Organization (WHO), *opened for signature* July 22, 1946, art. 61, 14 U.N.T.S. 185 [hereinafter WHO Constitution].

[143] See *supra* part B.

[144] For example, in many developing countries, childhood diarrhea is treated with oral rehydration solutions, and malnutrition is treated with supplemental feeding or food aid programs. These short-term strategies are essential, but a more comprehensive, long-term solution must address the socioeconomic conditions necessary to improve access to clean water and food security. Similarly, in industrialized countries where avertable injuries, noncommunicable conditions, and disadvantaged social and economic circumstances have become the prevalent determinants of childhood death and disability, long-term solutions must also address these socioeconomic problems. DESAI, *supra* note 29, at 67; UNICEF, *The Progress of Nations 1996 Summary* (visited Dec. 5, 1996) <http://www.oneworld.org/unicef/progress/summary.html>

[145] DESAI, *supra* note 29, at 1-32.

[146] Based on a literature review of 240 epidemiological research articles published between 1992 and 1993, Link and Phelan determined that less than 13 percent of the studies had focused on risk factors that are social in nature. *See generally* Link & Phelan, *supra* note 59.

[147] *See generally* DESAI, *supra* note 29, at 1-32; P. MUSGROVE, PUBLIC AND PRIVATE ROLES IN HEALTH (World Bank Discussion Paper No. 339, 1996).

Essential health and social services to reduce child death rates involve sharing limited resources and bringing preventive and treatment activities together. Such an approach supports integration of basic child health services such as ORT, immunization, and nutrition with health education and family planning services.[148] According to estimates from WHO and the World Bank, a minimum set of essential services can be delivered in low-income countries for less than US$12 per person per year.[149] Even traditionally intractable, poverty-related causes of death in children under age five have been abated in recent decades at reasonable cost through a combination of new technologies, falling costs, and community-based strategies.[150] Provision of clean water (e.g., a reliable hand-pumped well per 250 people) and safe sanitation (e.g., pit latrines) has become affordable for communities in rural areas.[151] In contrast, the cost of treating diseases and illnesses caused by unsafe or fecal-contaminated water or living environments is disproportionately higher, not including the cost of potential productive years lost due to premature death. Moreover, at a cost of less than US$10 per child per year the incidence of child malnutrition can be reduced by half through measures including nutrition education (about child feeding), breast-feeding promotion, and appropriate food and micronutrient supplementation.[152]

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[148] ORT, which is low-cost and uses oral rehydration salts (ORT is widely available at about 10 cents per sachet) or home-made versions (e.g., rice water), saves over 1 million young lives a year. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 58. The cost-effectiveness of the *Expanded Programme on Immunization* (EPI), which protects at least 80 percent of the children in developing countries from six major childhood diseases at an estimated annual cost per capita of 50 cents, is well established. WHO, *Integrated Management of the Sick Child*, 73 BULL. WHO 735-40, 739 (1995). Other essential packages with the potential to improve health at low costs are currently being evaluated by WHO and other research organizations. They include the *Mother-Baby* package and the package for the *Integrated Management of the Sick Child*.

[149] About one-third of the cost would be allocated to *public health measures* such as: immunizations; information and selected services for family planning and nutrition; school-based health services; AIDS prevention; programs to reduce tobacco and alcohol consumption; and regulatory action, information, and limited public investments to improve the household environment. The remaining two-thirds would be designated for *essential clinical services*, which include care for common serious illnesses of young children (diarrheal disease, acute respiratory infection, measles, malaria, and acute malnutrition); family planning services; pregnancy management; tuberculosis control; and control of sexually-transmitted diseases. J.L. Bobadilla, P. Cowley, P. Musgrove, & H. Saxenian, *Design, Content, and Financing of an Essential National Package of Health Services*, 72 BULL. WHO 653-62 (1994).

[150] *See, e.g.*, UNICEF, *Panel 6: Safe Water: Lesson from the Barrio*, *in* UNICEF, WORLD'S CHILDREN 1994, *supra* note 28, at 20; UNICEF, *Panel 8: Village Water Supplies*, *in* UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 52.

[151] In rural India, access to safe water has risen from 30 percent in 1980 to over 80 percent in 1992. At an initial investment of $4 per person, 2.2 million handpumps are now supplying safe water to over 550 million people. UNICEF, WORLD'S CHILDREN 1994, *supra* note 28, at 15.

[152] Large-scale trials in India and in Africa, involving mothers and community health workers, have illustrated the low cost and success of anti-malnutrition measures. In several developing regions, an investment of $10 per child per year has reduced child malnutrition by 50 percent. UNICEF, WORLD'S CHILDREN 1991, *supra* note 87, at 10.

The *20:20 initiative* endorsed in 1995 by such U.N. agencies as UNICEF, UNFPA, WHO, UNDP, and UNESCO suggests a strategy through which aid donors and governments can earmark 20 percent of their budgets towards meeting the social goal of universal access to primary health care and nutrition, reproductive health, water and sanitation, primary education, and other basic social services.[153] This initiative provides a useful tool for donors to restructure their aid allocations and for governments to review and adjust their budgets towards adequate provision of basic health and social services.

The IMF-World Bank's *Debt Initiative for Highly-Indebted-Poor-Country* (HIPC) is an important strategy for addressing the unsustainable debt burden of developing countries.[154] This multilateral debt initiative enables poor countries to utilize potential savings from debt relief for targeted priority development areas, particularly the social sector. Up to twenty low-income, severely indebted countries are now eligible under this new initiative (see Box 2.5). Many of the world's poor countries are overwhelmed by multilateral debt burdens. Large external debts continue to impede social development efforts by developing countries to meet the essential needs of their populations. Public investments in the social sector, including poverty reduction measures, are severely undercut by debt repayment obligations that lay claim to large proportions of export earnings and bilateral aid.[155]

While the HIPC initiative represents significant progress in resolving the debt crisis in the poorest countries, much more can be done. Many more poor and heavily indebted countries would benefit from inclusion in the initiative. The qualification time-frame could be shortened to less than six years for eligible countries that could then immediately address their most urgent social needs. Debtor countries must commit to a social agenda that reduces poverty and improves equity in social investment. A conditionality on debt relief proposed by the World Bank would provide a mechanism for ensuring the transfer of debt-relief savings to social welfare investments, particularly in basic education, primary health and other poverty reduction measures. Proponents of the multilateral debt initiative have called for a "comprehensive debt-for-poverty-reduction contract," a binding agreement between creditor and debtor countries to ensure transparency and accountability in converting debt-relief savings to health and social welfare investments.[156]

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[153] UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13, at 73.

[154] World Bank, *Sustainable Debt for Sustainable Development* (visited Sept. 24, 1997) <http://www.worldbank.org/html/extdr/hipc/hipcbr.htm>.

[155] In Uganda, one of the poorest and most indebted countries, total external debt repayment of $184 million in 1996/1997 is almost ten times the level of public spending on primary health, and seven times what the government now spends on primary education. Oxfam Int'l, *Debt Relief and Poverty Reduction: New Hope for Uganda, Sept. 1996* (visited Feb. 1997) <http://www.oneworld.org/oxfam/policy/papers/uganda.htm>, at 2 [hereinafter Oxfam, *Debt Relief*].

[156] *Id.* at 20.

Box 2.5. Debt relief: the case of Uganda

As a result of Uganda's full implementation of its economic structural adjustment policies, the country recently received a total debt relief package of approximately $340 million under the Debt Initiative for Heavily Indebted Poor Countries facilitated by the IMF, the World Bank and other multilateral creditors. The government, through its Action Plan for Poverty Eradication, has pledged to convert these debt service savings into poverty reducing initiatives in basic education, primary health care and other social investment priorities. The social benefits from the debt relief for millions of impoverished Ugandans are potentially enormous:

- Nearly 400,000 children surviving past age five;
- access to clean water and sanitation for one million people;
- basic health care for two million people;
- primary education for 2 million children who are currently out of school.

Despite recent gains from stringent economic reforms, Uganda remains extremely poor and still faces a significant external debt burden. Sixty percent of the population continues to live in poverty. Uganda's total foreign debt is $3.5 billion, with estimated debt ratio to export earnings of 200% by the end of the century. With the projection of economic recovery and a significant debt relief package, Uganda has now an exceptional opportunity to invest in sustainable social development and improve the survival and welfare of its children.

Sources: Oxfam, *Debt Relief*, Sept. 1996; IMF, *Uganda--Debt Issues*, Sept. 24, 1996 (visited Feb. 13, 1997), <http://www.imf.org/external/np/exr/facts/uganda.htm>;World Bank, *World Bank Approves Debt Relief Package for Uganda*, Apr. 23, 1997 (visited Sept. 24, 1997) <http://www.worldbank.org/html/extdr/extme/1324.htm>.

High rates of preventable child mortality worldwide are caused by the combined effects of biological, behavioral, and socioeconomic factors. More than 12 million children under the age of five die needlessly each year from the "diseases of poverty," including immunizable childhood diseases, intestinal infections, malnutrition, unclean water, violence, and lack of primary health care. These child deaths are unconscionable at a time when preventative and curative measures are available and remarkably cost-effective.

The excessive deaths among children under five from preventable causes is not only a global health crisis, it is a human rights violation. Although dramatic improvements in child survival have occurred in the past 50 years, many innocent children are still denied the chance to live to see their fifth birthday. Without their most fundamental human right—the right to survive—no other human rights have meaning.

A respect for the full range of human rights protected under international law will improve child survival and provide a clear mechanism to determine policy and programmatic priorities. In addition to increased child survival, a respect for human rights will improve the health and livelihood of women, decrease fertility rates, and enhance socioeconomic conditions for the entire population.

III. INTERNATIONAL LAW AND CHILD MORTALITY

The global challenge of eliminating preventable under-age-five child mortality requires states to fulfill their international legal obligations to protect and promote the full range of rights necessary for the survival, development and participation of children. These human rights obligations are derived from treaties and customary law.[157] Progress in reducing preventable child mortality requires states parties to treaties to recognize the interdependence of civil, political, economic, social and cultural rights. Achieving the enjoyment of a particular right, such as the right to health, is contingent on the exercise of other rights, such as the right to non-discrimination, the right to life, and the right to an adequate standard of living. International law[158] requires states to ensure all of these rights through the laws, policies and practices of the government. This chapter outlines the international legal obligations of states to protect the human rights of all people within their borders by reducing preventable under-age-five child mortality.

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[157] Customary international law, one of the main sources of international law, results primarily from a general and consistent practice of states followed from a sense of legal obligation. Customary law is not written, but is adhered to out of custom. The custom becomes law by use. Customary law becomes binding on states when enough states comply with a custom as law. A rarely-invoked exception exempts states from a particular obligation if the state openly and persistently objects to the practice prior to formation of the custom. Regional customary law may establish more stringent standards than universal custom. For further discussion of customary law, see The Case of the S.S. Lotus (France v. Turkey), 1927 P.C.I.J. (ser. A) No. 10; 2 Hudson, World Ct. Rep. 20 (1927); and The Paquete Habana, 175 U.S. 677 (1900).

[158] International human rights legal obligations and standards are derived from customary and treaty law. As a multilateral system of binding principles and commitments, international human rights law holds governments responsible for the acts of state organs, officials and, under certain circumstances, private actors. Under limited situations, international human rights law imposes direct responsibility on individuals, as is the case, for example, with proscriptions against certain internationally-recognized crimes such as genocide, slave-trade, or torture. A modern and still-debated approach to the analysis of international human rights norms infers a binding effect on individuals even when the norms are addressed to states. For further discussion of the issue, see ANDREW CLAPHAM, HUMAN RIGHTS IN THE PRIVATE SPHERE 89-149 (1993).

A. Framework for international obligations

1. International instruments protecting child health and survival

Box 3.1. International and regional instruments which protect child health and survival

Universal Declaration of Human Rights (UDHR)	adopted Dec. 10, 1948
International Covenant on Civil & Political Rights (ICCPR)	entered into force March 23, 1976
International Covenant on Economic, Social & Cultural Rights (ICESCR)	entered into force January 3, 1976
Declaration on the Rights of the Child	adopted September 30, 1990
Convention on the Rights of the Child (Children's Convention)	entered into force 1989
Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention)	entered into force September 3, 1981
International Convention on the Elimination of Racial Discrimination (ICERD)	entered into force January 4, 1969
African [Banjul] Charter on Human and People's Rights (African [Banjul] Charter)	entered into force October 21, 1986
African Charter on the Rights & Welfare of the Child (African Children's Charter)	signed 1990; not yet in force
American Declaration of the Rights and Duties of Man (American Declaration)	adopted 1948
American Convention on Human Rights (American Convention)	entered into force July 18, 1978
Additional Protocol to the American Convention (Protocol of San Salvador)	signed 1988; not yet in force
Constitution of the World Health Organization (WHO Constitution)	adopted April 7, 1948

The treaties and instruments listed in Box 3.1[159] include international human rights obligations to protect child health and survival that apply to states such as Mexico, Uganda and/or the United States. Among the listed instruments, this report particularly highlights the relevant provisions of the Universal Declaration of Human Rights (UDHR);[160] the International Covenant on Economic, Social and Cultural Rights (ICESCR);[161] and the Convention on the

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[159] Although Box 3.1. includes many of the international instruments relevant to child survival, it does not present an exhaustive list of all such instruments. The instruments listed are among the most recognized in international human rights law and include regional instruments particularly relevant for the three countries studied in this report.

[160] Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. GAOR, U.N. Doc. A/810 (Dec. 10, 1948) 71 [hereinafter UDHR].

[161] International Covenant on Economic, Social and Cultural Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, *entered into force* Jan. 3, 1976, 38 [hereinafter ICESCR].

Rights of the Child (Children's Convention).[162]

The UDHR, adopted by the United Nations General Assembly in 1948, defines the basic human rights and freedoms to which all individuals are entitled. The UDHR, though not a treaty, provides an authoritative interpretation of the human rights obligations of United Nations members, including Mexico, Uganda and the United States. Together, the UDHR, the ICESCR, the International Covenant on Civil and Political Rights (ICCPR)[163] and its Optional Protocol comprise the International Bill of Human Rights.

The ICESCR is the principal international treaty recognizing and protecting the broad range of economic, social and cultural rights to which all people are entitled. Like its counterpart, the ICCPR, the ICESCR is widely ratified. The ICESCR obligates states to take steps to achieve progressively the full realization of economic, social and cultural rights of all people within their borders, including the right to the highest attainable standard of health.[164] In particular, the ICESCR obligates states to reduce child mortality.

The Children's Convention is the first universal legally binding code of children's rights. The Children's Convention is the most widely ratified human rights treaty in history; only two countries have not ratified the treaty — Somalia and the United States. The Children's Convention comprehensively articulates a range of rights to which children are entitled and basic standards for children's well-being. The treaty includes economic and social rights, such as the rights to health (art. 24); education (art. 28); and civil and political rights, such as a qualified right to freedom of expression (art. 12 (1)).[165]

2. States obligations under international law

Under international law, states that are parties to international and regional treaties are legally obligated to abide by the provisions of these instruments, including those instruments that

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[162] Convention on the Rights of the Child, G.A. Res. 44/25, Annex 44, U.N. GAOR, Supp. No. 49, at 167, U.N. Doc. A/RES/44/49 (Nov. 20, 1989), 28 I.L.M. 1448, *entered into force* Sept. 2, 1990 [hereinafter Children's Convention].

[163] International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), Dec. 16, 1966, 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976, [hereinafter ICCPR].

[164] *See* ICESCR, *supra* note 161, art. 2, 12.

[165] The Children's Convention gives all rights equal emphasis. *See, e.g., Child Rights: Convention on the Rights of the Child* (visited Dec. 5, 1996) <http:/www.unicef.org/crc/conven.htm>. In this respect, the Convention departs significantly from the UN Declaration on the Rights of the Child, the instrument that inspired the drafting of the treaty. The Declaration included primarily economic, social and cultural rights. *See* Cohen, *supra* note 4, at 2-4.

are ratified but not yet in force.[166] Similarly, states that have signed, but not yet ratified, particular instruments express an intent to be bound by their provisions.[167] By identifying specific rights and duties, treaty law directs states parties to take measures that ultimately will reduce child mortality.

The rights articulated in these international human rights instruments include political, civil, economic, social and cultural rights. The UDHR, in its preamble, recognizes that "the highest aspiration of the common people" is the "advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want."[168] International treaties such as the Children's Convention,[169] and regional treaties such as the African Charter on Human and Peoples' Rights (African [Banjul] Charter)[170] also integrate guarantees of civil, political, economic, social and cultural rights. Recently, the World Conference on Human Rights reaffirmed the interdependence of civil, political, economic, social, and cultural rights.[171]

Under these international human rights instruments, states have a duty to take steps to reduce child mortality and ensure access to the basic means of survival. States are also obligated to ensure the enjoyment of the rights associated with child mortality, such as: the right to non-discrimination, the right to survival, the right to health, and the right to an adequate standard of living.[172] Where children die from preventable causes, these obligations include taking measures to prevent such deaths.[173]

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[166] *See* Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, U.S. No. 58, art. 18 (1980), 8 I.L.M. 679 (1969), *entered into force* Jan. 27, 1980.; *The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 122, 131 (1987) [hereinafter *The Limburg Principles*].

[167] *Id.*

[168] UDHR, *supra* note 160, pmbl.

[169] Children's Convention, *supra* note 162.

[170] African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), *entered into force* Oct. 21, 1986 [hereinafter African [Banjul] Charter].

[171] *See, e.g.*, Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, June 14-25, 1993, U.N. Doc. A/CONF.157/23, ¶ 5 (July 12, 1993) [hereinafter Vienna Declaration] ("all human rights are universal, indivisible and interdependent and interrelated").

[172] The health and well-being of children around the world depend on government recognition of and respect for rights such as the right to health and right to an adequate standard of living. Philip Alston, *Conjuring Up New Human Rights. A Proposal for Quality Control*, 78 AM J. INT'L L. 607 (1984). Moreover, enjoyment of all other rights depends upon a child's right to survival.

[173] *See, e.g.*, Cook, *supra* note 7, at 10. As Rebecca Cook observes:

The nature of states' duties to combat child mortality have been differentiated as *obligations of conduct* and *obligations of result*. The former involves taking actions designed to lead to the realization of rights; the latter focuses on the duty to ensure that certain standards are fully achieved.[174] Conduct and results relating to child survival include both *immediate* and *progressive* obligations. Emerging interpretation of these standards views states as having immediate obligations to act in at least three situations:[175] (1) to prevent government action or inaction that would directly violate a right, (2) to ensure non-discrimination in the enjoyment of a right, and (3) to fulfill the minimum core obligations contained in the treaty.[176]

> [T]he claim to human dignity from birth is of special concern where infants face the imminent prospect of death from diseases which can be prevented through provision of inexpensive and cost effective care . . . [. O]bligations binding upon countries under international human rights provisions [requires governments] to perceive the danger to their young populations from preventable causes, and thus to deploy public resources in order to reduce infant mortality rates to an acceptable level as defined by international standards").

Id. at 2.

[174] *See id.* ("In international treaty law, there is a traditional distinction between obligations of means and obligations of ends, that is, between obligations to take specified steps toward aspirational goals and obligations to achieve certain results by any lawful means.").

[175] Under the Limburg Principles, a set of authoritative guidelines drafted by legal experts, a state party may violate the ICESCR if:

- it fails to take a step which the Covenant requires it to take;
- it fails to remove promptly obstacles which it is obligated to remove in order to permit the immediate fulfillment of a right;
- it fails to implement without delay a right which the Covenant requires it to provide immediately;
- it willfully fails to meet a generally accepted international minimum standard of achievement which is within its powers to meet;
- it applies a limitation to a right recognized in the Covenant in a manner not in accordance with the Covenant;
- it deliberately retards or halts the progressive realization of a right, unless it is acting within a limitation permitted by the Covenant, because of a lack of available resources, or due *to force majeure;* or
- it fails to submit reports or to take certain steps as required under the Covenant, fails to remove obstacles to the enjoyment of rights, or if it deliberately slows the "progressive realization" of a right, among other things.

The Limburg Principles, supra note 166, at 131. *Accord Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, MCHR 97-124 (Feb. 12, 1997) [hereinafter *Maastricht Guidelines*]. *See also* Audrey R. Chapman, *A "Violations Approach" for Monitoring the International Covenant on Economic, Social and Cultural Rights*, 18 HUM. RTS. Q. 21, 39 (1996).

[176] The Committee on Economic, Social, and Cultural Rights has maintained that the ICESCR contains minimum core obligations, such as the duty not to deprive "any significant number of individuals" essential primary health care. Committee on Economic, Social and Cultural Rights, General Comment 3: The Nature of States Parties Obligations, *reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/Gen/2/Rev.2 (1996) ¶ 10. The Committee has not specified the particular dimensions of the duty to provide essential primary health care, and no consensus exists among "states or advocates and scholars regarding the scope of the state's responsibility for direct provision of services or resources necessary to ensure a core content of the right to health." Sofia Gruskin & Donna Sullivan, Draft Proposal for the

Progressive obligations, however, require states to "take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of [their] available resources, with a view to achieving progressively the full realization of the rights recognized in [the ICESCR] by all appropriate means, including . . . legislative measures."[177] The term "maximum available resources" has been interpreted to include assistance available from the international community.[178]

Progressive obligations vary according to the social, economic, and developmental circumstances in each country. Although measurements of progress are made with reference to absolute and relative standards,[179] states must work as "expeditiously and effectively" as possible toward the full realization of the rights in the Covenant."[180] At a minimum, "progressive" means that countries should not move backwards or regress in the fulfillment of these rights. The Committee on Economic, Social and Cultural Rights noted that "a minimum core obligation to ensure the satisfaction of, at the very least, *minimum essential levels of each of the rights* is incumbent upon every state party."[181] Specific indicators to measure essential levels or direction of progress, however, have not yet been developed for the rights most relevant to child survival.

Interpretation of the Right to Health in the ICESCR 383 (1996) (unpublished manuscript, on file with Minnesota Advocates for Human Rights). There is, however, general agreement that a state can and should be held accountable for a gross failure to protect the right to health or failure to dedicate available resources to protect the core content of such a right. *Id.* at 385 (referring primarily to women's rights to health). *See also Maastricht Guidelines*, *supra* note 175, ¶¶ 9-10.

[177] ICESCR, *supra* note 161, art. 2(1) (in pertinent part). The Children's Convention contains a similar formulation: "With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation." Children's Convention, *supra* note 162, art. 4 (in pertinent part).

[178] General Comment P I, *reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, Committee on Economic, Social and Cultural Rights, 5th Sess., General Cmt. P I (1990), U.N. Doc. HRI/Gen/1 (Sept. 4, 1992) [hereinafter Compilation of General Comments].

[179] An absolute standard, on the one hand, may involve variables, percentages, or extended time periods to reach certain goals, such as WHO's absolute standard for reducing infant mortality to no more than 50 deaths per 1000 live births by the year 2000. WHO, "HEALTH FOR ALL" SERIES NO. 3, GLOBAL STRATEGY FOR HEALTH FOR ALL BY THE YEAR 2000, at 76 (1981) [hereinafter WHO, "HEALTH FOR ALL" GLOBAL STRATEGY]. Relative standards, on the other hand, compare a country's progress with that of other countries in similar economic and developmental circumstances. The drawback of a relative standard is that it may reflect underfunding or a lack of commitment to health which is common among similarly situated countries. For a detailed discussion of absolute and relative standards, see Cook, *supra* note 7, at 29-31.

[180] *See* General Comment 3, *supra* note 176.

[181] *Id.* at 83.

B. International human rights standards[182]

1. Freedom from discrimination and right to equality

Under international law, states have an immediate obligation to eliminate discrimination and ensure equal enjoyment of rights (civil, political, economic, social and cultural) necessary to child survival. Under specific international and regional treaty provisions, states parties may not discriminate in their attempts to protect the rights to life, health, and other related rights, as discussed in the following subsections, and must ensure the equal enjoyment of treaty rights among all. These standards establish the government's accountability in situations where significant disparities exist within a country among population groups in such measurements as child mortality rates and allocation of health resources.

Discrimination on the basis of race, ethnicity, gender, socioeconomic class, birth, or other grounds negatively affects child survival in many ways.[183] Policies that appear neutral but have a discriminatory impact on a particular class are as harmful as policies which are discriminatory on their face. For example, a health care policy in a developing country that encourages investment in new technologies could result in a disproportionately high percentage of available resources being dedicated to urban hospitals at the expense of the basic health care needs of rural populations. In many countries, disparities in enjoyment of the highest attainable standard of health parallel race, gender, and class divisions. Governments and international monitoring bodies must recognize the discriminatory impact of their policies to achieve equality in access to health care resources.

1.1. General prohibitions against discrimination

The UDHR proclaims that "[e]veryone is entitled to the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."[184] This prohibition of discrimination applies to the UDHR's guarantee of the rights to life and an adequate standard of living, both of which have a direct bearing on child mortality. States parties to the International Covenants guarantee non-discrimination for all in the exercise of treaty

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[182] These legal standards are reflected in, and to some extent informed by, the work of international specialized agencies and the declarations of political commitment accepted by states participating in international conferences. For a summary of international conferences, see Appendix A.

[183] For a discussion of the impact of race, gender and socioeconomic status on child mortality, see *supra* ch. II, pt. A.3.3.

[184] UDHR, *supra* note 160, art 2.

rights, and ensure men and women equality in the enjoyment of treaty rights.[185]

The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)[186] also prohibits discrimination. The ICERD provides that states parties undertake to prohibit and eliminate racial discrimination in the enjoyment of "the right to public health, medical care, social security and social services."[187] Although this obligation is not a substantive undertaking to provide health and other resources, it obligates state parties to assess the extent to which there is equality in access to and enjoyment of health services and to eliminate any disparities.[188]

Regional treaties prohibit discrimination as well. The Charter of the Organization of American States provides that "[a]ll human beings, without distinction as to race, sex, nationality, creed, or social condition, have a right to material well-being and to their spiritual development, under circumstances of liberty, dignity, equality of opportunity, and economic security."[189] The American Declaration on the Rights and Duties of Man (American Declaration)[190] and the American Convention on Human Rights (American Convention).[191] also include prohibitions against discrimination. Similarly, the African [Banjul] Charter recognizes the entitlement of every individual to the enjoyment of Charter rights without distinction "of any

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[185] *See, e.g.*, ICCPR, *supra* note 163, arts. 2-3 (respect and ensure treaty rights to all individuals and their enjoyment equally among men and women); ICESCR, *supra* note 161, arts. 2-3 (undertake to guarantee exercise without discrimination, and to ensure the equal right of men and women to enjoyment of treaty rights).

[186] International Convention on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195, *entered into force* Jan. 4, 1969 [hereinafter ICERD].

[187] *Id.* art. 5(e)(iv).

[188] *Id.* art. 5(e)(iv).

[189] Charter of the Organization of American States, 119 U.N.T.S. 3, art. 44(a), *entered into force* Dec. 13, 1951, *amended* 721 U.N.T.S. 324, *entered into force* Feb. 27, 1970 [hereinafter OAS Charter].

[190] American Declaration of the Rights and Duties of Man, May 2, 1948, Ninth International Conference of American States, *reprinted in* BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM, OEA/Ser.L/V/II.71, 17 (1988) [hereinafter American Declaration].

[191] American Convention on Human Rights, O.A.S. Treaty Series No. 36, 1144 U.N.T.S. 123, art. 4, *entered into force* July 18, 1978), *reprinted in* BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM, OEA/Ser.L/V/II.82, doc. 6, rev. 1, at 25 (1992) [hereinafter American Convention]. *See also* Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"), O.A.S. Treaty Series No. 69 (1988), signed November 17, 1988, *not yet entered into force* [hereinafter San Salvador Protocol], *reprinted in* BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM, OEA/Ser.L.V./II.82, doc.6 rev.1 (1997); Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women ("Convention of Belem do Para") [hereinafter Inter-American Convention on Violence Against Women], *reprinted in* BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM, OEA/Ser.L/I.92, doc. 31, rev. 3, 109 (1996).

kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status."[192]

1.2. Discrimination against children

The ICCPR and the Children's Convention prohibit discrimination against children. Article 24 of the ICCPR provides, "Every child shall have, without any discrimination as to race, colour, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State."[193] States parties to the Children's Convention commit to respect and ensure its provisions to each child in their jurisdiction "without discrimination of any kind, irrespective of the child's or his or her 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."[194]

1.3. Discrimination against women and girl-children

Discrimination against women and girl-children in health care and access to health resources has a significant effect on rates of child survival.[195] Along with the provisions on non-discrimination and equality in the general human rights treaties previously discussed, the Convention on the Elimination of All Forms Against Women (Women's Convention)[196] focuses specifically on women's freedom from discrimination and right to equality, particularly in regard to health protections.

States parties to the Women's Convention "condemn discrimination against women in all its forms, agree to pursue by all appropriate means without delay a policy of eliminating discrimination against women . . . by any person, organization or enterprise[, and] . . . modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women."[197] Article 11(1)(f) obligates states parties to take all appropriate measures to eliminate discrimination against women in the enjoyment of "the right to protection of health . . . in

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[192] African [Banjul] Charter, *supra* note 170, art. 2. *See also* African Charter on the Welfare of the Child, OAU Doc. CAB/Leg/24.9/49 (1990), *not yet entered into force* [hereinafter African Children's Charter].

[193] ICCPR, *supra* note 163, art. 24(1).

[194] Children's Convention, *supra* note 162, art. 2(1).

[195] *See supra* ch. II, pt. A.3.3.

[196] Beyond the non-discrimination guarantees discussed in this subsection, the treaty's positive obligations to secure rights relating to health and family planning are discussed *infra* part B.3.

[197] Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, Supp. No. 46, at 193, U.N. Doc. A/RES/34/180, art. 2 (f), *entered into force* Sept. 3, 1981 [hereinafter Women's Convention].

working conditions."[198] The Women's Convention also obligates states parties to take appropriate measures to eliminate discrimination against women "in the field of health care in order to ensure on a basis of equality of men and women, access to health care services, including those related to family planning."[199] States parties violate these provisions when they arbitrarily prioritize issues related to men's health over those related to women's health.

The Women's Convention also specifically protects the health rights of rural women, and recognizes that access to health care is particularly difficult for rural women.[200] In addition to specifically prohibiting discrimination against rural women in the provision of health services, Article 14 (2) obligates States Parties to ensure that women in rural areas enjoy the right "to have access to health care facilities, including information, counseling and services in family planning."[201]

In addition to health resources, discrimination against women and girl-children in education also affects rates of child survival. For example, maternal illiteracy is a significant indicator of preventable child mortality.[202] In an effort to address disparate literacy rates between women and men and other educational inequities, the Women's Convention prohibits gender discrimination in education. The Convention states:

> States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: . . . (h) access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.[203]

Violence against women and girl-children is also a form of discrimination that negatively

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[198] *Id.* art. 11, l(l)(f). The Convention obligates states parties to use legislative and other appropriate measures to achieve full realization of the rights recognized in the treaty. *See* Cook, *supra* note 7.

[199] Women's Convention, *supra* note 197, art. 12.

[200] *Id.* at 193. The Convention prohibits discrimination against women in all realms of life including *inter alia* political participation, health, nationality, education, family life, and employment.

[201] *Id.* art. 14 (2)(b). The affirmative duty to ensure access to family planning services in Article 14 is undertaken together with a general obligation to take all appropriate measures to eliminate discrimination against women in access to family planning services in Article 12(1). For a discussion of international supervision relating to reproductive health care, see *Appendix B.*

[202] *See supra* notes 69-70 and accompanying text (discussing links between women's education and child mortality).

[203] Women's Convention, *supra* note 197, art. 10; 10(h).

impacts maternal health and mortality as well as child mortality.[204] Violence against women occurs in many forms, including traditional practices that harm women and girls such as genital mutilation, domestic violence, female infanticide, abortion of female fetuses, rape and sexual assault, dowry-related violence, sexual harassment, child and adolescent sex abuse, prostitution and trafficking in women.[205] The Women's Convention obligates states parties to "take all appropriate measures to eliminate discrimination against women by any person, or organization or enterprise."[206] States parties are responsible both for their actions in violating the human rights of their citizens and for their inaction in the face of systematic abuses of human rights regardless of whether the perpetrators of the abuse are private individuals or public officials. International and regional inter-governmental organizations have recognized the right to live free of gender-based violence as a fundamental human right and have developed specific standards for the protection of this right.[207]

As an act of political commitment, the Vienna Declaration and Programme of Action characterized the human rights of women and girl-children as "an inalienable, integral, and indivisible part of universal human rights."[208] In addition, the Platform for Action of the Fourth World Conference on Women (Beijing Platform) reflects the international consensus that violence against women is a human rights abuse that must be eradicated.[209] Additionally, the Beijing Platform outlines the human rights of girl children, noting that "[e]xisting discrimination against the girl child in her access to nutrition and physical and mental health services endangers her current and future health."[210]

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[204] *See* Declaration on Violence against Women, G.A. res. 48/104, GAOR Supp. (No. 49) at 217, U.N. Doc. A/48/49 (1993); Inter-American Convention on Violence Against Women, *supra* note 191.

[205] *See supra* ch. II, parts. A.3.2 & A.3.3.

[206] *See* Declaration on Violence against Women, *supra* note 204.

[207] *See, e.g.*, Declaration on Violence against Women, *supra* note 204; Inter-American Convention on Violence Against Women, *supra* note 191. The Women's Convention does not specifically address violence against women; however, the treaty's monitoring body, the Committee on the Elimination of Discrimination Against Women (CEDAW), has issued a General Recommendation explaining that violence against women is a form of gender discrimination that "seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men." General Recommendation No. 19, U.N. Doc. A/47/38 (1992).

[208] Vienna Declaration, *supra* note 171, ¶ 18.

[209] "Violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms . . . ." Platform for Action *in* Report of the Fourth World Conference on Women, Beijing (Sept. 4-15, 1995), U.N.Doc. A/Conf.177/20 (1995) [hereinafter Beijing Platform].

[210] *Id.* § L, ¶ 266. According to the Platform, "[a]n estimated 450 million adult women in developing countries are stunted as a result of childhood protein-energy malnutrition." *Id.*

2. Inherent right to life

Preventable child mortality directly violates the inherent right to life recognized in international and regional human rights treaty law and, in certain aspects, in international customary law.[211] States parties to the widely-ratified International Covenant on Civil and Political Rights (ICCPR) agree that "[e]very human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."[212] This provision protects against state actions such as extrajudicial executions.[213] It also creates an affirmative obligation for states to ensure that people within their borders are not denied the right to life because of the lack of basic needs such as food and health care.[214] The Human Rights Committee, which monitors implementation of the ICCPR, has specifically interpreted the provision to include an obligation to reduce child mortality.[215]

The Children's Convention reaffirms the inherent right of every child to life, and articulates a corollary obligation of states parties to "ensure to the maximum extent possible the survival and development of the child."[216] Read together with the treaty's obligations to meet

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[211] The corollary freedom from arbitrary deprivation of one's life is recognized as a preemptory norm of customary international law. *See, e.g.*, RESTATEMENT (THIRD) OF FOREIGN RELATIONS § 703, *in* IAN BROWNLIE, PRINCIPLES OF PUBLIC INTERNATIONAL LAW.

[212] ICCPR, *supra* note 163, art. 6(1). The ICCPR has been widely ratified; as of 1997, 135 countries are parties to the ICCPR.

[213] The Covenant's drafting history reveals that drafters considered a number of exceptions to the right to life, all of which dealt with legally justifiable killing by the state or a state official. *See* MANFRED NOWAK.

[214] *See, e.g.*, F. Menghistu, *The Satisfaction of Survival Requirements*, *in* THE RIGHT TO LIFE IN INTERNATIONAL LAW 63 (B.G. Ramcharan ed., 1985).

[215] The Committee stated:

> [T]he right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States Parties *to take all possible measures to reduce infant mortality and to increase life expectancy*, especially in adopting measures to eliminate malnutrition and epidemics.

Human Rights Committee, General Comment 6(16)d, *reprinted in Report of the Human Rights Committee to the Thirty-Seventh Session of the General Assembly*, U.N. Doc. A137/40, at 93 (interpreting art. 6) (emphasis added).

[216] Children's Convention, *supra* note 162, art. 6(2). The *travaux preparatoires* of the Children's Convention reveal that the majority of delegations, like the Human Rights Committee, agreed with a broad interpretation of the right to life. The Chairman-Rapporteur of the 1988 Working Group summed up the session by stating that "the approach to the right to life in the . . . Convention should be positive and should take into account economic, social and cultural conditions."

children's basic needs and basic rights,[217] the obligation to ensure survival of the child can be interpreted to require steps to ensure that children do not die unnecessarily from preventable causes such as poor sanitation or lack of immunization.[218]

Regional instruments also recognize the inherent right to life and the right of children to survive. The American Declaration proclaims the right to life,[219] and the American Convention requires that States Parties respect every individual's right to life.[220] In addition, Article 19 of the American Convention provides that "[e]very minor child has the right to the measures of protection required by his condition as a minor on the part of his family, society, and the state."[221] The African [Banjul] Charter protects the right to life.[222] The African Charter on the Rights and Welfare of the Child (African Children's Charter) also protects every child's inherent right to life, and contains a provision explicitly protecting, "to the maximum extent possible, the survival, protection, and development of the child."[223]

3. Right to the highest attainable standard of health

The right to the highest attainable standard of physical and mental health is guaranteed under various international and regional treaties. States are obligated to take steps to promote health and minimize avoidable death to the maximum extent possible.

The ICESCR provides for the "right of everyone to the enjoyment of the highest

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[217] *See, e.g., id.*, arts. 4, 6, 24, 25, 27.

[218] The phrase "to the maximum extent possible" raises issues of interpretation discussed *supra* notes 174-81 and accompanying text. Scholars interpret this phrase as an obligation to prevent avoidable child mortality. *See, e.g.*, Cook, *supra* note 7, at 1 ("[A]doption of governmental policies which address . . . dangers facing infants can enable the healthy survival of many more infants. Governmental neglect to pursue such policies violates infants' human rights.").

[219] American Declaration, *supra* note 190, art. I.

[220] Article 4 of the American Convention states: "Every person has the right to have his [or her] life respected. . . . No one shall be arbitrarily deprived of his [or her] life." American Convention, *supra* note 191, art. 4.

[221] *Id.* art 19.

[222] The African [Banjul] Charter states that "[h]uman beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right." African [Banjul] Charter, *supra* note 170, art. 4. This provision is similar to the right to life in the ICCPR, which the Human Rights Committee has interpreted to include an obligation to reduce child mortality. *See supra* text accompanying note 171. If, like the Human Rights Committee, one interprets the right to life broadly, parties to the African [Banjul] Charter must take steps to preserve life and reduce high child mortality rates.

[223] African Children's Charter, *supra* note 192, art. 5.

attainable standard of physical and mental health."[224] Parties to the ICESCR agree to take specific steps "for the full realization" of the right to health, including "provision for the *reduction of . . . infant mortality* and for the *healthy development of the child.*"[225] In addition, states parties to the ICESCR agree to take steps necessary for the "improvement of all aspects of environmental and industrial hygiene," and the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[226]

3.1. Children's health

Several treaties make explicit references to infant and child mortality in the context of the right to enjoyment of the highest attainable standard of health. In addition, there may be "a rule of customary international law . . . protecting a child's right to health, or embodying a 'best interests of the child' principle."[227] States parties to the Children's Convention "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."[228] States parties commit to striving "to ensure that no child is deprived of his or her rights of access to such health care services," and to pursuing "full implementation of this right and, in particular, [taking] appropriate measures . . . *[t]o diminish infant and child mortality.*"[229]

Regional human rights instruments contain either explicit or implicit references to the child in guaranteeing the means to enjoyment of the highest health standard possible. In the Americas, the American Declaration proclaims the right to the preservation of health "through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources."[230] Article 26 of the American Convention incorporates the economic, social, educational, scientific, and cultural standards of the OAS Charter,[231] a reference which has been interpreted to include relevant provisions of the Protocol

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[224] ICESCR, *supra* note 161, art. 12(1).

[225] *Id.* art. 12(2)(a) (in pertinent part) (emphasis added).

[226] *Id.* art. 12(b), (c)-(d) (in pertinent part).

[227] Fox & Young, *supra* note 7, at n.117.

[228] Children's Convention, *supra* note 162, art. 24(1) (in pertinent part).

[229] *Id.* art. 24(1), 24 (2)(a) (in pertinent part) (emphasis added).

[230] American Declaration, *supra* note 190, art. XI.

[231] American Convention, *supra* note 191, art. 26.

of Buenos Aires which amended the OAS Charter.[232] Although not yet in force, the Additional Protocol to the American Convention on Human Rights (the Protocol of San Salvador)[233] protects the right to health and requires states parties to adopt measures to ensure the exercise of the right to health.[234]

In the African region, both the African [Banjul] Charter and the African Children's Charter recognize that every individual and every child shall have the right to the "best attainable state of physical and mental health."[235] In addition to the individual's right to health, Article 16 of the African [Banjul] Charter contains an affirmative obligation under which parties agree to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[236] The African Children's Charter recognizes the right of every child to enjoy the "best attainable state of physical, mental and spiritual health."[237] Under

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[232] Protocol of Buenos Aires, *entered into force* 1970. *See also* Thomas Buergenthal, *International Human Rights Law and Institutions, in* THE RIGHT TO HEALTH IN THE AMERICAS: A COMPARATIVE CONSTITUTIONAL STUDY (Pan American Health Organization Scientific Publication No. 509, Hernan L. Fuenzalida-Puelma & Susan Scholle Connor eds., 1989).

[233] Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, "Protocol of San Salvador," O.A.S. Treaty Series No. 69 (1988), signed November 17, 1988, *reprinted in* BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM, OEA/Ser.L.V./II.82, doc.6 rev.1 (1997). The Additional Protocol to the American Convention on Human Rights Protocol (Protocol of San Salvador) will enter into force when eleven countries ratify it. To date, five countries, including Mexico, have ratified the Protocol of San Salvador. Although it is not yet legally binding, the Protocol of San Salvador demonstrates a commitment on the part of states that have ratified it to one day be bound by the Protocol's obligations. *Id.* States, including Mexico, that have ratified the Protocol have shown a commitment to its principles and a willingness to legally abide by them. Although a treaty is not yet in force, the Vienna Convention on the Law of Treaties obligates states that have signed, ratified, or acceded to the treaty to refrain from acts which would defeat the object and purpose of the treaty prior to its entering into force. Vienna Convention on the Law of Treaties, *supra* note 166.

[234] The Protocol of San Salvador provides that "[e]veryone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being." Protocol of San Salvador, *supra* note 191, art. 10.

[235] African [Banjul] Charter, *supra* note 170, art. 14.

[236] *Id.* art. 16(2). Under Article 16(2), governments have a responsibility to reduce child mortality through measures that are necessary to protect the health of the people. Additionally, Article 27 of the African [Banjul] Charter states that "[e]very individual shall have duties towards his family and society, the State and other legally recognized communities and the international community." This provision, however, should be interpreted consistently with the state's obligation to ensure children's access to and enjoyment of basic health services. *Cf.* Makau Wa Mutua, *The Banjul Charter and the African Cultural Fingerprint: An Evaluation of the Language of Duties*, 35 VA. J. INT'L L. 339 (1995) (arguing that duties in African [Banjul] Charter may provide impediments to realization of rights).

[237] For a more detailed discussion of the African Children's Charter, see Bankole Thompson, *Africa's Charter on Children's Rights: A Nonnative Break with Cultural Traditionalism*, 41 INT'L & COMP. L. Q. 432 (1992).

that Charter, parties specifically undertake to "*reduce infant and child mortality rates.*"[238]

3.2. Maternal health

International human rights instruments specifically address maternal health. The ICESCR provides that mothers should be provided "special protection" for a "reasonable period before and after childbirth."[239] This special protection includes paid leave from work or leave with adequate social security benefits.[240]

The Women's Convention requires states to ensure that women receive appropriate services in connection with "pregnancy, confinement and the post-natal period."[241] States must also ensure that women receive adequate nutrition during pregnancy and lactation; to ensure that all women receive these services, states must provide these services free of charge when necessary.[242] The Women's Convention also protects a woman's right to health and safety in working conditions, including the "safeguarding of the function of reproduction."[243] States must take measures "to provide special protection to women during pregnancy in types of work proved to be harmful to them."[244]

All of these rights to maternal health are reaffirmed in the Beijing Platform.[245] The Beijing Platform directs governments to strengthen health care services, particularly primary health care, to ensure universal access to health care, and to reduce maternal morbidity and mortality rates.[246] It also directs governments to enact legislation and develop special policies and programs to eliminate environmental and occupational health hazards with "attention to pregnant and lactating women."[247]

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[238] African Children's Charter, *supra* note 192, art. 14 (2)(a) (emphasis added).

[239] ICESCR, *supra* note 161, art. 10(2).

[240] *Id.*

[241] Women's Convention, *supra* note 198, art. 12(2).

[242] *Id.*

[243] *Id.* art. 11(1)(f).

[244] *Id.* art. 11(2)(d)

[245] Beijing Platform, *supra* note 209, ¶¶ 96, 98.

[246] *Id.* ¶ 107(I).

[247] *Id.* ¶107(p).

3.3. Measures to promote the right to health

International law identifies specific steps for governments to take in promoting health, including measures which ultimately have been shown to reduce child mortality.[248] Article 24 of the Children's Convention obligates states to take the following steps, all of which have been shown to reduce avoidable 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 prenatal and postnatal 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.[249]

Similarly, Article 14(2) of the African Children's Charter requires states parties to take measures:

> (b) to ensure the provision of necessary medical assistance and health care to all children with an emphasis on the development of primary health care;
> (c) to ensure the provision of adequate nutrition and safe drinking water;
> (d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;
> (e) to ensure appropriate health care for expectant and nursing mothers;[250]

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[248] For a discussion of linkages between child mortality and the various measures, see *supra* ch. II, pt. B.1.

[249] Children's Convention, *supra* note 162, art. 24 (in pertinent part).

[250] Although this provision attempts to include women's health care as a priority for the reduction of child mortality, it does so only to the extent that women are "expectant mothers." It fails to take into consideration the adverse impact that poor health among women generally can have on child mortality. The number of children orphaned as a result of high HIV/AIDS prevalence among women is one example.

(f) to develop preventive health care and family life education and provision of service;
(g) to integrate basic health service programs in national development plans;
(h) to ensure that all sectors of the society, in particular, parents, children, community leaders and community workers are informed and 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 domestic and other accidents;
(i) to ensure the meaningful participation of nongovernmental organizations, local communities and the beneficiary population in the planning and management of a basic service program for children;
(j) to support through technical and financial means, the mobilization of local community resources in the development of primary health care for children.[251]

The Protocol of San Salvador also enumerates the steps that states parties must take to ensure the exercise of the right to health, including: universal primary health care, universal access, universal immunization, prevention and treatment of disease, education related to health, and satisfaction of the health needs of the neediest populations.[252]

4. Rights enabling child survival involving an adequate standard of living, education, and the family

The rights to life and the highest attainable standard of health are integrally connected with independent rights that enable the realization of health and survival. Those rights include, but are not limited to, the right to an adequate standard of living, the right to education, and the right to preservation of the family. This section summarizes these rights and corresponding obligations.

4.1. Adequate standard of living

High child mortality rates occur in situations of insufficient food, clothing, shelter, medical care, and social insurance.[253] The Universal Declaration of Human Rights proclaims that

> [e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.[254]

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[251] African [Banjul] Charter, *supra* note 170, art. 14(2).

[252] Protocol of San Salvador, *supra* note 191, art. 10.

[253] *See supra* ch. II, pt. A.3 (discussing biological, behavioral, and structural factors).

[254] UDHR, *supra* note 160, art. 25.

Similarly, the ICESCR provides that "States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions."[255] Regional standards similarly recognize the right to an adequate standard of living, including the social insurance necessary to preserve that right.[256]

4.2. Right to education

The right to education is fundamental to the achievement of the right to the highest attainable standard of health and, ultimately, child survival.[257] The Universal Declaration of Human Rights recognizes that "[e]veryone has the right to education" and that "[e]ducation shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory."[258] States parties to the ICESCR recognize the universal right to education,[259] and the Human Rights Committee has emphasized the interdependence of education with enjoyment of the civil and political rights guaranteed in the ICCPR.[260] The Women's Convention obligates states parties to ensure "equal access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."[261] The European Social Charter, the American Declaration, American Convention, Protocol of San Salvador, and the African Charter on Human and People's Rights all recognize the human right to education.[262]

The right to education is associated with literacy, pre-natal and child care, and education about human rights. The Children's Convention specifically provides that states parties "shall

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[255] ICESCR, *supra* note 161, art. 11.

[256] *See, e.g.*, DAVID HARRIS, THE EUROPEAN SOCIAL CHARTER 281-83 (1984); American Declaration, *supra* note 190; American Convention, *supra* note 191, art. 26; African [Banjul] Charter, *supra* note 170; African Children's Charter, *supra* note 192.

[257] *See supra* notes 69-70 and accompanying text (discussing the linkage between education, literacy, and child mortality).

[258] UDHR, *supra* note 160, art. 26(1) (in pertinent part).

[259] ICESCR, *supra* note 161, art. 13. The ICESCR notes that education is critical for strengthening "the respect for human rights and fundamental freedoms." *Id.*

[260] General Comments, *supra* note 215.

[261] *See* Women's Convention, *supra* note 197, art. 10(h).

[262] *See, e.g.*, EUROPEAN SOCIAL CHARTER, *supra* note 256; American Declaration, *supra* note 190, art. XIII ("every person has the right to an education that will . . . raise his standard of living"); American Convention, *supra* note 191, art. 26; Protocol of San Salvador, *supra* note 191, art. 13; African [Banjul] Charter, *supra* note 170, art. 17. *See also* discussion of Protocol of Buenos Aires, *supra* notes 230-34 and accompanying text.

take appropriate measures . . . 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 . . ."[263]

4.3. Rights associated with the family

Violations of rights associated with the family also contribute to preventable child mortality.[264] The Universal Declaration of Human Rights recognizes that "[m]otherhood and childhood are entitled to special care and assistance."[265] The ICCPR and the ICESCR protect various rights associated with family, "the natural and fundamental group unit of society"; the ICESCR specifically recognizes the vulnerability of the family in its efforts to provide for children.[266] Likewise, the Children's Convention specifically states that governments shall make every effort to keep families intact,[267] and shall provide support and assistance to parents in fulfilling their primary responsibilities with regard to the upbringing and development of their children.[268]

The American Declaration, American Convention, and Protocol of San Salvador, all provide protection for rights associated with the family.[269] The African [Banjul] Charter

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[263] Children's Convention, *supra* note 162, art. 24(2)(e).

[264] *See supra* ch. II, pt. A.3.2.

[265] UDHR, *supra* note 160, art. 25(2) (in part).

[266] Article 23 of the ICCPR states that "[t]he family is the natural and fundamental group unit of society and is entitled to protection by society and the State." ICCPR, *supra* note 163, art. 23. Article 10 of the ICESCR obligates States Parties to recognize that:

> 1. The widest possible protection and assistance should be accorded to the family . . . particularly for its establishment and while it is responsible for the care and education of dependent children.
> 2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. . . .
> 3. Special measures of protection and assistance should be taken on behalf of all children. . . . Children . . . should be protected from economic and social exploitation. . . .

ICESCR, *supra* note 161, art. 10.

[267] Children's Convention, *supra* note 162, art. 9, 10.

[268] Children's Convention, *supra* note 162, art. 18(2)

[269] American Declaration, *supra* note 190; American Convention, *supra* note 191, art. 17 ("The family is the natural and fundamental group unit of society and is entitled to protection by society and the state."); Protocol of San Salvador, *supra* note 191, art. 15(1). In addition to the basic family protections in the ICCPR and the American Convention, the Protocol of San Salvador provides more substantial protection of the "right to formation and the protection of families." Article 15(2) provides:

specifically protects the physical and moral health of the family by providing that "[the family] shall be protected by the State which shall take care of its physical and moral health."[270] The African Charter on the Rights and Welfare of the Child also addresses protections associated with the family.[271]

C. International supervision of state compliance on rights affecting child survival

International and regional entities supervise states compliance with international standards and obligations. When states ratify international human rights treaties, they agree to give effect to treaty obligations in their legal systems.[272] This effect may take the form of legislative enactments or the repeal of inconsistent laws, collection and analysis of relevant data, and design and implementation of policies and programs as well as other administrative acts. Although international law generally leaves to the discretion of states parties the means by which treaty law will be made effective in domestic legal systems,[273] some states have opted to incorporate international treaty obligations directly into domestic law.[274] To monitor the effect given treaty obligations by states, treaty bodies,[275] international and regional agencies, funds, and

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The States Parties hereby undertake to accord adequate protection to the family unit and in particular:
(a) To provide special care and assistance to mothers during a reasonable period before and after childbirth;
(b) To guarantee adequate nutrition for children at the nursing stage and during school attendance years;
(c) To adopt special measures for the protection of adolescents in order to ensure the full development of their physical, intellectual and moral capacities.

[270] African [Banjul] Charter, *supra* note 170, art. 18. Article 18 also states:

2. The State shall have the duty to assist the family which is the custodian of morals and traditional values recognized by the community.
3. The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

[271] African Children's Charter, *supra* note 192, art. 18.

[272] *See* Cook, *supra* note 7, at 146.

[273] In the case of the ICESCR, for example, the treaty does not require direct incorporation into domestic law, but rather requires only that parties fulfill their treaty obligations. *See, e.g.*, Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties Obligations Under the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 156, 166 (1987); Oscar Schachter, *The Obligation to Implement the Covenant in Domestic Law*, *in* THE INTERNATIONAL BILL OF RIGHTS 314 (L. Henkin ed., 1981).

[274] Portugal, for example, has incorporated the Covenant through its Constitution. *See* Schachter, *supra* note 273.

[275] Treaty bodies are committees of experts that supervise states parties' compliance with treaty obligations. Relevant treaty bodies include the Committee on Economic, Social and Cultural Rights (CESCR), the Human Rights Committee (HRC), the Committee on the Rights of the Child (CRC), the Committee on the Elimination of

other organizations monitor states' progress and provide various forms of assistance.[276]

One primary method for monitoring is the reporting process under which states parties are obligated to submit periodic reports on compliance and obstacles to compliance to treaty monitoring bodies. In an effort to enhance the reporting process, treaty bodies have issued reporting guidelines.[277] Under the reporting system, treaty monitoring bodies hear the reports of states parties but often do not have the time or resources to verify the accuracy of the reports.[278] Reports are often late or superficial, and many discuss only the successes and strengths of government implementation.[279] States' reports vary widely in the extent to which they provide detailed, disaggregated data on health. NGOs may provide the treaty bodies with information that supplements or contradicts the governmental report.[280] The committees also question representatives from the reporting government to get a more accurate picture of a country's compliance with the treaty in a process intended to be a non-confrontational, constructive dialogue that reveals successes and obstacles in implementing the treaty.

To assist states in implementing treaty obligations and encourage effective reporting, treaty bodies and other organizations provide guidelines and other measures. The following are examples of reporting guidelines and monitoring mechanisms for the ICESCR and Children's Convention, international treaties particularly important to child health and survival rights.

All Forms of Discrimination Against Women (CEDAW), and the Committee on the Elimination of All Forms of Racial Discrimination (CERD).

[276] For a summary of international agencies, institutions, and organizations particularly relevant to monitoring and assisting child health and survival, *see* Appendix A.

[277] *See* UNITED NATIONS CENTRE FOR HUMAN RIGHTS AND UNITED NATIONS INSTITUTE FOR TRAINING AND RESEARCH, MANUAL ON HUMAN RIGHTS REPORTING, U.N. Doc. HR/Pub.91/1 (1991).

[278] Members of the CESCR, for example, are not paid for their work for the Committee, but receive travel reimbursement, *per diem*, and one U.N. Secretariat staff member to assist them. *See* Audrey R. Chapman, *Monitoring Women's Right to Health Under the International Covenant on Economic, Social, and Cultural Rights*, 44 AM. U. L. REV. 1157, 1160 (1995).

[279] The 134 States Parties to the ICESCR had a total of 115 overdue reports to the CESCR. *See* Status of the International Human Rights Instruments and the General Situation of Overdue Reports, U.N. Doc. HRI/MC/1996/3, July 24, 1996.

[280] Much more so than other treaty bodies, the Committee on Economic, Social and Cultural Rights (CESCR) and the Committee on the Rights of the Child (CRC) receive and welcome information from NGOs. The CESCR invites NGOs to participate in the reporting process. Because NGOs have traditionally focused on civil and political rights, however, the CESCR has had more difficulty in garnering information from NGOs on economic, social and cultural rights issues. For a discussion of effective monitoring, *see* Chapman, *supra* note 175.

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1. International Covenant on Economic, Social, and Cultural Rights (ICESCR)

The Committee on Economic, Social and Cultural Rights (CESCR) monitors obligations under the ICESCR. In addressing health, CESCR's reporting guidelines recommend that states parties provide information on "the physical and mental health of the population, both in the aggregate and with respect to different groups within [the] society; the existence of a national health policy; and the percentages of the GNP as well as national and regional budgets that are spent on health care."[281] In addition, the CESCR guidelines request that states parties provide information on the following World Health Organization's indicators:

> (a) Infant mortality (. . . by sex, urban/rural division, and ... if possible, by socioeconomic or ethnic group);
> (b) Population access to safe water (. . . disaggregate[d by] urban/rural);
> (c) Population access to adequate excretion disposal facilities (. . . disaggregate[d by] urban/rural);
> (d) Infants immunized against [major diseases] (disaggregated by sex and urban/rural);
> (e) Life expectancy (disaggregate[d by] urban/rural, by socio-economic group and by sex);
> (f) Proportion of the population having access to trained personnel for the treatment of common diseases and injuries, with regular supply of 20 essential drugs, within one hour's walk or travel;
> (g) Proportion of pregnant women having access to trained personnel during pregnancy and proportion attended by such personnel for delivery, . . . including maternity mortality rate, both before and after childbirth;
> (h) Proportion of infants having access to trained personnel for care.[282]

2. Convention on the Rights of the Child (Children's Convention)

Obligations under the Children's Convention are supervised by the Committee on the Rights of the Child (CRC). The CRC, like the CESCR, provides General Guidelines and is authorized to issue general comments for the effective implementation of the Children's Convention.[283] The CRC has yet to issue any general comments related to specific rights within

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[281] Committee on Economic, Social and Cultural Rights, *Guidelines Regarding the Form and Content of Periodic Reports from States Parties*, U.N. Doc. E/C.12/1991/1 (1991) [hereinafter *Reporting Guidelines*]. *See also* Chapman, *supra* note 278, at 1167.

[282] The drafters of the ICESCR intended the Covenant to contain general obligations to be further elaborated by competent specialized obligations. "The covenant . . . had been drafted so as to contain, in the main, general statements of obligations, on the understanding that it would in general be for the competent specialized agencies to elaborate the detailed obligations required for the realization of the rights . . . ." *Reporting Guidelines*, *supra* note 282 (citing Annotations on the Text of the Draft International Covenants on Human Rights, 10 U.N. GAOR, Annexes (Agenda Item 28, pt. II) 8, U.N. Doc. A/2929 (1955)).

[283] *See* Committee on the Rights of the Child, *Guidelines Regarding the Form and Contents of Initial Reports From States Parties*, U.N.Doc. CRC/C/5 (1991).

the Children's Convention; the CRC does, however, provide recommendations to countries based on reports submitted.[284]

UNICEF has also monitored certain standards under the Children's Convention. Like the "progressive realization" standard of the ICESCR, the Children's Convention obligates states parties to "undertake such measures to the maximum extent of their available resources."[285] Since 1993, UNICEF has addressed this standard in its publication *The Progress of Nations*.[286] The standard includes a measurement called the National Performance Gap (NPG), which UNICEF considers "as one measure of the extent to which positive child rights are being honored in relation to available resources."[287] The NPG is a relative standard that uses three indicators (the percentage of children adequately nourished, the percentage being educated to at least grade 5, and the percentage surviving to age five) and compares these to the per capita GNP, which is a reflection of the country's "available resources."[288] Through this process, UNICEF is able to compare what a country should be accomplishing in light of available resources with what it is actually accomplishing.[289]

Although this standard represents a significant advancement in the process of monitoring parties' compliance with the Children's Convention, UNICEF envisions replacing the relative

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[284] *See generally* LAWRENCE J. LEBLANC, THE CONVENTION ON THE RIGHTS OF THE CHILD: UNITED NATIONS LAWMAKING ON HUMAN RIGHTS (1995).

[285] Children's Convention, *supra* note 162, art. 4. According to this standard, one commentator has observed that "countries that are too poor to meet the Convention's standards for such rights as health and education will not be deemed in violation of the Convention if they can show that they are making a good faith effort to comply." Cohen, *supra* note 7, at 33.

[286] UNICEF, *The Progress of Nations 1996* (visited Feb. 13, 1997) <http:/www.unicef.org/pon96/conpg.htm>.

[287] *Id.*

[288] *Id.*

[289] According to UNICEF,

> [i]t should be stressed that the National Performance Gap roughly records how well a country is doing in relation to the average country with the same level of economic resources. This is not quite the same as fulfilling positive rights "to the maximum extent of available resources." To evaluate this, it would be better to measure performance not against the average but against the best that has been achieved at each economic level (though even this may not represent the best that is achievable). This stricter criterion has some attraction, but it has the disadvantage of assessing countries against a standard that may reflect exceptional conditions or very different geographical and historical circumstances and may therefore not be widely accepted.

Partha Dasgpta, *Commentary: National Performance Gaps, in* UNICEF, *The Progress of Nations 1996*, *supra* note 286.

standard with an absolute standard in the future. According to UNICEF, the long-term goal of the international community must be to move toward "a time when positive rights, like negative rights, can also be regarded as absolute and inviolable."[290] To this end, UNICEF argues that even the most destitute countries can fulfill positive rights given the improvements in modern knowledge and technology.[291]

The rights, duties, and measures provided by international and regional instruments and organizations outline the obligations of states to eliminate preventable child mortality. These obligations are further discussed in the following case studies of three countries: Uganda (Chapter IV), Mexico (Chapter V), and the United States (Chapter VI). These case studies examine the child mortality conditions in each country, consider the progress of each country in ensuring child survival, identify problems in access to and adequacy of health and other basic services, and recommend methods to improve the chances of survival for children in each country.

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[290] UNICEF, *The Progress of Nation 1996, supra* note 286.

[291] According to UNICEF, Sub-Saharan Africa illustrates the notion that poor countries can satisfy positive rights obligations with a relatively small shift or outlay of resources. *Id.* In 1985, government expenditures on basic needs in that region equaled less than 3 percent of GNP. *Id.* The World Bank estimated that a human resource development strategy designed to meet basic needs would require approximately 5.5 percent of GNP. *Id.* Based on these statistics, "[t]he necessary increase is therefore very small, and looks particularly affordable when we bear in mind that military expenditure at that time was running at approximately 4.2 percent of GNP." *Id.* UNICEF concluded that it is possible "to provide basic protection for the normal physical and mental development of all children at a cost that all nations can afford." *Id.*

IV. CASE STUDY: UGANDA

A. Findings and recommendations

1. Findings

- Uganda's under-five child mortality rate of 147 deaths per 1000 births is among the world's highest. Ugandan children still die from largely preventable diseases. Malaria is the leading killer, responsible for one in five child deaths. More than a quarter of all under-five deaths are attributable to measles, diarrheal diseases and respiratory infections. AIDS is now the fifth leading cause of death for children under age five. The AIDS epidemic continues to have an adverse impact not just on the children directly, but also on the family and community, as reflected in the rising numbers of AIDS orphans.

- The health and well-being of Ugandan children is harmed by the ethnic and regional tensions, the ongoing insurgency, and the legacy of social and economic disruption from decades of armed conflict, civil strife, and displacement. Uganda remains one of the world's poorest countries.

- Child survival in Uganda remains under-funded, while the debt burden, defense spending, and an unwritten commitment to low-impact, tertiary health care supersede basic child survival strategies.

- The low social status and high rate of illiteracy of women in Uganda undermine the health of children as well as women. Mortality and morbidity indicators demonstrate dramatically higher risk for rural children and women.

- The health and social service systems that implement Uganda's law are in transition during the ongoing process of decentralization. The Local Governments Act passed in 1997 devolves authority for providing medical and health services to the local district councils, subject to minimum, centrally-set health standards. Control of most resources has not yet devolved to the district level. Poor rural districts in particular lack the resources to carry out their new responsibilities. Current cost-sharing programs for the health sector have proven to be ineffective sources of revenue, and have made health services even more inaccessible to the very poor.

- Uganda's domestic law places a priority on child welfare. The 1995 Constitution recognizes and protects the right to life, but contains no explicit guarantee of the right to health and health protection in terms of health services, safe water, and the care of children. The enforcement provisions of the Constitution do not apply to the right to health. The Children's Statute of 1996 specifies the rights of children, and places shared responsibility for ensuring those rights on the nation, parents, extended families, and local authorities.

- While Ugandan law generally appears to address Uganda's international obligations (with the exception of the anachronistic Public Health Act), in practice the country faces the enormous challenge of marshaling adequate human and financial resources to implement the guarantees provided by the law.

2. Recommendations

- Comply with all human rights obligations under treaties and instruments to which Uganda is a party.

- Promote and protect children's rights, in particular those related to child health and survival, through adequate programs and funding.

- Continue legislative efforts as well as target social spending to promote the rights and status of women. Government funds should support the implementation of a massive women's literacy campaign.

- Repeal or update provisions of the Public Health Law that are inconsistent with the Local Governments Act. Increase the resources available to the Ministry of Health, Local Councils and District Health Offices to guarantee the implementation of reasonable minimum health standards regardless of the wealth of the various districts. The cost sharing programs for the health sector should be re-examined and modified to ensure accessibility to the poor.

- Observe the Alma-Ata principles of primary health care by ensuring equity, universality, community participation, and intersectoral collaboration in health policies and programs. All segments of the population must be enabled to define and guide their own well-being. Adopt a cohesive strategy for child survival that promotes long-term investments and solutions, and de-emphasizes short-term measures.

- Provide funds to support high-impact primary health care strategies as a national priority, including the required human capacity resources outlined in the Uganda National Plan of Action for Children reform program. Funds made available from the current IMF and World Bank debt relief initiative provide an excellent opportunity to invest in the Uganda National Plan of Action for Children primary health care package. Use debt relief funds effectively and sustainably to increase child survival. After the impact of debt relief on child survival has been demonstrated, more IMF and World Bank debt should be forgiven.

- Target rural communities in the provision of health and social service funds.

B. Child mortality in Uganda

Uganda has one of the highest under-five child mortality rates in the world. One in seven Ugandan children dies before reaching his or her fifth birthday. Children in rural areas of the country are particularly disadvantaged and most vulnerable to early death and disability. According to government statistics, at present the overall mortality rate for children under five years old is 147 deaths per 1000 live births; in the rural northern region of the country, child mortality is as high as 190 deaths per 1000 live births. It must be noted, however, that the government's rate varies substantially from the 1996 UNICEF rate, estimated at 187 deaths per 1000 live births.[292]

Today, Uganda's children still die largely from preventable diseases.[293] Malaria is the leading killer, responsible for one in five child deaths. More than a quarter of all under-five deaths are attributable to measles, diarrheal diseases, and respiratory infections. Further, the AIDS epidemic has profoundly impacted child survival in the country, as reflected in the mounting numbers of pediatric AIDS cases as well as significant numbers of infants and children orphaned by this epidemic. AIDS is now the fifth leading cause of death for children under age five. As discussed in this chapter, adequate health care services do not reach many of the most vulnerable.[294]

1. Child mortality in relation to level of national development

Uganda is one of the poorest and most heavily indebted countries in the world, as reflected in the distressing social indicators (see Box 4.1). This dire socioeconomic situation has impeded any real progress in child survival. Today, Uganda has an under-five child mortality

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[292] UGANDA STAT. DEP'T, MINISTRY OF FINANCE & ECON. PLAN. & MACRO INT'L INC., DEMOGRAPHIC AND HEALTH SURVEY 1995, UGANDA (1995) [hereinafter UDHS 1995]. The mortality data used for this chapter is derived primarily from the 1995 Ugandan Demographic and Health Survey (UDHS), which was conducted in all of the districts of the country except Kitgum District in the north. Child mortality data from this survey are officially recognized by the government of Uganda. The 1995 UDHS shows a 29 percent decline in child mortality over the last 15 years. UNICEF's country office in Uganda has questioned this reported decline in child mortality since important health indicators such as immunization coverage, malnutrition incidence, and access to clean water have not shown a corresponding improvement over the same period. Data from the World Bank also suggest that even though the Ugandan economy has been growing since 1986, there has not been a corresponding improvement in child health and survival. *See* WORLD BANK, UGANDA: SOCIAL SECTORS--A WORLD BANK COUNTRY STUDY (1993) [hereinafter WORLD BAN K, UGANDA: SOCIAL SECTORS].

[293] Memorandum from UNICEF, Uganda Country Office of Kampala, to Karen Kun, Research Assistant, Minnesota Advocates for Human Rights (Apr. 30, 1996) (on file with Minnesota Advocates for Human Rights).

[294] *See infra* part C.2.

rate that is "almost double the average for low income countries."[295] At 147 deaths per 1000 live births, this rate is one of the world's worst.[296] While infant mortality rates in many other developing countries have demonstrated a long-term decline, the mortality rate among Ugandan infants is 70 percent higher than the average for low income countries.[297]

Box 4.1. Selected social indicators affecting child survival in Uganda, 1990-95	
Adequate access to health services	49%
Rural	42%
Urban	99%
Within 15 minutes of safe water supply	11%
Chronic malnutrition among under-five children	39%
Maternal mortality rate	600-1200 deaths /100,000 births
Adult illiteracy level	50%
Among rural women	80%
Population living in poverty	61%

Sources: UDHS 1995; UNICEF, STATE OF THE WORLD'S CHILDREN 1996.

2. Disparities in reducing child mortality

2.1. Rural children

Children in rural areas face a greater risk of dying before reaching their fifth birthday than do urban children. Comparing the rural and urban areas, the mortality rate is 159 deaths per 1000 live births in the rural areas, in contrast to 134 in the urban areas. Of all children born in rural Uganda, one in six dies before reaching age five, compared to one in seven of those born in urban areas. Ninety percent of Ugandans live in the rural areas.[298]

2.2. Northern region children

Disaggregated by regions, differentials in mortality are also prominent (see Figure 4.1). The northern region has the highest child mortality rate, at 190 deaths per 1000 live births, while the western region has the lowest at 131. Whereas the northern and central regions of Uganda

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[295] Oxfam Int'l, *Debt Relief and Poverty Reduction: New Hope for Uganda*, Sept. 1996 (visited Feb. 1997), <http://www.oneworld.org/oxfam/police/papers/uganda.htm>, at 7 [hereinafter Oxfam, *Debt Relief*].

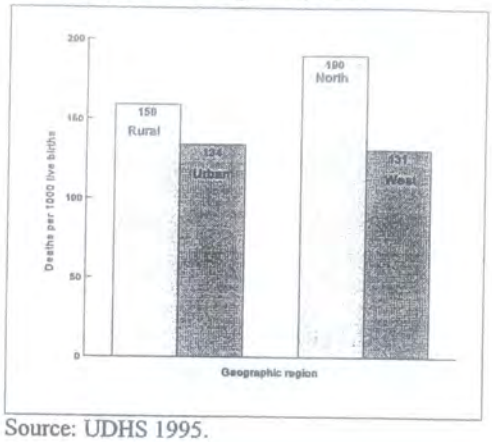
[296] Uganda's child mortality rate ranks the 20th worst in the world based on UNICEF data. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1.

[297] WORLD BANK, UGANDA: SOCIAL SECTORS, *supra* note 292.

[298] UDHS 1995, *supra* note 292.

have been severely marred by civil strife, the western region is the only area that has not been affected to any significant degree. Consequently, the health infrastructure in the western region has remained largely intact. This situation may have contributed to the lowest rates of child mortality within the country.[299]

Figure 4.1. Regional disparities in child mortality rates in Uganda, 1991



Source: UDHS 1995.

2.3. Children born to poorly-educated or illiterate mothers

In Uganda, children born to mothers who had no education or literacy suffer the highest mortality rates. Educating mothers up to the primary level reduces the overall child mortality rate by 20 percent.[300] For women with a secondary level education, the child mortality rates are reduced by nearly half.[301] According to UNICEF, in 1995 only half of all women in Uganda could read or write, and only half of primary-school aged girls were enrolled in schools. The substantial level of illiteracy among women and girls points to a high vulnerability in the socioeconomic status of women and, consequently, in the survival of their offspring.[302]

2.4. Children of mothers who received no prenatal or delivery care

Among Ugandan mothers who received both prenatal and delivery care, infant mortality was 64 deaths per 1000 live births, in contrast to 119 deaths per 1000 live births for mothers who

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[299] *Id.*

[300] *Id.*

[301] *Id.*

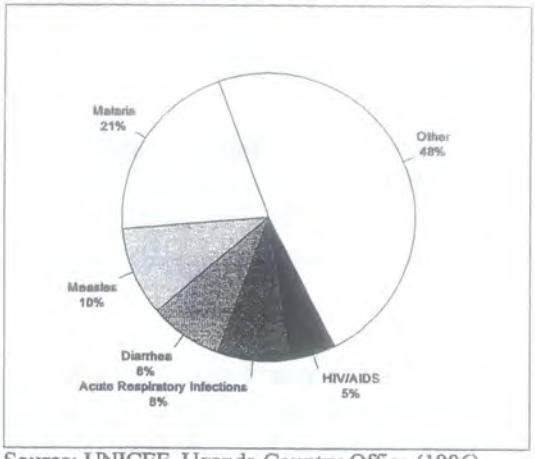
[302] *See* discussion *infra* part B.4.

received no care—a difference of almost 50 percent.[303] These statistics demonstrate that a woman's access to health care during pregnancy and delivery is crucial to child survival.

3. Preventable diseases as cause of most child mortality

Preventable diseases cause the vast majority of under-five child deaths in Uganda (see Figure 4.2). The leading causes of death for Uganda's children under the age of five are: malaria (21 percent of all under-five child deaths); measles (10 percent); diarrhea (8 percent); respiratory infections (8 percent); and AIDS (5 percent).[304]

Figure 4.2. Leading causes of death in Ugandan children under age five, 1996



Source: UNICEF, Uganda Country Office (1996).

3.1. Malaria

Malaria, endemic in Uganda, is the leading killer of children under age five. One in five child deaths is caused by this parasitic disease. Malaria poses one of the greatest public health threats in the country today. A 1989 study found that 44 percent of Ugandan children under five had suffered from malaria during the two week period under observation; this was one of the highest prevalence levels among the nations surveyed.[305] A more recent national survey reports a malaria infection rate of 46 percent.[306] The overall rate of malarial infection and death remains

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[303] UDHS 1995, *supra* note 292.

[304] Memorandum, UNICEF Uganda Country Office, *supra* note 293.

[305] UGANDA MINISTRY OF HEALTH & THE INSTITUTE FOR RESOURCE DEV./MACRO SYSTEMS, INC., DEMOGRAPHIC AND HEALTH 1988/1989 (Oct. 1989) [hereinafter UDHS 1989]; CENTER FOR INT'L HEALTH INFO. (CIHI), COUNTRY HEALTH PROFILE SERIES, UGANDA: COUNTRY HEALTH PROFILE (1995).

[306] UDHS 1995, *supra* note 292.

basically unchanged. In addition to being a direct killer of children, malaria in pregnant women contributes to other risk factors that result in maternal and/or child mortality, including maternal anemia, premature delivery, and low birth weight among infants.[307]

3.2. Measles

Measles is the second leading cause of child mortality in Uganda, accounting for 10 percent of all under-five child deaths. Measles is one of the deadliest diseases plaguing young children in the developing world as it often is accompanied by dehydration and malnutrition. WHO estimates that 4 percent of all measles cases worldwide are fatal. However, the impact of non-fatal cases is also profound, including blindness, malnutrition, and post-measles pneumonia—a primary cause of measles-associated mortality in developing countries.[308]

3.3. Fatal diarrheal diseases

Dehydration due to severe diarrhea ranks third among the leading killers of Ugandan children. Diarrhea is also linked inextricably with the dehydration that contributes to death from malaria, measles, and other infectious diseases. Diarrheal diseases are both preventable and treatable, yet 8 percent of all deaths among children under age five are caused by diarrhea and dehydration.

A simple and effective response to a child's dehydration is a prompt increase in fluid intake, i.e., oral rehydration therapy (ORT)—providing either a solution made by mixing a commercially produced packet of oral rehydration salts (ORS) with water, or a recommended home-made cereal-based solution. ORS packets are distributed through hospitals, health centers, and pharmacies in Uganda.[309] Unfortunately, less than half of mothers used either ORT or home mix to treat their child's diarrhea. According to a recent study, only 13 percent of mothers and 74 percent of health care providers appeared to mix the oral rehydration solution correctly.[310]

3.4. Respiratory infections

Pneumonia, a serious and potentially fatal lower respiratory infection, is the fourth

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[307] CIHI (1995), *supra* note 305.

[308] *Id.*

[309] During the site visit to Uganda, April 3-15, 1997 [hereinafter Site Visit to Uganda], MAHR representatives conducted interviews with government representatives at national and district levels, officials from the World Bank, UNICEF, and other international and local government and nongovernment organizations.

[310] Joseph Konde-Lule, Samuel Elasu, & David L. Musoge, *Knowledge, Attitudes, and Practices and Their Policy Implications in Childhood Diarrhea in Uganda*, 10 J. DIARRHEAL DISEASE RES. 25-30 (1992).

leading cause of death for children under the age of five in Uganda.[311] The four-week prevalence of acute respiratory infections is nearly 22 percent for children under five.[312] Urban and rural children are equally affected.

Acute bacterial respiratory infections (ARI) can be treated with antibiotics that are available at some of the Ugandan health centers. The capacity to diagnose and treat Ugandan children who have acute respiratory infections is limited by several factors: 1) parents' lack of information about the symptoms of lower respiratory infections, resulting in delay of treatment; 2) lack of access to health services; 3) health centers' lack of access to antibiotics; and 4) improper diagnoses of children's ailments—such as confusion between malaria and ARI, which may result in improper or delayed treatment.[313]

3.5. AIDS

AIDS is now the fifth leading killer of children under the age of five in Uganda. AIDS has become a central feature of social, economic and political life in Uganda today. It is now estimated that almost 1.5 million Ugandans have contracted HIV.[314] About one quarter of all Ugandans infected with HIV are women of child-bearing age. Mother-to-child transmission is estimated to be 25 to 50 percent, with 25 to 40 percent of infected infants dying before their first birthday.[315] The most recent Ministry of Health reports suggest that since 1993 there has been a decline in HIV prevalence among urban pregnant women. This is one of the first hopeful signs in Uganda's experience with AIDS to date.[316] Nonetheless, projection scenarios developed by epidemiologists to estimate the effects of AIDS on future demographics indicate that AIDS will negatively impact Uganda's child mortality rates over the next decade.[317]

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[311] Memorandum, UNICEF Uganda Country Office, *supra* note 293.

[312] CIHI (1995), *supra* note 305.

[313] Interview with INGO representative, Site Visit to Uganda, *supra* note 309.

[314] Elizabeth Marum, HIV/AIDS and Its Impact on Infant Mortality Rate (Nov. 27, 1996) (unpublished manuscript, on file with USAID, Kampala).

[315] In the cities of Kampala and Mbarara, nearly one third of all pregnant women have tested positive for HIV. CIHI (1995), *supra* note 305. Research conducted at Mulago Hospital in Kampala has documented that HIV infection in mothers has a dual influence on infant and child mortality. Healthy infants, who themselves become HIV-infected, have a much higher infant and early childhood mortality rate than the national average. Even those infants who are not infected through vertical transmission, however, have a one-third higher infant and under-five mortality rate than infants born to HIV-negative mothers. This data supports the concern that maternal mortality from AIDS is another risk factor for infant and young child mortality. *See* Marum, *supra* note 314.

[316] Marum, *supra* note 314.

[317] Preble, *supra* note 43; WORLD BANK, UGANDA: SOCIAL SECTORS, *supra* note 292.

The impact of the AIDS epidemic is also reflected in the numbers of children orphaned by the disease. The Ministry of Health projects that by the year 1998, Uganda will have one million children orphaned by AIDS. Information about the lives and conditions of these children remains lacking.[318] It is estimated that one out of eight Ugandan children under the age of 19 has lost one or both parents as a result of AIDS. AIDS orphans now make up about 6 percent of the population of each of the most AIDS-devastated southern districts of Masaka, Rakai, and Kalangala.

3.6. Malnutrition, dehydration, and infectious diseases

In Uganda, malnutrition is pervasive—four of ten Ugandan children suffer from chronic malnutrition (see Figure 4.3).[319] Malnutrition can be a direct cause of child death, but most commonly it is considered a contributing factor. Malnutrition, combined with dehydration, leaves a child more vulnerable to contracting an infectious disease and less capable of recovery. Many infectious diseases contribute to malnutrition as they suppress appetite and reduce food intake. The role of malnutrition in child mortality—including inadequate intake of protein and energy as well as micronutrient deficiencies—is typically underestimated.[320]

In Uganda, as elsewhere, the primary cause of childhood malnutrition is the family's lack of access to proper nutritious foods.[321] International aid agencies have developed comprehensive

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[318] Sana Loue, Janet McGrath, & Gilbert Bukenya, *Children and AIDS in Uganda, available in* Earthwatch Homepage, Health & Nutrition Library. *See also* CIHI, *Executive Summary: Country Health Profile on Uganda* (visited Feb. 1995), <gaia.info.usaid.gov:70/00/regional_country/africa/uganda.txt> [hereinafter CIHI, *Country Health--Uganda*].

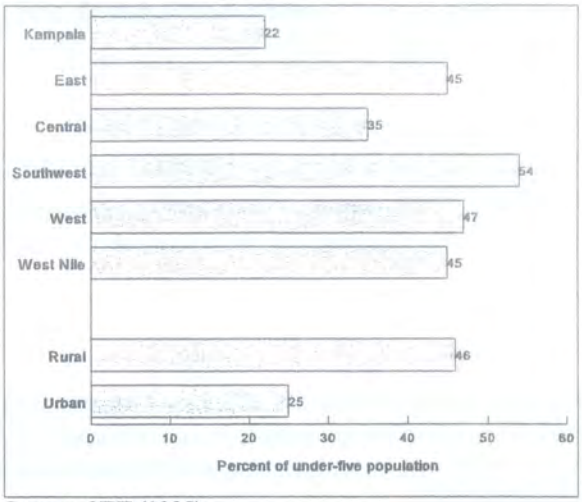
[319] UDHS 1995, *supra* note 292. Although Uganda's children manifest a fairly low prevalence of short-term malnutrition as evidenced by wasting (i.e., low weight for a given height), there is a much higher prevalence of chronic malnutrition evidenced by stunting (i.e., low height for a given age). Although only 5 percent of children exhibit wasting, 39 percent are under-height for their given age; this is one of highest rates of stunting in Africa. Stunting is twice as frequent among rural children as among urban children, and is highest in the northwest and southwest regions. Factors that lead to stunted growth include low birth weight, poor weaning practices, and inadequate food consumption. UGANDA NAT'L COUNCIL FOR CHILDREN (UGANDA NCC), EQUITY AND VULNERABILITY: A SITUATION ANALYSIS OF WOMEN, ADOLESCENTS AND CHILDREN IN UGANDA (Oct. 1994).

[320] CIHI (1995), *supra* note 305.

[321] Millard, *supra* note 29; Cheryl Robertson, Evaluation of the Primary Health Care Worker Program at Kasangati Health Centre, Kasangati, Uganda (1988) (unpublished master's thesis, University of Minnesota School of Public Health); WORLD BANK, UGANDA: SOCIAL SECTORS, *supra* note 292. Over 55 percent of Ugandan households consume less than 80 percent of the recommended daily number of calories. UGANDA MINISTRY OF FIN. & ECON. PLAN., UGANDA NATIONAL PROGRAMME OF ACTION FOR CHILDREN: PRIORITIES FOR SOCIAL SERVICES SECTOR DEVELOPMENT IN THE 1990S AND IMPLEMENTATION PLAN 1992/93-94/95 (Sept. 1992) [hereinafter UNPAC (Sept. 1992)]. The malnutrition of pregnant women is thought to be the primary cause for low birth weight in 20 percent of newborns; low birth weight is a primary factor leading to future growth stunting. CIHI (1995), *supra* note 305; WORLD BANK, UGANDA: SOCIAL SECTORS, *supra* note 292. Heavy workloads often force women to

education programs for mothers to learn about balanced diets and proper weaning practices, but these programs often fail to meet their objectives because the education deficit is only a small part of the problem. Programs to improve food security, in addition to programs in nutrition education, the development of model gardens, the increased availability of cooking charcoal, and the monitoring of each child's growth can contribute to the alleviation of childhood malnutrition.

Figure 4.3. Regional comparisons of chronic malnutrition among Ugandan children, 1988/1989



Source: CIHI (1995).

4. Need to address behavioral and socioeconomic determinants of child mortality

Preventable diseases and malnutrition, the primary killers of children in Uganda, are exacerbated by behavioral and socioeconomic determinants. These determinants include maternal health factors, the low status of women, violence against women, poverty at the household and national levels, the erosion of health infrastructures, and the lack of food security, all of which are affected by civil instability, the debt burden, and resource availability and allocation.

4.1. Maternal factors

As discussed in Chapter II, high maternal mortality contributes to infant deaths. Uganda has one of the world's highest rates of maternal mortality, estimated at 600 to 1200 deaths per

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decrease breast-feeding and wean their infants before the recommended one year period in order to sustain heavy workloads. Even when there is adequate caloric intake, protein-deficiency malnutrition results from the inadequacies of the typical Ugandan weaning diet which centers on low-protein foods such as bananas and potatoes. *Id.*

100,000 live births.[322] Maternal mortality, an enormous problem for reproductive age women, is positively correlated with infant mortality. Poor access to prenatal, delivery, and postpartum care—particularly in the rural areas—means that only about 26 percent of women deliver babies in health institutions with the assistance of trained personnel; another 23 percent of women are cared for by traditional birth attendants in their communities. The remaining 51 percent give birth at home, often without any specialized assistance, and often in an unhygienic environment.[323] The majority of births in Uganda are risky, leading to high numbers of maternal and child deaths. Improving access to reproductive health and family planning services for reproductive age women can improve survival of both mothers and their children.[324]

Maternal education is highly correlated with child mortality.[325] The majority of Ugandan women are illiterate.[326] In the rural areas, where child mortality is highest, 80 percent of women were found to be illiterate.[327] Increased levels of education have also been linked to delaying the initiation of sex and decreasing the rates of teen pregnancy, HIV/AIDS and STDs.[328]

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[322] UDHS 1995, *supra* note 292; UNICEF, WORLD'S CHILDREN 1996, *supra* note 1. The main causes of maternal deaths are hemorrhage, infection, pre-eclampsia and eclampsia, obstructed labor, and abortions. These risks are compounded by the effects of malaria, anemia, and pregnancies at either end of the reproductive age limits. UNPAC (Sept. 1992), *supra* note 321.

[323] UNPAC (Sept. 1992), *supra* note 321.

[324] Comprehensive family planning services also can reduce fertility rates and increase birth intervals. Large family size with short intervals between births is linked to higher maternal and infant mortality rates. *See supra* text accompanying notes 74-76. Short birth intervals reduce markedly a child's chance of survival. Ugandan children born less than two years after a preceding sibling are about twice as likely to die in infancy and under the age of five as those born two to three years after. One in five births occurs less than 24 months after the previous birth. High-order births (i.e., the mother had previously given birth to three or more children) further exacerbate the risk of a Ugandan child dying before age one or five. In Uganda today, high-order births account for almost half of all births, and the total fertility rate of 7 remains extremely high. UDHS 1995, *supra* note 292.

[325] *See generally* Mammo, *supra* note 35; WORLD BANK, UGANDA: SOCIAL SECTORS, *supra* note 292.

[326] UDHS 1995, *supra* note 292. The educational system of Uganda, once the best in east and central Africa, was devastated during the civil instability and war of the past 25 years. The proportion of children in the total population has nearly quadrupled in 40 years. Uganda has more children and a much lower proportion of trained teachers than in the past, resulting in an increased strain on human and financial resources. In 1987, the National Resistance Movement government established the Educational Policy Review Commission to make recommendations for education rehabilitation, including universal primary education and gender equity in education. Despite some gains, the solutions are not keeping pace with the problem. "There are still inequities in access to education: between boys and girls; between rural and urban children; between the economically able and the poor; and between the able-bodied and the disabled." UGANDA NCC (Oct. 1994), *supra* note 319, at 84.

[327] UNPAC (Sept. 1992), *supra* note 321.

[328] Interview with INGO representative, Site Visit to Uganda, *supra* note 309.

Pervasive illiteracy makes it difficult to improve knowledge and skills among women concerning hygiene, family planning, and primary health care. Similar to women in other nations, Ugandan women are primarily responsible for both reproductive and productive work within the household; they bear many children and work long hours each day. Without education they lack channels for obtaining clear and appropriate health information. Many lack the time, knowledge, and skills to care adequately for themselves and their children.[329]

The multiple factors contributing to poor education levels among women and girls in the country relate largely to issues of resources and attitudes: access to financial resources by local schools and households, and household and societal attitudes toward the value of educating girl children. Household income determines a family's ability to pay for schooling, which is a primary reason that young women drop out of both primary and secondary school.[330] Parents are often more eager to allocate scarce resources to educate a boy child. Girls are often required to help with domestic chores and, because they often marry at an early age, their education is not seen as a valuable investment.[331] Finally, the quality and quantity of available education is poor. Rural schools have minimal resources, and urban schools are severely overcrowded.[332]

4.2. High fertility

Uganda's total fertility rate of 7.1 (children born per woman) is among the world's highest. Large family size, with short intervals between births, is linked to higher infant and maternal mortality rates.[333] In fact, the infant mortality rate for children born less than two years apart is more than twice as high as it is for children born four or more years apart.[334] Larger families are also more likely to have problems with increased work loads for women, poor child care, and more malnutrition in the children.

Addressing the problems associated with high fertility often comes into conflict with the deeply held value placed on children in Uganda. Women are esteemed for their reproductive capacities. Therefore, infertility is usually regarded, especially by men, as a greater problem than excess fertility. The negative attitudes of men towards family planning is a major obstacle to reducing fertility. About 84 percent of women have a favorable attitude to family planning, but

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[329] UGANDA NCC (Oct. 1994), *supra* note 319.

[330] UDHS 1995, *supra* note 292.

[331] UNPAC (Sept. 1992), *supra* note 321.

[332] *Id.* For discussion of the Ugandan government's programs to target education, see *infra* pt. C.2.

[333] UGANDA NCC (Oct. 1994), *supra* note 319.

[334] UDHS 1989, *supra* note 305; UDHS 1995, *supra* note 292.

over 40 percent of husbands disapprove of family planning.[335] Another major constraint to higher use of family planning is the poor accessibility to such services. Very few health units provide family planning services. In rural areas, services are often provided by health workers without training in family planning.[336]

4.3. Low status of women

Common beliefs and behaviors that directly affect the well-being of Ugandan women and their children are deeply rooted in culture, and therefore are very resistant to change. Many efforts to improve the status of women, for example, through education, land ownership, and access to credit, directly conflict with tradition. The traditional gender role for women is narrow and confining.[337] Within the home, women are expected to be obedient to men and responsible for all the domestic work. The father is the patriarchal head with power, authority, and control, especially in economic matters. The mother is responsible for all the daily domestic needs, including food and water, in addition to agricultural work. To meet all of these expectations, a Ugandan woman's workload averages 15 to 18 hours a day.[338]

During the annual dry season, the Banyankole men take the cattle to find food and water, leaving the women and children with no food or money, often for months at a time. The women described times when they believed they or their children might die from hunger. When asked if a man would sell a cow to pay for health care for his wife or child, the women looked surprised. They stated that such a circumstance would be quite rare. The women clearly recognized that their situation was not good, but they saw no alternatives to their circumstance.[339]

Frequently, women's freedoms of association and movement are controlled by husbands or fathers. Restricted to domestic work, women are prevented from participating in community or political activities, women's groups, and income-generating activities. In cases where a woman has to get permission from the husband before taking a child to the clinic, it can even interfere with the health of their children.[340]

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[335] UDHS 1989, *supra* note 305.

[336] UGANDA NCC (Oct. 1994), *supra* note 319.

[337] The family into which a girl is born sees her as a "visitor" who will grow up to belong to another clan. In marriage, because she has been "paid for" with the bride price, a woman is often viewed as a possession of the man or a property of the clan, but not as a clan member. UGANDA NCC (Oct. 1994), *supra* note 319.

[338] Site Visit to Uganda, *supra* note 309.

[339] Site Visit to Uganda, focus group of Banyankole women, *supra* note 309.

[340] UGANDA NCC (Oct. 1994), *supra* note 319.

4.4. Violence against women and children

The United Nations, in the Declaration on the Elimination of Violence Against Women, recognizes domestic violence as "a manifestation of historically unequal power relationships between men and women" and condemns the violence as one of the "crucial social mechanisms by which women are forced into a subordinate position compared with men."[341] Violence has a profound effect on women's lives in Uganda. Infertility in couples tends to be blamed on the women, often leading to stigmatization and mistreatment by their husbands.[342] Ugandan newspapers report stories of husbands beating their wives for enrolling daughters rather than sons in school.[343] Other reports describe incidents where women were beaten for immunizing their children and murdered by their husbands for voting for a particular candidate. Many women fear that efforts to increase women's freedoms enrage the men and make them more violent.[344]

Domestic assault, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation, and other harmful traditional practices, all limit women's abilities to make choices about their lives.[345] During a focus group in Ntuusi, the women identified domestic violence as one of their primary problems. They also described their feeling of helplessness to stop the abuse. They believed that most women in their community either have been beaten or are at risk of being beaten.[346]

Divorce often leads to economic deprivation for women and children. A divorced woman is not only deprived of material property, but she also loses access to land for cultivation. Moreover, a former husband's family may demand repayment of the bride wealth, even if the man is asking for the divorce. Many women stay in abusive marriages because they are likely to lose their children if they divorce. The husband or his family may insist that they are entitled to keep the children, especially if the bride price has been paid. Even if the woman could take the children, it is unlikely that she could independently support herself and her children. In addition to the economic stress, a single woman with children is often stigmatized.[347]

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[341] Declaration on Violence against Women, *supra* note 204.

[342] UGANDA NCC (Oct. 1994), *supra* note 319.

[343] Interview with INGO representative, Site Visit to Uganda, *supra* note 309.

[344] PROOF IN PRINT: DOMESTIC VIOLENCE IN THE NEWS (Feb. 1997) (Isis-WICCE, Kampala, Uganda).

[345] Sofia Quintero Romero, *Abortion: Magnitude, Management and Prevention*, 2 AFR. WOMAN & HEALTH 26-28 (Nov./Dec. 1995).

[346] Site Visit to Uganda, *supra* note 309.

[347] UGANDA NCC (Oct. 1994), *supra* note 319.

In Uganda, visible and vocal groups are working for increased women's rights and change in women's roles. Advocates for cultural modification and those for the status quo are debating in many arenas, including the National Resistance Council (Parliament), the courts, the schools, and the home.[348]

4.5. Poverty

According to the government's own analysis, in Uganda, poverty claims the life of one child every four minutes.[349] Scarcity of resources is a key factor which limits the survival, protection, and development of many Ugandan children. Poverty is the underlying cause of the specific health care problems for most of Uganda's children in at least three ways. First, a lack of resources at the household level limits access to health care, clean water and education.[350] Second, health care service in much of the country is inadequate, and even then, basic physical access to those inadequate services is difficult or even impossible in many circumstances. Third, there is a lack of demand for health care services due to traditional knowledge, attitudes, and practices that are perceived as sufficient.[351] In a November 1996 report, the Ugandan Ministry of Finance and Economic Planning noted, "Poverty remains deep and widespread because past programmes have concentrated on improving the macro-economy and not targeted the poor. The social indicators remain among the worst in the world."[352]

Despite Uganda's World Bank status as a "model" developing country, more than 61 percent of Ugandans live in abject poverty—between eleven and thirteen million people have incomes below the levels needed to afford adequate nutrition, shelter, health, and other basic needs.[353] The constraints of poverty fuel a vicious cycle: households are unable to fully

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[348] *Id.*

[349] UNPAC (Sept. 1992), *supra* note 321.

[350] Lack of household resources precludes access to nutritious food, health care, clean water, sanitation, and education—all of which are both symptoms and causes of poverty and vulnerability. For example, over three quarters of Ugandan women have not completed primary education, implying that the minimum household income is not sufficient to secure access to basic education. Gender bias also significantly influences household expenditures. UNPAC (Sept. 1992), *supra* note 321.

[351] UNPAC (Sept. 1992), *supra* note 321.

[352] UGANDA MINISTRY OF FIN. & ECON. PLAN., UGANDA NATIONAL PROGRAMME OF ACTION FOR CHILDREN: PRIORITIES FOR SOCIAL SERVICES SECTOR DEVELOPMENT IN THE 1990S AND IMPLEMENTATION PLAN 1995/96-1997/98 (Nov. 1992) [hereinafter UNPAC (Nov. 1992)].

[353] HUMAN DEVELOPMENT REPORT, *supra* note 13. About 20 percent are "core poor" and have incomes of less than half the basic level. In the poorest rural areas, such as in the northern region, more than one third of the population is in the "core poor" category. Millions live just above this poverty line, vulnerable to hunger in the event of a poor harvest or illness. Malnutrition increases in the pre-harvest period, when food supplies and income reserves are low, but the work intensifies. Probably as many as three quarters of Uganda's households fall below the

participate in the continued development of the economy; national revenue is therefore unable to adequately fund social services; and, without social services, the undereducated and weakened population is not able to promote national development.[354]

Even though Uganda is experiencing increased stability and prosperity, poverty remains pervasive. Uganda is still one of the poorest countries in the world, with a per capita GNP of $240.[355] The steady but unbalanced economic growth has had minimal impact on the daily lives of the majority of Ugandans. Impoverished families live outside the cash economy and barely manage to survive in normal times. Any misfortune, such as a major illness or a poor harvest, can have a devastating effect on these families. There is no safety net. Poor families often cannot even afford "free" health care; the cost of transportation to the health center, let alone the cost of medicine, is simply too high. Yet, under the cost recovery program,[356] impoverished Ugandans are assuming an increasing burden of the costs for primary health and education; households typically finance about half the costs.[357] Implications for the health and survival of impoverished children are apparent.

Uganda's general mortality and morbidity indicators suggest that income data underestimate the extent and impact of poverty. The high incidence of child stunting reflects the cumulative effects of chronic malnutrition and chronic lack of household resources. Women and girl children are especially prone to malnutrition and micro-nutrient deficiencies, reflecting gender biases toward resource allocations at the household level.

4.6. External debt and structural adjustment

World leaders and policy analysts have praised Uganda for achieving peace, stability, and increased prosperity since the end of the civil war in 1986 which brought the National Resistance Movement (NRM) government into power.[358] In an effort to rebuild the economy and attract foreign investors, the NRM government embraced the structural adjustment programs of the

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poverty line for the three pre-harvest months. Oxfam, *Debt Relief*, *supra* note 295.

[354] UNPAC (Sept. 1992), *supra* note 321.

[355] UNICEF, PROGRESS OF NATIONS 1997, *supra* note 139, at 66.

[356] *See* discussion *infra* pt. C.2.4.

[357] Oxfam, *Debt Relief*, *supra* note 295.

[358] *See generally* Voluntary Services Overseas (VSO), *Uganda Rising from the Ashes* (visited July 24, 1995), <www.oneworld.org/vso/orbit59/overview.html>. *See also* Bill Berkeley, *An African Success Story?*, ATLANTIC MONTHLY, Sept. 1994, at 22-30; IMF, *Uganda--Debt Issues*, Sept. 24, 1996 (visited Feb. 13, 1997), <http://www.imf.org/external/np/exr/facts/uganda.htm>.

World Bank and the IMF.[359] Over the last eleven years, Uganda has developed a strong record of compliance with structural adjustment programs.[360]

The government's Economic Policy Package of Reconstruction and Development sought to rehabilitate the economy with a combination of demand management and supply stimulation measures.[361] This economic recovery program has contributed to a remarkable recovery in the national economy; economic growth has been strong and steady, domestic savings and investment have risen, and inflation has fallen.[362] However, this growth is unbalanced and has benefitted few Ugandans.[363] Despite the recent gains, Uganda remains one of the world's most indebted countries, with total foreign debt at $3.5 billion.[364] The debt service, as a percent of exports of goods and services, had increased from 3 percent in 1970 to 115 percent in 1993,[365]

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[359] Godber Wilson Tumushabe, An Analysis of the Impact of Structural Adjustment Programmes on the Health of Under-Five Ugandans (March 1997) (unpublished manuscript, on file with Minnesota Advocates for Human Rights and Makerere University, Kampala, Uganda). The NRM government, which assumed power amidst economic chaos in 1986, initially undertook a national strategy to rebuild the economy into an independent, integrated, and self sustaining system. This strategy entailed integrating agriculture and industry more systematically, diversifying production in both sectors, expanding import substitution, establishing basic industries, and building an independent research and technological development capacity. YOWERI MUSEVENI, SELECTED ARTICLES ON THE UGANDA RESISTANCE WAR (1985). However, by mid-1987, the government had agreed to a new economic policy package with the IMF and World Bank, as its own economic policies had become untenable. IMF, *IMF Approves Third Annual ESAF Loan for Uganda*, Nov. 18, 1996 (visited Aug. 20, 1997), <http://www.imf.org/external/np\sec\pr\1996\PR9656.HTM>. This change in approach was a sobering and pragmatic decision by the government to adopt economic strategies that Ugandans had previously identified with the oppressive Obote II government. *See* Godber Wilson Tumushabe, An Overview Study of Uganda Government Legislation, Policies and Programmes that Impact on Child Health and Well-Being with Particular Reference to Under-Five Ugandans (1996) (unpublished manuscript, on file with Minnesota Advocates for Human Rights and the Human Rights and Peace Center, Makerere University Faculty of Law, Kampala, Uganda).

[360] *See* World Bank, *World Bank Approves Debt Relief Package for Uganda*, Apr. 23, 1997 (visited Sept. 24, 1997) <http://www.worldbank.org/html/extdr/extme/1324.htm>; IMF, *Camdessus Applauds Debt Relief for Uganda under HIPC*, Apr. 24, 1997 (visited Aug. 20, 1997) <http://www.imf.org/external/np\sec\nb\1997\NB9707.HTM>.

[361] *See generally* Tumushabe (1997), *supra* note 359.

[362] *See generally* IMF, *IMF Approves Third Annual ESAF Loan for Uganda*, *supra* note 386; IMF, *IMF Approves Second Annual Loan for Uganda under ESAF*, Nov. 29, 1995 (visited Aug. 20, 1997), <http://www.imf.org/external/np\sec\pr\1995\PR9561.HTM>. *See also* Kathy Selvaggio & Amy Jerslid, *Debt Burden Threatens Uganda's Success*, BREAD FOR THE WORLD (Bread for the World, Silver Spring, M.D.), Dec. 1996, at 1-3.

[363] While the economic growth is at an annual rate of 4.5 percent, 90 percent of GDP goes to only 10 percent of the population. *See* CIHI, *Country Health--Uganda*, *supra* note 318.

[364] IMF (Apr. 24, 1997), *supra* note 360.

[365] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 90.

and is projected by the IMF to be around 20 percent of exports in the near future.[366] Continued heavy reliance on export earnings from primary cash crops like coffee creates an economic situation vulnerable to the volatility of the global agricultural market.[367] In 1994, Uganda paid $173 million in debt payments, accounting for almost three fourths of its export earnings. The World Bank considers Uganda's debt to be more than three times higher than what it considers manageable. The money that Uganda pays on its debt takes away from badly needed investments in its people.[368]

Approximately 73 percent of Uganda's foreign debt is owed to the World Bank, the IMF, and the African Development Bank. Between 1987 and 1990, Uganda paid $89 million more to the IMF on its debt than it received in new multilateral funds. Uganda is forced to use bilateral aid to repay multilateral debt, which steadily increases its dependence on foreign donors. For every $3 transferred by donors to Uganda, $1 is transferred back to creditors for debt payment. Uganda has thus far been a model debtor in repaying its creditors, recognizing that failure to pay would jeopardize future loans.[369]

The government's restrictions on public spending shift its resources away from the health sector—a shift that is clearly articulated in the 1992 Government Policy Statement.[370] Debt repayments are consuming vast resources that are needed to increase public investment in primary health care, education, clean water, and sanitation. Total external debt repayment of $184 million in 1996/1997 is almost ten times the level of public spending on primary health, and seven times what the government now spends on primary education.[371] Further, resources earmarked for health have been drained by infrastructure rehabilitation and single-focus vertical programs (e.g., control of diarrheal disease, immunization, vitamin A programs).[372] The Ugandan Ministry of Health worked with large international aid programs to develop appropriate national health plans that focus on primary health care. The objectives were well articulated, but these plans never included sufficient financial support to cover actual operating costs, so the objectives continue to remain unmet. Health funds are diverted from the very strategies that

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[366] IMF, *Uganda--Debt Issues*, *supra* note 358, at 1.

[367] An example of global agricultural market volatility is the collapse of the International Coffee Agreement in 1989. *See generally* Oxfam, *Debt Relief*, *supra* note 295; IMF (Apr. 24, 1997), *supra* note 360.

[368] Selvaggio & Jerslid, *supra* note 362.

[369] *Id.*

[370] Tumushabe (1997), *supra* note 359.

[371] Oxfam, *Debt Relief*, *supra* note 295, at 2.

[372] OXFAM UGANDA, HEALTH SECTOR REVIEW (July 1995).

could profoundly improve Uganda's health situation.[373]

High debt burden is a significant impediment to reducing poverty and improving the health and welfare of vulnerable populations in the country. Provisions of basic needs, primary health and basic education continue to be hampered by scarcity of resources, thus placing Ugandan children at high risk of premature death and disability. Most Ugandans are not affected by the country's current economic growth. The poorest families see little improvement in their standard of living, and the majority have suffered a deterioration.[374]

As a result of Uganda's full implementation of its economic structural adjustment policies, the country recently received a total debt relief of approximately $340 million under the Debt Initiative for Heavily Indebted Poor Countries facilitated by the IMF, World Bank, and multilateral creditors.[375] The government, through its Action Plan for Poverty Eradication, has pledged to convert the debt service savings into poverty reducing initiatives in basic education, primary health and other social development priorities.[376] The social benefits from the debt relief for millions of impoverished Ugandans are potentially enormous:

- nearly 400,000 children surviving past age five;
- access to clean water and sanitation for one million people;
- basic health care for 2 million people; and
- primary education for 2 million children who are currently out of school.[377]

With the projections of strong economic recovery, a substantial debt relief package, and the government's commitment to sound fiscal and social policies, Uganda has now an exceptional opportunity to invest in sustainable social development and improve the welfare and survival of its children by carefully targeted use of these resources.

4.7. Civil strife, armed conflict, and displacement

The health and well-being of Ugandan children are harmed by the ethnic and regional tensions between north and south, the ongoing insurgency, and the legacy of economic disruption from decades of armed conflict, civil strife, and displacement. Children are born into

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[373] Oxfam, *Debt Relief*, *supra* note 295.

[374] *See, e.g.*, Selvaggio & Jerslid, *supra* note 362; Oxfam, *Debt Relief*, *supra* note 295; Action Aid, *Country Strategic Paper*, 1994-99; OXFAM UGANDA, STRATEGIC PLAN (1994).

[375] IMF (Apr. 24, 1997), *supra* note 360.

[376] World Bank, *Sustainable Debt for Sustainable Development* (visited Sept. 24, 1997) <http://www.worldbank.org/html/extdr/hipc/hipcbr.htm>.

[377] Oxfam, *Debt Relief*, *supra* note 295.

communities where families have been displaced, traditional support structures destroyed, and limited government resources diverted from meeting basic needs to suppressing armed conflicts.

Child mortality is dramatically higher in the northern areas where the insurgency persists, and there is an extreme lack of health care services and ever-increasing poverty. In part as a result of policies from the pre-independence years, economic growth has benefitted the south and central regions of Uganda, leaving citizens in the northern regions feeling alienated from the central government. Dissident forces in the north, and the government's counter-insurgency, disrupt the relative economic and political stability of Uganda. The northern districts are isolated from the rest of Uganda. The areas are heavily mined and threatened by armed bandits. Few health care professionals and community leaders remain in the region. The communities are despairing; there is no work, and residents report that alcohol use and domestic violence are increasing.[378]

The cumulative effects of the devastated educational and health infrastructures, together with the internal displacement of families dating from the 1960s until 1986, continue to affect the health of children today. National education and health services collapsed during Idi Amin's government;[379] schools and health clinics were not maintained and facilities were damaged by vandalism and warfare. The general quality of health and education declined; many teachers and health care providers fled the country. The nation's beleaguered health care system could not cope with the health needs of an increasingly impoverished populace. The violence, chaos, and human rights atrocities continued unabated, and eventually escalated into a full-scale civil war which lasted until 1986, when Yoweri Museveni and his National Resistance Movement finally took control, establishing relative peace in much of Uganda for the first time in fifteen years.[380]

During the years of civil war, armed forces terrorized the countryside, atrocities were endemic, and long-standing communities experienced tremendous upheaval and internal displacement. This traumatic social disruption resulted in the break-up of traditional family and community supports for children. Uncounted children suffered and died.[381] Today, the loss of

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[378] Site Visit to Uganda, *supra* note 309.

[379] Idi Amin's military dictatorship lasted from 1971 to 1979. UGANDA: A COUNTRY UPDATE (R.M. Byrnes ed., 1990)

[380] Two very brief governments of Lule and Binaisa immediately followed the Amin era. In 1980, Obote was brought back to power in a highly controversial election. Under the second Obote government, human rights atrocities continued. Mafigiri, personal communication (1985). The material devastation and sheer scale of atrocities perpetrated by the second Obote government (1980-85) and the short-lived Okello government in 1985 left the country in complete ruin. In the early 1980s, the random human rights atrocities developed into full-scale civil war. UGANDA NOW: BETWEEN DECAY AND DEVELOPMENT (Holger Bernt Hanson & Michael Twaddle eds., 1988).

[381] John B. Ssekkamatte-Ssebuliba, Determinants of Infant and Child Survival in Uganda (1992) (unpublished doctoral dissertation, Brown University).

land and livelihood due to internal displacement continues to affect the composition of families, with more men (and women) leaving their families and migrating to urban areas in search of work, dramatically impacting the care of children at home. Often women are left to fend for themselves and their children; their access to food and income are severely threatened. This situation has a particularly profound impact on women without property ownership.[382]

C. Uganda's domestic law and practice

1. Law

1.1. Constitution

The Ugandan Constitution directly addresses the right to non-discrimination, right to life, and protection of children. The Constitution, which became effective in 1995, is the supreme law of the land.[383] The Constitution requires that Parliament enact legislation that will ensure the enjoyment of the rights and freedoms enshrined in the Constitution.[384] The Constitution does not explicitly address the right to health. Therefore, enforcement provisions of the Constitution do not apply to the right to health. Provisions related to health are relegated to the section on National Objectives and Directive Principles of State Policy, which are not justiciable.

- **Non-discrimination**

The Ugandan Constitution expressly prohibits discrimination. Article 21 generally recognizes equality and freedom from discrimination for all Ugandans.[385] Article 34 provides that "no child shall be deprived by any person of medical treatment, education or any other social or economic benefit by reason of religious or other belief."[386] The Constitution also provides that Parliament could enact laws "that are necessary for implementing policies and programmes

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[382] Site Visit to Uganda, *supra* note 309.

[383] UGANDA CONST. ch. 1, art. 2, §1. The constitution was adopted by the Ugandan Constituent Assembly on September 22, 1995, and came into effect on October 8, 1995. The Constitution also notes that "[t]he foreign policy of Uganda shall be based on the principles of . . . respect for international law and treaty obligations." UGANDA CONST. pt. XXVIII (National Objectives and Directive Principles of State Policy). Although this provision addresses foreign policy rather than domestic policy, it demonstrates Uganda's commitment to respect international treaty law and obligations.

[384] Uganda's Constitution requires that Parliament enact laws "for the enforcement of the rights and freedoms under [the Chapter on Protection and Promotion of Fundamental and Other Human Rights and Freedoms]." UGANDA CONST. ch. 4, art. 50, §4.

[385] UGANDA CONST. ch. 4, art. 21.

[386] *Id.* art. 34.

aimed at redressing social, economic, or educational or other imbalance in society.[387]

- **Right to life**

The Ugandan Constitution recognizes the right to life. Article 22(1) of the Ugandan Constitution provides that "[n]o person shall be deprived of life intentionally except in execution of a sentence passed in a fair trial."[388] It is possible that Uganda's constitutional protection of the right to life may be interpreted to include an obligation to take steps to reduce infant mortality. Uganda is a party to the ICCPR, which contains a right-to-life provision that has been interpreted by the Human Rights Committee to include measures to reduce infant mortality and increase life expectancy.[389]

- **Health and related rights**

The right to health is not explicitly addressed in the Constitution. Health and related provisions are specified under the section National Objectives and Directive Principles of the Constitution. Because these objectives are not contained in the Bill of Rights, the enforcement provisions of the Constitution do not apply.[390] These objectives provide that "all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work, decent shelter, adequate clothing, food security and pension and retirement benefits."[391]; "[t]he state shall take all practical measures to ensure the provision of basic medical services to the population."[392] Another objective provides that "[t]he state shall take all practical measures to promote a good water management system at all levels."[393]

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[387] *Id.* art. 21, §4(a).

[388] *Id.* art. 22, § 1.

[389] *See* General Comment 6 (16)d, *supra* 215, at 93-94.

[390] UGANDA CONST. ch. 4, Protection and Promotion of Fundamental and Other Human Rights and Freedoms. Art. 50 provides for enforcement of Rights and Freedoms by Courts.

[391] UGANDA CONST. pt. XIV (National Objectives and Directive Principles of State Policy). Unlike the Guinean Constitution, which provides that "[m]an has the right to health and physical well-being," the Ugandan Constitution contains no such explicit guarantee of the right to health. Zachary A. Lomo, Review of the General Health Situation and Child Mortality in the Context of the Right to Health in Uganda (1996) (unpublished manuscript, on file with Minnesota Advocates for Human Rights Child Mortality Project and the Human Rights and Peace Center, Makerere University Faculty of Law, Kampala).

[392] UGANDA CONST., pt. XX (National Objectives and Directive Principles of State Policy).

[393] *Id.* pt. XXI (National Objectives and Directive Principles of State Policy). Another constitutional provision states that every Ugandan has a right to a clean and healthy environment. *Id.* art. 39.

Specific provisions of the Constitution address children's rights and conditions affecting child mortality. Subject to laws enacted in their best interest, children shall have the right to know and be cared for by their parents or guardians.[394] The Constitution also protects children from unsafe employment conditions.[395]

1.2. Statutory law

Health care and policy are the function of statutory law in Uganda, although customary and Islamic law, which operate simultaneously in Uganda, may govern issues relating to behavioral and socioeconomic determinants of child mortality.[396] The statutory legal system in Uganda consists of principal legislation, or statutes, and subsidiary legislation. The subsidiary legislation, called "statutory instruments," includes rules, regulations, notices, orders, and bylaws.[397]

No complete set of the laws of Uganda currently exists.[398] The last official compilation of laws occurred in 1964.[399] Since 1972, the government of Uganda has promulgated

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[394] UGANDA CONST. ch. 4, art. 34, § 1.

[395] *Id.* art. 34, § 4.

[396] Statutory, customary, or Islamic law may govern any particular circumstance depending on the type of issue or the parties involved. Customary law governs many legal disputes, particularly in the rural areas of Uganda. Islamic law is a third legal system that governs certain issues within the relatively small Muslim community in Uganda, including domestic relations and child support. The systems of law vary in substance particularly with respect to issues related to family law. Differing human rights implications, particularly for women and children, arise under statutory, customary, and Islamic law. The multiple legal systems operating in Uganda are primarily a product of its history. Uganda gained independence from Great Britain in 1962, and much of the contemporary statutory legal system was inherited from the British. African customary law (which should not be confused with international customary law and the wide acceptance of international legal principles, *see supra* notes 154-55 and accompanying text) is based on the traditions and customs of indigenous populations and is not codified or written. Under the Judicature Act of 1967, however, customary law, like statutory law, is legally binding. Judicature Act, S.3 (Nov. 1967).

[397] Interview with Sir Harold Platt, Ugandan Law Reform Commission official, in Kampala (April 9, 1997). As authorized by statute, a minister or local government may issue or promulgate statutory instruments, akin to administrative regulations and/or local ordinances, designed to implement the statute. Regulations may be amended over time to reflect current conditions, but must always be consistent with and authorized by the core statute. Similarly, while local by-laws may differ from each other on a given topic, each must be consistent with and authorized by statute. *Id.*

[398] ANN BATESON, CHECCHI & COMPANY CONSULTING, INC., UGANDA CODIFICATION PROJECT CONSULTANCY REPORT 4 (Sept. 30, 1992). The Supreme Court's collection of laws, for example, was missing at least 540 documents in 1992. *Id.*

[399] The last time that Ugandan laws were compiled and revised was in 1964. Previous compilations and revisions occurred in 1910, 1923, and 1935. *Id.*

approximately 2000 legal documents; many records were literally destroyed,[400] and others were not systematically copied, organized, catalogued, referenced, or stored. An effort to compile all current laws is now underway as a joint project of USAID and the Ugandan government.

- **The Children's Statute**

General framework

The Children's Statute of 1996 (see Box 4.2) directly incorporates Uganda's treaty obligations respecting children's rights, and specifically enumerates a range of children's rights.[401] The First Schedule to the Children's Statute states that:

> [a] child shall have the right . . . to exercise, in addition to all the rights stated in this Schedule and this Statute, all the rights set out in the U.N. Convention on the Rights of the Child and the OAU Charter on the Rights and Welfare of the Child with appropriate modifications to suit the circumstances in Uganda that are not specifically mentioned in this Statute.[402]

The specifically enumerated rights include education and guidance, immunization, adequate diet, clothing, shelter, and medical attention,[403] and protection from discrimination, violence, abuse, and neglect.[404] The statute prohibits "social or customary practices that are harmful to the child's health,"[405] and it prohibits engaging a child in "any activity that may be harmful to his or her health, education, mental, physical or moral development."[406]

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[400] Interview with Ann Bateson, Technical Consultant to the Uganda Codification Project, in St. Paul (Mar. 24, 1997).

[401] The Children's Statute also sets up a new court with jurisdiction to enforce the rights under the Statute. A governmental task force is presently working on the implementation of the statute, particularly the new court system.

[402] CHILDREN STAT. first sched., § 4 (Apr. 1996) (emphasis added). Section 4 also states that the children's rights set out in the First Schedule shall be the guiding principles in the making of any decision based on the statute. *Id.* For the full schedule, see Box 4.2. Uganda ratified the treaties listed in Section 4 without reservations so the phrase "with appropriate modification to suit the circumstances in Uganda" should not diminish the substantive meaning of those rights or Uganda's obligations under the treaties. For a discussion generally of the instruments referenced, see supra ch. III.

[403] CHILDREN STAT., No. 6, § 6.

[404] *Id.* § 6(2).

[405] *Id.* § 8.

[406] *Id.* § 9.

Box 4.2. Selected portions of Uganda's Children's Statute of 1996

Part II: Rights of the Child

4. The welfare principles and the children's rights set out in the First Schedule to this Statute shall be the guiding principles in the making of any decision based on the provision of this statute.

6.(1) It shall be the duty of a parent, guardian or any person having custody of a child to maintain that child and, in particular that duty gives a child the right to—

(a) education and guidance;
(b) immunization;
(c) adequate diet;
(d) clothing;
(e) shelter; and
(f) medical attention

(2) It shall be the duty of any person having custody of a child to protect the child from discrimination, violence, abuse and neglect."

7.(1) Every parent shall have parental responsibility for his or her child.
(2) Where the natural parents of a child are deceased, parental responsibility may be passed on to relatives of either parent, or by way of a care order, to the warden of an approved home, or to a foster parent.

8. It shall be unlawful to subject a child to social or customary practices that are harmful to the child's health.

9. No child shall be employed or engaged in any activity that may be harmful to his or her health, education, mental, physical or moral development.

10. The parents of children with disabilities, and the State, shall take appropriate steps to see that those children are—

(a) assessed as early as possible as to the extent and nature of their disabilities;
(b) offered appropriate treatment; and
(c) afforded facilities for their rehabilitation and equal opportunities to education.

First Schedule: Guiding Principles in the Implementation of the Statute

1. Whenever the state, a court, a local authority or any person determines any question with respect to—

(a) the upbringing of a child or,
(b) the administration of a child's property or the application of any income arising from it, the child's welfare shall be of the paramount consideration.

2. In all matters relating to a child, whether before a court of law or before any other person, regard shall be had to the general principle that any delay in determining the question is likely to be prejudicial to the welfare of the child.

3. In determining any question relating to circumstances set out in paragraphs (a) and (b) of paragraph (1), the court or any other person shall have regard in particular to—

(a) the ascertainable wishes and feelings of the child concerned considered in light of his or her age and understanding;
(b) the child's physical, emotional and educational needs;
(c) the likely effects of any changes in the child's circumstances;
(d) the child's age, sex, background and any other circumstances relevant in the matter;
(e) any harm that the child has suffered or is at the risk of suffering;
(f) where relevant, the capacity of the child's parents, guardians or others involved in the care of the child in meeting his or her needs.

4. A child shall have the right—

(a) to leisure which is not morally harmful and the right to participate in sports and positive cultural and artistic activities.
(b) to a just call on any social amenities or other resources available in any situation of armed conflict or natural or man-made disasters.
(c) to exercise, in addition to all the rights stated in this Schedule and this Statute, all the rights set out in the U.N. Convention on the Rights of the Child and the OAU Charter on the Rights and Welfare of the African Child with appropriate modifications to suit the circumstances in Uganda that are not specifically mentioned in this Statute.

Source: *Reprinted from* The Children Statute 1996, Statutes Supplement 5, Uganda Gazette No. 21, vol. LXXXIX, Apr. 1996.

The Statute places a priority on the needs and welfare of the child. It provides: "[T]he child's welfare shall be of the paramount consideration . . . whenever the state, a court, a local authority or any person determines any question with respect to the upbringing of a child."[407] It is too early to draw conclusions about the effectiveness of this provision in practice, but the reference could be interpreted consistently with the "best interests of the child" principle in the Children's Convention.

Responsibility for child welfare

The Children's Statute places shared responsibility for child welfare on parents, the local government, and the State. This tripartite allocation of responsibility reflects the conclusions of

[407] *Id.* § 4; first sched., § 1.

the Child Law Review Committee which determined that children were generally treated harshly in Uganda. Formed in 1990 and composed of representatives of many sectors of Ugandan society,[408] the Committee examined the situation of hundreds of orphans of AIDS victims; thousands of children separated from parents by years of conflict and persecution, abandonment, loss, or flight, and the social problem of irresponsible parenting.[409] Committee members felt that many Ugandan parents did not fully appreciate their own vital role in educating and providing for basic health needs, including the responsibility of bringing the child to the clinic for immunizations, which the state is required to provide. The Committee became convinced that the family and the local community need to play an important role in protecting children, and are the most appropriate units of society to deal, in particular, with responsible child rearing.[410]

The Children's Statute imposes a duty on every local government from the village to district level to safeguard and promote the welfare of children within its area and to appoint a Secretary for Children's Affairs to be responsible for the welfare of children.[411] The Secretary

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[408] Two years after its formation, the Committee prepared substantive recommendations that were passed into law as the Children's Statute, effective in 1996. The Committee was composed of representatives from, among other sectors, the Law Reform Commission, the judiciary, various government agencies addressing social issues, academia, non-governmental organizations, and the current acting Commissioner of Child Welfare. REP. CHILD LAW REV. COMM. (Mar. 1992). MAHR interviewed committee members and others about the process leading to the Children's Statute during its mission to Uganda in April 3-15, 1997. Interviews were conducted with sources including two members of the Law Reform Commission (including its chair); a twelve-year employee of the Ministry of Justice who provides interpretations of statutes on behalf of the attorney general and other government officials; the acting commissioner of Child Welfare in the Ministry of Justice; the Ugandan USAID lawyer who is responsible for child survival programs; legal aid lawyers and feminist activists in NGOs; and a lawyer in the Parliamentary Counsel's office who drafted the statute after the committee determined the substance of the statute. Interviews with Child Law Review Committee members, in Kampala, Site Visit to Uganda, *supra* note 309. As described by Committee members to MAHR, the Committee looked to the obligations in the international conventions protecting the rights of the child, particularly the Children's Convention and the OAU Charter as its core mandate. A lengthy study was undertaken, followed by extensive discussion and debate. The committee sent researchers around the country where they interviewed local authorities, probation officers, and health care workers, among others.

[409] Many men take multiple wives, or father children with several women not necessarily their wives. FIDA, a Ugandan women's legal aid organization, reported that the majority of their cases are women who come to them seeking maintenance, i.e., support from the father(s) of their children because they are literally starving. Interviews with FIDA Children's Desk and other lawyers, in Kampala, Uganda (Apr. 11, 1997). Men are taught at puberty that daily sex is necessary and it is their right. Many men use alcohol as an excuse for irresponsible sex. Consequently, many children are born without a man to provide food, even though the customary law is that the man is responsible for basic needs. *See* also discussion *supra* parts B.4.2-4.4.

[410] The legislative history and interviews with drafters and others demonstrate an intent to expand the rights of the child *vis-a-vis* their parents, as well as in relation to the state, along with the intent to maintain the state's responsibility to children as established in the Children's Convention, the African Children's Charter, and the Ugandan Constitution.

[411] CHILDREN STAT. No. 6, § 11(1).

shall be assisted by officers of the local government council.[412] It is the duty of the local government council to mediate any situation where the rights of a child are infringed[413] and to provide special assistance to disabled, lost or abandoned children.[414] Community members have a duty to report to the local government council the infringement of a child's rights including the refusal or neglect of a parent to provide adequate food, shelter, clothing, medical care, or education.[415] The Statute sets forth a procedure for the Secretary for Children's Affairs to take action and for referral to courts.[416]

The Children's Statute establishes district-based Family and Children Courts which shall have the power to issue supervision and care orders for children who are suffering or likely to suffer significant harm attributable to lack of reasonable parental care.[417] A supervision order places a child under the supervision of a Probation and Social Welfare Officer while leaving the child in the custody of parents. A care order removes the child from the home and places him or her into foster care.[418]

The responsibilities of parents or guardians to care for children enumerated in the Children's Statute are highly significant to child mortality, and include immunization, adequate diet, and medical attention.[419] A person who contravenes the provisions of the Statute commits

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[412] *Id.* § 11(2).

[413] *Id.* § 11(3).

[414] *Id.* §§ 11(5), (6), (7).

[415] *Id.* § 12(1).

[416] *Id.* § 12(2), (3). Before a disciplinary matter is taken to the special central level court, it first is reviewed by the village council composed of local people thought to be the most knowledgeable about the particular circumstances of a given family.

[417] *Id.* parts IV & V.

[418] *Id.* part V.

[419] Section 6(1) provides that:

> It shall be the duty of a parent, guardian or any person having custody of a child to maintain that child and, in particular that duty gives a child the right to—
>
> (a) education and guidance;
> (b) immunization;
> (c) adequate diet;
> (d) clothing;
> (e) shelter; and
> (f) medical attention.

Id. § 6 (in pertinent part).

an offence and, if convicted, may be fined and/or imprisoned.[420] The Penal Code makes it a misdemeanor for a parent or guardian to "refuse or neglect (being able to do so) to provide sufficient food, clothes, bedding and other necessaries for such child, so as thereby to injure the health of such child."[421] The intent of the Statute is to prevent injury to the health of the child. The "other necessaries" in the Statute would, therefore, seem to include a variety of health needs. The Children's Statute, however, recognizes that some parents will be unable to provide for the basic needs of their children and contains an exclusion under those circumstances.

- **The Local Governments Act**

The Local Governments Act (LGA)[422] is one response of the present government to the turmoil of the 1970s and 1980s. It creates a scheme that may radically affect health services, and consequently child mortality. The LGA gives "full effect to the decentralisation of functions, powers, responsibilities and services at all levels of Local Governments . . . to ensure democratic participation in, and control of decision making by the people concerned."[423] On its face the Local Governments Act represents a combination of local empowerment backed by national funding and medical expertise. Only with full implementation of the law will its effectiveness in addressing child health issues be known.

Under the LGA, the central government retains responsibility for health policy, control and management of epidemics and disasters, and "water resources and the environment."[424] Local governments, through District Councils created under the LGA,[425] are responsible for all medical and health services, including all primary health care services, all health centers and dispensaries, maternity and child welfare services, the control of disease (including HIV/AIDS), environmental sanitation, health education, rural ambulance services, and also for some hospitals, but not those with a "referring" or "teaching" function.[426] The central government is to establish minimum standards for the districts' health plans, provide technical assistance in developing and implementing the plans, and with the assistance of the Ministry of Local

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[420] *Id.* § 110.

[421] The Penal Code Act, § 153.

[422] The Local Governments Act became effective March 24, 1997.

[423] Local Governments Act § 2.

[424] *Id.* second sched., part 1, §§ 27, 26, 7, respectively.

[425] The Act provides for the election of five levels of local councils, at the village, parish, sub-county, county and district level. *Id.* Act §§ 4, 46, *inter alia*.

[426] The division of governmental responsibilities between the central government and local units, and among the local councils is detailed in the Second Schedule, one of several appendices to the law. *Id.* second sched., part 2, § 2(a-j).

Government and district officials, monitor compliance with national policy and the submitted plan documents.[427] The Uganda Ministry of Health is currently developing minimum standards to be incorporated in the district health plans and is working with the local medical directors in the development of those plans.[428]

Each district is to develop a plan through a Planning Authority, and the District Medical Officer is responsible for the public health plan.[429] The District Planning Authority must work within the guidelines of the National Planning Authority.[430] It is the duty of the Ministry of Local Government to monitor and coordinate the activities of local governments.[431] The Ministry would note if a given district were not in compliance with the minimum national standards. The Ministry would then pass that information to the Ministry of Public Health, which would provide the assistance to bring the district into compliance.[432] The law also requires certain local authorities, such as the Resident District Commissioner and the Local Government Finance Commissioner, to inform the Ministries when there is a "divergence or non-compliance with government policy by any Council" or when a local council's budget "detracts from national priority programme areas."[433]

The line ministries, including the Ministry of Health, are authorized to take corrective steps if a local council is exercising a "duty or power" in an "improper, unlawful, or inefficient manner." The Minister can call a meeting and point out the problem and appropriate response or institute a commission of inquiry.[434] Ultimately, the central government, with the approval of Parliament, can take over the administration of a district when it becomes clear that it is "extremely difficult or impossible" for the district to carry out its functions.[435]

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[427] For example, Government Line Ministries, such as the Ministry of Health, are to "monitor and coordinate Government initiatives and policies as they apply to Local Governments," and to "[a]ssist in provision of technical assistance to Local Governments." *Id.* § 98(1)(a), (c).

[428] Interviews with district medical officers, in Masaka, Uganda (Apr. 8, 1997), Site Visit to Uganda, *supra* note 309.

[429] *Id.*; Local Governments Act, §§ 36-38.

[430] *Id.* § 36(2-3).

[431] *Id.* § 98(2)(a).

[432] Interviews with Director of Rural and Urban Health Services, in Kampala, Uganda (Apr. 14, 1997), Site Visit to Uganda, *supra* note 309.

[433] Local Governments Act § 72(2)(e), 58, respectively.

[434] *Id.* § 100.

[435] *Id.* § 101. The allocation of responsibilities described above can be altered in certain circumstances. The District Council can request the central government to take over a function delegated to it, and can delegate its

The law anticipates that the districts will receive funds to carry out their various mandates.[436] The district health care budget is a combination of a tripartite grant from the central government along with revenues raised locally.[437] The government grant consists of three parts: an unconditional grant, to be allocated among all district governmental functions as the district sees fit; a conditional grant, which is to be used only for designated purposes; and an equalization grant, intended to provide some measure of equity among districts whose resources vary significantly.[438]

District Medical Directors report that they receive funds from the unconditional grants to their respective districts, but they must lobby for allocation to their health care budget within the context of the district's overall budget. This process pits health against education, infrastructure expenses, and so forth. The conditional grants go to support any hospitals in the districts, leaving inadequate funds for primary health care, health education, and the other functions devolved to the district's control. To date the equalization grants have not gone into effect.[439]

Although the LGA went into effect just months ago, some of its provisions have been gradually implemented. The conditional and unconditional grants are in use, and the District Medical Officers have drafted or are drafting district health plans. During this period of transition, the Ministry of Health continues to control the hospitals and the budget for the hospitals. Therefore, the majority of the money for health care is controlled centrally, rather than by the local authorities who now have the primary responsibility for health care.

- **Public Health Act**

Uganda's Public Health Act (PHA) is outdated and appears to contradict the new LGA in defining who is responsible for various public health issues. The PHA, officially titled "An Act To Consolidate The Law Regarding The Preservation Of Public Health," was originally enacted in 1935 and last amended in 1965.[440] It contains some provisions dating to distant colonial rule. The most recent provisions have been on the books more than thirty years, through both the

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functions to lower-level councils. Similarly, the line Ministries can delegate their functions to district councils. All such reallocations of responsibilities must be approved by both the delegator and recipient of the authority, and must be consistent with the Constitution and other laws. *Id.* §§ 31-34.

[436] The Act provides that "[n]o financial obligation shall be placed on a Local Government by Government . . . without providing for funds for the discharge of that obligation. *Id.* § 83(3).

[437] *Id.* pt. VII, §§ 75 et seq.

[438] *Id.* § 84.

[439] Interviews with national and local government representatives, Site Visit to Uganda, *supra* note 309.

[440] Public Health Act, ch. 269.

devastating rule of Amin and Obote as well as the dozen years of Museveni's government.

The PHA addresses a number of issues affecting public health including the identification, prevention and suppression of infectious diseases, administration of sanitation, housing, sewerage and drainage standards, the prevention and destruction of mosquitos, and the protection of the integrity of water and food supplies.[441] The PHA contemplates that "local authorities" will carry out its various mandates as supervised and directed by the Ministry of Health which has broad powers under the PHA.

The PHA is obsolete in some medical and environmental aspects. For example, the PHA mandates universal immunization for smallpox.[442] Smallpox has been eradicated worldwide; neither in Uganda nor elsewhere are children vaccinated for this disease. The law is silent as to any other childhood vaccinations but, as discussed earlier, the Ugandan government provides free immunization for a range of diseases.[443] Lawmakers have simply not caught up with modern medicine or the work of the Ministry of Health.[444]

The mandates of the PHA are wide ranging and, if implemented, would go far to reduce some of the causes of disease in young children. The law envisions that local governments will, among other things, construct adequate public sewers, clean dangerous or polluted water supplies, cause the repair of any dwelling, sewer, street, or public space that is dangerous or injurious to health, cause mosquito breeding sites to be cleaned up, and quarantine and treat those with infectious diseases.[445] In each of these areas the Minister of Health is explicitly authorized to make rules for the preservation of health or the prevention of disease.[446]

2. Practice

Despite Uganda's constitutional and statutory provisions and health advancements in earlier decades, by 1986 Uganda's health and other infrastructures were in ruins after nearly 25 years of civil strife. Even the most basic health and social services were completely lacking in

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[441] *Id.*

[442] *Id.* ch. 269. §§ 40-46.

[443] Interviews with local government officials, health care providers, NGOs, and parents, Site Visit to Uganda, *supra* note 309.

[444] An employee in the office of the Reviser of Statutes explained during the site visit that many laws may have become technically outdated or otherwise obsolete, but the government does not have adequate resources to review all statutes and statutory instruments to ascertain such problems and to repeal the offending provisions. Site Visit to Uganda, *supra* note 309.

[445] Public Health Act, ch. 269, §§ 56-59, 78, 95, 105(a).

[446] *Id.* §§ 72, 109.

much of the country. From independence to 1986, each government had tried to control the economy and increase political support through nationalization schemes that resulted in a bloated bureaucracy. When the NRM came to power, it inherited this deeply corrupt and inefficient bureaucracy and a passive populace overwhelmed by years of political violence.[447]

At independence in 1962, Uganda had a solid health care system of health centers and hospitals. In the later 1960s, the government had started developing early primary health care strategies. By 1971, Uganda's level of trained health care staff and quality of health services were among the best in Africa. During the destructive Amin era of the 1970s, however, the health sector collapsed. Government health services were destroyed, and the voluntary agencies (NGOs and missionaries) were left to deliver care. Many health professionals including physicians fled the country.[448] Government funding for health care almost disappeared by 1986 and the public health budget was only 6.4 percent of its 1970 levels. Lacking regular pay, many trained personnel left the government health sector.

Today, half of the central government's health employees are untrained. Since 1986, most of the new resources for health have been used to rehabilitate hospitals and health centers, and to support single focus vertical programs such as control of diarrheal diseases (CDD). This process has led to a crisis in health delivery and donor dependency. Today, the Ugandan government is not able to raise sufficient funds to sustain the rehabilitated facilities and vertical programs.

2.1. Accessibility and quality of health and social services

Health care services in Uganda are inequitably distributed, favoring the urban and rich population. Even where they do exist, facilities are inadequate and personnel largely untrained.

- **Inaccessibility of health care services by the rural and poor**

Nearly 99 percent of the urban population has access to some form of health care services in comparison to only 42 percent of the rural population.[449] The urban bias in the delivery of the health care system means that the needs of the majority of the population—the rural poor—are often unmet.[450] In spite of government policies articulating support for primary health care and prevention and the preponderance of preventable in-patient morbidity and mortality, the health

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[447] UGANDA NCC (Oct. 1994), *supra* note 319.

[448] CIHI (1995), *supra* note 305.

[449] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1.

[450] UGANDA NCC (Oct. 1994), *supra* note 319.

system is still largely curative and hospital-oriented.[451] National budget allocations within the social sector are largely biased against the rural poor. Urban hospitals receive a disproportionate 60 to 80 percent of the national health budget.[452]

Health facilities in Uganda are far more prevalent in urban areas and are sorely lacking in rural communities, where 90 percent of the population resides. Over 50 percent of the hospitals are in the urban areas, and most health centers are near trading centers.[453] Oxfam International, an international NGO with many years of health development experience in Uganda, notes that "in [rural] districts such as Rukungiri and Ntungamo in the south-west and Kotido, Moroto and Soroti in the north, less than one quarter of the population is within five kilometers of a health unit."[454]

Deployment of qualified staff is uneven, favoring urban areas and hospitals. In 1993, close to 80 percent of registered nurses, 63 percent of enrolled nurses (LPNs), and 43 percent of medical assistants were based in hospitals. Many rural units are staffed only with nursing aides who have no formal education. There is also uneven distribution of staff among districts. For instance, the Kampala district has 170 physicians, or 34 percent of all physicians in the country working in government posts. An additional 49 physicians work in Ministry of Health headquarters, while eight districts have only one or two physicians total.[455]

Finally, primary health clinics and hospitals typically charge patients to receive drug therapy; within health clinics, some payments are made on an informal basis and there is no regulation or uniformity in the structure of charges.[456] The lack of affordable drugs precludes the impoverished majority from benefitting from recent medical and pharmaceutical advances.

- **Inadequacy of services**

A recent example illustrates the inadequacy of rural health care in Uganda. Upon

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[451] Jitta, David Kawesa-Kisitu, Sylvia Tereka, Daniel Babikwa, & Allen Magezi, Evaluation of Health Financing Reforms in Uganda: A Document Review of User Fees (1996) (unpublished manuscript, on file with Child Health and Development Centre, Makerere University, Kampala).

[452] Interview with District Medical Officer, in Masaka, Uganda (Apr. 8, 1997), Site Visit to Uganda, *supra* note 309. Mulago hospital in Kampala received almost one quarter of all government health spending in 1991/92. *See also* UNPAC (Sept. 1992), *supra* note 321.

[453] Jitta et al., *supra* note 451.

[454] *Id.* at 8.

[455] *Id.*

[456] Oxfam, *Debt Relief*, *supra* note 295, at 2.

returning from a series of women's meetings, representatives from an international non-governmental organization (INGO) traveling by four-wheel drive vehicle were stopped and asked to see an ill man who had been unconscious for over 24 hours. With no available transportation and the nearest health clinic over an hour away by vehicle, the community had seen no way to bring this man to care. He was brought to the nearest rural health clinic in the INGO's vehicle. The clinic staff examined the man, but could do nothing as they had no supplies or medicines. The INGO staff had to buy the needed drugs and supplies from a private clinic. Clearly, if the INGO had not been present the man would have been left to die without treatment in the village. But he would also have been left to die without treatment at the rural health clinic.[457]

The lack of access to adequate health care is correlated with infant and child mortality.[458] The health care system in Uganda is plagued by insufficient funds and inadequately trained personnel. Lack of funds results in chronic shortages of drugs and medical supplies that are essential for the most basic care; the quarterly supply of essential drug kits supplied by the Danish government and the Uganda National Drug Authority often runs out after a few weeks, leaving a health clinic with no medicines. Clinics and dispensaries in the rural areas are severely understaffed, often relying on nursing aides and dressers trained on the job.[459]

A rural health dispensary is often an empty room with immunization posters, aspirin, chloroquine, and staffed by an untrained nursing aide who has not been paid regularly. Water supplies and sanitation facilities are inadequate in the dispensaries as well.[460] Moreover, rural health care suffers from a lack of transportation. Funds to transport patients, supervisors, drugs and supplies to rural clinic sites are unavailable.[461] Many facilities lack basic diagnostic equipment.[462] Equipment and buildings are poorly maintained and often not functional.[463] The

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[457] Interview with INGO representative, Site Visit to Uganda, *supra* note 309.

[458] Recent studies have identified improved access to health care, and transportation to health care, as critical factors in lowering child mortality. *See generally* Peter Sandiford, Patricia Morales, Anna Gorter, Edward Coyle, & George Davey Smith, *Why Do Child Mortality Rates Fall? An Analysis of the Nicaraguan Experience*, 81 AM. J. PUB. HEALTH 30-37 (1991); Swensen et al., *supra* note 35. For a full discussion of the correlation, see *supra* ch. II, part A.3.3.

[459] UGANDA MINISTRY OF FIN. & ECON. PLAN. (MFEP), BACKGROUND TO THE BUDGET (1995/1996).

[460] Lomo, *supra* note 391.

[461] Site Visit to Uganda, *supra* note 309.

[462] Jitta et al., *supra* note 451.

[463] For example, in one southwestern district, the District Medical Officer (DMO) was seeking funds simply to build a small structure to protect the essential drug kits from the rains. Instructions to keep the drugs dry and cool are clear, but every three months when the kits arrive, they sit stacked beside a building for lack of a simple storage space. The problem of wet drug kits was only a small example of the many challenges facing the DMO. He is responsible for delivering services to a community that does not receive sufficient funds to provide even the most

community quickly loses respect and trust for government health units that can offer so little.

A lack of qualified health personnel remains a major impediment to improving delivery of health care. Health care providers often are minimally qualified and suffer from low morale. Monthly salaries average an equivalent of US$30, and payment is routinely behind. Many staff are overwhelmed by the health needs surrounding them and a total inability to respond. Community members recount stories of staff incivility, requests for bribes, exorbitant fees for medicines, and dismissal with no treatment or medicines. Health administrators are generally concerned about the issue of untrained health staff, particularly those who improperly diagnose or over-prescribe medication, and either open illegal pharmacies or request bribes to augment their unlivable wage.[464]

The physician to population ratio, an indirect measure of access to health care, has deteriorated dramatically since 1970. For the 1970-75 period, there was one physician for approximately every 9300 persons in Uganda; by the 1989-94 period, there was only one physician for every 23,000 persons (see Figure 4.4). Similarly, the hospital bed to population ratio has increased markedly. In 1970-75, there was one bed for every 600 persons; in 1989-94 there was only one bed for approximately every 1100 persons (see Figure 4.5).[465]

Ugandan government representatives recognize these problems and openly discuss the barriers to resolving them. International non-governmental organizations and the Ugandan government are jointly developing some innovative projects to provide training and general capacity development on all levels of the health delivery system in the country. There are capacity building programs for traditional birth attendants, community "pharmacists," and community health workers, as well as professional continuing education programs to enhance the skills of health care professionals.[466]

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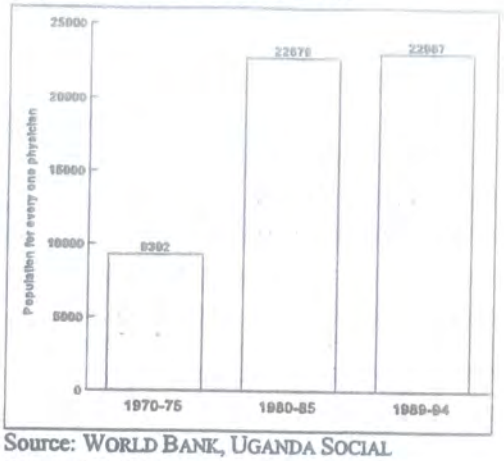
health care. Site Visit to Uganda, *supra* note 309.

[464] *Id.* Many health care staff, whether trained or untrained, continue to work diligently, even with sporadic pay and minimal access to tools of the trade. Some untrained workers become very skilled at learning the needs of their community and advocating for the most vulnerable. Through tireless effort, these health workers continue to attempt to prop up the under-funded health system. Robertson (1988), *supra* note 321; Cheryl Robertson, Sustainability of the Primary Health Care Worker Program at Kasangati Health Centre, Kasangati, Uganda: A Report to Minnesota International Health Volunteers and the McKnight Foundation (Nov. 23, 1992) (unpublished manuscript, on file with Minnesota International Health Volunteers).

[465] WORLD BANK, SOCIAL INDICATORS OF EQUALITY (1996).

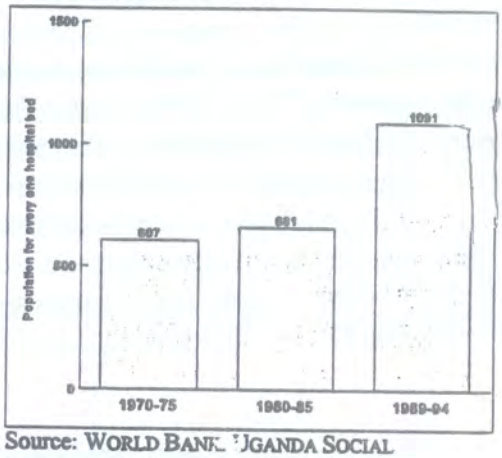
[466] Interview with INGO representative, Site Visit to Uganda, *supra* note 309.

Figure 4.4. Uganda population to physician ratio, 1970s to 1990s



Source: WORLD BANK, UGANDA SOCIAL SECTORS (1996).

Figure 4.5. Uganda population to hospital bed ratio, 1970s to 1990s



Source: WORLD BANK, UGANDA SOCIAL SECTORS (1996).

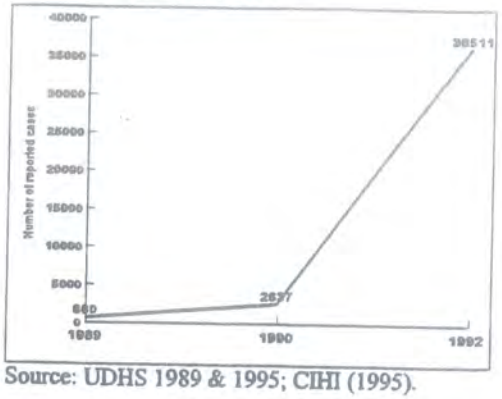
- **Immunization**

Immunization coverage as a whole has improved in Uganda. In 1989, 31 percent of Ugandan children were fully immunized for polio, tuberculosis, diphtheria, pertussis, and tetanus; by 1995, the coverage had risen to 47 percent.[467] The Ugandan National Expanded

[467] The UNEPI recommends the following schedule of childhood vaccinations: polio and BCG at birth; polio and DPT at ages 6, 10, and 14 weeks; and measles at 9 months of age. BCG confers protection against tuberculosis, and DPT protects against diphtheria, pertussis and tetanus. A child is considered fully immunized if he or she has received the following: a BCG vaccination; three doses of DPT vaccine; at least three doses of polio vaccine; and one dose of measles vaccine. *See* UDHS 1995, *supra* note 292; UDHS 1989, *supra* note 305.

Programme on Immunization (UNEPI) in the late 1980s significantly improved coverage by providing vaccines and vaccinator training to all districts of Uganda. Even the war-torn districts like Moyo have access to vaccines.

Figure 4.6. Increase in number of reported measles cases since 1990



Source: UDHS 1989 & 1995; CIHI (1995).

However, there remain many barriers to immunization in Uganda. For example, many families still fear the vaccines, believe that they spread AIDS, or know of a child who died from the measles vaccine. These families choose to use traditional medicine instead for preventing immunizable diseases, particularly measles.[468] By 1990, measles was no longer considered a leading cause of mortality among children. Unfortunately, the measles vaccination rates have dropped to 60 percent in 1995,[469] while the number of reported measles cases has risen dramatically (see Figure 4.6). In 1989, 660 measles cases were reported; by 1992, over 36,000 cases were documented. Measles has once again reemerged as a leading cause of death and disability among young children.[470] Today women in both urban and rural areas readily identify measles as a primary threat to their children's survival and health.[471]

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[468] Robertson (1988), *supra* note 321; Site Visit to Uganda, *supra* note 309.

[469] *See* UDHS 1995, *supra* note 292; UDHS 1989, *supra* note 305.

[470] CIHI (1995), *supra* note 305. A review of the measles research conducted by Burstrom, Aaby, and Mutie confirms that measles seems more severe in Africa than on other continents. Infants seem to experience faster waning maternal antibodies, leaving them susceptible to the disease prior to the age of proper vaccination efficacy (9 months). Measles is particularly severe in infants younger than 9 months and thus alternative control measures are recommended—such as a two dose schedule at both 6 and 9 months, and administering prophylactic vitamin A as a complementary strategy. *See generally* B. Burström, P. Aaby, & D.M. Mutie, *Measles in Infants: A Review of Studies on Incidence, Vaccine Efficacy and Mortality in East Africa*, 72 E. AFR. MED. J. 155-61 (Mar. 1995); A. Ross, Betty Rosamund Kirkwood, Fred Newton Binka, Paul Arthur, Nicola Dollimore, Saul Sutkover Morris, Rosaleen P. Shier, John Owusu Gyapong, & Peter G. Smith, *Child Morbidity and Mortality Following Vitamin A Supplementation in Ghana: Time Since Dosing, Number of Doses, and Time of Year*, 85 AM. J. PUB. HEALTH 1246-51 (1995).

[471] Site Visit to Uganda, *supra* note 309.

- HIV/AIDS prevention strategies

Since the mid-1980s, the Ugandan government has responded to the HIV/AIDS crisis with candor and openness, thereby encouraging innovative programs to address the problem. In 1990, the government appointed a National Task Force on AIDS which developed into the Uganda AIDS Commission (UAC). Partnering with major international aid agencies, government ministries, non-governmental organizations and others in Uganda, the UAC became actively involved in developing the national multi-sectoral approach to combating HIV/AIDS. This approach focuses on AIDS prevention and basic care for people with HIV and AIDS, strengthens district and local sector capacity, mobilizes resources, and establishes research standards.[472] The result is one of the most effective AIDS education and prevention programs in the developing world.[473]

Both governmental and non-governmental programs have pioneered innovative programs for testing, counseling and long-term social support. The AIDS Support Organization is one of the leading organizations in Africa to provide medical care, emotional support, and practical assistance to persons living with AIDS and their families. The first anonymous testing and counseling center in Sub-Saharan Africa, the AIDS Information Centre, was established in Kampala in 1990.[474] In spite of initial resistance and much controversy, Uganda now sees a growing acceptance of condom use. Comprehensive education and prevention efforts have targeted urban and rural, young and old, Christian and Muslim, and men and women.[475] Gradually, leaders in health and government have begun to address some of the prevalent sociocultural practices that make women, in particular, more vulnerable to AIDS. These practices include early sexual activity for girls, polygamous unions, traditional practices that mandate multiple partner, and widow inheritance, in which a widow becomes the wife of her late husband's brother. Traditional practices are extremely resistant to change. In this context, conveying AIDS messages that stress mutual monogamy is a notable challenge. The current efforts to delay the onset of sexual activity and concurrently reduce HIV infection in young girls are impeded by the lack of control that girls have regarding their sexuality. Perhaps one of the greatest tragedies in Uganda's AIDS saga is the vulnerability of young girls, even those living in rural areas. Findings continue to confirm that young women in Uganda remain at extremely high risk of HIV infection. It is imperative to find ways to empower young girls to resist sexual exploitation.

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[472] AIDS COMMISSION SECRETARIAT, AIDS CONTROL IN UGANDA: THE MULTI-SECTORAL APPROACH (Feb. 1993).

[473] Jeffrey Goldberg, *Their Africa Problems and Ours*, N.Y. TIMES MAGAZINE, Mar. 2, 1997, at 32-39, 59, 62, 75-77.

[474] Site Visit to Uganda, *supra* note 309.

[475] Marum, *supra* note 314.

Other disease control strategies

Many issues affecting high child mortality remain to be addressed. Mosquito breeding grounds frequently exist unabated. Clean water is not easily available. Sanitation systems are lacking in many areas.[476]

The central government has yet to implement a national anti-malaria program.[477] Mosquito control is basically nonexistent, and the public has a low understanding of the causes and the prevention of malaria. Families have few, if any, resources to take preventative measures. Window screens and bednets are effective, but prohibitively expensive. In Masaka, for example, bednets are $15 each. This amount is equivalent to about half the average health care worker's monthly salary. Children who contract malaria frequently receive poor treatment and follow-up. Although chloroquine-resistant strains of the disease have now become prevalent, chloroquine is often the only antimalarial medication available at government clinics and private pharmacies.[478]

Clean drinking water and environmental sanitation are essential to preventing diarrheal diseases. Access to safe drinking water and sanitation in Uganda lags behind most Sub-Saharan and low-income nations (see Figure 4.7). A gross disparity in access persists between urban and rural populations in Uganda. Forty-three percent of urban residents have access to clean water, compared with only 30 percent of rural residents. Similar disparities in access to adequate sanitation also continue.[479] Only 11 percent of households in all of Uganda are within 15 minutes of a safe water supply.[480] Without access to safe water, almost two thirds of Ugandans are at high risk for diarrhea and dehydration. Uganda's Control of Diarrheal Diseases (CDD) program focuses primarily on the promotion of ORT. While it is important to educate mothers and health care providers in the proper treatment of dehydration with ORT, it is imperative to address the direct cause of diarrheal disease—a lack of access to clean drinking water. Some NGOs have expressed concern that the CDD focus has gradually shifted from prevention to treatment.[481]

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[476] *See* discussion *infra* part 2.2.

[477] When a child is "diagnosed" with malaria—without laboratory facilities, virtually all fevers are treated as malaria, the mother may be able to afford only half of the required dose of chloroquine to treat her child, and thus facilitate greater resistance to the antimalarial drug. Site Visit to Uganda, *supra* note 309.

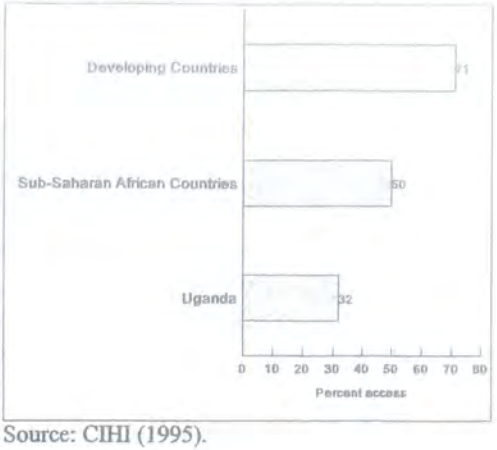
[478] CIHI (1995), *supra* note 305.

[479] *Id.*

[480] UDHS 1995, *supra* note 292.

[481] Site Visit to Uganda, *supra* note 309.

Figure 4.7. Poor access to safe water in Uganda, 1988-92



Source: CIHI (1995).

- **Education**

The Ugandan government recognizes the importance of improving public education. Its declared aim is to achieve Universal Primary Education (UPE) by the year 2000 for all 6 to 10 year olds. The Action Plan for Poverty Eradication envisages phased progress towards a free basic education for all children. The UPE goal is an important advance in social policy. Withou the investment of additional public resources, however, families will continue to bear a large proportion of education costs. Many communities, particularly in the rural districts, are unable t support a functional school even with school fees.[482]

2.2. Fiscal and reform policies in social sector

Uganda's social sector spending on health care is among the lowest proportionately in Sub-Saharan Africa. Funds that are expended on health care often fail to meet the needs of the most vulnerable.

- **Social sector spending**

Uganda has limited available public funds, but even the resources that do exist have not been prioritized towards achieving the country's primary goals of universal education and access to health care.[483] The Ugandan government spends a much smaller percentage of its budget on

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[482] Oxfam, *Debt Relief*, *supra* note 295.

[483] UNPAC (Sept. 1992), *supra* note 321. To its credit, the NRM government has increased social sector expenditures, which were at minimal levels when it came to power in 1986. In 1986, spending on health amounted to one quarter of the 1970 levels. Similarly, in 1991, the central government expenditure on health was just over US$1 per capita compared to US$5 in the early 1970s. This was partly due to the rising costs of operating health care and to the collapse of the political and economic foundation of the country. Over the last ten years, however,

health and social services in comparison to military and other expenditures. Between 1986 and 1993, the Ugandan government spent 2 percent of central government expenditure on health programs; by comparison, the government spent 26 percent on defense programs during the same time period.[484] Regarding the broader category of social service spending, the Ugandan Ministry of Finance and Economic Planning reported that during the funding period 1993/94 to 1995/96 allocations to basic social services had increased from 6.6 percent of total government expenditure to 7.7 percent. Although this is an increase, it is still low compared to other similarly situated countries.[485] According to UNICEF, the governments of the developing countries have been allocating, on average, only about 10 percent of their annual budgets to expenditures for nutrition, water supply, primary health care, primary education, and family planning.[486] The Ministry of Finance and Economic Planning further noted:

> The Health Sector has been characterized by underfunding and low health expenditures per capita, which is two to three times lower than the figure for Sub-Saharan countries. The minimal expenditure is exacerbated [by] curative dominated services, limited coverage, demotivated and ill-distributed staff, and weak management coupled with poor quality of services.[487]

The Ugandan central government currently spends about 7 percent of its total expenditures on health.[488] A World Bank study found that the level of per capita health spending was one of the lowest in Sub-Saharan Africa; only Somalia, Sudan, and the Democratic Republic of Congo commit fewer government funds to health.[489] The U.N. has recommended a US$12 per capita expenditure to provide a basic package of preventive and promotive health services to each person. This amount would include funds from central government, private, and foreign aid sources. Uganda's total health expenditure from all sources is less than US$8 per capita, of which

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spending on health has begun a slow but steady recovery—increasing from 2 percent of the national budget to just over 7 percent. Education spending has doubled in the last ten years. Even with the increased spending in the health sector, by 1993 the Ugandan government was attempting to run a health care system slightly bigger than that of the 1970s (both in terms of infrastructure and personnel) with less than half the funding. Jitta et al., *supra* note 451.

[484] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 90.

[485] UGANDA MINISTRY OF FIN. & ECON. PLAN. (MFEP), PRIORITIES FOR SOCIAL SERVICES SECTOR DEVELOPMENT IN THE 1990S AND IMPLEMENTATION PLAN 1995/96-1997/98 (Nov. 1992).

[486] UNICEF (visited Feb. 14, 1997), at 3, <gopher://hqfausOl.unicef.org:70/00/.cefdata/.pon93/intro>.

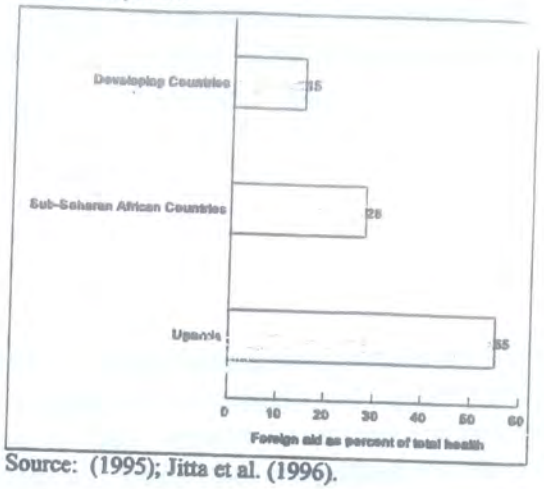
[487] MFEP, *supra* note 485, at 5.

[488] Oxfam, *Debt Relief*, *supra* note 295.

[489] CIHI (1995), *supra* note 305.

the Ugandan government contributes only US $2.3.[490] This is simply not enough to support the most basic health care.[491] It is difficult to see how, without a major increase in budget resources, the government can finance a functional health care system.

Figure 4.8. Foreign aid as percent of total health spending in Uganda and comparable countries, 1990



Source: (1995); Jitta et al. (1996).

The low revenue base in the country has led to overdependence on external funding to finance the development budget. In 1995, close to 70 percent of Uganda's development budget, and more than half of the health sector budget, was financed through foreign aid[492] (see Figure 4.8). This dependence on the external support agencies lacks sustainability and makes Uganda vulnerable to international dominance in its health policy.[493]

- **Curative focus of health services funds**

Allocations within the health and social services sector have failed to meet the needs of the most vulnerable. The government has acknowledged that a curative focus, among other factors, has limited the success of Uganda's health system. The government spends a disproportionate amount of money on relatively expensive technology for use in urban hospitals. More than half of current government health spending goes to urban hospitals instead of rural

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[490] Oxfam, *Debt Relief*, *supra* note 295.

[491] Jitta et al., *supra* note 476.

[492] *Id.*

[493] Agatre Okuonzi & Joanna Macrae, *Whose Policy Is It Anyway? International and National Influences on Health Policy Development in Uganda*, 10 HEALTH POL'Y & PLAN. 122-32 (1995).

health clinics used by the poor.[494] A comparison of budget allocations from 1993/94 to 1995/96, however, suggests a positive trend toward increased funding for primary health care rather than only curative programs.[495]

The recent increased allocation of funds for primary health care has the potential to reduce child mortality.[496] In 1993/94, the government allocated nearly US$27 million for primary health care and US$30 million for curative health programs. In 1994/95, the allocation for primary health care increased to nearly US$57 million, while allocation for curative programs increased only marginally; the 1995/96 budget allocation for primary health care was more than double the allocation for curative health programs.[497] Primary health care, primary education, and rural water supply are expected to receive increased allocations in real terms from 1995/96 to 1998/99.

2.3. Decentralization

As described earlier,[498] the central government initiated a process of decentralization of health services which continues today. The districts vie for needed funds from the central government to support local primary health care efforts. Each of Uganda's 45 districts is responsible for developing a district health plan that reflects the objectives set by Uganda National Programme of Action for Children (UNPAC).[499] The Ministry of Health is currently determining mandatory minimum standards.[500]

Funding for the district health plans is derived from three main sources—central government funds, local revenues from taxes, and NGO grants. Unfortunately, and contrary to the UNPAC mandate for primary health care, much of the central funding is still earmarked for tertiary (hospital-based) care that is inaccessible to most Ugandans. Indeed, financing these district health plans, in particular transferring resources from the historical curative, hospital-based focus to highly decentralized primary and preventative health care will be the challenge.

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[494] Oxfam, *Debt Relief*, *supra* note 295.

[495] Unlike curative programs that treat the *symptoms* of disease, primary health care focuses on *preventing* health problems through the widespread delivery of basic health care.

[496] *See* discussion *supra* ch. II, part B.2.

[497] MINISTRY OF FINANCE AND ECONOMIC PLANNING (MFEP), REHABILITATION & DEVELOPMENT PLAN 1993/94-1995/96 (Dec. 1993), at 8. It should be noted that although the government allocated $56,735,000 for primary health care in 1994/95, the government only "released" $39,198,000 during that fiscal year.

[498] *See* discussion *supra* text accompanying notes 447-464.

[499] *See infra* part C.2.5.

[500] Site Visit to Uganda, *supra* note 309.

There is a plan to assist impoverished districts by equalizing resources as they are allocated by the central government to the districts. That plan has not yet been implemented, nor has central control of most resources devolved to the district level. In each district, health care will compete with other priorities like roads and education as the respective districts develop and implement their budgets.[501]

As even proponents of decentralization have recognized, an uninformed and ill-planned decentralization process may undermine delivery and impair accountability. As one UNICEF representative said, "there is much greater freedom to respond at the local level, but what good is that freedom if there are no resources to create change?"[502] On the one hand, shifting control to the districts allows greater flexibility to respond appropriately to community health problems. However, the central government still largely controls the allocation of funds and, at present, the local leadership often lacks the capacity to adequately develop a district health plan and budget. Local leadership needs technical training in policy development, budgeting, personnel management, and financial management system. While there is a broad base of support for decentralization, important responsibility has been thrust into the laps of impoverished district leaders without corresponding technical supports and infrastructure development.[503]

For example, Masaka is a large rural district located south of the capital city of Kampala. It has an area of 7084 square kilometers and nearly one million people—90 percent of whom live in its rural areas. Masaka's health problems reflect the problems of most of Uganda. Malaria the primary cause of morbidity and mortality, access to safe water is minimal, and the rural have very poor or no access to health care facilities. The district has one government hospital, six health centers, five dispensaries and 20 sub-dispensaries. Approximately 75 percent of the district health funds come from the central government, 23 percent come from local taxes, and 2 percent come from NGO support. Eighty percent of the central government funds are allocated for the one hospital. Due to lack of funds and transportation the rural inhabitants have virtually no access to this hospital, while the services in their communities are devoid of supplies and staffed by untrained personnel.[504]

The grim situation in Moyo District demonstrates the failure of the current decentralization efforts to meet even the most basic needs in Uganda's most impoverished region. Moyo District is a northern district bordering the country of Sudan. Decentralization has been rather meaningless in this bankrupt district with a non-viable tax base, decrepit health facilities,

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[501] *Id.*

[502] Interview with UNICEF Country Officer, in Kampala, Uganda (Apr. 4, 1997), Site Visit to Uganda, *supra* note 309.

[503] Multiple interviews, Site Visit to Uganda, *supra* note 309.

[504] Site Visit to Uganda, *supra* note 309; MASAKA MED. DEP'T UGANDA, MASAKA DISTRICT PROFILE (Mar. 11, 1997).

and no trained personnel. Qualified health care professionals and managers fled some time ago. Current government grants are woefully inadequate to address primary health care. Part of the decentralization plan calls for the government to provide an equalization fund to the poorest districts—those with no tax base and minimal NGO activity. The plan, however, is not yet operational. Moyo's request for equalizing resources is unrealized. Nine INGOs operate in Moyo district, with the primary focus of serving the Sudanese refugees in camps along the border. Seventeen health units do provide some basic care; however, there is only one physician and one trained midwife in the entire district. Currently the physician serves as both the district medical officer and the medical director of the local hospital. Moyo ranks at the bottom for most health indicators, and there is seemingly little hope for improvement in the near future.[505]

2.4. Cost recovery: fee-for-service

The government instituted a cost recovery (fee-for-service) program under the Health Cost Sharing Policy and Plan of 1990. This plan, to date, has failed to increase revenue for health facilities and has resulted in decreased use of essential health services. Fee-for-service, supported by the World Bank as a sustainability strategy, was implemented throughout most of Uganda without requisite research in pilot areas to demonstrate the consequences.[506] The main objective of user fees was to raise additional funds to improve the quality of care. Funds collected at the health facility were to be retained at that level and used to boost staff renumeration, purchase additional drugs, and maintain the health units. Health Unit Management Committees (HUMCs) were created to manage the cost recovery program.[507]

Although some revenue has been raised at the health facility level, such revenue has had only limited impact on financial and institutional sustainability. In general, user fees have had little effect on efficiency because the revenue collected is minimal and poorly managed. Most clinics charge around 400 USh (40 US cents) per visit, and the poorer district clinics, such as Moyo, charge only 100 USh (10 US cents). For many, however, this fee is simply too high.[508] In general, cost sharing has been ineffectual and serves as a further barrier to care for the very poor. Only one clinic, Kasangati Health Centre in Mpigi District, reported that cost recovery was useful. The fees had been used there to augment staff salaries, buy additional drugs, and repair the clinic roof.[509]

Along with minimal revenue potential, in many instances the implementation of cost

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[505] Site Visit to Uganda, *supra* note 309.

[506] Okuonzi & Macrae, *supra* note 493, at 122.

[507] Jitta et al., *supra* note 451.

[508] *Id.*

[509] Site Visit to Uganda, *supra* note 309.

recovery schemes at local public clinics has been undermined by minimal government investment and poor management. The quality of services has not improved as anticipated, which leads to diminished clinic utilization. As a result revenue generated through user fees is minimal, which again leads to worsening quality of care.[510] Thus, a failed user fee scheme has a a synergistic negative effect.

Utilization rates for public hospitals and clinics dropped dramatically as fee-for-service was implemented. Poor households are now left with the choice to either pay more at a private practice where they are likely to be provided with treatment and medicines, or pay less at a public clinic that is unlikely to provide quality care. Families often choose to bypass the health care system altogether because it costs too much and offers poor quality services. A 1996 Oxfam report cites the medical superintendent of Masaka Hospital as observing that "[t]he rural poor do not attend Masaka hospital except in extreme cases. They do not attend because they cannot afford the costs involved, including transport, drugs and the minimum fee for cost-sharing."[511] In Uganda, poverty is so extreme that even modest fees place basic health care and drugs beyond the means of much of the population.

2.5 Reform programs

At the World Summit for Children in September 1990, Uganda, along with 158 other countries, pledged to develop a National Program of Action for Children to guide the development of social services during the next decade. In 1992, the Uganda National Programme of Action for Children (UNPAC) was developed by representatives from government and selected external support agencies and NGOs. The UNPAC is a well developed package of appropriate primary health care strategies to address child survival. If the financial and human resources were made available to implement UNPAC, the result would be a dramatic decrease in Uganda's child mortality levels.

The UNPAC establishes a national policy framework for the social services sector for the remainder of the decade, and provides a detailed plan to implement those policies.[512] The overarching goal of UNPAC is to "establish survival, protection, and development goals related to children and women for the 1990s that build on existing government policies and sectoral plans."[513] These goals were developed to establish priorities, coordinate activities, and measure progress of the social service sector at the national, district, and local community levels. The main strategy of UNPAC is to provide basic, minimum social services to as many Ugandans as

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[510] Jitta et al., *supra* note 451.

[511] Oxfam, *Debt Relief*, *supra* note 295, at 10.

[512] UNPAC (Sept. 1992), *supra* note 321.

[513] *Id.* at 1.

possible, in the areas of primary health care, clean water, basic sanitation, primary education, adult literacy, and community care of vulnerable children.[514]

Monitoring and reporting on the progress towards meeting the UNPAC objectives is the primary responsibility of the National Council for Children (NCC), a semi-autonomous government agency. NCC is responsible for coordinating all activities in Uganda related to child survival. In 1994, the NCC commissioned the Situation Analysis of Women, Children and Adolescents in Uganda, conducted by the Child Health and Development Centre of Makerere University. This analysis was the first step in monitoring and evaluating the UNPAC objectives. The NCC is also using data collected in the 1989 and 1995 Uganda Demographic and Health national surveys of reproductive age women to monitor key health indicators that reflect UNPAC progress.

The government has expressed its commitment to children's health and well-being by the introduction of UNPAC. In view of the extremely limited resources available in the country, it is not likely that the ambitious goals of UNPAC will be fully realized in the near future. Indeed, it is likely that UNPAC will be grossly under-funded. As discussed previously, the government is decentralizing control and delegating authority to the local level in all sectors, including health. Initially, this decentralization is likely to have a negative impact on child health and survival.

D. International legal obligations of Uganda

1. Framework for Uganda's international obligations

The international instruments shown in Box 4.3 define Uganda's international legal obligations as discussed in chapter II, and provide a framework for Uganda's compliance with obligations relevant to child health and survival.

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[514] *Id.*

Box 4.3. International instruments regarding child health and survival applicable to Uganda

Universal Declaration of Human Rights	adopted Dec. 10, 1948
International Covenant on Civil & Political Rights (ICCPR)	ratified by Uganda June 21, 1995
International Covenant on Economic, Social & Cultural Rights (ICESCR)	ratified by Uganda Jan. 21, 1987
Convention on the Rights of the Child (Children's Convention)	ratified by Uganda Aug. 17, 1990
Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention)	ratified by Uganda July 22, 1995
International Convention on the Elimination of Racial Discrimination (ICERD)	ratified by Uganda Nov. 21, 1980
African Charter on Human and People's Rights	ratified by Uganda Oct. 21, 1986
African Charter on the Rights & Welfare of the Child	not yet in force; signed by Uganda
WHO Constitution	adopted by Uganda March 7 1963

Uganda has both obligations of conduct and result in regard to the right to health and child survival.[515] Obligations of conduct include monitoring and reporting, and non-discrimination both in law and in practice. Obligations of result require Uganda to "take all effective and appropriate measures" with a "view to achieving progressively the full realization" of the right to health protection and child survival.[516] In addition, Uganda is obligated to utilize to the maximum extent its available resources to undertake such measures,[517] and to do so without discriminating among children on the basis of race, sex, religion, ethnic or social group, or other status. The concept of "progressive realization" takes into account that certain of Uganda's obligations related to health and child survival may not be able to be achieved immediately.[518] But it also "imposes an obligation to move as expeditiously and effectively as

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[515] *See* Maastricht Guidelines, *supra* note 175. *See also* discussion *supra* ch. III, part A.2.

[516] ICESCR, *supra* note 161, art. 2 ("Each State Party . . . undertakes to take steps . . . with a view to achieving progressively the full realization of the right . . . ."); Women's Convention, *supra* note 197, art. 14(2) ("States . . . shall take all appropriate measures and shall ensure . . . access to adequate health care . . . ."); Children's Convention, *supra* note 162, art. 24(2) ("States . . . shall take appropriate measures to diminish infant and child mortality . . . [and] to ensure provision of medical assistance and health care to all children . . . .").

[517] ICESCR, *supra* note 161, art. 2 ("Each State Party . . . undertakes to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant . . . ."); Children's Convention, *supra* note 162, art. 4 ("With regard to economic, social, and cultural rights, States Parties shall take undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation.").

[518] General Comments, *supra* note 176.

possible towards that goal."[519]

Under its obligations of conduct and result, Uganda must adopt legislative, judicial, social, educational, administrative, economic, and other measures for the protection of children's health and survival rights.[520] Uganda must take immediate steps to eliminate discrimination in the enjoyment of the right to health protection and adopt progressive measures to reduce preventable child mortality and ensure the survival, development, and adequate standard of living of children.[521] These measures must provide particular attention to the specific health needs of mothers and children.[522] The principles of Alma-Ata which emphasize preventive measures, community participation, equal access, local sustainability, and priority concern for vulnerable segments of society, should be incorporated in Uganda's policies and programs.[523]

1.1. Obligation to monitor and report accurately

The Ugandan government must monitor and report the extent to which it is meeting its international obligations related to child health and survival. The government must also report on the measures it has adopted in regard to health and children's rights, and on its progress or limitations in alleviating health concerns and furthering health protection.[524] Such reports must include a comprehensive review of its national legislation, administrative rules and procedures, and practices to ensure adequate monitoring of the actual health situation.[525] Uganda must submit reports to the following international human rights bodies: the Committee on Economic, Social and Cultural Rights every five years;[526] the Committee on the Elimination of Racial Discrimination every two years;[527] the Committee on the Elimination of Discrimination against

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[519] *Id.*

[520] Article 2 of the ICESCR requires that States Parties take steps to fully realize the rights in the Covenant "by all appropriate means, including particularly the adoption of legislative measures." ICESCR, *supra* note 161. Article 4 of the Children's Convention also provides that "States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention." Children's Convention, *supra* note 162.

[521] *See supra* ch. III, part A.2.

[522] See *supra* ch. III, part B.2.

[523] *See supra* ch. II, part B.2 and ch. III, part C.

[524] ICESCR, *supra* note 161, part IV. *See also* General Comments, *supra* note 176, at 50-52.

[525] General Comments, *supra* note 176.

[526] ECOSOC Res. 1988/4. *See* MANUAL ON HUMAN RIGHTS REPORTING, *supra* note 277.

[527] ICERD, *supra* note 186.

Women every four years;[528] and the Committee on the Rights of the Child every five years.[529]

1.2. Right to non-discrimination in law and in practice

Non-discrimination is essential to the full realization of children's rights to health and survival. According to the WHO Constitution, which Uganda adopted in 1963, "the enjoyment of the maximum level of health that can be attained is a fundamental right for all without distinction of race, religion, political ideology, or economic and social condition."[530] Similarly, the ICESCR obligates Uganda to recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[531] Along with the non-discrimination provisions in the general human rights treaties,[532] the ICERD and the Women's Convention specifically obligate Uganda to take measures to prohibit gender and race-based discrimination, particularly with regard to health care.[533]

Under these instruments discrimination in the availability, accessibility, affordability, and quality of health services constitutes a direct denial of the right to health.[534] Therefore, Uganda's minimum obligations include steps to eliminate not only discriminatory policies or practices, but also discriminatory impact or effects which impair child survival and health.[535] The Women's Convention as well as other international instruments impose an affirmative duty on the Ugandan government to incorporate the right to non-discrimination in its domestic laws and policies, as well as to ensure non-discrimination in the application and impact of its programs.

1.3. Right to life, health, and adequate standard of living

Under the ICESCR and the Children's Convention, the right to life, to health, and to an adequate standard of living are necessarily interlinked for the survival and development of children in Uganda.[536] Without adequate nutrition, housing, health and other services, children

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[528] Women's Convention, *supra* note 197, art. 18.

[529] Children's Convention, *supra* note 162, art. 44.

[530] WHO Constitution, *supra* note 142.

[531] ICESCR, *supra* note 161, art. 12(1).

[532] *See supra* ch. III, part B.1.

[533] ICERD, *supra* note 186, art. 5 (e)(iv); Women's Convention, *supra* note 197, art. 11(1)(f).

[534] Gruskin & Sullivan, *supra* note 176.

[535] *Id.*

[536] ICESCR, *supra* note 161, arts. 11, 12; Children's Convention, *supra* note 162, arts. 24-27.

and their families cannot attain the highest standard of health or ensure their survival. In order to meet its international obligations for the health, development, and survival rights of its children, Uganda must not only promote health-related programs, but must also ensure the appropriate socioeconomic conditions to attain an adequate standard of living.

2. Assessment of Uganda's compliance

2.1. Reporting

Uganda has not met its obligations to report to the human rights treaty bodies on its progress in complying with human rights treaties.[537] As of 1992, Uganda had a total of 10 overdue reports. This was the third largest number of overdue reports for ICERD, the Women's Convention, ICPPR, and ICESCR.[538] By 1996, Uganda's total number of overdue reports had increased to 12, but ten countries had surpassed Uganda in the total number of overdue reports.[539] Uganda's failure to submit reports to the treaty bodies violates its treaty obligations and frustrates the process of monitoring Uganda's progress under international law.

2.2. Non-discrimination

Uganda's inequitable distribution of services and resources between urban and rural areas has created a discriminatory impact on rural inhabitants. As previously discussed,[540] inequitable policies or practices contravene the non-discrimination clauses of the ICCPR, ICESCR, Children's Convention, and the Women's Convention.[541] The non-discrimination clause prohibits discrimination on the basis of the enumerated characteristics as well as any "other status." The distinction between urban and rural inhabitants falls within the "catch-all" prohibition of discrimination based on "other status." In addition, the Women's Convention explicitly prohibits discrimination against women living in rural areas. The Women's Convention requires states parties to "take into account the particular problems faced by rural women," and specifically guarantees that rural women, "on a basis of equality of men and women," have the right "to have

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[537] *See supra* ch. III, part C.

[538] Anne F. Bayefsky, *Making the Human Rights Treaties Work, in* HUMAN RIGHTS: AN AGENDA FOR THE NEXT CENTURY 288, table D (L. Henkin & J.L. Hargrove eds., 1994). The grouping of treaties for which Uganda has the third largest number of overdue reports includes the Convention Against Torture. *Id.*

[539] Status of the International Human Rights Instruments, *supra* note 279. The countries with a greater number of overdue reports than Uganda include Cape Verde, Congo, Gabon, Gambia, Guinea, Guyana, Liberia, Mali, Sierra Leone, and Togo. *Id.*

[540] *See supra* ch. IV, part D.1.

[541] *See supra* ch. III, part B.1.

access to adequate health care facilities."[542] The sizable disparity between rural and urban maternal mortality suggests that Uganda has not taken adequate measures to ensure rural women's access to health care.

2.3. Progressive realization and resource allocation

Uganda has not effectively realized child health and survival rights nor has it utilized the maximum available resources for health protection. Neglect of its most vulnerable children, as documented in this chapter, contravenes Uganda's obligations to protect the right to life and health.[543] Uganda's record of spending discussed in part C.2 demonstrates that the government has not allocated sufficient resources to child health care, despite the high level of need resulting from Uganda's relatively poor progress in meeting child health rights. The large percentage of government spending on defense programs, as opposed to health expenditures, indicates that Uganda may not have fulfilled the ICESCR's and Children's Convention's requirement to utilize the maximum available resources to reduce child mortality.

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[542] Women's Convention, *supra* note 197, art. 14.

[543] *See supra* ch. III, parts B.2-3.

V. CASE STUDY: MEXICO

A. Findings and recommendations

1. Findings

- Mexico has made significant progress in reducing overall child mortality, but disparities in child survival are increasing between urban and predominantly rural areas. Socio-economic inequities make children who are in Mexico's poor and rural areas, and those who are indigenous, more vulnerable to preventable deaths before reaching age five than children in urban centers:
  - Mexican children in the poorest states (rural with large indigenous populations) die at twice the rate of children in the wealthiest states.
  - Sixty percent of reported maternal deaths occurred in rural areas, contributing to higher numbers of perinatal deaths in these regions.
  - Preventable childhood diseases still cause the majority of under-five child deaths, especially for children from impoverished rural states.
  - Malnutrition levels in the southern poverty belt are four times greater than those in the wealthier urbanized states. Infant and child death rates due to nutritional deficiencies have increased by 23 percent since 1980.
  - Close to 14 million Mexicans live in conditions of extreme poverty, unable to meet their daily nutritional needs; two-thirds of these people reside outside the urban areas.
  - The incidence of poverty among indigenous people is 81 percent, compared with 18 percent among non-indigenous people.
- Persistent socioeconomic inequities are exacerbated by economic and structural adjustment policies. Government economic policies have been biased toward urban centers at the expense of marginalized areas. In the past decade, the Mexican government has systematically pursued austerity and structural adjustment programs in accordance with World Bank and IMF specifications. The process has aggravated inequities in socioeconomic development between urban and rural areas. Under the structural adjustment programs, the Mexican government has considered poverty and disparity as by-products of the country's economic development, rather than as violations of economic, social, and cultural rights. As a result, issues such as child mortality are treated as inevitable rather than preventable.

- The Mexican government's response to preventable child mortality in marginalized areas remains inadequate, in law and practice. Mexico's domestic laws, institutions, and administrative programs embrace the discourse of the Alma-Ata primary health care approach, but in practice they create social dependency rather than social empowerment. Government programs to address child mortality are framed in terms of short-term poverty alleviation or social assistance rather than long-term investments, solutions and priorities. Health and social programs are often politicized and do not adequately address the disparity in child survival nor the underlying socioeconomic conditions which threaten the health and survival of children.

- Although the Mexican government has ratified or adopted international instruments relevant to child health and survival, Mexico has not effectively complied with its international obligations for right to life, health, and non-discrimination. The continued and increasing socioeconomic and child survival disparities constitute a discriminatory impact in marginalized communities in violation of international law.

2. Recommendations

- Comply with all human rights obligations under treaties and instruments to which Mexico is a party.

- Promote and protect children's rights, in particular rights related to child health and survival, through adequate programs and funding.

- Combat preventable childhood deaths and diseases among all segments of the population as a national health priority to which the maximum available resources must be allocated.

- Adopt a cohesive strategy for child health and survival which promotes long-term investments and solutions to alleviate underlying socioeconomic disparities in marginalized areas, including:

  - *poverty*: reorient socioeconomic development policies to redress the devastating impacts in rural and poor communities resulting from World Bank/IMF austerity programs, and government biases and "reforms";

  - *malnutrition*: establish equitable food policies which promote self-sufficiency through food production and livable wages rather than dependency on micronutrient/food supplementation subsidies;

  - *lack of clean water, basic sanitation, and safe housing*: improve environmental conditions to prevent childhood diseases resulting from unsafe housing and water, and lack of basic sanitation systems; and

lack of health and social services: ensure affordable, accessible, and quality health and social services, especially for women and children, which take into account the socioeconomic and cultural concerns of marginalized, particularly indigenous, populations.

- Observe the Alma-Ata principles of primary health care by ensuring equity, universality, community participation, and intersectoral collaboration in health policies and programs. All segments of the population must be enabled to define and guide their own well-being.
- Improve the productive life and health of women, particularly rural women, as well as the welfare of their children and families.
- Target resources to poor and rural communities, and implement urgent measures to ensure balanced and equitable economic growth in both urban and rural areas.
- Correct inconsistencies in child health data, with particular attention to issues of validity and reliability, and utilize disaggregated indicators for vulnerable populations.
- Consult nongovernmental organizations and consider their information and recommendations in health policies and programs.

B. Child mortality in Mexico

Despite Mexico's development and resource levels, its present child mortality rates are higher than similarly situated countries. In addition, glaring disparities in child mortality exist between rural and urban children, poor and wealthier children, and indigenous and non-indigenous children. Discrepancies in data collection and inequities in socioeconomic development adversely affect child survival in marginalized areas. The available data reflect a need to address both biological and socioeconomic determinants to combat preventable child deaths in all segments of the Mexican population.

1. Child mortality in comparison to level of national development

Mexico's overall child mortality rate has been considerably reduced. Figure 5.1 depicts a steady drop in death rates based on official government data for the period 1980 to 1994. The rates of child mortality in the country as a whole, however, are disproportionately high for its development level and comparatively higher than those of other countries with similar or lower levels of GNP per capita.[544] Mexico's 1994 GNP was US$4180 per capita, while its 1995 under-five mortality rate was 32 per 1000 live births,[545] or 27 per 1000 live births as reported by the Mexican government. As shown in Table 5.1, other middle-income Latin American countries, such as Argentina, Chile, Colombia, Costa Rica, Uruguay, and Venezuela, had lower under-five mortality rates than Mexico. These countries also share some common social characteristics, including lower fertility rates, higher female literacy, a good rate of access to basic health services and safe water.[546]

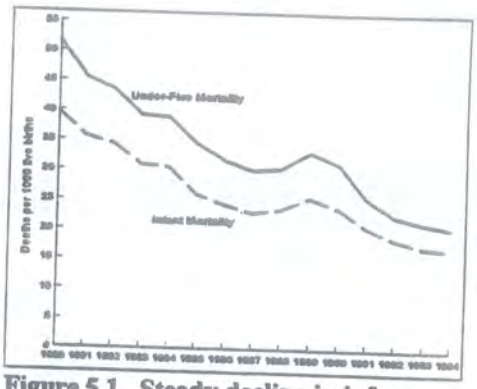

Figure 5.1. Steady decline in infant and child mortality rates in Mexico, 1980-94

Source: Mexico Ministry of Health, 1995.

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[544] While GNP is only one factor in determining a country's development level, it does provide a useful point of comparison between countries.

[545] UNICEF, WORLD'S CHILDREN 1996, *supra*, note 1.

[546] Conversely, Bolivia, Guatemala, and El Salvador have much higher rates of child death, while their rates of female literacy and access to basic services are markedly lower, especially access to health services, and their fertility rates are higher in comparison.

Table 5.1. Child mortality rates in relation to GNP per capita and other social indicators for Mexico and selected middle-income countries in Latin America, 1997*

Countries	Under-five mortality 1995**	GNP per capita 1994 (US$)	Female literacy 1995 (%)	Total fertility 1995	Population urbanized 1994 (%)	Percent of population in 1990-95 with access to: safe water	adequate sanitation	health services
Bolivia	105	770	76	4.6	61	66	55	67
Guatemala	67	1200	49	5.5	42	64	59	57
Brazil	60	2970	83	2.8	78	73	44	–
El Salvador	40	1360	70	3.8	45	69	81	40
Ecuador	40	1280	88	3.3	58	68	76	–
Peru	55	2110	83	3.3	72	71	57	44
Colombia	36	1670	91	2.6	73	85	85	81
Mexico	**32**	**4180**	**87**	**3.0**	**75**	**83**	**72**	**93**
Argentina	27	8110	96	2.7	88	71	68	71
Venezuela	24	2760	90	2.4	93	79	59	–
Uruguay	21	4660	98	2.3	90	75	61	82
Panama	20	2580	90	2.8	53	93	83	70
Costa Rica	16	2400	95	3.0	50	96	84	–
Chile	15	3520	95	2.5	84	85	83	97
Cuba	10	1170	95	1.8	76	89	92	100

* Middle-income countries: GNP per capita of $696 to $8,625 in 1993 (UNDP, 1996).
** Rate per 1000 live births.
– Data not available
Source: UNICEF, STATE OF THE WORLD'S CHILDREN, 1997.

2. Disparities in reducing child mortality

Although Mexico's overall under-five child mortality rate has shown a steady downward trend since the 1960s, progress in children's health and survival has not been shared equally between urban and marginalized areas. Mexico significantly reduced its overall mortality rate for children under five from 148 deaths per 1000 births in 1960 to 27 deaths per 1000 live births in 1995, according to the Mexican government.[547] In 1996, UNICEF reported an under-five mortality rate of 32 deaths per 1000 births.[548] Yet each year an estimated 158,000 Mexican children still die from preventable childhood diseases before reaching age five.[549] A disproportionate number of these deaths occur among children who are indigenous and those in

[547] *See infra* part B.3 (discussing limitations and discrepancies in available data on under-five child mortality in Mexico).

[548] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1.

[549] Roberto Garduño Espinosa, *Mueren de Enfermedades Curables 158 Mil Niños Mexicanos al Año, Señala UNICEF* [*UNICEF Points Out that 158 Thousand Mexican Children Die of Curable Illnesses per Year*], LA JORNADA, Dec. 12, 1995.

rural and poor areas who suffer from the disparities of poverty.

2.1. Disparity in mortality of rural and urban children

Rural children in Mexico are far more vulnerable to early death than urban children. Infants in rural areas are almost three times more likely to die than infants in urban metropolitan areas—79 and 29 deaths per 1000 live births occurred in these areas respectively between 1977 and 1987. Mortality rates for children aged one to five follow a similar pattern (see Table 5.2).[550]

Table 5.2. Comparisons of child mortality rates in urban and rural areas, 1977-1987

Area of residence (by population levels)	Mortality rates (deaths per 1000 live births)	
	Infants	Children aged 1 through four
Rural—2500 pe or less	79	
2500 - 19,999 people	62	
20,000 people and more	40	
Urban—Metropolitan areas	29	3

Source: Secretaria de Salud, Demographic Health Survey (1989).

The disparities between urban and rural child mortality reflect the impact of inequitable socioeconomic development on child survival. The socioeconomic gap between rural and urban populations remains wide—two thirds of the estimated 14 million extremely impoverished Mexicans reside in rural areas.[551] Children in urban and metropolitan settings are more likely to survive than children in rural and poor areas, in large part because they are more likely to have access to health and social services such as hospitals and clinics, sewage systems, and safe drinking water. Disparities in access to basic services between the rural and urban areas have not improved since the later 1980s.[552] The situation is most acute in rural states of the southern region, especially in Oaxaca, Chiapas, Puebla and Guerrero.[553] According to UNICEF, these states have the highest levels of poverty, suffer the greatest food insufficiency, and experience a

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[550] SUBSECRETARIA DE SALUD, SUBSECRETARIA DE SERVICIOS DE SALUD Y DIRECCIÓN GENERAL DE PLANIFICACIÓN FAMILIAR, DEMOGRAPHIC HEALTH SURVEY, ENCUESTA NACIONAL SOBRE FECUNDIDAD Y SALUD–MEXICO (July 1987) [hereinafter MDHS 1987].

[551] WORLD SUMMIT FOR SOCIAL DEVELOPMENT, MEXICO: SOCIAL DEVELOPMENT (1995).

[552] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1.

[553] Roberto Garduño Espinosa, *20 Millones de Mexicanos en Serias Condiciones de Pobreza* [*Twenty Million Mexicans in Serious Conditions of Poverty*], LA JORNADA, Nov. 1, 1995. *See also* Espinosa (Dec. 12, 1995), *supra* note 549.

chronic lack of basic services.[554]

Compared to national levels, deaths from acute respiratory infections (pneumonia and influenza) and intestinal infections are more frequent in states with large segments of rural and indigenous residents such as Oaxaca, Quintana Roo, Puebla, and Chiapas.[555] The death rate from pneumonia/influenza was 3.8 per 1000 live births in these four states in contrast to the national rate of 2.6 per 1000 live births.[556] Pneumonia causes three-fourths of all deaths from acute respiratory infections. Because the duration of the illness is short, it is essential to seek treatment immediately. Most deaths occur because of late or no treatment, which makes it imperative to maintain readily accessible treatment as well as to educate mothers and caretakers about the need to seek health care. Risk factors for acute respiratory infections include malnutrition and low birth weight.

Rates of death from intestinal infections are higher in rural and indigenous areas (ranging from 2.6 to 6.9 deaths per 1000 live births) compared to the national rate of 2.4 per 1000 live births. Diarrheal diseases, one of the leading killers of children in Mexico, occur mainly among marginal groups in rural municipalities.[557] Risk factors contributing to diarrheal diseases include lack of adequate amounts of clean water and adequate sanitation, both of which are often deficient in rural areas.

2.2. Disparity in mortality of poor and wealthier children

Children living in poor communities suffer greater incidences of deaths than those in wealthier communities. Children under five in the poorest five states in Mexico, including Chiapas, Oaxaca, and Puebla, die at twice the levels of those in the five wealthiest states.[558] In addition, children under age five whose mothers live in extreme poverty face a risk of death two and a half times greater than children of women not living in poverty.[559]

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[554] Espinosa (Nov. 1, 1995), *supra* note 553; *see also* Espinosa (Dec. 12, 1995), *supra* note 549.

[555] Vilchis J. J. Gonzales, *Principales Causas de Mortalidad en Menores de Cinco Años* [*Leading Causes of Mortality of Children Under Age Five*], LA SALUD DE LOS NIÑOS [THE HEALTH OF CHILDREN] (Nov. 1994).

[556] The extent of the preventable child mortality problem may be significantly underestimated as unregistered deaths in rural communities appears to be more frequent than acknowledged by the government. Gonzales, *supra* note 555.

[557] S.E. Larrauri, C.A. Larrauri, & J.J. Carreras, *Learning to Prevent Dehydration in Distant Mexican Communities and Markets*, 38 SOC. SCI. MED. 1499-1507 (1994). UN, FROM NAIROBI TO BEIJING, *supra* note 54.

[558] The child mortality rate is 40 deaths per 1000 live births in Puebla, 36 per 1000 in Oaxaca, and 33 per 1000 in Chiapas. Rates are statistically adjusted from official government child mortality statistics for 1994.

[559] COMEXANI, *supra* note 19.

Poverty and under-development contribute to the conditions that place children at extreme risk of early death and disability.[560] Scarcity of family resources often precedes conditions of malnutrition. The high cost of transportation from rural areas to health care clinics restricts access to medical treatment for sick children. Often, these children do not receive the necessary treatment or their treatment is significantly delayed. Extreme lack of basic necessities such as clean water and sanitation, coupled with an insufficient diet, result in high rates of infections, malnutrition, and death.

2.3. Vulnerability of indigenous children to early death

Children in indigenous communities are particularly vulnerable to death before reaching age five. Indigenous populations are disproportionately impacted by poverty, social inequalities, and, consequently, health risks. Recent census counts indicate that indigenous people make up from 8 to 13 percent of Mexico's 93 million people. Yet eight out every ten indigenous people live in poverty, compared to 18 percent of those in the non-indigenous population.[561] Indigenous populations are generally concentrated in the poor, rural municipalities of Mexico. For example, Chiapas, Oaxaca and Puebla are mostly rural areas and are three of the poorest states in Mexico today. These states also have some of the highest populations of indigenous people, ranging from 20 to 42 percent of the total local populations.[562] These areas also have higher child mortality rates than the national average. Chiapas reports a rate of 41 infant deaths per 1000 live births. Oaxaca and Puebla have estimated rates of 33 infant deaths per 1000 live births.

3. Discrepancies in child mortality data in marginalized areas of Mexico

Although all sources show a steady decline in Mexico's national child mortality rate, significant discrepancies in data collection and reporting raise serious questions for monitoring and improving child mortality disparities, particularly for indigenous children or those in rural and poor areas. Data on child mortality in Mexico vary widely by sources, and reliability is mixed. Discrepancies in data collection commonly result from under-reporting, selection bias, and misclassification. In addition, data collection among Mexico's government institutions is often individualized and not coordinated, adding to the likelihood of discrepancies between

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[560] Espinosa (Nov. 1, 1995), *supra* note 553; Ruiz A. Romero, *Reportan la Muerte de 15 Niños Tarahumaras por Desnutrición* [*15 Tarahumara Children Reported Dead from Malnutrition*], LA JORNADA, June 13, 1996; R. Miranda-Ocampo, B. Salvatierra-Izaba, B. Vivanco-Cedeño, C. Alvarez-Lucas, & M.A. Lezana-Fernandez, *Inequidad de los Servicios de Salud a Población Abierta en México* [*Inequalities in the Use of Health Services for the Non-Insured Population in Mexico*], 35 SALUD PUBLICO DE MEXICO 576-84 (1993).

[561] UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13.

[562] Mexico Ministry of Health, *Basic Health Map* (visited 1994) <http//:148.246.247.112.html.diario.official>. Estimates of indigenous populations within individual states vary widely. While the 1990 Census stated that Chiapas has an indigenous population of 716,000, the National Indigenous Institute uses a figure of 1.13 million. COMEXANI, *supra* note 19.

sources. At the least, these limitations warrant cautious use and interpretation of the Mexican government's child mortality data.

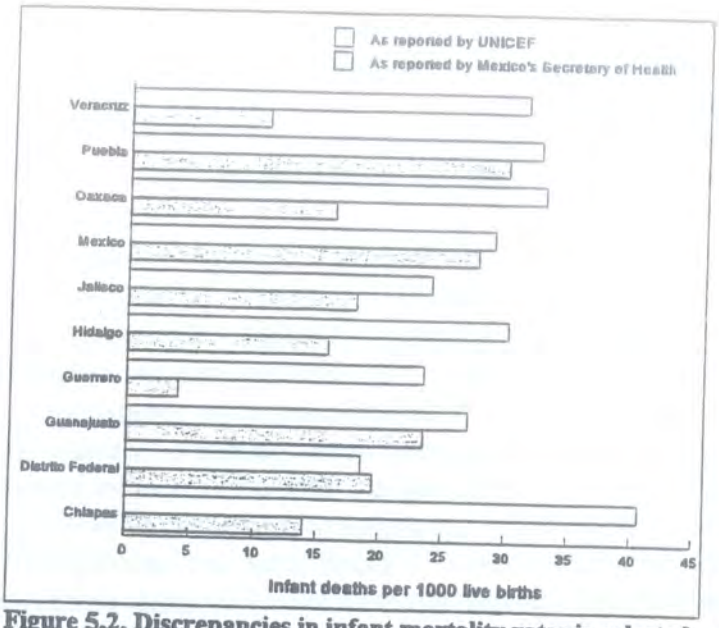

Figure 5.2. Discrepancies in infant mortality rates in selected Mexican States, 1994.

Source: Secretaria Nacional de Salud, Sistema Nacional de Salud, Información Básica por Estado, 1994. MEXICO & UNICEF, WORLD SUMMIT FOR CHILDREN, *supra* note 19; UNICEF, ADVANCES IN MATERNAL CHILD HEALTH 1980-1994.

As shown in Figure 5.2, the 1994 infant mortality rates reported for the selected states vary widely between two sources, the Undersecretariat of Planning for UNICEF and Mexico's Secretariat of Health. For example, for the state of Chiapas, the Secretariat of Health indicates a rate of 15 infant deaths per 1000 births, as compared to 41 per 1000 births reported by the Undersecretariat of Planning/UNICEF.

Obtaining accurate data for marginalized communities is a critical component for reducing child survival disparities in Mexico. Indigenous populations are concentrated in poor, rural municipalities with high under-five child mortality rates; however, the necessary analysis of child mortality among indigenous populations is constrained by the lack of child mortality data disaggregated by ethnicity. For example, the Ministry of Health 1995 report on advances in maternal child health did not report on the status of indigenous child survival. Mexico's 1987 national demographic survey excluded municipalities where 90 percent or more of the population are non-Spanish speakers, the majority of whom are indigenous people. Both the lack of data and the discrepancies in data reflect a failure to systematically confront the issue of children's health and survival with respect to these most vulnerable communities.

4. Inequitable social development in Mexico

While Mexico has undergone significant economic growth in the past several decades, the continuing cycle of poverty, malnutrition, and preventable diseases remains an imposing barrier to reduction of mortality among disadvantaged children. Modernization and economic prosperity brought improvements in social conditions. These improvements, however, were not accompanied by equitable social development across population groups. While gains in national levels of individual income, social well-being, and child survival were reflected in urban centers, the prevalence of poverty and lack of access to basic infrastructure, health care, and social services has persisted and often worsened in marginalized areas. Yet progress can be made in

reducing disparities if equitable social development accompanies economic growth—a challenge Mexico must meet to protect the survival of all its children.

4.1. Disparity of growth and social progress between urban and rural areas

To a considerable extent, Mexico's child survival disparities are attributable to inequitable allocation of resources between rural and urban areas. Disproportionately high levels of economic and development resources to urban centers result in widening levels of inequities in health and socioeconomic well-being. Since the 1940s, rapid growth of the Mexican economy led to the transformation of an essentially rural, agrarian society to industrialized urban centers with an emerging middle-class.[563] Today, three-fourths of the Mexican population is urbanized.[564] Socioeconomic improvements in Mexico have largely been directed toward these urban areas, leaving rural areas, particularly in the impoverished southern states, with only marginal attention. Indigenous children and those in rural and poor communities have lower literacy levels, higher rates of poverty, and higher mortality rates than do their urban counterparts.[565] The sharp child mortality differential between rural and urban areas parallel the disparities in socioeconomic development. Mexico must extend the gains experienced in urban centers to its marginalized areas.

4.2. Impact of Mexico's structural adjustment programs on socioeconomic inequities

The inequities in socioeconomic development have been exacerbated by Mexico's austerity and structural adjustment programs. In the past 15 years the Mexican economy has undergone a series of reforms designed to bring inflation down, generate foreign exchange to pay off tremendous external debt, and enable Mexico to integrate into the global economy. Beginning in 1982, the Mexican government implemented almost every component in a package of economic structural adjustments recommended by the International Monetary Fund (IMF) and the World Bank (WB). These measures included:

- reductions in public expenditures, including social services;
- elimination or targeting of subsidies;
- tax reform;
- restriction of credit;
- privatization of many state enterprises;
- trade liberalization;
- monetary devaluation;

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[563] B. Heredia, *The Political Economy of the Mexican Crisis*, *in* THE IMF AND THE SOUTH.

[564] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1.

[565] *Id.*; UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13.

- removal of barriers to foreign investment; and
- the maintenance of "competitive wages."[566]

While the adjustment programs may have increased gross national product (GNP) and national income, the increases have had little or no direct benefit for poor, rural, and indigenous communities.[567]

Despite the structural adjustment programs, Mexico has undergone severe disruptions to its macro-economic stability. Most recently, in late 1994, the value of the peso dropped dramatically while the cost of living rose sharply. The 1994 economic crisis and accompanying severe recession in 1995 had a devastating socioeconomic impact on workers and their families, particularly in poor, rural, and indigenous communities. Millions of workers lost jobs, over one-third of small business failed, and poverty increased. This economic crisis resulted in the increased vulnerability of poor communities to disparities and partisan social programs.[568]

The combination of unequal socioeconomic development, negative impacts of structural adjustments, and persistent and pervasive poverty have left marginalized communities in Mexico with neither the economic opportunities to attain an adequate standard of living, nor the environmental conditions to maintain the health and survival of their children.

5. Need to address biological and socioeconomic determinants of child mortality

Widening gaps in socioeconomic development and child survival necessitate measures to improve the health and well-being of Mexico's rural, poor, and indigenous communities. To reduce these disparities, the Mexican government should utilize an integrated approach geared toward preventing biological diseases and improving socioeconomic conditions affecting child survival in the most vulnerable populations.

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[566] Latin America Working Group (LAWG), Mexico's Economic Crisis (Mar. 1997) (background information article on file with Minnesota Advocates for Human Rights). These structural adjustment programs are intended to maintain economic stability, but are geared toward the industrialized global economy, not the pervasive poverty in marginalized areas. Economic growth is encouraged through state-society and state-led market relations, a closer integration into the world economy, and the active promotion of exports.

[567] *Id.*

[568] Other impacts of the economic crisis included:
- accelerated migration;
- an increase in the disintegration of family and community life;
- an increased potential for political violence;
- an increase in drug trafficking; and
- intensified pressure for Mexican communities to accept public or private investment for the development of sectors like forestry and tourism. *Id.*

5.1. Preventability of most causes of death for children under age five in Mexico

The leading causes of death for children under age five in Mexico are still "diseases of poverty" and, therefore, largely preventable. According to Mexican government statistics, the seven leading causes of death are perinatal diseases, acute respiratory infections, congenital anomalies, intestinal infections, nutritional deficiencies, injuries, and vaccine preventable diseases (see Table 5.3). Of these, only congenital anomalies (and some perinatal diseases[569]) are not readily preventable.

Table 5.3. Leading causes of under-five child death in Mexico, 1994

Causes	Under-five mortality rate (deaths per 100,000 registered live births)
Perinatal diseases [a]	708
Acute respiratory infections*	322
Congenital anomalies	278
Intestinal infections*	186
Injuries*[b]	115
Nutritional deficiencies*	71
Vaccine preventable diseases*[c]	5

[a] Perinatal diseases are potentially avoidable if associated with preventable conditions of reproductive-age women, such as maternal malnutrition or a lack of obstetric care leading to perinatal deaths.
[b] Includes traffic-related accidents, fire, falls, poisoning, medical treatment, drugs-related, and unspecified others.
[c] Includes polio, diphtheria, neonatal tetanus, whooping cough, measles and tuberculosis.
* Refers to preventable causes of death.
Source: Mexico's General Directorate of Statistics - Ministry of Health (1995).

The Ministry of Health reports that child deaths attributed to these major causes, with the exception of congenital anomalies and nutritional deficiencies, declined sharply between 1980 and 1994.[570] Important overall achievements were made in reducing child death rates resulting from immunizable diseases (97 percent reduction), intestinal infections (85 percent), and acute respiratory infections (69 percent).[571] Mexico's success at the national level in reducing child deaths resulting from these conditions indicates that progress can also be made in preventing the majority of causes of under-five deaths of children in marginalized areas.

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[569] *See* discussion regarding perinatal diseases, *infra* part B.5.1.

[570] MEX. GEN. DIRECTORATE OF STAT., WORLD SUMMIT FOR CHILDREN, *supra* note 19.

[571] *Id.*

Although government data does not show domestic violence as one of the leading causes of preventable child death in Mexico, preliminary studies by NGOs indicate that domestic violence also impacts the health and survival of children in Mexico. On the national level, children make up 57 percent of those who suffer from physical, mental or social abuse.[572] In addition, 23 percent of mothers are victims of domestic violence and other abuse.[573] These percentages indicate a need for government efforts to address domestic violence as a preventable children's health concern.

- **Preventable deaths among children ages 1-4**

Most deaths to children aged one through four can be prevented (see Table 5.4). The leading killer for this age group is preventable injuries—accounting for almost one in three deaths in this age group. The high percentage of injuries may reflect the results of domestic violence or an increase in accidents related to urbanization. The other primary causes of death are acute respiratory infections, intestinal infections, congenital anomalies, malnutrition, and immunizable diseases. With the exception of congenital anomalies, all of these primary causes are preventable.

Table 5.4. Leading causes of death among children aged one to four in Mexico, 1994

Causes	Mortality rate (deaths per 100,000 population aged 1 to 4 years)
Injuries *[a]	24
Acute respiratory infections*	19
Intestinal infections*	17
Congenital anomalies	9
Nutritional deficiencies*	7
Vaccine preventable diseases*[b]	0.7

* Refers to preventable causes of death.
[a] Includes traffic-related accidents, fire, falls, poisoning, medical treatment, drugs-related, and unspecified others.
[b] Includes polio, diphtheria, neonatal tetanus, whooping cough, measles and tuberculosis.
Source: Mexico's General Directorate of Statistics - Ministry of Health, 1995.

- **Preventable infant deaths**

Infants in Mexico suffer the greatest proportion of preventable child deaths. More than 80 percent of the estimated 158,000 deaths of children under age five each year occur within the

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[572] *See* La Assocacion Mexicana Contra La Violencia a Las Mujeres, *Encuesta Nacional 1995 Sobre La Violencia Familiar* [*1995 National Report on Family Violence*], at 4.

[573] *Id.*

first year of life (see Figure 5.3). Nearly a third of these infant deaths are preventable. Since the vast majority of preventable under age five deaths occur during the infancy period,[574] comprehensive primary health care aimed at children in their first year of life should greatly improve child survival overall.

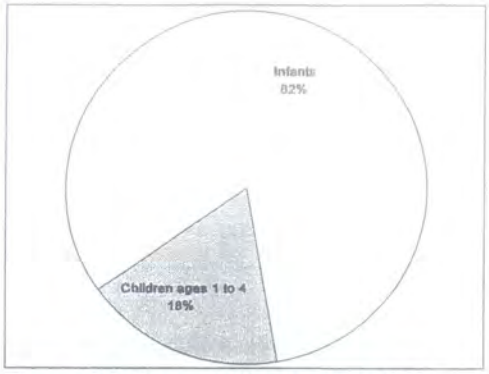

Figure 5.3. Percent distribution of all deaths in under-five population in Mexico, 1994

Source: Mexico Ministry of Health, 1995.

Five of the seven identified leading causes of infant death can be prevented or treated by currently available and inexpensive primary health care measures such as provisions of clean water and sanitation, immunization, ORT, and food sufficiency (see Table 5.5). Another leading cause of infant deaths, perinatal diseases, can be avoided when associated with improvements in health and socioeconomic circumstances of reproductive-age women, such as maternal malnutrition, adverse work environments, or lack of access to emergency obstetric care. Only congenital anomalies are not currently preventable.

[574] For example, 82 percent of acute respiratory deaths among children under five occurred during the infancy period (first year of life), as did 72 percent of deaths due to intestinal infections, and 71 percent of deaths due to malnutrition. *Id.*

Table 5.5. Leading causes of infant death in Mexico, 1994

Causes	Infant mortality rate (deaths per 100,000 live births)
Perinatal diseases[a]	708
Acute respiratory infections*	265
Congenital anomalies	250
Intestinal infections*	135
Nutritional deficiencies*	50
Injuries*[b]	41
Vaccine preventable diseases*[c]	3

* Refers to preventable causes of death.

[a] Perinatal diseases are potentially avoidable if associated with preventable conditions of reproductive-age women such as maternal malnutrition or a lack of obstetric care leading to perinatal deaths.

[b] Includes traffic-related accidents, fire, falls, poisoning, medical treatment and drugs-related, and unspecified others.

[c] Includes polio, diphtheria, neonatal tetanus, whooping cough, measles and tuberculosis.

Source: Mexico's General Directorate of Statistics - Ministry of Health, 1995.

- **Preventable perinatal and maternal deaths**

Perinatal mortality[575] is closely associated with the health and social status of reproductive-age women. Close to half of all infant deaths occur during the perinatal period. Many of these perinatal deaths occur as a result of the effects on the developing fetus of poor health or disease of the mother (e.g., maternal malnutrition, multiparity—i.e., women who have had more than five previous pregnancies, infections, renal vascular diseases, etc.).

As discussed in chapter II, poverty predisposes women to unhealthy pregnancies. Risks of poor maternal health and maternal mortality and, in turn, perinatal deaths are exacerbated in the rural areas. A large percentage of women in these rural areas are poor and lack access to emergency obstetric care and basic reproductive health services. Sixty percent of all reported maternal deaths in 1994 occurred in rural areas, although 75 percent of Mexicans reside in urban areas.

In Mexico inadequate services in health care, family planning, birth spacing, breast-feeding promotion, and safe birth control contribute to both maternal and infant morbidity and

[575] Perinatal mortality is defined as death between the 28th week of fetal development and the completed 7th day after birth.

mortality.[576] Obstetric and other pregnancy-related complications often lead to both maternal and perinatal death, especially in situations where reproductive health care, including emergency obstetric care, is lacking. Although Mexico's maternal mortality rate has declined, the current rate of maternal deaths in Mexico stands at an unacceptably high rate of 48 to 110 maternal deaths per 100,000 live births.[577] Hemorrhage, the leading cause of maternal death, has increased by 50 percent since 1980.[578] In 1994, more than one in three maternal deaths resulted from hemorrhage. Close to 80 percent of the maternal deaths due to hemorrhage occurred in rural areas. These figures are highly indicative of an extreme lack of access to emergency obstetric care in marginalized communities.[579]

5.2. Poverty

Children from impoverished rural and indigenous communities are most affected by preventable childhood diseases and conditions. Malnutrition, childhood respiratory infections, and intestinal infections afflict, to a large extent, children living in adverse social and environmental conditions who lack adequate nutrition, living conditions, clean water, basic sanitation, and health services. The situation has been worsened by economic crises which have eliminated jobs and wages for poor workers and by recent changes in land tenure laws.

Close to 14 million Mexicans live in conditions of extreme poverty, unable to meet their daily nutritional needs.[580] The poor live disproportionately in rural areas. Whereas only one-fourth of the total population lives in rural areas, two-thirds of the poor live in rural areas.[581] The

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[576] A recent study using Mexico's Demographic and Health Survey data suggests that family planning practices, breast-feeding, improved birth spacing and maternal age are strongly associated with a 20 to 40 percent reduction in infant mortality. A. Palloni, G. Aguirre Pinto, & S. Lastiri, *The Effects of Breast-feeding and the Pace of Childbearing on Early Childhood Mortality in Mexico*, 28 BULL. OF THE PAN-AMERICAN HEALTH ORG. 92-111 (1994).

[577] Mexican government sources report a rate of 48 maternal deaths per 100,000 live births, while WHO/UNICEF reports a rate of 110. The current maternal mortality rate for industrialized countries is seven per 100,000; for the Americas region, which includes Mexico, the rate is 140 per 100,000. Most recent data from the Ministry of Health indicate that maternal mortality in Mexico decreased by 38 percent during the period between 1980 and 1994. MEXICO, WORLD SUMMIT FOR CHILDREN, *supra* note 19.

[578] *Id.*

[579] The high incidence of hemorrhage-related maternal deaths may also indicate the negative results of self-induced abortions. Abortion is currently illegal in Mexico, and thus not provided as a health service nor administered by trained medical professionals.

[580] WORLD SUMMIT FOR SOCIAL DEVELOPMENT.

[581] *Id.*

incidence of poverty among indigenous people is 81 percent, compared with 18 percent among non-indigenous people.[582]

Recent changes in land tenure laws in Mexico threaten to erode the one viable means of livelihood for most poor agrarian families. Prompted by macroeconomic structural adjustment policies, the Mexican government significantly amended Article 27 of the Mexican Constitution in 1992 by reducing agrarian subsidies and opening community lands to private or corporate ownership. (For a discussion of the land tenure amendments, see Box 5.1.) These amendments have had adverse implications for the rural poor, many of whom are subsistence peasants.[583] The changes appear to have limited access to arable land. The market-oriented land reform can be expected to further deteriorate the cycle of poverty and food insecurity, with devastating effects on the survival and health of Mexico's disadvantaged children.

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[582] UNDP, HUMAN DEVELOPMENT REPORT, *supra* note 13.

[583] Mexico's 1991 official statistics registered over 2.4 million rural farmers, 90 percent of whom have holdings of 5 hectares or less. C.E. HEWITT DE ALCANTARA & CENTER FOR U.S.-MEXICAN STUDIES, ECONOMIC RESTRUCTURING AND RURAL SUBSISTENCE IN MEXICO: CORN AND THE CRISIS OF THE 1980S (Transformation of Rural Mexico Series No. 2, 1994). *See also* GEORGE A. COLLIER & ELIZABETH LOWERY QUARATIELLO, INSTITUTE FOR FOOD & DEV. POL'Y, ¡BASTA! LAND AND THE ZAPATISTA REBELLION IN CHIAPAS (1994).

Box 5.1. Mexico's Land Tenure Reform

As an outcome of the Mexican Revolution, agrarian reforms were institutionalized under Article 27 of the Mexican Constitution of 1917, which established:

- that the nation is the owner of the lands and waters located within the national territory;
- that the nation will, at all times, have the right to impose on private property the characteristics dictated by public interests;
- that the Mexican state has the authority to restore and provide lands to Indian communities and peoples, and that lands would be taken from estates that exceed the limits established for small property;
- the foundation for the creation of special institutions in charge of agrarian administration and the procedures for the restoration and provision of lands.

From this legislation three forms of agrarian tenure developed: small property, *ejidal* lands, and agrarian community lands. The *ejido* is a community-based system of land tenure in which the government protected privately held parcels and communal lands within the community from the market. These lands could not be bought, sold, or rented and were subject to strict size limits. The agrarian community lands were indigenous lands based on historical claims and have operated more autonomously than the *ejidos*.

In 1992 the Mexican government instituted land reforms by revoking certain sections of Article 27. The reforms were developed in the interest of "modernization" of the economy. The reform followed a neoliberal economic perspective which held that state intervention and regulation inhibited free market forces, private capital, and investment. Basic aspects of the constitutional reform include:

- the end of the distribution of rural lands;
- the end of subsidies for such agricultural inputs as fertilizer and seeds, reduction of farm credit, and liberalization of prices so they would drop to international levels;
- lifting of the prohibition for companies (civil or mercantile) to become owners, through stocks and bonds, of rural lands dedicated to farming;
- the laying of foundations for communal lands and communities to reach autonomy in their internal affairs, mainly in regard to their forms of representation and organization;
- the laying of foundations for mechanisms and requirements for the nucleus of the *ejidal* and communal lands and the communal landholders to exercise their subjective rights as to the disposal of the communal property;
- the reorganization of organisms and authorities in charge of resolving controversies and administering and procuring justice in agrarian matters;
- establishment of gradual liberalization and state help.

These reforms marked the end of the agrarian distribution of land and allowed the privatization of *ejidos* and community lands, and the appropriation of national territory by international corporations. Critics of the reform point out that it reduces the profitability of peasant farming or makes it less attractive to investors than other sectors (particularly petroleum and commercial cultivation for export), leading to the loss of sovereignty and self-sufficiency in rural areas of Mexico.

Sources: REFORMING MEXICO'S AGRARIAN REFORM (Laura Randall ed., 1996); TOM BARRY, ZAPATA'S REVENGE: FREE TRADE AND THE FARM CRISIS IN MEXICO (1995); GEORGE A. COLLIER & ELIZABETH LOWERY QUARATIELLO, BASTA! LAND AND THE ZAPATISTA REBELLION IN CHIAPAS (1994).

5.3. Food insecurity and malnutrition

According to Mexico's National Institute of Nutrition (INN), 82 children die every day from malnutrition, accounting for 30,000 child deaths annually.[584] The death rate from nutritional deficiencies among Mexican children under age five has risen dramatically by 23 percent between 1980 and 1994. Even these alarming figures may be underestimated because malnutrition is often not registered as the cause of death. For example, a child's death may be

[584] *Eighty-two Children Die Daily of Malnutrition*, INTER PRESS SERVICE/SPANISH (Mexico News Pack), Sept. 16, 1995.

attributed to diarrheal disease when the true cause of death is the combined effect of protein energy malnutrition and dehydration from diarrhea.

Malnutrition is particularly widespread and severe among children in marginalized areas of Mexico. In the southern rural poverty belt, malnutrition levels are four times greater than those in the wealthier urbanized states of the north.[585] A recent nation-wide survey done by the INN revealed that the malnutrition level among indigenous children has reached 43 percent.[586] Chiapas and Oaxaca, regions with large indigenous populations, have the highest rate of underweight children at 45 and 42 percent, respectively.[587] A 1993 study of the three national food surveys conducted since 1974 concluded that there was increasing "nutritional polarization, that is, the areas that began with lower malnutrition continued to improve, while the poor and indigenous areas with initially high prevalence of malnutrition deteriorated further."[588] According to UNICEF's representative in Mexico, the most inaccessible indigenous regions suffer the greatest food insufficiency.[589]

Current levels of nutritional deficiencies continue to pose grave danger to the survival of Mexico's vulnerable children. Food security and adequate nutrition to meet basic daily minimum calories are essential in order to reduce childhood deaths resulting from the combined effects of malnutrition and infections. According to the INN, 42 percent of children under five show some signs of malnutrition based on weight and age indicators.[590] The Economic Commission for Latin America and the National Institute of Statistics, Geography and Informatics have indicated that over 9 million Mexicans have access to only one fourth of the minimum daily calorie intake.[591] A study by Bancamex, one of Mexico's most important financial institutions, reveals that one half of Mexico's population (46 million people) do not

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[585] COMEXANI, LOS NIÑOS, *supra* note 19.

[586] INSTITUTO NACIONAL DE LA NUTRICION, ENCUESTA NACIONAL DE ALIMENTACION Y NUTRICION EN EL MEDIO RURAL 1996 [NATIONAL NUTRITION INSTITUTE, NATIONAL DIET AND NUTRITION STUDY IN RURAL AREAS] (1996) [hereinafter INN NUTRITION STUDY].

[587] R. Wong-Luna & A.V. Mayagoitia, *La Desnutrición en la Infancia* [*Childhood Malnutrition*], LA SALUD DE LOS NIÑOS (1994).

[588] M. Avila Curiel, A. Chavez-Villasana, T. Shamah-Levy, & H. Madrigal-Fritsch, *La Desnutrición Infantil en el México Rural: Analysis de las Encuestas Nacionales de Alimentación* [*Child Malnutrition in Rural Mexico: An Analysis of National Food Surveys*], SALUD PUBLICA DE MÉXICO, Nov.-Dec. 1993.

[589] Espinosa (Nov. 1, 1995), *supra* note 553.

[590] MEXICO NAT'L COMM'N FOR CHILDREN, NATIONAL PROGRAM OF ACTION FOR CHILDREN 1995-2000: EVALUATION 1996, at 62 (1996) [hereinafter NPAC EVALUATION].

[591] R. Gonzales Amador, *50% de Mexicanos sin Ingresos para Comprar el Minimo de Calorias Diarias* [*50% of Mexicans Without Resources to Acquire the Minimum Daily Calories*], LA JORNADA, June 16, 1996.

have sufficient financial resources to purchase the minimum daily calories required for proper nutrition. At the same time, they no longer have the security of growing their own food.[592]

5.4. Unsafe water, lack of basic sanitation, and inadequate living conditions

The lack of adequate living conditions, safe drinking water, and basic sanitation services is a widespread problem in rural and sparsely populated regions of Mexico. Recent figures show that of Mexico's population of 93.7 million,[593] nearly 16 million Mexicans—a disproportionate number of whom live in marginalized areas—lack access to safe water supplies; 31 million lack basic sanitation services.[594] According to UNICEF, safe drinking water reaches only 62 percent of the rural population, while an estimated 91 percent of the urban population has such access. Only 17 percent of the rural population has basic sanitation systems, compared with at least 70 percent of the urban population (see Table 5.6).

Table 5.6. Comparisons of urban and rural populations with access to basic services, 1996

	Urban	Rural
Safe water	91%	62%
Adequate sanitation	70%	17%

Source: UNICEF, State of the World's Children (1996).

Safe drinking water and basic sanitation are critically important to the health and survival of infants and children.[595] Unsafe water or lack of sanitation contributes to higher incidence of infectious and intestinal diseases. Long-term solutions to the control of diarrheal diseases resulting from lack of clean water and sanitation must include improved water supplies and sanitation, coupled with enhanced domestic hygiene that such measures would facilitate. In addition, adequate living conditions—including safe and clean environments, adequate housing, and warm clothing—are essential to minimizing the risk of death from such diseases as pneumonia and influenza.

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[592] *Id.*

[593] UNICEF, STATISTICS FOR LATIN AMERICA & THE CARIBBEAN 2 (July 1996).

[594] NPAC EVALUATION, *supra* note 590, at 116.

[595] See *supra* ch. II, parts B & C.

5.5. Inadequate health care services

According to the Mexican government's statistics, an estimated 8 to 10 million Mexicans do not have access to health care.[596] Seventy six percent of the uninsured population lives in the regions with the highest poverty levels. Health coverage in the wealthier states is almost twice the level of that in poor states.[597] Hospital mortality rates among infants in poor states are substantially higher than those in wealthier urban regions.[598]

Access to primary health care services is fundamental to ensuring protection of health and life. Yet in the context of Mexico's macroeconomic policies and adjustment programs, health related costs fell increasingly on individual Mexicans. Hidden costs and privatization of the health system, combined with inadequate safety nets for the poor, created serious barriers to health care for disadvantaged Mexicans. As a result, Mexico's indigenous children and those in poor and rural areas have faced disproportionately greater risks of poor health and premature death.

C. Mexico's law and practice

1. Law

Mexican law respecting health protection and child survival is contained primarily in the Political Constitution of the United Mexican States and General Health Laws, the Organic Federal Law on Public Administration, and the State Health Law provisions.

1.1. Right to non-discrimination and equality

The Mexican government is obligated to ensure that its health policies and programs are applied non-discriminatorily, and that they equitably protect the health of children in poor, rural, communities and those who are indigenous. Mexico's Constitution prohibits discrimination in the enjoyment of rights, including the rights to life and health protection discussed above. The Constitution recognizes that "[e]very person in the United Mexican States shall enjoy the guarantees granted by this Constitution,"[599] and that "men and women are equal before the law."[600] In addition, the Constitution acknowledges Mexico's indigenous populations, and

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[596] Espinosa (Nov. 1, 1995), *supra* note 553.

[597] Miranda-Ocampo et al., *supra* note 560.

[598] *Id.*

[599] MEXICO CONST. tit. 1, ch. 1, art. 1.

[600] *Id.* art. 4.

protects and promotes the development of their cultures and resources.[601] Through the General Health Law, the National Health System also guarantees quantitative and qualitative health services, particularly to vulnerable groups.[602]

1.2. Right to life

The Mexican Constitution upholds the right to life. Article 14 states that "[n]o one can be deprived of life . . . or rights except through a trial held before previously established courts."[603] This guarantee extends to all people in Mexico in accordance with Mexico's international obligations under such instruments as the ICCPR and Children's Convention.

Mexico's interpretation of the right to life includes child survival. Mexico's report to the Human Rights Committee regarding its compliance under the ICCPR includes data on infant mortality within the discussion of the right to life. This information demonstrates Mexico's acceptance of the Human Rights Committee's interpretation of the right to life, which includes children's right to life.[604]

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[601] *Id.*

[602] GENERAL HEALTH LAW, tit. III, ch. 1, art. 25 ("In conformity with their priorities, the National Health System guarantees the provision of quantitative and qualitative health services, particularly to vulnerable groups.") [unofficial translation].

[603] MEXICO CONST. tit. I, ch. 1, art. 14.

[604] The U.N. Human Rights Committee, which monitors implementation of the ICCPR, to which Mexico is a party, has interpreted the right to life broadly to include an obligation to reduce preventable infant mortality. *See Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant: Second Periodic Reports of States Parties due in 1987*, U.N. Hum. Rts. Comm., U.N. Doc. CCPR/C/76/Add.2 (1993).

1.3. Right to health protection

• Constitutional provisions

The Mexican Constitution guarantees the right to health protection.[605] Article 4 establishes that "[e]very person has the right to health protection. The law shall define the ways and means to provide access to health services, and shall establish the participation of the Federation and of federal agencies concerning health . . . ."[606] Although the term *health* is not precisely defined in the Mexican Constitution, Mexico has adopted the broader concept of health based on the WHO Constitution which states "health is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."[607] The broad interpretation of health implies a governmental obligation to adopt a primary health care approach rather than linking health programs only to curative measures.[608]

The Mexican Constitution grants authority to the legislative and executive powers to protect health. It gives the Mexican Congress the power to enact laws related to the "general health," and establishes a General Health Council with authority to make general provisions which are obligatory throughout the country.[609] In addition, the Constitution requires the Ministry of Health to take appropriate measures in the case of serious epidemics or the danger of the importation of exotic diseases.[610]

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[605] Mexico's constitutional history includes early, though somewhat vague, references to health. In 1814, the Constitutional Decree for the Freedom of Mexican America established the power of the Supreme Congress to approve "regulations that would lead to the health of citizens." PAN AMERICAN HEALTH ORGANIZATION (PAHO), SCIENTIFIC PUB. NO. 509, THE RIGHT TO HEALTH IN THE AMERICAS: A COMPARATIVE CONSTITUTIONAL STUDY (Hernan L. Fuenzalida-Puelma & Susan Scholle Connor eds., 1989) [hereinafter PAHO, HEALTH IN THE AMERICAS]. In 1824, however, Mexico became a republic and promulgated a federalist constitution that made no reference to health; subsequent constitutions relegated responsibility for health to local governments until the Constitutional Congress of 1917 again empowered Congress to legislate regarding health issues. *Id.* at 375. Despite the vacillation regarding jurisdiction over health issues, the Mexican government has historically treated health as an issue worthy of constitutional protection. *Id.* It was not until the amendment of February 3, 1983, however, that health protection acquired constitutional status. *Id.* at 374.

[606] MEXICO CONST. tit. I, ch. 1, art. 4. The current formulation was adopted by amendment in 1984. *See also* PAHO, HEALTH IN THE AMERICAS, *supra* note 605.

[607] WHO Constitution, *supra* note 142. *See also* PAHO, HEALTH IN THE AMERICAS, *supra* note 605.

[608] PAHO, HEALTH IN THE AMERICAS *supra* note 605, at 376.

[609] MEX. CONST., tit. III, ch. 2, art. 73, § XVI(1).

[610] *Id.* § XVI(2).

General Health Law

The General Health Law ensures health protection, and contains programmatic provisions, which commit the State to action on health matters.[611] The law identifies the objectives of health protection to include physical and mental well-being, improved length and quality of life, social development, health services and social assistance, health education and research.[612] Specific provisions of the General Health Law address medical care particularly for the benefit of vulnerable groups, maternal-infant care, education for health advancement, nutrition, occupational health, and basic sanitation.[613]

In addition, the goals of the National Health System, set forth in the General Health Law, integrate the biological and socioeconomic factors essential to good health. Specifically, the National Health System objectives are to supply quality health services to all, pay special attention to preventative actions, contribute to harmonious demographic development, collaborate through social assistance services toward equitable economic and social well-being,

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[611] PAHO, HEALTH IN THE AMERICAS, *supra* note 605.

[612] GENERAL HEALTH LAW, tit. II, ch. 1, art. 2:

The right to health protection has the following purposes:
(1) The physical and mental well-being of the [person], to contribute to the full exercise of his or her abilities;
(2) The prolongation and improvement of the quality of life;
(3) The protection and improvement of values which assist the creation, conservation, and enjoyment of health conditions that contribute to social development;
(4) The extension of attitudes of solidarity and popular responsibility in the preservation, conservation, improvement and restoration of health;
(5) The enjoyment of health services and social assistance that effectively and timely
(6) The [knowledge/education] for adequate health development and utilization of health services and;
(7) The development of scientific and technological [education/training] and [investigation/research] for the advancement of health.

[unofficial translation].

[613] *Id.* tit. I, ch. 1, art. 3:

In the terms of the law, the matter of general health [includes] . . .:
(1) Medical attention, particularly for the benefit of vulnerable groups; . . . .
(4) Maternal-infant [care]; . . . .
(10) Information related to the health conditions, resources, and services in the country;
(11) Health education;
(12) Orientation and assistance in the matter of nutrition; . . . .
(14) Occupational health and basic sanitation . . . .

[unofficial translation]

and give impetus to family and community development including the physical and mental growth of children.[614]

The General Health Law places a priority on maternal-infant care. Maternal-infant care is comprised of: "(I) the care of women during pregnancy, child birth, and the post-natal period; (ii) the care of the child and regard for his/her growth and development, including the promotion of timely vaccinations; and (iii) the promotion of the integration and welfare of the family."[615] In the organization and operation of maternal-infant health services, health authorities are directed to establish procedures for active participation of the family in prevention and care, promotion of breast-feeding and direct food assistance, and actions to control diarrhea, acute respiratory infection, and vaccine-preventable diseases.[616]

The General Health Law also contains an integrated, multi-sectoral approach to maternal-infant care by calling on health, education, and labor authorities to support and promote maternal-infant care, strengthen the health of families, encourage occupational safety for minors and pregnant women, and take actions related to education, as well as access to potable water and

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[614] *Id.* title II, ch. 1, art. 6:

The National Health System has the following objectives:
(1) To supply health services to all the population and to improve the quality of such services, considering the priority of health problems and the factors that cause harm to health, with special interest in preventative actions;
(2) To contribute to the harmonious demographic development of the country;
(3) To collaborate for the social well-being of the population through social assistance services, particularly to (abandoned minors/orphans), helpless elderly, and disabled to promote their well being and to probe for the inclusion in an equitable life economically and socially;
(4) To give impetus to the development of the family and the community, such as social integration and the physical and mental growth of children.

[unofficial translation]

[615] *Id.* tit. III, ch. 5, art. 61.

[616] *Id.* tit. III, ch. 5, art. 64:

In the organization and operation of health services designated for attention to maternal-infant health:
(1) procedures that will allow the active participation of the family in the prevention and timely care of [the sufferings of health care user];
(2) actions for institutional guidance and vigilance, [promotion/encouragement] of breast-feeding, and, in any give case, direct food assistance to improve the nutritional status of the maternal-infant groups; and
(3) actions to control diseases preventable by vaccinations, diarrhea [intestinal infections], and acute respiratory infection in minors under age five.

[unofficial translation]

sewage systems.[617] In addition, with regard to the prevention of maternal and infant mortality, the General Health Law promotes the institutional organization of committees to understand, systematize, and evaluate the problem, as well as to adopt appropriate measures.[618]

- **Legal protections of conditions that promote health**

Mexico's laws include additional measures which promote general health, including clean water and public education. The Constitution stipulates that municipalities and, if necessary, states shall take responsibility for sanitation, drinking water, and sewerage.[619] In addition, the General Health Law promotes education geared toward public participation in prevention of illness, public awareness of cases of illness and environmental hazards to health, and public orientation in the areas of nutrition, family planning, occupational health, and adequate use of health services.[620]

- **Responsibility for children's health**

Under the Mexican Constitution and General Health Law, parents and the government hold shared responsibility for the health of children. Constitutional Article 4 sets forth

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[617] *Id.* tit. III, ch. 5, art. 65:

> Health, education, and labor authorities in their respective fields of competency, will support and promote:
> (1) Programs for parents that promote maternal-infant care;
> (2) Recreational activities, for leisure and cultural ends to strengthen the nuclear family and promote the physical and mental health of its members;
> (3) Watchfulness against occupational activities that place at risk the physical and mental health of minors and pregnant women; and
> (4) Actions related to basic education, adult literacy, access to potable water and sewage systems.

[unofficial translation]

[618] *Id.* tit. III, ch. 5, art. 62.

[619] MEX. CONST., tit. V, art. 115, § III.

[620] GENERAL HEALTH LAW, tit. VII, ch. 2, art. 112:

> The purpose of health education is:
> I. To promote within the public the development of attitudes and conduct that permits them to participate in the prevention of individual illnesses, (collective illnesses) and accidents, and to protect them from the risks of putting their heath in danger;
> II. To supply to the public, knowledge about the cases of illnesses and of the harms provoked by the effects of environmental hazards on health; and
> III. To orient and enable the public, particularly in the areas of nutrition . . ., family planning . . ., occupation health, adequate use of health services . . . .

[unofficial translation].

governmental obligations to protect the right to health of children, while amendments to Article 4 establish parental responsibility for children's right to health protection. The provisions state: "It is the parents' duty to observe the right of minors to the satisfaction of their needs and to physical and mental health. . . . The law shall determine the support for the protection of minors to be given by public institutions."[621] In addition, the General Health Law recognizes that responsibility for the physical and mental health protection of minors entails shared responsibility among parents or guardians, the state, and society.[622]

- **Remedies**

Mexico's domestic law does not provide enforcement mechanisms for the right to health protection. The General Health Law does, however, include a provision regarding health related legal claims. Article 60 provides for denouncement "before the health authorities [of] every deed, act, or omission that represents a risk or could cause harm to the health of the population. This public action can be exercised by any person, it being sufficient to start the suit by setting out the facts that make it possible to locate the cause of the risk."[623] Despite the broad language, the Article 60 provision does not allow for claims regarding the accessibility or adequacy of the health care system. Instead, the provision functions as a negligence lawsuit against personnel in medical malpractice cases reviewed by the National Commission on Human Rights (CNDH) and the National Medical Arbitration Commission (CONAMED).[624]

The CNDH is mandated to propose and ensure compliance of national policy and protection of human rights and charged with implementing preventative, remedial and coordinating measures to safeguard the rights of Mexicans. The CNDH, however, largely functions as a non-judicial complaint mechanism with authority to carry out investigations, to afford the complainant direct access to the agency, and to prepare periodic publicly available reports. Similarly, the National Medical Arbitration Commission (CONAMED), which reports to CNDH, was created in 1996 to address increased medical complaints and conflicts between health care recipients and health care providers. Despite review of negligence claims brought against medical personnel, neither of these institutions offer mechanisms to enforce the health protection rights articulated in Mexico's domestic law.

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[621] MEX. CONST. tit. I, ch. 1, art. 4 (as amended). *See also* PAHO, HEALTH IN THE AMERICAS, *supra* note 605, at 385.

[622] GENERAL HEALTH LAW, tit. I, ch. 5, art. 63 ("The physical and mental health protection of minors is the shared responsibility of parents, guardians or any individuals who bear legal rights over them, the state and society in general.") [unofficial translation].

[623] *Id.* tit. I, ch. 4, art. 60.

[624] *See infra* part 2.1.

2. Practice

Although Mexico's domestic law includes the legal guarantee of health protection and programmatic provisions related to the health system, in practice the Mexican government has not effectively implemented the health and survival rights of children in vulnerable sectors. The disparities in the provision of basic health services and in child mortality rates indicate that children who live in rural and poor regions and those who are indigenous do not enjoy the rights guaranteed in the Mexican Constitution.

The institutional structure of the Mexican health system is composed of three large sectors: (1) the public sector and institutions; (2) private sector individuals and corporations providing health services; and (3) other coordinating mechanisms for health services.[625] The public health sector is the most important health service provider in terms of the number of programs it administers and the number of health care users it services.[626] The many public health institutions and programs, however, create an extensive bureaucracy which fails to provide quality, affordable, and accessible services to protect the health and ensure the survival of children in all segments of Mexico's population.

2.1. Mexico's public health institutions

Mexico's public health system has experienced problems in administering primary health care, including inefficient administration, insufficient coverage, lack of cooperation among various agencies, unequal quality of services, and excessive centralization.[627] In addition, recent decentralization of the health system has shifted the health-related responsibilities increasingly upon state institutions instead of federal authorities. The federal authorities and public institutions within Mexico that are charged with the coordination of appropriate measures and compliance with health policy relating to children include: the Ministry of Health, the Social Security Institute (IMSS), the Institute of Safety and Social Services for State Workers (ISSSTE), the Institute for the Integral Development of the Family (DIF), and the National Commission for the Study of Perinatal and Maternal Mortality.

- **Ministry of Health**

Mexico's Ministry of Health, the Federal executive agency that acts as the regulator of Mexico's health system, directs and implements Mexico's health policy. Under the direction of the Secretary of Health (currently Juan Ramón de la Fuente), the Ministry of Health administers

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[625] PAHO, HEALTH IN THE AMERICAS, *supra* note 605.

[626] *Id.*

[627] Pan-American Health Organization (PAHO), *Mexico Undergoing Health Sector Reform* (Contact: Daniel Epstein at (202) 861-3458), May 9, 1996 [hereinafter PAHO, *Mexico Undergoing Health Sector Reform*].

most of the health care services provided by the public health sector, the largest direct provider of health services. As the highest authority within the health sector, the Ministry of Health also coordinates the other public health institutions, including health services provided through social security and social welfare programs.

Despite its broad administrative authority, Mexico's Ministry of Health has not effectively provided nor coordinated health services to marginalized communities. Although the Ministry of Health is the largest health care provider, over 10 million Mexicans lack access to health services. These uninsured millions are principally rural workers. In addition, women and children in poor, rural areas suffer the gravest deficiencies in access to and quality of health services. The high child and maternal mortality differentials in poor, rural, and indigenous populations indicate that the Ministry has not provided essential health care to these communities.

The Ministry of Health also operates a vital registration system through which it is required to provide adequate and accurate vital statistics in reporting data and policy regarding Mexico's health system. Although the Ministry's statistics are of consequence to determining child survival disparities and implementing programs, the data actually provided by the Ministry of Health significantly varies from that of other agencies or international organizations.[628]

- **Social security agencies**

Basic social services, including health care services, fail to reach many of the most needy, including indigenous groups and displaced workers. The Mexican Social Security Institute (IMSS) and the Institute of Safety and Social Services for State Workers offer social services and emphasize health services for city and rural workers and the general population. IMSS administers many of the social services for the general population including child-day care services, health care education, and recreation services. Through its Solidarity Program (recently renamed Bienestar), IMSS also implements services geared toward reproductive health and family planning services. In addition, IMSS runs rural hospitals that provide a significant percentage of maternal health care.

As of 1991, the social security system covered nearly 55 percent of the population; the remaining 45 percent came under the nominal responsibility of other services. Despite the number of social security programs, an estimated 6 percent of the population, particularly indigenous groups, lacks social services due to geographic, economic, or cultural accessibility problems. Given the growing number of displaced workers following the 1994-1995 economic crisis, the numbers of individuals qualifying and receiving social security services may be further declining.

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[628] *See supra* part B.3.

- **Other health and social assistance institutions**

A number of other institutions provide health and social assistance programs and studies, but there is little coordination among them. For example, the National Commission for the Study of Perinatal and Maternal Mortality was established in 1995 to investigate, analyze and report perinatal and maternal mortality. In addition, the Institute for the Integral Development of the Family (DIF) provides legal advice for persons receiving social assistance as well as regulates the health provisions of the General Health Law regarding social assistance and development matters. In that capacity, the DIF is charged with monitoring and evaluating health, education, and other social development matters in conjunction with other institutions in the National Health System as well as international organizations such as UNICEF.

While the DIF and other agencies within and outside the health sector, pursue a number of child and family oriented programs, there is little coordination among them.[629] Not only do the agencies pursue programs independently from one another, they often function competitively with each other.[630] Time and resources are often spent in "public relations." The agencies efforts are focused in promoting the interests of the institution rather than the needs of the populations affected by their programs. Such an organizational structure detracts from the efficient use of resources and prevents inter-sectoral collaboration on programs.

2.2. Quality and access of Mexico's health care facilities, personnel, and programs

Mexico's public health system administers a number of programs to address health related issues such as primary health care, maternal-infant care, and nutrition. Many of these programs are inadequate in terms of staffing, equipment, location, or approach. Many use short-term strategies that foster dependency and do not effectively address the underlying socioeconomic factors that create health risks. Mexico's public health system has been most successful in vertical programs that administer a particular service, such as national immunization. But programs that confront socioeconomic issues are often politicized and non-participatory.

- **Inadequacy and inaccessibility**

Mexico's growing population has increasingly depended on public rather than private health care facilities because of their lower cost.[631] Private Mexican hospitals, located only in

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[629] Interview with DIF spokesperson, in Mexico (Aug. 8, 1997).

[630] *Id.*

[631] *See* Roberto Garduño Espinosa, [*Demographic Growth is the Most Important Problem of the Country*], LA JORNADA, Dec. 8, 1996; Nancy Nusser, *Death Raises Questions About Mexico's Clinics*, AUSTIN AMERICAN-

urban areas, are comparable to those in more industrialized countries such as the United States in terms of equipment, facilities, and staffing, but are often too expensive for large segments of the population.[632] The public facilities, however, often have shortages of supplies and medical personnel.[633] Coupled with the growing health care demands of the population, these shortages create a "vicious cycle" of health care inadequacy within the public health facilities.[634]

Mexico's public health facilities are often not accessible to many Mexicans in marginalized communities. The distance from the communities to the facilities as well as the lack of paved roads, transportation costs, and other infrastructure prevent many individuals from poor, rural communities in isolated areas from obtaining health care. Moreover, many people in these communities report inhumane or culturally insensitive treatment in public health care facilities.[635] As a result, many rural, poor, and particularly indigenous families must travel long distances to private or alternative health care facilities. (For an example of an alternative facility administering health care particularly to the health needs of indigenous children, see Box 5.2).

STATESMAN, Jan. 14, 1997.

[632] Nusser, *supra* note 631.

[633] *Id.*

[634] *See* Espinosa (Dec. 8, 1996), *supra* note 549.

[635] Interview with NGOs and community members, in Chiapas (Aug. 7, 1998).

Box 5.2. San Carlos Hospital - Villa Altamirano, Chiapas

The mountain region of Altamirano, in the state of Chiapas, has a 97 percent indigenous population. In this remote area, San Carlos Hospital was established in 1967. San Carlos Hospital, a church-run health provider, is the only such facility in the region, and perhaps in the country, which has a structure and organization adapted for indigenous cultures.

San Carlos provides three levels of health care. The first level is a program for community health. The San Carlos health workers promote health in 78 communities of Altamirano and 20 communities in the Lacandona Jungle region. Their focus includes nutrition programs geared toward cultivation and consumption according to the conditions of the communities, as well as vaccination programs in coordination with the Secretary of Health. The second-level provides medical attention to particular health concerns and ailments impacting the marginalized indigenous communities, including malnutrition and infectious diseases. With initial funding from Canada, Holland, and other supporters, San Carlos services include dental and medical care, as well as gynecological and obstetric, pharmacological, and vaccination services. At the third level, San Carlos offers facilities for recovery and recuperation of patients with on-going conditions.

With modest resources, facilities, supplies, and personnel, San Carlos has successfully maintained health care services to communities throughout the region. In 1996 alone, the small facility attended to 3302 patients. In each level of health care, San Carlos accommodates the cultural needs and practices of the patients and their families. For example, as a cultural practice, many families travel great distances and remain for days or even weeks with their ailing family member as they undergo treatment. San Carlos respects the families needs to be close to their family member and provides simple accommodations near the hospital.

The IMSS-Solidarity Program erected a new government run hospital just a short distance from San Carlos Hospital. While the government hospital has potentials for servicing community members, a reported lack of attention to cultural needs (e.g. lack of family accommodations, indigenous language interpreters, etc.), adequate health services, and personnel have left the facility virtually empty, despite the numerous health concerns in the area.

Source: San Carlos Hospital, Statistics 1996.

- **Maternal-infant care**

Maternal-infant care has not provided either basic health care or emergency services to mothers in indigenous or economically marginalized areas. Although the government reports that prenatal care is common in Mexico (from 1993 to 1995 medical personnel in Mexico provided prenatal care to 86 percent of all pregnant women), a significantly high number (7 percent) of pregnant women received little or no prenatal care.[636] Postnatal care is not common in Mexico. Less than half of the women giving birth during 1993 to 1995 received postnatal care; only one in three rural women received such care, while over half of the urban women saw a physician at least once.[637]

According to Mexico's National Programme of Action for Children (1995-2000),[638] "multiple pregnancies is one of the risk factors affecting women's health, making family planning fundamental for reducing the incidence of undesired, unplanned or high-risk

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[636] NPAC EVALUATION, *supra* note 590, at 55. *See* also *supra* part B.5.1.

[637] *Id.*

[638] *See infra* part C.2.3.

pregnancies, and for reducing maternal and perinatal mobility and mortality."[639] The number of people using birth control services provided by the public sector increased to 72 percent by 1995.[640] Numerous accounts from non-governmental organizations, however, allege forced sterilizations and coerced birth control among poor, rural, and indigenous women.[641] In implementing its program for birth control services, the Mexican government must not violate women's rights through force or coercion. The government must ensure women's rights to determine whether to use family planning and what forms of family planning they prefer.

- **Immunization and prevention of disease**

Mexico claims to have successfully achieved an overall immunization rate of 90 percent for vaccine-preventable diseases such as diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis, and against tetanus for women of child-bearing age.[642] In contrast to immunizations, Mexico has had limited success in addressing other preventable diseases. The leading causes of child deaths in Mexico are still preventable diseases and conditions which disproportionately affect poor, rural, and indigenous children. Mexico has been able to reduce overall under-five mortality caused by diarrhea and acute respiratory infections by 65.2 percent and 32.8 percent respectively from 1990-1995.[643] The problem remains the most severe in areas with the most vulnerable children. The states with the highest rates of child death due to preventable causes are poor rural areas: Chiapas, Puebla, Oaxaca, Guanaguato, Campeche, San Luis Potosí, Queretaro, Tabasco, and Tlaxcala.[644]

- **Nutrition programs**

Nutrition programs focus on food subsidies rather than food security. At present, government food and nutrition programs reportedly reach only half of the 14 million Mexicans living in conditions of extreme poverty. Despite existing subsidies and food programs, Mexico ranks among those countries with the most severe problems of malnutrition in the world.[645] This situation strongly indicates the inadequate levels and poor implementation of current food programs in the country. According to UNICEF, Mexico lacks adequate strategies to reduce the

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[639] NPAC EVALUATION, *supra* note 590, at 50.

[640] *Id.*

[641] Site visit to Mexico, Oaxaca, Chiapas, Federal District (Aug. 3-10, 1997).

[642] NPAC EVALUATION, *supra* note 590, at 31.

[643] *Id.* at 23-29.

[644] *Id.* at 29.

[645] *Eighty-two Children Die Daily of Malnutrition*, *supra* note 584.

malnutrition level to below 10 percent of the under-five childhood population.[646] The current 16 percent malnutrition level among all Mexican children is unchanged from that of 20 years ago.[647]

According to the Mexican government, its actions to combat malnutrition have faced difficulties in expense and distribution, or have lacked definition and systematic documentation.[648] Further, a lack of sufficient infrastructure and faulty coordination of actions between the different offices and agencies responsible for monitoring the nutrition, growth and development of children, and those that provide food supplementation, are among the reasons cited for the persistence of malnutrition throughout Mexico.[649]

For many decades, Mexico supplied subsidized food through government outlays. Subsidies for foodstuffs, however, are often expensive and difficult to target. By 1983, one percent of Mexico's GNP was spent on these food subsidies, and by 1986, as a result of limiting the subsidies to two foods and targeting their distribution, expenditures were decreased to 0.2 percent of GNP.[650] Mexico continues to use food subsidy programs, including subsidies on milk and the provision of free tortillas and school breakfasts, to address malnutrition.[651] While these food subsidy programs offer a partial short-term solution to nutritional insufficiencies, they do not address the underlying poverty, land, and other issues which create environments in which people are not able to maintain an adequate nutrition level. They create dependency on government outlays, but do not provide the foundation to create self-sustaining environments through food production and other methods (see Box 5.3).

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[646] *Id.*

[647] *Id.*

[648] NPAC EVALUATION, *supra* note 590, at 71-72.

[649] *Id.*

[650] GUY P. PFEFFERMANN & CHARLES C. GRIFFIN, NUTRITION AND HEALTH PROGRAMS IN LATIN AMERICA: TARGETING SOCIAL EXPENDITURES 9 (1989).

[651] COUNTRY REPORT: MEXICO (The Economist Intelligence Unit, London, England), 1st Quarter 1997, at 16.

Box 5.3. Mexico's Rural Kitchen Programs

Recently the Mexican public health system, through the DIF, has endorsed a food outlay program referred to as rural kitchen program. Each state administers its own form of the rural kitchen. For example, the State of Oaxaca's rural kitchen program is referred to as *Aula Abierta*. Each of the rural kitchen programs, however, function similarly. According to government officials, the idea behind these rural kitchens is to encourage rural communities to participate in creating a food distribution and education program established by the government and maintained by community members. Although the rural kitchens are created under the rubric of community participation, the program both creates and endorses dependency.

A standard rural kitchen is established with an initial supply of materials from the Mexican federal government. The state government then provides initial food outlays. Community members build the facility, a small hut or other quarter which serves as the rural kitchen. The food is prepared by community members and provided to women and children in the community, but not to the men who construct the rural kitchen. While participating in the rural kitchen program, women and children are schooled in a nearby location. The "schooling" is often geared toward family planning. Thus, the rural kitchen creates a program in which food outlays are combined with government social policy, ultimately using the communities own resources. The program does not address the underlying socioeconomic and environmental factors which prevent these poor, rural communities from attaining adequate dietary levels and healthy standards of living.

Source: DIF.

- **Clean water and sanitation services**

Safe water and sanitation services are still not provided to many marginalized communities. The Mexican government claims to have expanded coverage to the rural areas of Guerrero, Oaxaca, and Chiapas, including 130 safe drinking water systems benefiting approximately 76,000 people, as well as 4300 ventilated improved pit latrines benefiting 26,000.[652] The severe lack of water and basic sanitation services in these and other areas, however, requires increased attention to, resources for, and construction of these services. Furthermore, building these water and sanitation structures also necessitates educating the communities on proper use and maintenance of the services.

2.3. Health reform efforts

In 1993, Mexico was among the 50 nations that drew up national programs of action (NPAs) aimed at reaching the goals agreed to at UNICEF's World Summit for Children. Year 2000 goals included "halving of child malnutrition, control of major childhood diseases, a one-third reduction in under-five death rates, a halving of maternal mortality, the provision of safe water to all communities, the universal availability of family planning services, and a basic education for all children."[653] Mexico has had some success in addressing maternal and children's health issues but must improve its basic services, nutrition programs, and protections for the rights of children and women in marginalized areas.[654] In order to fulfill its commitments,

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[652] UNICEF, COUNTRY PROGRAMME RECOMMENDATION, U.N. Doc. E/ICEF/1996/P/L.47 (1996).

[653] UNICEF, THE STATE OF THE WORLD'S CHILDREN 1993, at 8.

[654] UNICEF, COUNTRY PROGRAMME RECOMMENDATION, *supra* note 652, at 6.

the Mexican government must ensure that quality health care and related services are accessible and affordable for its disadvantaged and uninsured populations.

In 1996, the Mexican government launched a five-year health reform program.[655] As part of its reform efforts, Mexico has created the Programme for Expansion of Service Coverage (PAC), which provides a "package" of basic health services to target populations in eleven states with the greatest problems in health, poverty, and lack of basic services.[656] These states include Campeche, Chiapas, Guerrero, Hidalgo, Michoacán, Oaxaca, Puebla, San Luis Potosí, Vera Cruz, Yucatán, and Zacatecas.[657] Specific components of the PAC include:

(1) Basic health at the family level;
(2) Effective management of cases of diarrhea;
(3) Anti-parasitic treatment to families;
(4) Identifying alarming signs of acute respiratory infection and referring them to medical attention;
(5) Prevention and control of pulmonary tuberculosis;
(6) Prevention and control of arterial hypertension and diabetes;
(7) Immunization;
(8) Attention to nutrition and development of children;
(9) Family planning;
(10) Attention to prenatal, child-birth, and post-natal care;
(11) Prevention of accidents and initial care of lesions; and
(12) Community participation for personal health care.

While it is too early to determine the effectiveness of the PAC services, the program indicates Mexico's health priorities and raises specific health issues. These issues stem not so much from the components of the programs as much as how they are applied. The PAC does not mention how significant concerns such as malnutrition or maternal mortality will be addressed. In addition, a government defined package may not adequately address the actual needs of health care users.[658] Furthermore, delivering the PAC services to sparsely populated rural areas requires increased resource allocation to ensure access to affordable and quality services in these areas.

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[655] PAHO, *Mexico Undergoing Health Sector Reform*, *supra* note 627.

[656] NPAC EVALUATION, *supra* note 590, at 85-87.

[657] *Id.*

[658] A method to help alleviate this concern would be to include a self-selection mechanism in which health care users choose the types of good and services they need or desire. PFEFFERMANN & GRIFFIN, *supra* note 650, at 6.

2.4. Macro-economic policies and programs

Mexico's economic constraints and austerity programs have severely impacted the resources available for the public health system. The economic recession has exacerbated the historical socioeconomic disparities and inequities within the country, and has limited the amount of resources available to address major health and social issues.[659]

The Mexican economy is now recovering, reflected by a 5.1 percent increase in gross domestic product (GDP) in 1996, as well as substantial progress in increasing tax receipts and decreasing inflation and unemployment rates.[660] But, this growth does not cover the 6.5 percent drop in GDP experienced in 1995, nor generate enough jobs for the many workers replaced by the economic crisis or the additional numbers joining the job market.[661] On the whole, Mexico's current account balance has increased to 695 billion pesos;[662] only 164 billion pesos, however, is allocated through its programmable budget.[663]

The programmable budget can and does vary based on macroeconomic priorities, since it is the sum of resources allocated annually to state governments, and federal government institutions and programs, including the military, labor, education, and health. Expenditures such as external debt repayments are not included within the programmable budget. The amounts allocated to these external expenditures significantly impact the resources the government deems to be available for health and social spending.

- **Social sector spending**

Despite recent increases in social spending, Mexico's health expenditures, at 18.4 billion pesos for 1997, remain less than 2 percent of its total governmental budget.[664] In comparison, allocation for other social spending was higher. For example, public education received 45.3 billion pesos (6.5 percent).[665] While the percentage of resources allocated to particular institutions or programs is not sufficient to determine whether the maximum available resources

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[659] J.G. Castañeda, *Mexico's Circle of Misery*, FOREIGN AFFAIRS, July/August 1996; UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 59.

[660] *See* COUNTRY REPORT: MEXICO, *supra* note 651, at 16, 20-21.

[661] *See id.* at 21.

[662] *See id.* at 18.

[663] The Embassy of Mexico provided the programmable budget figures.

[664] The Embassy of Mexico provided the figures for Mexico's budgetary allocations.

[665] The Embassy of Mexico provided the figures for Mexico's budgetary allocations.

are allocated for the protection of children's health and survival rights, it does provide a good indication of the government's priorities.

As of 1996, Mexico's social sector spending was at 55 percent of federal programmable expenditures.[666] From 1988 to 1994, Mexico had steadily increased spending on social development from about 6 percent of GNP to 10 percent.[667] For 1997, the Mexican government's plan was to increase overall social spending by 9.3 percent through allocations for food, health, and education programs.[668]

Mexico's resource allocation within its health budget includes: (1) additional services provided by the IMSS; (2) the Health and Nutrition Program; (3) education programs in 35 percent of schools; (4) teacher training in the state and indigenous educational systems; (5) the Universal Vaccination Program; (6) disease control programs (i.e., acute respiratory infections, diarrheal diseases, HIV/AIDS); and (7) family planning services.[669] The Mexican government also increased by 51.7 percent allocations for the PAC.[670] The list of services provided by the PAC and many of the individually funded programs, however, seem to overlap, raising some issue as to the efficiency of health expenditures.

- **Foreign aid programs**

International organizations such as UNICEF and the World Bank provide financial and technical resources and assistance to Mexico through various foreign aid programs. UNICEF has agreed to allocate general resources of US$6.28 million and supplementary funding up to US$40.4 million. UNICEF's allocations focus on programme assistance to reduce disparities in child and maternal survival and development through expansion of services; to support the decentralized implementation of the National Program of Action in states and municipalities through establishment of viable local programmes of action; and to advocate more effective policies to address implementation of the Children's Convention, including legal protection and participation.[671] In addition, the World Bank provides support for Mexico's adjustment program

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[666] WORLD BANK, MEMORANDUM OF THE PRESIDENT OF THE INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT AND THE INTERNATIONAL FINANCE CORPORATION TO THE EXECUTIVE DIRECTORS ON A COUNTRY ASSISTANCE STRATEGY OF THE WORLD BANK GROUP FOR THE UNITED MEXICAN STATES, Report No. 16056-ME, ¶12 (Oct. 15, 1996) [hereinafter WORLD BANK, COUNTRY ASSISTANCE STRATEGY].

[667] WORLD SUMMIT FOR SOCIAL DEVELOPMENT, *supra* note 551, at 11.

[668] *See* COUNTRY REPORT: MEXICO, *supra* note 651, at 16.

[669] WORLD SUMMIT FOR SOCIAL DEVELOPMENT, *supra* note 551.

[670] IMPULSO DE BIENESTAR SOCIAL at § IV.16 (document excerpt provided by the Mexican Embassy, on file with Minnesota Advocates for Human Rights).

[671] UNICEF, COUNTRY PROGRAMME RECOMMENDATION, *supra* note 652, at 6.

through a $1 billion Financial Sector Restructuring Loan as well as an Essential Social Services Loan totaling $500 million which targets social programs for the poorest sectors and systems of monitoring and evaluating social expenditures for efficiency.[672] Despite these significant foreign aid disbursements, Mexico has not adequately allocated resources to address the problem of preventable child mortality.

D. International legal obligations of Mexico

1. Framework for Mexico's international obligations

The following international instruments (see Box 5.4) define Mexico's international legal obligations, as discussed in chapter II, and provide a framework for Mexico's compliance with obligations relevant to child health and survival:

[672] WORLD BANK, COUNTRY ASSISTANCE STRATEGY, *supra* note 666.

Box 5.4. International instruments regarding chi[illegible]ealth and survival applicable to Mexico	
Universal Declaration of Human Rights	adopted Dec. 10, 1948
International Covenant on Civil and Political Rights (ICCPR)	ratified by Mexico Mar. 23, 1981
International Covenant on Economic, Social, and Cultural Rights (ICESCR)	ratified by Mexico Mar. 23, 1981
Convention on the Rights of Children (Children's Convention)	ratified by Mexico Sept. 21, 1990
Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention)	ratified by Mexico Mar. 23, 1981
American Declaration of the Rights and Duties of Man (American Declaration)	adopted 1948
American Convention on Human Rights (American Convention)	ratified by Mexico Mar. 2, 1981
Additional Protocol to the American Convention (Protocol of San Salvador)	not yet in force; signed by Mexico Nov. 17, 1988
Convention on the Elimination of All Forms of Racial Discrimination (CERD)	ratified by Mexico Feb. 20, 1975
Constitution of the World Health Organization (WHO Constitution)	adopted April 7, 1948

Mexico has both international obligations of conduct and result[673] in regard to the right to health and child survival. Obligations of conduct include monitoring and reporting, and non-discrimination both in law and practice. Obligations of result require Mexico to "take all effective and appropriate measures" with a "view to achieving progressively the full realization" of the right to health protection and child survival.[674] In addition, Mexico is obligated to utilize to the maximum extent its available resources to undertake such measures,[675] and to do so without discriminating among children on the basis of race, sex, religion, ethnic or social group, or other status. The concept of "progressive realization" takes into account that certain of Mexico's obligations related to health and child survival may not be able to be achieved

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[673] *See* Maastricht Guidelines, *supra* note 175. *See also* discussion *supra* ch. III, part A.2.

[674] ICESCR, *supra* note 161, art. 2 ("Each State Party . . . undertakes to take steps . . . with a view to achieving progressively the full realization of the right . . . ."); Women's Convention, *supra* note 197, art. 14(2) ("States . . . shall take all appropriate measures and shall ensure . . . access to adequate health care . . . ."); Children's Convention, *supra* note 162, art. 24(2) ("States . . . shall take appropriate measures to diminish infant and child mortality . . . [and] to ensure provision of medical assistance and health care to all children . . . .").

[675] ICESCR, *supra* note 161, art. 2 ("Each State Party . . . undertakes to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant . . . ."); Children's Convention, *supra* note 162, art. 4 ("With regard to economic, social, and cultural rights, States Parties shall take undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation.").

immediately.[676] But it also "imposes an obligation to move as expeditiously and effectively as possible towards that goal."[677]

Mexico is obligated to adopt legislative, judicial, social, educational, administrative, economic, and other measures for the protection of children's health and survival rights.[678] Mexico must take immediate steps to eliminate discrimination in the enjoyment of the right to health protection, and progressive measures to reduce preventable child mortality and ensure the survival, development, and adequate standard of living of children.[679] These measures must provide particular attention to the specific health needs of mothers and children in Mexico's most vulnerable populations.[680] In that regard, the principles of Alma-Ata which emphasize preventive measures, community participation, equal access, local sustainability, and priority concern for vulnerable segments of society, should be incorporated into Mexico's policies and programs.[681]

1.1. Obligation to monitor and report accurately

Mexico's international obligations require the government to monitor and provide reports detailing the extent to which it is meeting its international obligations related to child health and survival. Mexico must report on conditions relating to health and child survival, the measures it has adopted in regard to health and children's rights, and its progress or limitations in alleviating health concerns and furthering health protection.[682] Such reports must include a comprehensive review of its national legislation, administrative rules and procedures, and practices to ensure adequate monitoring of the actual health situation.[683] Mexico's reporting requirements include submissions to the following international human rights bodies: the Committee on Economic, Social and Cultural Rights every five years;[684] the Committee on the Elimination of Racial

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[676] General Comments, *supra* note 176.

[677] *Id.*

[678] Article 2 of the ICESCR requires that States Parties take steps to fully realize the rights in the Covenant "by all appropriate means, including particularly the adoption of legislative measures." ICESCR, *supra* note 161. Article 4 of the Children's Convention also provides that "States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention." Children's Convention, *supra* note 162.

[679] *See supra* ch. III, part A.2.

[680] *See supra* ch. III, part B.2.

[681] *See supra* ch. II, part B.2 and ch. III, part C.

[682] ICESCR, *supra* note 161, part IV. *See also* General Comments, *supra* note 176, at 50-52.

[683] General Comments, *supra* note 176.

[684] ECOSOC Res. 1988/4. *See* MANUAL ON HUMAN RIGHTS REPORTING, *supra* note 277.

Discrimination every two years;[685] the Committee on the Elimination of Discrimination against Women every four years;[686] and the Committee on the Rights of the Child every five years.[687]

1.2. Right to non-discrimination

Non-discrimination is a fundamental principle for the full realization of children's health and survival rights. According to the WHO Constitution, which Mexico adopted in 1948, "the enjoyment of the maximum level of health that can be attained is a fundamental right for all without distinction of race, religion, political ideology, or economic and social condition."[688] Similarly, the ICESCR obligates Mexico to recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[689] Along with the non-discrimination provisions in the general human rights treaties,[690] the ICERD and the Women's Convention specifically obligate Mexico to take measures to prohibit discrimination, particularly with regard to health care.[691]

Under these instruments, discrimination in the availability, accessibility, affordability, and quality of health services constitutes a direct denial of the right to health.[692] Therefore, Mexico's obligations extend not only to discriminatory policies or practices, but also to discriminatory impact or effects which impairs the right to health.[693] The Women's Convention as well as other international instruments impose an affirmative duty on the Mexican government to incorporate the right to non-discrimination in its domestic laws and policies, as well as ensure non-discrimination in the application and impact of its programs.

1.3. Right to life, health, and adequate standard of living

Under the ICESCR and the Children's Convention, the right to life, to health, and to an adequate standard of living are necessarily interlinked for the survival and development of

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[685] ICERD, *supra* note 186.

[686] Women's Convention, *supra* note 197, art. 18.

[687] Children's Convention, *supra* note 162, art. 44.

[688] WHO Constitution, *supra* note 142.

[689] ICESCR, *supra* note 161, art. 12(1).

[690] *See supra* ch. III, part B.1.

[691] ICERD, *supra* note 186, art. 5 (e)(iv); Women's Convention, *supra* note 197, art. 11(1)(f).

[692] Gruskin & Sullivan, *supra* note 176.

[693] *Id.*

children in Mexico.[694] Without adequate nutrition, housing, health and other services, children and their families can not attain the highest standard of health or ensure survival. Therefore, to meet its international obligations for the health, development, and survival rights of all of its children, particularly among poor, rural, and indigenous children, Mexico must not only promote health-related programs, but must also ensure the appropriate socioeconomic conditions to attain an adequate standard of living. To create self-sustaining environments which support children's health and survival, poor, rural, and indigenous populations must have equal opportunities to determine and pursue their livelihood.

2. Assessment of Mexico's compliance

2.1. Reporting

Although the Mexican government has generally complied with its reporting requirements, the country reports reflect a number of concerns for child health and survival, particularly among marginalized areas. As reported by the government, Mexico continues to face problems of poverty and disparity. In addition, government data related to child health and survival is neither disaggregated nor reliable to accurately determine progress.

For example, in Mexico's third periodic report under the ICESCR, the government stated that indigenous, rural, and peasant populations are the most vulnerable in regard to nutrition and health.[695] The government also noted that the most severe problems of poverty are located in dispersed rural zones where deficient communications place high costs on obtaining access to education and health services, receiving basic information, or taking advantage of employment opportunities in other regions.[696] In addition, the report stated that the over 10 million uninsured Mexicans who lack adequate health protections are those who are not participants in the formal sector of the economy, principally rural workers.[697] While these reports are alarming, discrepancies in government data increase the likelihood that child health and survival conditions in poor and rural areas are worse than reported.

In evaluating Mexico's progress under the Children's Convention, the Committee on the Rights of the Child (CRC), in its 1994 report, recognized Mexico's initiatives in promulgating new laws, amending its Constitution, and adopting programs for the protection and promotion of

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[694] ICESCR, *supra* note 161, arts. 11, 12; Children's Convention, *supra* note 162, arts. 24.27.

[695] HUMAN RIGHTS COMMITTEE, INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS: THIRD PERIODIC REPORT OF THE MEXICAN GOVERNMENT 58 (June 1997).

[696] *Id.*

[697] *Id.*

children's rights.[698] The CRC noted, however, the existing disparities in the economic and social situations of children in Mexico.[699] Mexico's external debt, insufficient resources designated to basic social services, and unequal distribution of national wealth all severely affected children, particularly those in poor, minority, or indigenous communities.[700] Among the areas of concern, the CRC noted the following:

- Mexico's laws and regulations related to children's rights are not always stipulated in the best interests of the child or for the prohibition of discrimination against children;

- Unequal distribution of national wealth, and the disparities and discrepancies in the execution of rights under the Children's Convention between different regions, prejudice children in rural and indigenous communities;

- A large percentage of children that live in difficult situations, in particular children in marginalized and indigenous communities, have abandoned school and are powerless to complete their primary education.[701]

2.2. Non-discrimination

In spite of Mexico's domestic laws prohibiting discrimination in the application of rights, the government discriminates in health protection of poor, rural and indigenous children through the increasing disparities in socioeconomic development in the country. Government policies and programs biased toward urban centers, and inequitable distribution of resources and services to rural areas, violate Mexico's international obligations not to discriminate.

2.3. Progressive realization and resource allocation

Despite Mexico's success in reducing overall rates of child mortality, persistent disparities in socioeconomic development and child survival inhibit the progressive realization of health and survival rights of children in poor, rural, and indigenous populations. As a middle-income country with well-developed domestic laws and institutions, Mexico has the capacity to maintain adequate health services to marginalized communities. Yet Mexico's public health system is both inefficient and ineffective in providing health and social services to vulnerable

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[698] COMMITTEE ON THE RIGHTS OF THE CHILD, CONSIDERATION OF THE REPORTS SUBMITTED BY MEMBER STATES UNDER ARTICLE 44 OF THE CONVENTION, fifth session, U.N. Doc. CRC/C/1/Add.13 (1994) [unofficial translation] [hereinafter CRC, STATES REPORTS]. *See also* COMEXANI, *supra* note 19.

[699] *Id.*

[700] *Id.*

[701] *Id.*

populations. This ineffectiveness is largely attributable to the Mexican government's resource allocation priorities which remain with urban centers and the global market. Although social spending is a significant portion of Mexico's programmable budget, only two percent is allocated to health expenditures. Comparing the programmable budget and health expenditures to Mexico's external allocations (such as exports or debt repayment), the Mexican government may not be utilizing the maximum available resources to protect the health and survival rights of all of its children.

VI. CASE STUDY: UNITED STATES OF AMERICA

A. Findings and Recommendations

1. Findings

- The United States has seen dramatic improvements in child survival in the past century. Important strides in living conditions, public health, and medicine have largely eliminated many health threats posed by a vast array of deadly but preventable childhood diseases. Nonetheless, the United States has an *infant mortality rate* that is worse than 20 other industrialized countries.

- Eight in ten deaths to children under age five in the United States occur in the first year of life. There is more information available about *infant deaths* than deaths to children aged 1 through 4 years because U.S. data collection, reporting, and research focuses on the infancy period.

- Gross disparities in infant and child mortality rates persist among different groups in the country. Poor children and Black[702] children are the most vulnerable. Black infants die at more than twice the rate of White infants. The mortality rate among infants from poor families is 60 percent higher than for infants above the poverty level. These disparities are growing in terms of both race and poverty.

- Child mortality rates in the United States are linked to biological, behavioral, social, and economic factors including maternal health, socioeconomic conditions, public health practices, and access to quality health care and social services. The disparities in these factors among population groups generally parallel the disparities in the death rates.

- In its failure to address socioeconomic and racial disparities in mortality rates and underlying causes of death, the United States has failed to live up to international standards to protect equally all of its infants—no matter their race or economic status—and to provide conditions adequate for survival and healthy development.

2. Recommendations

- Ratify the Convention on the Rights of the Child, the International Covenant of Economic, Social, and Cultural Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women.

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[702] The term "Black" is used in this report because it is the term widely used in data reporting in the United States.

- Ensure implementation and compliance with all human rights obligations under treaties and instruments to which the U.S. is a party.

- Promote and protect children's rights, in particular rights related to child health and survival, through adequate programs and funding.

- Achieve further reductions in the disparity in infant mortality and morbidity. Such reductions require changes in social and economic barriers to healthy pregnancy and birth outcome. Both the public and private sectors should increase their investment in health care coverage, child care, education and training.

- Ensure that the changes in public benefits and health-care delivery do not further threaten child health and survival. Several examples include:

  - Changes in Medicaid eligibility for pregnant women;
  - Food stamp allocations and the effects on pregnant women and children;
  - Change in prenatal care services for immigrants;
  - Changes in supplemental security income eligibility for infants and children with disabilities;
  - Federal funding for Maternal and Child Health State Block Grants Program; and,
  - Transition from welfare to work.

- Implement strategies that minimize the risks of unintentional injuries and violence toward children. Child-welfare and law-enforcement agencies should collaborate to help protect children who are not adequately protected by their own families. When child abuse and neglect occur, existing services that deal with child maltreatment need to respond more quickly. Prevention of child abuse and neglect should focus on the millions of high-risk families who are living below the poverty line or are plagued by domestic violence and substance abuse—major risk factors for child maltreatment.

- Adopt an integrated policy on children's health and well-being in both the federal and state governments, addressing not only the medical needs of all expectant mothers and newborns, but also investing in broad-based preventive approaches. An integrated policy on infant and child health should include:

  - Redistribution of health care and social services toward children;
  - Expansion of earned income tax credit;
  - Paid parental leave;
  - Subsidized child care;
  - Guaranteed access to social and health care for all pregnant women and infants;
  - Health insurance for all uninsured children.

- Strengthen coordination between state and federal programs and social and health services for women and their children. A comprehensive service delivery system is needed, offering perinatal clinical services and linkages between community-based health care and social services.

  - Refer and coordinate services to assure a healthy pregnancy and a safe, supportive environment for the infant. Referrals from medical/health to social or community-based services should be made, especially in times of crisis when families may have the most difficulty following through.

  - Link mechanisms for referral, tracking, and follow-up of clients among health and social service organizations that provide:

    > health services specific to preconception, prenatal, perinatal, postpartum, and pediatric care; and,

    > social services specific to housing, employment, mental health, substance abuse, poverty, and childcare.

- Increase funding at the federal and state level for monitoring, data collection, and research on the status of children's health and well-being:

  - Demonstration projects aimed at reducing the racial and socioeconomic disparities in mortality (and morbidity) among infants and children;

  - Infant Mortality Reviews;

  - Monitoring of health status of racial, ethnic, and socioeconomic subgroups of the population; and,

  - Interdisciplinary research in the following areas:

    > Etiology of major causes of infant death (and morbidity) including preterm birth, low birth weight, congenital anomalies, etc., with an emphasis on what factors are responsible for the racial/ethnic disparities in cause-specific infant mortality;

    > Availability and potential development of prenatal care systems, with emphasis on how specific prenatal care services that may reduce infant mortality; and

    > the role of socioeconomic, environmental, and lifestyle factors, along with genetic and physiological factors.

B. Infant and child mortality in the United States

1. Infant and child mortality in comparison to level of national development

The *infant mortality rate* in the United States is worse than 20 other industrialized countries.[703] Although the U.S. infant mortality rate is at an all-time low, it compares unfavorably with rates in other industrialized countries (see Table 6.1). As recently as 1989, infant mortality rates among U.S. Black infants in cities with predominantly Black populations, such as Detroit (21 deaths/1000 live births) and Washington, D.C. (23/1000 live births), were not only more than double the rates for White infants, but these rates were even higher than those in developing countries such as Costa Rica, Cuba, and Sri Lanka.[704] The comparison is even more dramatic in light of the fact that the United States is one of the wealthiest nations in the world and spends a higher proportion of government monies (17 percent of total government expenditures) on health-related services and benefits for its citizens than do many other industrialized countries with lower rates of infant death.[705]

Despite the comparatively low ranking for U.S. child mortality rates, the health and survival of U.S. children under the age of five has improved dramatically during this century. Infant mortality (children under 1 year of age)[706] in the United States has declined significantly over time.[707] In 1994, the U.S. attained the lowest infant mortality rate in its history with 8 infant deaths for every 1000 live births,[708] compared to a rate of 47 in 1940.

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[703] There are potential problems with comparing infant mortality rates between countries. Varying definitions amongst countries of what constitutes a live-born infant may compromise the comparability of infant mortality rates between countries. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 80-81.

[704] D. ANDRULIS, C. GINSBERG, Y. SHAW-TAYLOR, & V. MARTIN, URBAN SOCIAL HEALTH: A CHART BOOK PROFILING THE NATION'S ONE HUNDRED LARGEST CITIES (1995).

[705] UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 90-91.

[706] *Infant mortality* refers to deaths among live-born infants during the first year of life. Rates of infant mortality are usually reported as the number of infant deaths for every 1000 live births. J.M. LAST, A DICTIONARY OF EPIDEMIOLOGY (1988).

[707] Singh et al., *supra* note 22, at 64-65.

[708] The 1994 infant and child mortality data was the latest available at the time this report was written.

Table 6.1. Countries with lower infant mortality rates than the United States, 1960 and 1994

Infant Mortality Rates (Deaths per 1000 live births)			
1960		1994	
Sweden	16	Sweden	4
Netherlands	18	Finland	4
Norway	19	Japan	4
Australia	20	Singapore	5
Finland	22	Hong Kong	5
Denmark	22	Denmark	6
Switzerland	22	Germany	6
New Zealand	22	Ireland	6
United Kingdom	23	Switzerland	6
United States	26	Un. Kingdom	6
		Austria	6
		Canada	6
		Norway	6
		Netherlands	6
		Italy	7
		Australia	7
		Slovenia	7
		New Zealand	7
		Israel	7
		France	7
		Korea	8
		Spain	8
		Greece	8
		Belgium	8
		United States	8

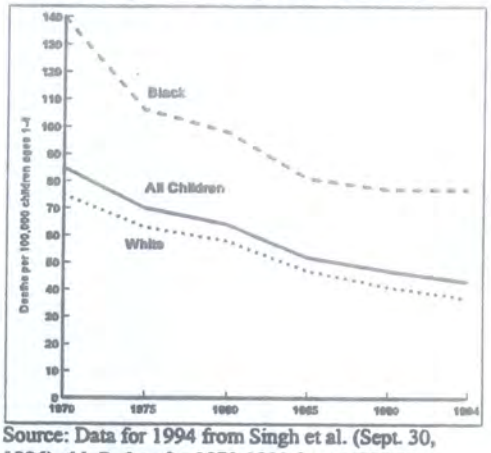
Source: UNICEF, THE STATE OF THE WORLD'S CHILDREN 1996, table 1, 80-81, and table 6, 90-91 (1997).

In the first half of the century, infant mortality declined due to the control of infectious diseases through antibiotics and improved living standards in housing, water and sewage systems. During that period, the primary increase in survival was seen in older infants—those in the postneonatal period. The second half of the century brought medical and technological advances in neonatal intensive care which improved the survival of newborn infants.[709] Today,

[709] M.F. MacDorman, D.L. Rowley, S. Iyasu, J.L. Kiely, P.G. Gardner, & M.S. Davis, *Infant Mortality, in* FROM DATA TO ACTION, CDC'S PUBLIC HEALTH SURVEILLANCE FOR WOMEN, INFANTS, AND CHILDREN 231, 246 (L.S. Wilcox & J.S. Marks eds., 1994); D.L. Rowley, S. Iyasu, M.F. MacDorman, & H.K. Atrash, *Neonatal and Postneonatal Mortality, in* FROM DATA TO ACTION, *supra*, at 251-52; H. WALLACE, R.P. NELSON, & P.J. SWEENEY, MATERNAL & CHILD HEALTH PRACTICE 429-30 (4th ed. 1994).

deaths during the first year of life account for 82 percent of deaths to U.S. children under the age of five.[710] Almost two-thirds of these infant deaths occur within the first 27 days of life (the neonatal period) as opposed to the postneonatal period,[711] which is the interval between the 28th day of life and an infant's first birthday.[712]

Figure 6.1. Mortality rates of U.S. children aged 1 to 4 by race, 1970-94



Source: Data for 1994 from Singh et al. (Sept. 30, 1996), tbl. 7; data for 1970-1990 from USDHHS, TRENDS IN THE WELL-BEING OF AMERICA'S CHILDREN AND YOUTH, tbl. HC 1.1b.1.

Mortality rates for children between the ages of 1 through 4 years[713] also decreased significantly between 1970 and 1994, from 85 to 43 deaths per 100,000 children[714] (see Figure 6.1).

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[710] Singh et al., *supra* note 22, at 17.

[711] *Neonatal mortality* refers to deaths that occur in the period between the birth of a live infant and the first 27 days of life. *See* LAST, *supra* note 706. *Postneonatal mortality* refers to deaths that occur in the interval between the 28th day of life and an infant's first birthday. *Id.*

[712] Rowley et al., *supra* note 709.

[713] *Child mortality* refers to deaths of children between the ages of 1 through 4 years. In industrialized countries including the United States, where infant deaths (up to the age of 1) are more common than child deaths (ages 1 through 4). Singh et al., *supra* note 22, at 17. *Child mortality rates* are reported as the number of child deaths for every 100,000 children aged 1 through 4 years. LAST, *supra* note 706.

[714] USDHHS, TRENDS IN THE WELL-BEING OF AMERICA'S CHILDREN AND YOUTH 81 (1996) [hereinafter USDHHS, TRENDS].

2. Disparities in reducing infant and child mortality

2.1. Poverty

Striking disparities in mortality rates between poor and non-poor children exist in the United States. The mortality rate for infants whose mothers live below the poverty level[715] is 60 percent higher than for infants whose mothers live above the poverty level.[716] The effects of socioeconomic conditions such as poverty are more strongly associated with older infants than with newborns. Many neonatal deaths have been associated with circumstances surrounding the prenatal period and delivery and are believed to have an endogenous etiology, that is, a cause of death based on a genetic predisposition or internal physiological process, such as congenital malformations or respiratory distress syndrome.[717] In contrast, many postneonatal deaths have been associated with conditions or circumstances that occur after delivery and are more likely to reflect environmental factors such as poverty. These deaths are often described as deaths from exogenous causes. The utility of classifying infant deaths in this manner, however, is somewhat limited because a majority of deaths in the postneonatal period can be attributed to endogenous causes—these infants, in other words, survived their conditions beyond the neonatal period only to die in the postneonatal period.[718] For infants living below the poverty level, the neonatal

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[715] The poverty level is based on money income and does not include noncash benefits, such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index (CPI) level. *Id.* at 41. The average poverty threshold for a family of four was $13,924 in 1991 and $10,989 in 1985. *Id.* at 39. Evidence showing a link between low-income status and increased risk for infant death was first presented in the early 1900s. Since then, other reports have confirmed these earlier findings. Because there have been few reports on this subject and they have been sporadic, additional research in this area is necessary. *See, e.g.*, Woodbury, 1924, *in* CDC, *Poverty and Infant Mortality*, *supra* note 21; J.D. Parker, K.C. Schoendorf, & J.L. Kiely, *Associations Between Measures of Socioeconomic Status and Low Birth Weight, Small for Gestational Age, and Premature Delivery in the United States*, 4 ANNALS EPIDEMIOLOGY 271 (1994), *reprinted in* G.K. Singh & S.M. Yu, *Infant Mortality in the United States: Trends, Differentials, and Projections, 1950 Through 2010*, 85 AM. J. PUB. HEALTH 957 (1995).

[716] At least two limitations apply to this data on poverty and infant mortality from the National Maternal and Infant Health Survey. CDC, *Poverty and Infant Mortality*, *supra* note 21, at 922-27. First, at the sampling stage, 26 percent of the sample of mothers with babies who lived over 1 year, and 35 percent of the sample of mothers with babies who died in their first year, chose not to respond to the survey. Adjustments were made after the sample was drawn, however, to correct this problem. Second, of the mothers who responded, 14 percent did not report information about their household incomes. Although this may have biased the results, the effect is estimated by the editor of the *Mortality & Morbidity Weekly Report* (MWWR) to be quite small.

[717] R. Michielutte, M.L. Moore, P.J. Meis, J.M. Ernest, & H.B. Wells, *Race Differentials in Infant Mortality from Endogenous Causes: A Population-Based Study in North Carolina*, 47 J. CLINICAL EPIDEMIOLOGY 119 (1994), *cited in* J. Eiesland, Preventable Infant Mortality: Strategies for Classification (July 1995) (unpublished manuscript on file with the University of Minnesota School of Public Health).

[718] Eiesland, *supra* note 717, at 8.

mortality rate 1.4 times greater, and the postneonatal mortality rate is 2 times greater, than for infants above the poverty level (see Figure 6.2 and Table 6.2).

Mortality rates for children ages 1 to 4 are also higher among lower-income families. A North Carolina study indicated that families receiving Aid to Families with Dependent Children (AFDC) assistance had higher mortality rates than those who did not. Factors related to socioeconomic status, such as environmental conditions, general-health knowledge, and access to health care were correlated with the higher death rates.[719]

Figure 6.2. Estimated U.S. mortality rates for infants born to women living above and below poverty level* by age of infant, 1988

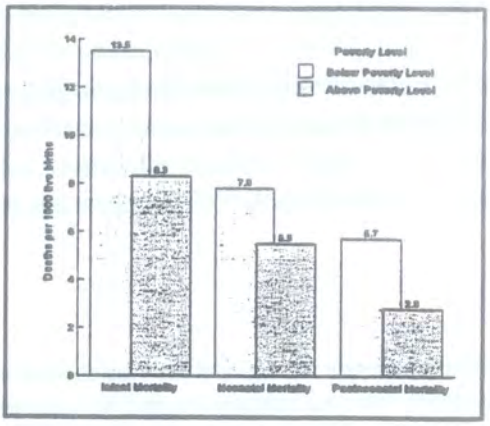

Table 6.2. Estimated U.S. mortality rates for infants born to women living above and below poverty level* by age of infant, 1988

Mortality Rate	Household Income	
(Deaths per 1000 live births)	Below Poverty Level	Above Poverty Level
Infant	13.5	8.3
Neonatal	7.8	5.5
Postneonatal	5.7	2.8

* In 1988, the poverty level was $12,092 for a family of four. U.S. BUREAU OF THE CENSUS, CURRENT POPULATION REP., SERIES P60, NO. 171, POVERTY IN THE UNITED STATES, 1988 AND 1989 (1991).
Source: CDC, *Poverty and Infant Mortality*, at 922-27, and tbl. 2, at 926-27.

[719] *See, e.g.*, J. Nelson, *Socioeconomic Status and Child Mortality in North Carolina*, AM. J. PUB. HEALTH (1992).

2.2. Race and ethnicity

Disparity in rates of mortality among infants and children also appear along racial and ethnic lines. In general, the United States lacks data on infant and child mortality disaggregated by race and ethnicity. This report focuses largely on two groups, *Blacks and Whites*, because of the enormity of the disparity in their death rates and because there is a larger amount of information available for these groups.[720] A growing amount of data, however, shows that some other racial and ethnic groups also fare worse on child health measures in comparison to White children, while still others fare better.[721]

Black infants die at more than twice the rate of White infants. This disparity has persisted for decades; for example, in 1940 Black infants died at a rate of 73 per 1000 live births, while White infants died at a rate of 43.[722] Although survival has improved significantly for both groups, Black infants continue to die at a higher rate than White infants. In 1994, Black infants died at a rate of 16 per 1000, compared to a rate of 7 for Whites, a rate 2.4 times greater than that for White infants (see Table 6.3 & Figure 6.3).[723]

Box 6.1. National goals for the Year 2000 to reduce mortality among Black infants may not be met.

National health objectives for the United States for the year 2000 are to reduce infant mortality to 7 per 1000 live births for the total population, to 11 for Blacks, to 8.5 for Native Americans, and to 8 for Puerto Rican American infants. This goal to reduce infant mortality will not be achieved for Blacks unless the decline in the 1990s exceeds that from 1981 through 1986.

Source: MacDorman et al. (1994), at 246.

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[720] *See infra* section B.3 (discussing technical issues regarding data on infant mortality rates).

[721] Singh & Yu, *supra* note 715, at 957-64.

[722] See technical notes on methods used by the National Center for Health Statistics to assign race of an infant to vital records of births and deaths. The U.S. case study of this report uses the terms *White* and *Black* as they are used in the government document: Singh et al., *supra* note 22, at 64-65; MacDorman et al., *supra* note 709, at 240-41.

[723] The death rate among Black infants in the United States ranks worse than the infant mortality rate of 38 other countries. UNICEF, WORLD'S CHILDREN 1996, *supra* note 1, at 80-81. U.S. Black infants died at a rate of 16 per 1000 in 1994 (see Table 6.3), a death rate higher than that of infants in 38 nations, including Cuba, Sri Lanka, Poland, and Costa Rica—all of these countries have rates of 15 infant deaths per 1000 live births, or lower.

Table 6.3. Ranking of infant mortality rates of U.S. Whites and Blacks compared to other countries, 1994

Rank	Country	Infant Mortality Rate (Deaths per 1000 live births)
1	Sweden	4
	Finland	4
	Japan	4
2	Singapore	5
	Hong Kong	5
3	Denmark	6
	Germany	6
	Ireland	6
	Switzerland	6
	United Kingdom	6
	Austria	6
	Canada	6
	Norway	6
	Netherlands	6
4	**U.S. Whites**	7
	Italy	7
	Australia	7
	Slovenia	7
	New Zealand	7
	Israel	7
	France	7
5	Republic of Korea	8
	Spain	8
	Greece	8
	Belgium	8
	United States	8
6	Czech Republic	9
	Cuba	9
	Portugal	9
7	Jamaica	10
8	Kuwait	12
	Croatia	12
	Malaysia	12
9	Hungary	13
	Slovakia	13
	Chile	13
10	Costa Rica	14
	Poland	14
11	Bosnia/ Herzegovina	15
	Sri Lanka	15
12	**U.S. Blacks**	16
	Columbia	16
	Bulgaria	16

Source: UNICEF, THE STATE OF THE WORLD'S CHILDREN 1996, tbl. 1, at 80-81.

Figure 6.3. U.S. infant mortality rates by race, 1940-1994*

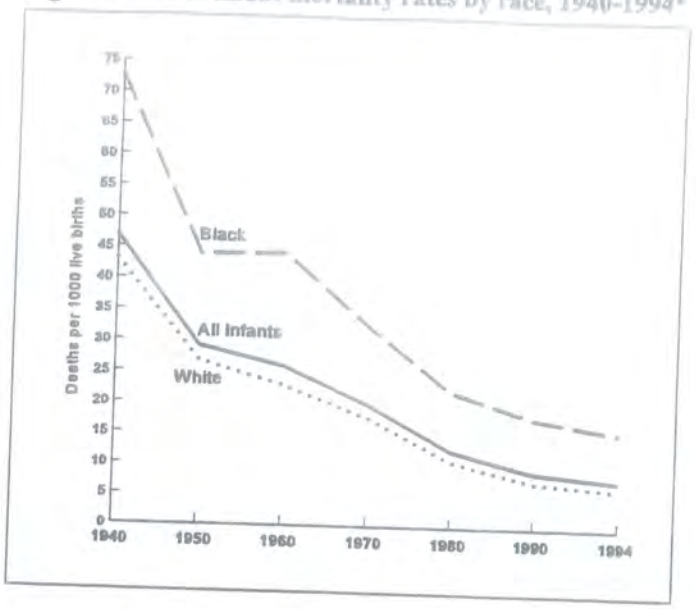


Table 6.4. U.S. infant mortality rates by race, 1940-1994*

	1940	1950	1960	1970	1980	1990	1994
Infant Mortality Rate (Deaths per 1000 live births)							
All Infants	47.0	29.2	26.0	20.0	12.6	9.2	8.0
Black	72.9	43.9	44.3	32.6	22.2	18.0	15.8
White	43.2	26.8	22.9	17.8	10.9	7.6	6.6
Black/White Ratio	1.7	1.6	1.9	1.8	2.0	2.4	2.4

* The denominator for rates is based on race of infant for 1940-1970, and race of infant's mother for 1980-1994.
Source: Data from G. K. Singh, K. D. Kochanek, & M. F. MacDorman, *Advance Report of Final Mortality Statistics, 1994*, MONTHLY VITAL STAT. REP., Vol. 45, No. 3 (Supp.) (Sept. 30, 1996) table 24.

For all ten leading causes of infant death, except congenital anomalies, Black infants are at much higher risk of death—the Black infant mortality rate attributable to each cause is twice to quadruple the rate of White infants.[724] Black infants die at 4.5 times the rate of White infants from preterm birth and low birth weight; the death rate for Black infants due to these disorders, in addition to other leading causes like pneumonia and influenza, has increased over time and contributed to a deepening overall disparity between Black and White infant mortality rates.[725]

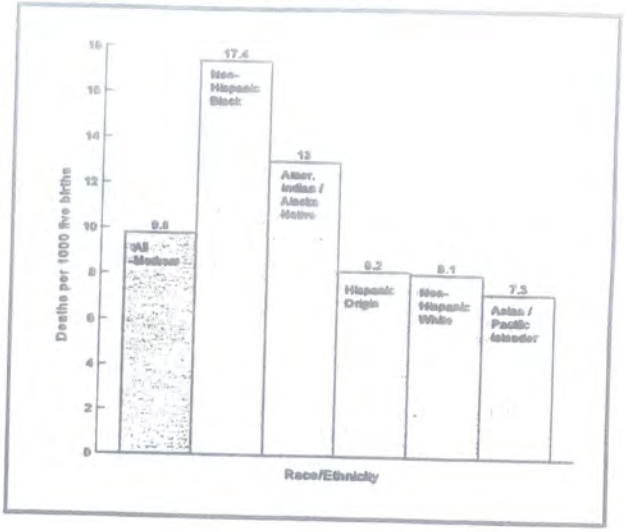
[724] Singh & Yu, *supra* note 715, at 961.

[725] Between 1981 and 1991 there was a 9 percent increase in the mortality rate for Black infants dying from preterm delivery and low birth weight. *Id.*

Disparity in death rates between Black and White children aged 1 through 4 has also increased over time. In 1970, Black children died at 1.9 times the rate of Whites; by 1994, the disparity had reached 2.1.[726]

In addition to disparities between Blacks and Whites, there are disparities in mortality rates among infants from other racial/ethnic groups in the United States as well.[727] Puerto Rican and Native American infants also have higher mortality rates than Whites, although not as high as Blacks (see Table 6.5). In comparison, infants of Chinese, Japanese, and Filipino mothers had the lowest rates of mortality among all racial groups.[728]

Figure 6.4. U.S. infant mortality rates by race/ethnicity* of mother, 1987



[726] USDHHS, TRENDS, *supra* note 714, at 81.

[727] There are important interpretation issues with data on race and ethnicity. *See infra* part B.3. (discussing technical issues regarding data on infant mortality rates).

[728] MacDorman et al., *supra* note 709, at 240-41.

Table 6.5. U.S. infant mortality rates by race/ethnicity* of mother, 1987

Race and Hispanic Origin of Mother	Infant Mortality Rate (Deaths per 1000 live births)
All Mothers	9.8
Non-Hispanic Black	17.4
American Indian or Alaska Native	13.0
Hispanic Origin	8.2
Mexican American	8.0
Puerto Rican	9.9
Cuban	7.1
Central and South American	7.8
Other and Unknown Hispanic	8.7
Non-Hispanic White	8.1
Asian or Pacific Islander	7.3
Chinese	6.2
Japanese	6.6
Filipino	6.6
Other Asian or Pacific Islander	7.9

* Figures for "Hispanic origin" include mothers of all races. Data are shown only for states with a Hispanic origin item on their birth certificates. In 1987, only 23 states and the District of Columbia included this item; therefore this data should be viewed cautiously.

Source: Data from USDHHS, FROM DATA TO ACTION, CDC'S PUBLIC HEALTH SURVEILLANCE FOR WOMEN, INFANTS, AND CHILDREN 241 (L.S. Wilcox & J.S. Marks eds., 1994).

Research findings have raised the possibility of a role for biological differences in explaining racial/ethnic disparities in infant mortality, along with socioeconomic factors.[729] However, biological differences need to be better understood before they are attributed to infant mortality differentials. For example, Black and Asian-American infants weigh about one-half pound less than those of White infants at birth.[730] Yet, despite their smaller size at birth, Asian-American infants have mortality rates that are lower than Whites, while Blacks have rates twice those of Whites and Asian Americans.[731] A 1997 study of low birth weights among African-born Blacks, U.S.-born Blacks and U.S. Whites discredits the genetic theory of race differentials in low birth weight.[732]

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[729] *See infra,* section B.4 (discussing socioeconomic factors in racial/ethnic disparities).

[730] P.H. Shiono & R.E. Berhman, *Low Birth Weight: Analysis and Recommendations*, 5 FUTURE OF CHILDREN 4, 14 (Spring 1995); P.H. Shiono, M.A. Klebanoff, & B. Graubard, *Birth Weight Among Women of Different Ethnic Groups* 255 J. AM. MED. ASS'N 48 (1986).

[731] Shiono & Berhman, *supra* note 730, at 15; MARCH OF DIMES BIRTH DEFECTS FOUNDATION, STATBOOK: STATISTICS FOR HEALTHIER MOTHERS AND BABIES (1993).

[732] R. J. David & J.W. Collins, *Differing Birth Weight Among Infants of U.S.-Born Blacks, African-Born Blacks, and U.S.-Born Whites*, 337 NEW ENGL. J. MED. 1209 (1997).

To date, the public health and medical communities have been largely responsible for documenting and reporting the mortality disparities among infants of different socioeconomic and racial/ethnic backgrounds. Responsibility for *reducing* these disparities has also, in large part, been the purview of these health-related groups. More recently, those within the health fields have called for less focus on "high tech" medical interventions, such as those used in neonatal intensive care units, and more focus on preventive services[733] and on pathways that link social and economic disparities to health.[734]

3. Discrepancies in data collection (on infant mortality)

In the United States, infant mortality rates are typically determined and reported by: (1) racial and ethnic groups; (2) specific locations such as states, counties, or cities; and (3) age, which for infants usually include rates of neonatal, postneonatal, and infant mortality. However, significant discrepancies exist in the collection of data useful for understanding and preventing the causes of disparities in mortality.

3.1. Lack of data on income-specific mortality rates

There is a lack of available data on infant mortality rates by income status. Vital records of births and deaths are the primary data sources for understanding patterns of infant mortality, but information about the household income status of infants at the time of their birth or death has never been collected on vital records in the United States. Vital records are typically revised every 10 years in the United States; the opportunity exists to advocate for the inclusion of income data on these records.

Most of the information on the income status of infants that die comes from special studies. Most of these studies have obtained measures of income-specific infant and child mortality rates from population-based interviews and others have determined rates by linking data sets that contain information about income, such as census data, with death certificate data. Unfortunately, educational status is the closest approximation of income status available when birth and infant death records are linked. Recent studies have shown that employment status and family income are better predictors of health status than level of education.[735] The residential address of the mother and father, which can also be used to approximate income status, are also given on birth certificates, but not death certificates. However, unless these records are linked to

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[733] R.M. Kliegman, *Neonatal Technology, Perinatal Survival, Social Consequences, and the Perinatal Paradox*, 85 AM. J. PUB. HEALTH 909, 911 (1995).

[734] CDC, *Poverty and Infant Mortality*, *supra* note 21, at 925; P.R. Lee, N. Moss, & N. Krieger, *Measuring Social Inequalities in Health*, 110 PUB. HEALTH REP. 302 (1995).

[735] Paul Sorlie, Eric Backlund, & Jacob B. Keller, *US Mortality by Economic, Demographic, and Social Characteristics: The National Longitudinal Mortality Study*, 85 AM. J. PUB. HEALTH 949, 949-956 (July 1995).

a data set, such as census data, that determines the income status of the address (usually through the zip code), the address can not be used as a proxy for income status.

3.2. Lack of comprehensive race/ethnicity-specific mortality data

Available data on infant mortality rates by race and ethnicity is limited. Data collection in the United States has only recently included information on race and ethnicity; even more recent were efforts to identify people of Hispanic background. Therefore analysis of many historical trends by race and ethnicity are not possible. Also, in many studies, even large studies, numbers of racial and ethnic groups other than White and Black, are too small for meaningful analysis.[736] In its report on health status and issues related to women, infants, and children, the U.S. Public Health Service urges caution when interpreting race and ethnic data from different data sources.[737] Some data sources have measurement problems and others lack sufficient socioeconomic co-variates so that researchers could control for confounding factors; both problems can seriously weaken the conclusions that can be drawn from the data.

For example, methods used by the National Center for Health Statistics to assign the race of an infant to vital records of births and deaths provide incomplete information in some cases. In its processing and reporting of data from birth certificates, the National Center for Health Statistics, typically, but not always, defines the race of an infant as the race of the mother. On the death certificate, only the infant's race is recorded. In this report, where possible, the tables indicate whether the mother's race was used as the infant's race.

3.3. Lack of data on preventable causes of death

The United States does not have an adequate system for identifying deaths from preventable causes. Data regarding the cause of infant mortality are typically collected and reported in a way that does not include a process for classifying deaths in terms of preventability.[738] This impedes the ability to identify infant deaths that could have been avoided by the use of preventive interventions. Attempts to classify infant deaths as preventable/not preventable began in the United States in the early 1900s with the Federal Children's Bureau. Work in this area remains underdeveloped and therefore limited in its practical application.[739]

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[736] CDC, *Poverty and Infant Mortality*, *supra* note 21, at 922-927.

[737] MacDorman et al., *supra* note 709, at 240.

[738] Eiesland, *supra* note 717, at 9.

[739] *Id.*

3.4. Lack of understanding of etiology underlying causes of death

Efforts to prevent deaths among infants are further impaired by gaps in knowledge regarding disease processes. Experts strongly advocate for further research to advance understanding of the etiology (the study or theory of the factors that cause disease and the method of their introduction to the host)[740] of leading causes of infant deaths.

Although research findings have improved understanding of the situation, definitive causes of socioeconomic and racial disparities in infant mortality are not known. A vast amount of literature debating possible reasons for socioeconomic and racial disparities exists; some of the literature in the public health and medical fields asserts that racial disparities reflect the effects of racism in the United States.[741] Studies have attempted to increase understanding about these disparities by examining various factors of a medical, behavioral, and socioeconomic nature, including chemical/substance use, under-use of medical care, poor health, income levels, employment, physical and emotional stress, poor nutrition, and lack of social support. Some of these factors are discussed in the following sections of this case study.

3.5. Lack of sufficient efforts to understand death due to abuse and neglect

At all levels, insufficient efforts are made to understand the phenomenon of deaths due to physical abuse or neglect. Systems similar to those used in the investigation of adult homicides have never been implemented for investigation of child deaths resulting from parental abuse. Contrary to state laws that mandate the reporting of child abuse and neglect by various professionals, many individuals from the medical, social service, and education fields do not report suspected cases. As a result, more than half of the cases of children who die from abuse and neglect may have never been investigated by child protection services. Child homicides are difficult to prove, especially when there is insufficient evidence due to weak investigations, autopsies performed by untrained professionals, and prosecutors with little education regarding child abuse and neglect. In addition, the likelihood of witnessing child abuse occurring in the

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[740] In order to reduce infant mortality, the etiology of diseases and the modifiable factors associated with the etiology need to be determined. Although data typically reported on infant deaths is referred to as causes of disease, it does not mean that the etiology of diseases is well understood. For example, a leading cause of infant death is disorders related to short gestation and unspecified low birth weight. The etiology of short gestation, or preterm birth, is unknown, and the etiology of low birth weight is not definitively understood. In contrast, the etiology of another leading cause of infant death, respiratory distress syndrome, is better understood. This knowledge led to the development of a medical intervention, exogenous surfactant therapy, which has been successful in reducing the number of infant deaths from this condition. DORLUND'S ILLUSTRATED MEDICAL DICTIONARY 469 (W.B. Saunders Co. ed., 26th ed. 1981) [hereinafter DORLUND].

[741] *See* Kliegman, *supra* note 733, at 909-12 (citing C.J.R. Hogue & M.A. Hargraves, *Class, Race, and Infant Mortality in the United States*, 83 AM. J. PUB. HEALTH 9-12 (1993); J.W. Collins, Jr., *Disparate Black and White Neonatal Mortality Rates Among Infants of Normal Birth Weight in Chicago: A Population Study*, 120 J. PED. 954-60 (1992)).

privacy of the home is rare, and many people find it hard to believe that a parent would cause his or her own child's death.[742]

4. Challenge of behavioral and socioeconomic determinants in reducing disparities in infant and child mortality

Infant and child mortality are attributable to a number of behavioral and socioeconomic determinants. This section of the U.S. case study will discuss several factors affecting infant mortality in the United States in general, and highlight specific issues of five large Midwestern cities—Chicago, Detroit, Indianapolis, Milwaukee, and Minneapolis.

4.1. Interrelationship of factors injurious to infant and child health

The slow progress in reducing disparities in infant mortality in the United States today is considered attributable to a chain of interrelated biological, behavioral, and socioeconomic factors.[743] The risk of death exists for all infants born in the United States, but it is not evenly distributed across the population. It varies widely by certain characteristics of the mother, the pregnancy, and the social context. An understanding of the nature and role of these characteristics is crucial for determining methods for reducing risks and preventing infant deaths.

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[742] *See generally* USDHHS, A NATION'S SHAME: FATAL CHILD ABUSE AND NEGLECT IN THE UNITED STATES, FIFTH REPORT OF THE US ADVISORY BOARD ON CHILD ABUSE AND NEGLECT (Apr. 1995) [hereinafter USDHHS, A NATION'S SHAME].

[743] *See generally, supra* ch. II (discussing interrelationship of these factors).

Box 6.2: Factors linked to low birth weight and/or infant mortality

Present Before or During Pregnancy

Demographic risks

- Race
- Maternal age
- Low socioeconomic status
- Low level of education

Behavioral and Environmental Risks

- Smoking
- Poor nutritional status
- Alcohol or other substance abuse
- Exposure to toxic substances

Medical Risks

- Number of previous pregnancies is 0 or more than 3
- Low height for weight
- Certain diseases (diabetes, etc.)
- Poor obstetric history

Related to Pregnancy

Medical Risks

- Twins, triplets, etc.
- Poor weight gain
- Brief interval between pregnancies
- Low or high blood pressure
- Selected infectious diseases
- Anemia
- Fetal abnormalities
- Complications of pregnancy
- Poor birth outcomes (low birth weight, preterm delivery)

Health-Care Risks

- Late start or no prenatal care (PNC)
- Fewer than the recommended visits for PNC

Other Risks

- Physical and psychosocial risks
- Selected infections
- Events triggering contractions
- Marital status at time of delivery

Adapted from: C.B. HALE, POPULATION REFERENCE BUREAU, POPULATION TRENDS AND PUBLIC POLICY, NO. 18, INFANT MORTALITY: AN AMERICAN TRAGEDY (Apr. 1990).

Many of the risks of infant mortality (see Box. 6.2) show an association between death and poverty.[744] Although selected key factors are discussed individually, it is important to recognize that they do not operate independently. Children born into impoverished socioeconomic environments, particularly children of racial and ethnic minorities, face a higher risk of premature death.

Infant mortality in the United States is often linked to teen and single motherhood, low level of education, unemployment, and lack of health care coverage. Substantial evidence does exist that the negative effects of poverty-related risks (e.g., crowding, nutrition, sanitation) and resource disparities (e.g., income, health insurance coverage) are strongly correlated with high rates of poor birth outcomes, especially among racial minorities.

Some of the literature in the public health and medical fields asserts that racial disparities reflect the effects of racism in

[744] *See* C.B. HALE, INFANT MORTALITY: AN AMERICAN TRAGEDY 4-8 (Population Reference Bureau, Population Trends Pub. Pol'y No. 18, Apr. 1990).

the United States.[745] Studies have attempted to increase understanding about these disparities by examining various factors of a medical, behavioral, and socioeconomic nature including substance abuse, under-utilization of medical care, income levels, employment, poor health, physical and emotional stress, poor nutrition, and lack of social support. For example, among U.S. women, the rates of inadequate prenatal care and low birth weight are two to three times higher among Black mothers than White mothers. And the risk of maternal death for Black women, at 18.5 per 100,000 births is three times higher than that for White women.[746] Teenage mothers, ethnic/racial minorities, and poorly educated mothers are much more likely to bear infants with adversely low birth weight, which is the leading cause of death among Black newborns.[747]

4.2. Poverty and family income

Infants born to women living in poverty are more likely to die.[748] Poverty is closely linked with other risk factors, especially poorly educated, unmarried and teenage mothers, and with racial and ethnic minorities. The mortality rate is 60 percent higher for infants whose

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[745] *See* Kliegman, *supra* note 733, at 909-13 (citing Hogue & Hargraves, supra note 741; Collins, *supra* note 741).

[746] *See* ANDRULIS ET AL., *supra* note 704.

[747] *See* Aday *supra* note 20.

[748] Clearly, poverty adversely affects child health, but some studies have shown that Black infants have poorer health compared to White infants even when socioeconomic status is controlled. Kliegman, *supra* note 733, at 911; Hogue & Hargraves, *supra* note 741; E.C. Davidson, Jr., & T. Fukushima, *The Racial Disparity in Infant Mortality*, 327 NEW ENG. J. MED. 1022 (1992); K.C. Schoendorf, C.J.R. Hogue, J.C. Kleinman, & D. Rowley, *Mortality Among Infants of Black as Compared with White College Educated Parents*, 326 NEW ENG. J. MED. 1522 (1992); D.N. Greenberg, B.A. Yoder, R.H. Clark, C.A. Butzin, & D.M. Null, Jr., *Effect of Maternal Race on Outcome of Preterm Infants in the Military*, 91 J. PEDIATRICS 572 (1993); Collins, *supra* note 741. Other findings also suggest that poverty may not be the sole reason for the disparity in mortality rates between Blacks and other groups. Groups such as Hispanic and Asian-American women, that have levels of poverty similar to those of Black Americans, have lower rates of infant mortality compared to Blacks, and have rates that are comparable to those of Whites. Shiono & Berhman, *supra* note 730, at 14. Some researchers have suggested that explanations for the racial disparities in infant mortality rates may be scarce because Black women may have risk factors that are more difficult to measure. HALE, *supra* note 767, at 8. A further explanation is that pregnancy outcomes may be negatively affected by adverse conditions experienced by the mother during her childhood. Both of these possibilities require further study. *See also* A.T. Geronimus, *The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations*, 2 ETHNICITY & DISEASE 207 (1992).

mothers live below the poverty level[749] than for infants whose mothers live above the level.[750] Researchers estimate that up to 50 percent of postneonatal deaths as well as a significant percentage of deaths occurring near the time of birth could be prevented if social class differences were reduced.[751]

One in five U.S. children lives in poverty today (14.7 million of children under 18); one in four infants and children under six live in poverty, and the number of impoverished children is increasing.[752] More than one in four U.S. children is hungry or at risk of hunger.[753] The increase in the percentage of children raised in poverty has occurred among White, Black, Hispanic, Asian, and Native-American children, with the largest jump occurring among Native- American children (from 32 percent in 1979 to 39 percent in 1989). The incidence of child poverty is most pervasive among Blacks and Native Americans. Children from these two groups are more than three times as likely as White children to be raised in poverty. Based on the 1990 census, the percentage of Black children living in poverty was 40 percent; Native Americans, 39 percent; Hispanics, 32 percent; Asians, 17 percent; and Whites, 13 percent.[754]

A set of interrelated factors helpful in explaining the racial disparities in mortality include differentials between Blacks and Whites in the incidence of poverty, health insurance coverage, and adequate prenatal care.[755] First, Black infants are up to 3 times more likely than White infants to live in families with incomes below the poverty level. Infants living in households

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[749] The poverty level is based on money income and does not include non-cash benefits, such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index (CPI) level. The average poverty threshold for a family of four was $13,924 in 1991. USDHHS, TRENDS, *supra* note 714, at 39, 41.

[750] CDC, *Poverty and Infant Mortality*, *supra* note 21, at 922.

[751] Kliegman, *supra* note 733, at 910 (citing D.A. Leon, D. Vagero, & P.O. Olausson, *Social Class Differences in Infant Mortality in Sweden: Comparison with England and Wales*, 305 BRIT. MED. J. 687 (1992)); I. Delke, R. Hyatt, L. Feinkind, & H. Minkoff, *Avoidable Causes of Perinatal Death at or After Term Pregnancy in an Inner-City Hospital: Medical Versus Social*, 159 AM. J. OBSTET. & GYN. 562 (1988).

[752] Between 1979 and 1989, the percentage of children under age 18 living in poverty grew from 16 percen to 18.3 percent. USDHHS, TRENDS, *supra* note 714, at 41. In 1995, an estimated 38 million Americans lived in poverty, of which one quarter are children, and 11 million had no health care coverage. The long-term trends are toward increasing inequality. U.S. Bureau of the Census, *Poverty 1995* <http://www.census.gov/hhes/poverty/pov95/pov95hi.html>; U.S. Bureau of the Census, *Health insurance coverage 1995* (visited Dec. 13, 1996) <http://www.census.gov/hhes/hlthins/cov95asc.html>.

[753] *See* Bread for the World, *What Governments Can Do: Hunger 1997, 7th Annual Report on the State of World Hunger* (1997) (visited Dec 4, 1996) <http://www.bread.org/bfw/h97summ.html>.

[754] USDHHS, TRENDS, *supra* note 714, at 42.

[755] MacDorman et al., *supra* note 709, at 240.

below the poverty level are at increased risk of death.[756] Second, a higher incidence of poverty often indicates less access to health insurance to cover the costs of pregnancy and delivery.[757] This lack of insurance likely contributes to the lower use of prenatal care by Black women than White women.[758]

In each of the five Midwestern cities in this study, child poverty has risen dramatically since the late 1960s, and has exceeded the national child poverty rate of 18 percent (see Table 6.6).[759] The worsening situation of children in these cities is reflected in the significant percentage of children who were born into and lived in distressed neighborhoods with multiple risk factors including concentrations of poverty (above 25 percent of total residents), large percent of female-headed households (above 37 percent), dependency on public welfare (above 18 percent), and high unemployment (above 45 percent of males not in the labor force).[760]

Table 6.6. Poverty rates among children under five in five Midwestern cities by race, 1990

City	All Children	Black	White
Chicago	36 %	52%	17%
Detroit	51	54	39
Indianapolis	20	41	12
Milwaukee	41	75	17
Minneapolis	33	60	13

Source: U.S. Census 1990.

The situation in Chicago illustrates clearly the social inequality in infant mortality.[761] Data comparing five Chicago communities with the highest infant mortality rates (highest

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[756] *Id. See also* J.B. Gould, B. Davey, & S. LeRoy, *Socioeconomic Differentials and Neonatal Mortality: Racial Comparison of California Singletons*, 83 J. PEDIATRICS 181 (1989); E.G. Stockwell, D.A. Swanson, & J.W. Wicks, *Economic Status Differences in Infant Mortality by Cause of Death*, 103 PUB. HEALTH REP. 135 (1988).

[757] MacDorman et al., *supra* note 709, at 240.

[758] *Id. See also* U.S. NAT'L CTR. HEALTH STAT. (USNCHS), [1 NATALITY] VITAL STATISTICS OF THE UNITED STATES, 1988 (1990).

[759] ANNIE E. CASEY FOUNDATION, KIDS COUNT: DATA ON THE WELL-BEING OF CHILDREN IN LARGE CITIES 5 (1997) [hereinafter KIDS COUNT: CHILDREN IN LARGE CITIES]. The child poverty rate of 18 percent is derived from the 1990 Census data. The Luxembourg Income Study, reported in UNICEF's *Progress of Nations*, puts the 1991 U.S. child poverty rate at 22 percent. *See* UNICEF, PROGRESS OF NATIONS 1996, *supra* note 27.

[760] KIDS COUNT: CHILDREN IN LARGE CITIES, *supra* note 759, at 115.

[761] CHICAGO DEP'T PUB. HEALTH (CDPH), COMMUNITY AREA HEALTH INVENTORY, 1992-1994 (vol. I-II, 1996); CDPH, INFANT MORTALITY IN CHICAGO, 1993-1994 (1996).

communities) to five communities with the lowest infant mortality rates (lowest communities) reveals extreme differences in poverty and related socio-economic factors.

- The *average infant mortality rate* in the five communities with highest rates, at 23 infant deaths per 1000 births, is nearly eight times the average rate of the five communites with lowest rates, at 3 per 1000.

- Compared to the lowest communities, the highest communities are consistently imperiled by disproportionate levels of socioeconomic deprivation:

  > Almost half of the residents in highest communities live below poverty, compared to only 8 percent of residents in lowest communities;
  > 57 percent of residents in the highest communities are on public aid—less than 6 percent in lowest communities;
  > unemployment rate in highest communities, averaging 23 percent, reflects a situation of severe economic insecurity, both at the community and household levels, compared to 6 percent in lowest communities; and
  > 72 percent of householders are female in highest communities—less than 18 percent in lowest communities.

- Communities with the highest infant deaths have approximately two times as many low weight births and births to teenage mothers compared to the lowest communities.

- Communities with highest infant mortality rates are overwhelmingly Black, averaging 95 percent of the total population within these communities; average percentage of Black residents in lowest communities is 1.4 percent.

- The percentage of expectant mothers with no prenatal care in highest communities was triple that of lowest communities.

- Finally, these highest communities have significantly greater rates of reportable health conditions, including lead poisoning and AIDS. The high rates of elevated lead levels among children under age six in these communities point to substandard housing conditions that increase the risk of lead exposure—rates are nearly six times higher than those in lowest communities.

4.3. High teen pregnancy rates

Infant mortality is more likely to occur among *younger women* (20 years of age or younger) and *older women* (40 years of age or older) than among women between the ages of 20 and 39. The rate of infant death among teenage mothers in 1987 was 14.5 per 1000 live births and among mothers age 39 or older was 12.6 per 1000 live births. In comparison, infant death rates among women aged 25-29 was 8.1 per 1000, and among those 30-34 was 8.4 per 1000.[762] Nationally, 5 percent of all births in 1994 were to females under 18 years of age; the average rate for the 50 largest U.S. cities was 7 percent.[763] Since young mothers are more likely than older women to experience infant deaths, it is a significant health and social concern that birth rates among U.S. adolescents have not historically shown a steady downward trend;[764] that they are higher among Black teenagers than White teenagers (see Box 6.3); and that they remain higher compared to birth rates of adolescents in other developed countries.[765]

Box 6.3. Teen pregnancies in the Midwestern region

Births to teenagers is a significant social and health concern in the large urban centers of the Midwestern region. In addition to higher rates of low birth weight and infant death, teenage mothers more often face increased risks of a variety of social and health problem, including: higher incidence of poverty, repeat pregnancy, poor access to prenatal care, school drop-out, and unemployment. Racial disparities in teen births is striking.

The Chicago teen birth rate in 1994 (for under 20 years old), was nearly 19 percent, a slight decline from the 1980 at 22 percent. Rate of birth to Black teens, at 27 percent is more than double that of White teens. Milwaukee has an equally high teen birth rate; one in five women younger than 19 years gave birth in 1994. In Minneapolis, the highest rates of teen births occur in the poorest, most racially diverse neighborhoods. Only 6 percent of all births were to teenage mothers in Indianapolis in 1993; but the rate for Black teens were double that of their White peers. Finally, Detroit has one of the highest teen birth rates in the country; even more troubling, 87 percent of all teen mothers were Black.

Source: USDHHS (1994); Chicago Dep't Public Health, IMC93-4, at 30-31; City Kids Count (1997), at 5, 108; Minneapolis Dep't of Public Health (1994); Milwaukee Health Dep't (1994); Minneapolis Planning Dep't (1997), at 137; Marion County Health Dep't (1993), at 32.

4.4. Unintended pregnancies

Despite the decline in unwanted fertility over the decades, more than half (57 percent) of all pregnancies in the United States are still unintended and 7 percent of these infants have low birth weights, a leading cause of infant death.[766] A woman who experiences an unintended pregnancy may be less likely to be involved in prenatal care and may be more likely to expose the fetus to harmful substances such as tobacco, alcohol, or drugs; a child born as the result of an

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[762] MacDorman et al., *supra* note 709, at 241.

[763] KIDS COUNT: CHILDREN IN LARGE CITIES, *supra* note 759, at 5.

[764] USDHHS, TRENDS, *supra* note 714, at 175.

[765] E.F. Jones, J.D. Forrest, N. Goldman, et al., *Teenage Pregnancy in Developed Countries: Determinants and Policy Implications*, 17 FAM. PLAN. PERSP. 53 (1985).

[766] Planned Parenthood, *Planned Parenthood Fact Sheet: Access to Family Planning and Reproductive Health Care Services* (visited July 20, 1997) <http://www.ppfa.org/ppfa/access.html>.

unintended pregnancy may be at risk of low birth weight, of dying in its first year of life, and of going without the necessary resources for optimal growth and development.[767] In cases of financial and emotional hardship, children born as a result of unintended pregnancy may be at higher risk of being abused or neglected.[768]

Box 6.4. Percent of all births to unmarried teen mothers in five Midwestern cities, 1994

Chicago	17%
Detroit	21%
Indianapolis	13%
Milwaukee	19%
Minneapolis	14%

Source: CITY KIDS COUNT (1997).

Births from unintended pregnancies are more likely to occur to mothers who are adolescent, unmarried or over the age of 40 (see Box 6.4).[769] Minority and low-income women also experience unintended pregnancy at a higher rate than the general population. Eighty percent of pregnancies to adolescents are considered unintended. Babies born to teenage mothers are twice as likely to have low birth weight and three times more likely to die in the first 28 days than those of older mothers, and the incidence of Sudden Infant Death Syndrome and the rates of illness and injury are higher among infants of adolescents[770] whose pregnancies are often compounded by environmental and social factors such as poverty, poor health, and insufficient supervision.[771] The high likelihood of teen mothers living in impoverished households makes many adverse social and economic conditions much more prevalent in their families.[772]

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[767] INSTITUTE OF MEDICINE, THE BEST INTENTIONS: UNINTENDED PREGNANCY AND THE WELL-BEING OF CHILDREN AND FAMILIES 1 (1995) [hereinafter INSTITUTE OF MEDICINE: THE BEST INTENTIONS].

[768] *Id.* at 73.

[769] *Id.* at 61.

[770] *Id.* at 59.

[771] Planned Parenthood, *supra* note 766.

[772] *Id.*

4.5. Inadequate prenatal care

Infants are more likely to die when their mothers have less than adequate prenatal care.[773] In 1987, the infant mortality rate among mothers who did not use prenatal care services was nearly 42 compared with 8.4 per 1000 live births among women who started prenatal care during the first trimester of pregnancy.[774] Mothers under age 15 and those between 15-19 years of age are more likely to use prenatal-care services too late in their pregnancies or receive no care at all compared to older women.[775] A higher proportion of Black women (10 percent) do not have prenatal care or start it late (in the third trimester of pregnancy), compared to White women (4.2 percent).[776] (See Box 6.5.)

Box 6.5. Disparity in prenatal care in Detroit

Detroit has fewer mothers receiving early prenatal care compared with national figures. Nationally up to 80 percent of mothers in 1994 began prenatal care in the first trimester of pregnancy, while the Detroit rate was 10 percent lower. In addition, in Detroit 9 percent of all mothers received late or no prenatal care.

Disparities in prenatal care usage persist between Whites and communities of color; Black mothers are less likely to receive early prenatal care and more likely to receive no prenatal care at all. In 1994, the largest percentage of mothers going without prenatal care were Black mothers ages 20-24. Despite the poor ranking in terms of women receiving prenatal care, there have been overall improvements in reducing the numbers of babies born without comprehensive prenatal care, with a substantial decrease among Black mothers.

Source: NCHS1994; MDPH1994; NCHS 1996.

Although there are still unanswered questions about prenatal care,[777] it is considered by many to be an effective approach to improving low birth weight, leading to a reduction in infant mortality.[778] Existing evidence suggests that prenatal care delivered by nurses in mothers' homes can improve birth weights among infants of young adolescents.[779] It is estimated that every dollar spent on

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[773] In a 1973 report of the Institute of Medicine, David M. Kessner developed an index for measuring the adequacy of prenatal-care utilization. The Kessner Index defines care as adequate, inadequate, and intermediate depending on the time in pregnancy in which prenatal care begins, gestational age, and the number of prenatal visits. Adequacy of care varies by weeks of gestation; care cannot be adequate unless it begins within the first 13 weeks of pregnancy (first trimester) and will always be inadequate if begun at 28 or more weeks of gestational age. 1 DAVID M. KESSNER, INFANT DEATH: AN ANALYSIS BY MATERNAL RISK AND HEALTH CARE (1973), *cited in* HALE, *supra* note 744, at 9.

[774] MacDorman et al., *supra* note 709, at 241.

[775] USDHHS, TRENDS, *supra* note 714, at 113.

[776] USDHHS, TRENDS, *supra* note 714, at 115.

[777] More recent research casts doubt on some of the earlier findings. *See, e.g.*, G.R. Alexander & C.C. Korenbrot, *The Role of Prenatal Care in Preventing Low Birth Weight*, 5 FUTURE OF CHILDREN 103 (Spring 1995). *See also infra* part C.1.3 (discussing reducing rates of low birth weight, preterm birth, and prenatal care). Continued research on prenatal care is necessary to determine the benefit of prenatal care in increasing the likelihood of healthy pregnancy outcomes.

[778] HALE, *supra* note 744, at 11.

[779] D.L. Olds, C.R. Henderson, R. Tatelbaum, & R. Chamberlin, *Improving the Delivery of Prenatal Care and Outcomes of Pregnancy: A Randomized Trial of Nurse Home Visitation*, 77 J. PEDIATRICS 16 (1986); Alexander

prenatal care targeting low-income, poorly-educated women could save as much as $400,000 during the lifetime of the child.[780] Barriers to adequate use of prenatal care are attributable to a wide range of factors concerning quality, availability and accessibility of health services for expectant mothers, which further contribute to the disparity in utilization of prenatal health services (see Box 6.6).

Box 6.6. Inadequate use of prenatal care due to numerous barriers in Midwestern cities

In Minneapolis, lower rates of prenatal-care usage are found in the poorest and most racially diverse neighborhoods. Mothers whose infants have died in Minneapolis reported feeling a lack of respect and communication from their health care providers. Differences between providers and patients in terms of culture, language, educational level, and socioeconomic status were the main reasons identified as contributing to poor communication. As a result, insufficient information was provided to these mothers and they were not aware of or referred to other health and social services that may have assisted them. These missed opportunities for further assistance and intervention likely played an important role in the eventual death of the infant.

The Fetal Infant Mortality Review Project in Milwaukee has been studying infant deaths in neighborhoods with high rates of children dying in the first year of life in the attempt to focus on prevention. Of the major issues identified through 12 cases reviewed thus far, many were associated with access to health care, primarily prenatal and pediatric care. These issues included inadequate link to pediatric care, perceived lack of care by providers, and infant coverage gap.

In Chicago, the failure to access adequate prenatal care spans a variety of availability and accessibility factors such as a lack of child care, transportation, and finance; long waiting time; fear of being tested for drugs; and problems with getting appointments.

An Indianapolis survey of attitudes of consumers regarding health care organizations/providers revealed important barriers, including: understanding of the needs and concerns of the community; communication problems; inappropriate and/or inadequate services; and, disrespectful treatment by the health care system.

Sources: MARION COUNTY HEALTH DEP'T (1995); MINNEAPOLIS DEP'T HEALTH & FAMILY SUPPORT (1995), at 8-9; Foldy, Hammel, & Zelazek (1996), at 3; CHICAGO DEP'T PUB. HEALTH, IMC93-94 (1996).

4.6. Low maternal education

In general, infant death rates are higher among women with fewer years of education. In 1987, among mothers who did not complete high school, the infant mortality rate was close to 15 per 1000 live births compared to 6.3 among mothers who completed college.[781] Higher levels of education (at least 12 years of schooling) is associated with earlier onset of prenatal care, as well

& Korenbrot, *supra* note 806, at 105. A 1997 study of long-term effects of home visitation on maternal and child health among low-income, unmarried mothers shows a reduction in the number of subsequent pregnancies, decreased use of welfare, and lower incidence of child abuse and neglect. D. L. Olds et al., *Long-term Effects of Home Visitation on Maternal Life Course and Child Abuse and Neglect: Fifteen-Year Follow-up of a Randomized Trial*, 278 J. AM. MED. ASS'N 637-43 (Aug. 1997).

[780] HALE, *supra* note 744 (citing S. BROWN, PRENATAL CARE: REACHING MOTHERS, REACHING INFANTS (1988)).

[781] MacDorman et al., *supra* note 709, at 241.

as a number of health enhancing factors such as higher maternal age and higher marketability and earning potential in the job market.[782]

4.7. Single mothers

The marital status of the mother at the time of the delivery is correlated with infant mortality, with higher rates of infant death among mothers who are not married. The infant mortality rate among unmarried mothers was 12.5 per 1000 live births compared to 7.3 among married mothers.[783] The percentage of babies born to unmarried mothers has increased significantly nationwide. Between 1970 and 1992, the percentage of infants born to unmarried mothers almost tripled, from about 11 percent to 30 percent (see Figure 6.5 & Table 6.7).[784]

Unmarried (or single) mothers more often live in poverty and lack the social and financial support necessary for maintaining the well being of their infants. In Chicago, the nation's third largest city, poor children are disproportionately represented in households headed by a single female parent, and over half of these households live in poverty.[785] The situation in other large Midwestern cities like Milwaukee and Minneapolis is similar. The percentage of children living with a single female parent in Minneapolis jumped from 26 percent to 32 percent from 1980 to 1990; 60 percent of these households are renters, and of these renters, two thirds live in poverty; the proportion of births to unmarried women in Minneapolis increased dramatically from 26 percent in 1981 to 46 percent in 1994.[786] Further, racial disparity in rates of birth to unmarried women is evident.[787]

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[782] *See supra* parts B.4.3 (discussing teen pregnancy) and B.4.5 (discussing inadequate prenatal care).

[783] MacDorman et al., *supra* note 709, at 241.

[784] USDHHS, TRENDS, *supra* note 714, at 24-25.

[785] CDHP, *supra* note 761.

[786] MINNEAPOLIS PLAN. DEP'T, STATE OF THE CITY 1996: A STATISTICAL PORTRAIT OF MINNEAPOLIS (1997).

[787] In 1992, 23 percent of White infants and 68 percent of Black infants were delivered to unmarried mothers. The infant mortality rate was about 20 per 1000 births among Black unmarried mothers, compared to 15 among Black married mothers. MacDorman et al., *supra* note 709, at 241. In Indianapolis, 40 percent of all infants were born to unmarried women in 1992; in the same year, three in four Black infants were born to a single mother, nearly triple the situation of White infants. MARION COUNTY HEALTH DEP'T, REPORT TO THE COMMUNITY (1994-95).

Figure 6.5. Percent of U.S. births to unmarried women* by race, 1970-1992

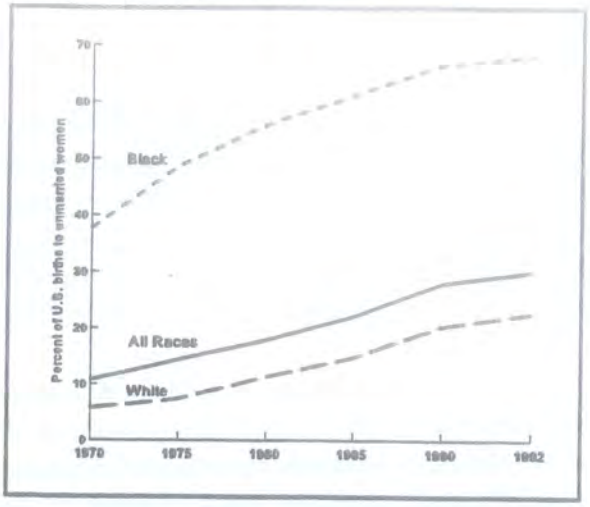

Table 6.7. Percent of U.S. births to unmarried women* by race, 1970-1992

Race	1970	1975	1980	1985	1990	1992
All Races	10.7	14.3	17.8	22.0	28.0	30.1
White	5.7	7.3	11.2	14.7	20.3	22.6
Black	37.6	48.8	56.1	61.2	66.5	68.1

* Includes women in all age groups from 15 to 39.
Source: Data from USDHHS, TRENDS (1996), tbl. PF 2.2, at 25.

4.8. Geographic variation

Infants in some geographic areas in the United States die at higher rates than those in other areas. A twofold difference exists between states with the highest and lowest infant mortality rates.[788] In 1994, Mississippi had the highest overall infant mortality rate at 11 deaths per 1000 live births, and Rhode Island had the lowest nationwide rate at 5. When disaggregating data by race, among Whites the lowest rate was 4.1 per 1000 in Rhode Island and the highest rate was 8.3 per 1000 in Oklahoma. For Blacks, the low and high rates were 11 per 1000 in Massachusetts and 22.7 per 1000 in Iowa, respectively. Data also show up to a threefold difference in city-specific infant mortality rates.[789]

Among the five large Midwestern cities highlighted in this case study, infant mortality rates for 1994 ranged from a low of 9.8 infant deaths per 1000 live births for Minneapolis to a high of 16.6 per 1000 live births for Detroit (see Figure 6.6). Racial disparities in mortality are

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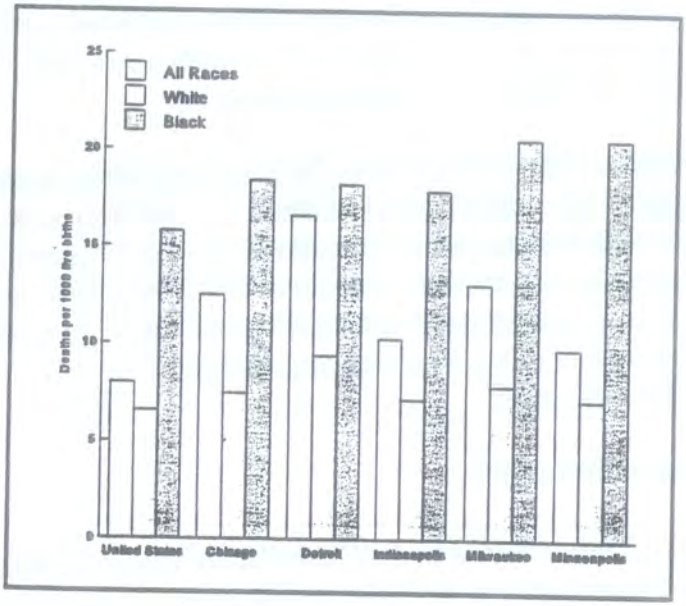
[788] Singh et al., *supra* note 22.

[789] CityMatCH, *Urban Infant Mortality Data 1985-1989*, 2 CITY LTS. 4 (1993). The city-specific rates referred to are for cities with populations greater than 100,000.

significant. Minneapolis, a wealthy city with a strong system of health care and social services, has one of the lowest White infant mortality rates in the country (7.2), yet also has one of the highest rates of Black infant mortality in the country. The Black infant mortality rate for Minneapolis (20.6) is greater than that for Chicago (18.4) and Detroit (18.2), which are larger cities and have sizable or predominantly Black populations. The disparity in infant mortality between Blacks and Whites is 3 to 1 in Minneapolis, and 2 to 1 in Detroit.

Some researchers have found a strong relationship between state-level infant mortality rates and racial, educational, and poverty distributions within a state.[790] This relationship persists even when not considering health service factors such as distribution of health insurance coverage within states and state expenditures for health, hospitals, and public welfare. Other reasons, still unknown, are suggested by findings that continue to show geographic differences in death rates between states even after controlling for race and birth weight.[791]

Figure 6.6. Infant mortality rates in five Midwestern cities by race, 1994



[790] *See, e.g.*, S.T. Bird & K.E. Bauman, *The Relationship Between Structural and Health Services Variables and State-Level Infant Mortality in the United States*, 85 AM. J. PUB. HEALTH 26-29 (1995).

[791] M.C. Aoyama et al., Variation in State-Specific Infant Mortality Rates, 1983-87: The Potential for Reducing the U.S. Infant Mortality Rate, Presentation at the Epidemic Intelligence Service Conference, Atlanta, Georgia (Apr. 19-23, 1993), *in* MacDorman et al., *supra* note 709, at 242.

Table 6.8. Infant mortality rates in five Midwestern cities by race, 1994

Geographic Sites	All Races	White	Black	Black/White Ratio
United States	8.0	6.6	15.8	2.4
Chicago	12.5	7.5	18.4	2.4
Detroit	16.6	9.4	18.2	1.9
Indianapolis	10.3	7.2	17.9	2.3
Milwaukee	13.1	7.9	20.6	2.9
Minneapolis	9.8	7.2	20.6	2.9

Sources: Data for U.S. from Singh et al. (Sept. 30, 1996), tbl. 24, at 64; data for U.S. cities from various sources.

5. Need to address biological and socioeconomic determinants

An understanding of the leading causes of death for U.S. infants and children aged 1 through 4, and in particular the differences between Whites and Blacks, supports the belief of experts that a significant portion of infant deaths is preventable, and illustrates a need to focus on socioeconomic as well as biological and behavioral strategies.

The top four causes of death are the same for Black and White infants, but their rank order varies dramatically.[792] The leading cause of death among Black infants is disorders relating to preterm birth and low birth weight, which accounts for almost 20 percent of the deaths to Black infants. In comparison, only about 11 percent of all White infant deaths resulted from these disorders. The leading cause of death among White infants is congenital anomalies, which accounts for more than a quarter of all White infant deaths; whereas only 13 percent of Black infants that die perish from this cause.

5.1. Causes of infant deaths

Over one-half of all infant deaths in the United States are due to four causes: 1) congenital anomalies; 2) disorders related to short gestation (pre-term birth) and unspecified low birth weight; 3) sudden infant death syndrome (SIDS); and 4) respiratory distress syndrome (see Figure 6.7 & Table 6.9).[793]

[792] Singh et al., *supra* note 22, at 67.

[793] *Id.*

Figure 6.7. Percent of U.S. infant deaths by leading causes, 1994

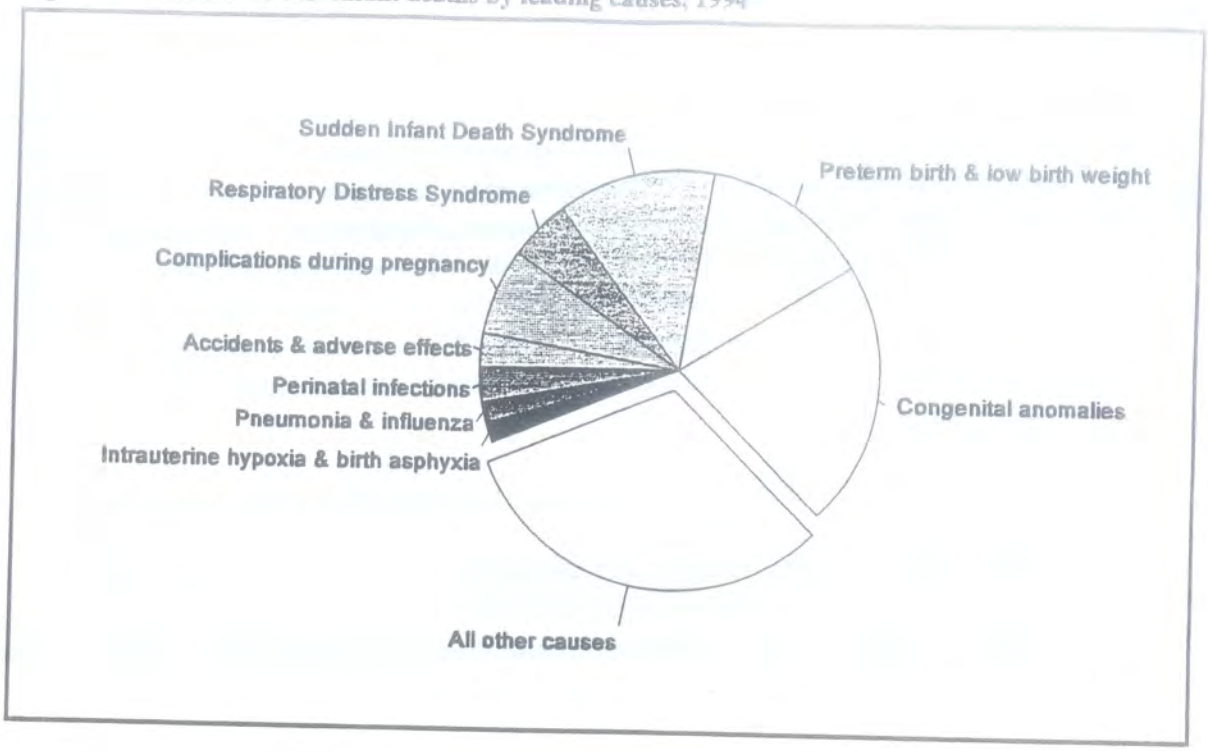


Table 6.9. Percent of U.S. infant deaths by leading causes, 1994

Cause of Death	% of Total Infant Deaths
Congenital anomalies	21.6
Preterm birth & low birth weight	13.4
Sudden Infant Death Syndrome	12.8
Respiratory Distress Syndrome	4.9
Complications during pregnancy	7.1
Accidents & adverse effects	2.8
Perinatal infections	2.6
Pneumonia & influenza	1.8
Intrauterine hypoxia & birth asphyxia	1.7
All other causes	31.3

Source: Singh et al. (Sept. 30, 1996), tbl. 26.

- **Congenital anomalies**

Congenital anomalies are structural defects present at birth such as Down's Syndrome, spina bifida, and congenital heart disease.[794] In 1994, congenital anomalies were the leading killer of children in the United States causing 22 percent of all deaths.[795] Little is known about specific causes of congenital anomalies,[796] thus prevention strategies have not been developed. Screening tests to detect the presence of some congenital anomalies exist and are done during pregnancy, such as ultrasound, amniocentesis, chorionic villus sampling, and umbilical blood sampling.[797] These tests can detect conditions such as Down's Syndrome and neural tube defects. Tertiary prevention strategies include genetic counseling for couples at high risk for having an infant with congenital anomalies, induced abortion, and continued health care for children born with these conditions.[798]

- **Disorders relating to short gestation and unspecified low birth weight**

Disorders relating to short gestation and unspecified low birth weight constitute the second leading killer of U.S. infants, accounting for more than one in ten infant deaths (or 13 percent of all infant deaths).[799] These disorders include live-born infants who die before reaching

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[794] These defects can be "isolated or multiple, inherited or sporadic, apparent or hidden, gross or microscopic." THE MERCK MANUAL OF DIAGNOSIS AND THERAPY (R. Berkow & A.J. Fletcher eds., 16th ed. 1992) [hereinafter MERCK MANUAL]. Although some congenital anomalies are apparent at birth, others become apparent as the infant grows into childhood. Factors associated with an increased risk for congenital anomalies include: (1) pregnant women over age 35 who have never been pregnant (primiparas); (2) breech presentation of a baby during labor and delivery; and (3) poly- or oligohydramnios (excess of amniotic fluid), or the presence of <300 ml. of amniotic fluid at term. DORLUND, *supra* note 763. Genetic factors lead to or predispose some fetuses to the development of congenital malformations. Teratogenic agents are also known to lead to certain anomalies including: (1) drugs taken during pregnancy, such as the drug thalidomide which resulted in defects of extremities in infants; (2) illnesses of the mother present during pregnancy, such as diabetes; (3) certain infections contracted by the mother during pregnancy, such as rubella; and (4) irradiation. MERCK MANUAL, *supra*.

[795] Singh et al., *supra* note 22, at 67.

[796] MERCK MANUAL, *supra* note 794.

[797] WALLACE ET AL., *supra* note 709.

[798] *Id.*

[799] Singh et al., *supra* note 22.

gestational age,[800] and/or those born at a weight considered below normal.[801] Although preterm delivery and infant birth weight are separate phenomenon, they are strongly correlated. Many of the key factors thought or known to lead to increased risk for each of these phenomenon are the same factors as those related to infant mortality. Preterm delivery is the main cause of low birth weight and infant mortality in the United States.[802] The role of low birth weight in infant mortality is also significant.[803]

Although many infant deaths are linked to preterm delivery and low birth weight, relatively little is known about what causes these conditions.[804] Research has established that cigarette smoking during pregnancy increases the risk that an infant will be born at a low birth weight.[805] Compared to low birth weight, even less is known about the causes of preterm delivery. Important lessons, however, can be learned from a French program implemented in the early 1970s which combined biological, behavioral and socioeconomic interventions to successfully reduce preterm births.[806]

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[800] The gestational age of a fetus or newborn infant is the elapsed time since conception. However, as the moment when conception occurred is rarely known precisely, the duration of gestation is measured from the first day of the last normal menstrual period. Categories typically used to describe gestational ages are: *preterm*: less than or equal to 37 weeks gestation; *term*: 38-41 weeks; *postterm*: greater than or equal to 42 weeks. LAST, *supra* note 706, at 103-04.

[801] Infant's weight recorded at the time of birth and, in some countries, entered on the birth certificate. Certain variants of birth weight are precisely defined: *very low birth weight*: <1500 grams; *low birth weight*: <2500 grams; *normal birth weight*: 2500-4249 grams; *heavy birth weight*: 4250 grams or greater. *Id.* at 103-04.

[802] Despite the more prominent role of preterm delivery in infant mortality, policies, programs, and the literature focus more on low birth weight than on preterm delivery. There is recognition now, however, that prevention and evaluation efforts should focus more specifically on determinants of preterm delivery and less on low birth weight. *See, e.g.*, Alexander & Korenbrot, *supra* note 806, at 115; M.S. Kramer, *Determinants of Low Birth Weight: Methodological Assessment and Meta-Analysis*, 65 BULL. WHO 663 (1987); Shiono & Berhman, *supra* note 730, at 14.

[803] For example, in 1987, 6.9 percent of infants were born at low birth weights, but these infants made up 61 percent of all infant deaths. Shiono & Berhman, *supra* note 730, at 164. In 1990, Black infants were 2 times as likely as Whites to be born at low birth weights. Further, preliminary data suggests that 92 percent of deaths to Black infants occurred among those born with low birth weights. *Id.*

[804] *Id.* at 8.

[805] It is estimated that up to 20 percent of all low birth weight births could be prevented if women across the nation stopped smoking during pregnancy. *Id.* at 5. *See also* Chomitz et al., *supra* note 765, at 21.

[806] In France, preterm births fell dramatically after implementation of a preterm birth prevention program which included increasing the number of prenatal care visits; organization of regional prenatal care clinics; local and mass media efforts to teach pregnant women to recognize the signs of uterine contractions that could lead to preterm delivery; the improvement of maternity leave practices; paid parental leave; subsidized child care; tax credits; and child allowances. The main objectives of prenatal care services in France include: (1) monitoring signs of premature labor or cervical dilation; (2) dissemination of educational materials about preventing early uterine

Sudden infant death syndrome (SIDS)

Sudden Infant Death Syndrome (SIDS), as the third leading cause of death, accounts for nearly 13 percent of infant deaths.[807] SIDS is a sudden death that is unexpected from the infant's history and for which a thorough postmortem examination fails to show a definitive cause of death.[808] Because the cause of SIDS remains unknown, primary prevention strategies are not well developed. Factors that appear to be associated with increased risk for a SIDS death include: 1) more months of the year that are cold in temperature; 2) low socioeconomic status; 3) preterm birth; 4) experience of severe apnea requiring resuscitation among infants; 5) siblings born subsequent to a sibling that died of SIDS; and 6) maternal smoking during pregnancy.[809]

In response to the high rate of deaths from SIDS and research findings showing a connection between an infant's sleep position and SIDS, a national program called Back to Sleep was implemented. Between 1992 and 1994 this program found a 30 percent decline in deaths from SIDS which appeared to be tied to the campaign. The campaign educated parents to lay their babies on their backs during naps and bedtime and encouraged parents to provide a smoke-free environment for their infants.[810]

Two recent reports on SIDS suggest that some cases of child abuse or infanticide may have been misdiagnosed as SIDS, or as "near miss" SIDS in which an apparently healthy infant comes close to death as a result of a life threatening event.[811] According to these reports, a lack of investigation into suspicious infant deaths and injuries may have resulted from misclassifications of sudden infant deaths by the medical examiner system. It is important to point out that suspected cases of abuse and infanticide may only represent a small proportion of

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contractions; and (3) reducing high risk behaviors of pregnant women such as smoking, alcohol use, and drug use. Prenatal care services in France also include assessment of medical as well as other physical and emotional stresses that may increase risk of preterm delivery. Kliegman, *supra* note 733, at 911. Evaluations of the program reported a steady decline in preterm births from 1972-1981; preterm birth rates decreased from 5.4 percent to 3.6 percent. G.S. Berkowitz & E. Papiernik, *Epidemiology of Preterm Birth*, EPI. REV. 414, 432-33 (1993).

[807] Singh et al., *supra* note 22, at 67.

[808] MERCK MANUAL, *supra* note 794, at 2048.

[809] *Id.*

[810] USDHHS, *Preventing Infant Mortality* (visited June 25, 1997) <http://www.hhs.gov/cgi-bin/WAISdocID=503905567>, at 1.

[811] These two reports are expected to be published in the November issue of the medical journal *Pediatrics*. The first report is authored by U.S. Drs. Thomas L.Truman and Catherine Ayoub. The second report is written by British pediatric researcher David Southall. *See* Philip J. Hilts, *Misdiagnoses are Said to Mask Lethal Abuse*, N.Y. TIMES, Sept. 11, 1997, at A10.

all SIDS cases. In light of these reports, however, full investigations of all suspicious SIDS cases are warranted.

- **Respiratory distress syndrome**

In 1994, respiratory distress syndrome was the fourth leading killer of infants at almost 5 percent of all infant deaths.[812] Respiratory distress syndrome is caused by incomplete expansion of the lung[813] which occurs when pulmonary surfactants[814] are deficient at birth, resulting in breathing difficulties; infants with this condition are almost always preterm, and the more premature the infant, the more likely the infant will be to having the syndrome.[815]

Infant deaths from respiratory distress syndrome decreased significantly between 1972 and 1994.[816] This decrease has been due, in large part, to improvements in the medical management of this condition by exogenous surfactant therapy.[817] The use of this medical therapy occurs typically within minutes to hours after birth and leads to immediate improvements in infant survival. Consequently, use of this therapy has contributed to reductions in the neonatal mortality rate.

5.2. Preventability of infant deaths

Research indicates that from 36 percent to 52 percent of infant deaths in the United States could be classified as potentially preventable to preventable.[818] More specifically, because of the association between socioeconomic factors such as poverty with postneonatal mortality,[819]

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[812] Singh et al., *supra* note 22, at 67.

[813] DORLUND, *supra* note 740, at 133.

[814] Pulmonary surfactants are secretions produced in the body. When the surfactants are deficient, the lung tissue becomes stiff and, in turn, the stiffness makes breathing difficult.

[815] MERCK MANUAL, *supra* note 794, at 1981-82.

[816] Singh et al., *supra* note 22, at 11.

[817] W. Long, A. Corbet, R. Cotton, et al., *A Controlled Trial of Synthetic Surfactant in Infants Weighing 1250 G. or More with Respiratory Distress Syndrome*, 325 N. ENG. J. MED. 1696 (1991); E.M. Zola, A.M. Overbach, J.H. Gunkel, et al., *Treatment Investigational New Drug Experience with Survanta (Beractant)*, 91 J. PEDIATRICS 546 (1993).

[818] Eiesland, *supra* note 717.

[819] Neonatal and postneonatal mortality are typically examined separately. Rowley et al., *supra* note 709, at 251-62. Many neonatal deaths have been associated with circumstances surrounding the prenatal period and delivery and are believed to have an endogenous etiology—a cause of death based on a genetic predisposition or internal physiological process, such as congenital malformations or respiratory distress syndrome. Eiesland, *supra*

researchers suggest that more than 50 percent of the postneonatal deaths, as well as a significant percentage of deaths occurring near the time of birth, could be prevented if socioeconomic differences were reduced.[820] Some postneonatal mortality has been associated with preventable causes such as infantile diarrhea.[821]

In addition to poverty reduction, specific primary prevention strategies which can benefit both maternal and infant health include maternal smoking cessation, adequate prenatal care, monitoring and education regarding premature labor, and education regarding infant's sleep position (for SIDS prevention).[822] One reason infants continue to die from causes that are preventable is that the application of knowledge about the etiology of some diseases and prevention methods has fallen short. Examples include the under-use of relatively low-tech treatments to prevent deaths from diarrhea, and the lack of smoking cessation programs for pregnant women.[823] Public policies aimed at preventing commercial access to tobacco and curbing tobacco advertising are gaining support as an effective response to the problem of cigarette use among adolescents.[824]

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note 717; Michielutte et al., *supra* note 717. In contrast, many postneonatal deaths have been associated with conditions or circumstances that occur after delivery and are more likely to reflect environmental factors such as poverty. These deaths are often described as deaths from exogenous causes. The utility of classifying infant deaths in this manner, however, is somewhat limited because a majority of deaths in the postneonatal period can be attributed to endogenous causes—these infants, in other words, survived their conditions beyond the neonatal period only to die in the postneonatal period. Eiesland, *supra* note 717, at 8.

[820] Leon et al., *supra* note 751; Delke et al., *supra* note 751; *cited in* Kliegman, *supra* note 733, at 911.

[821] M.S. Ho, R.I. Glass, P.F. Pinsky, et al., *Diarrheal Deaths in American Children: Are They Prevent* ? 260 J. AM. MED. ASS'N 3281 (1988), *cited in* Kliegman, *supra* note 733, at 910; L. Richards, M. Claeson, & N. Pierce, *Management of Acute Diarrhea in Children: Lessons Learned*, 12 PED. INFECT. DIS. J. 5, 5-9 (1993).

[822] The three levels of prevention include: (1) *Primary prevention*. Activities aimed at reducing the incidence (new occurrences) of disease and at protecting and promoting health. Examples include preserving good nutritional status, physical fitness, and emotional well-being, immunizing against infectious diseases, and making the environment safe; (2) *Secondary prevention*. Activities aimed at reducing prevalence (overall occurrence) of disease or poor health by shortening their duration. These include activities available to individuals and populations for the early detection and prompt and effective intervention to correct departures from good health; and (3) *Tertiary prevention*. Activities aimed at reducing the complications of disease or poor health. These include activities to reduce or eliminate long-term impairments and disabilities, minimize suffering caused by existing departures from good health, and to promote the individual's adjustment to irremediable conditions. LAST, *supra* note 706, at 103-04.

[823] Shiono & Berhman, *supra* note 730.

[824] USDHHS, SMOKING AND TOBACCO CONTROL MONOGRAPH 3, MAJOR LOCAL TOBACCO CONTROL ORDINANCES IN THE U.S. (NIH93-3532, May 1993).

5.3. Causes of deaths of children aged 1 through 4

Deaths of children ages 1-4 are predominantly the result of: injuries, congenital anomalies, malignant neoplasms (i.e., cancer), diseases of the heart, genetic-related conditions, and HIV/AIDS.[825] HIV/AIDS became the sixth leading cause of death in this age group. And, while deaths due to other infectious diseases have decreased by 90 percent over the last decade, injury has become the leading cause of death in children aged 1 through 4.[826]

- **Injuries**

Injuries are the leading cause of death in children. Although the prevalence of injuries has decreased by 40 percent in the last 60 years, among children aged 1-19 years injuries still cause more deaths than all other diseases and conditions combined.[827] Injuries, both intentional and unintentional, are receiving more attention as a major public health concern. Although deaths from unintentional injuries have declined over time, fatalities from intentional injuries have seen a steady increase.[828]

Injuries are increasingly referred to as *unintentional* or *intentional*, even though the most commonly used classification system is not designed to accommodate this distinction.[829] The

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[825] Singh et al., *supra* note 22.

[826] Rowley et al., *supra* note 709, at 301.

[827] *Id.* at 299.

[828] F.P. Rivara & D.C. Grossman, *Prevention of Traumatic Deaths to Children in the United States: How Far Have We Come and Where Do We Need to Go?*, 97 J. PEDIATRICS 791, 796 (June 1996).

[829] As stated above, the International Statistical Classification of Diseases, Injuries, and Causes of Death (ICD) classification scheme is used to determine and report the cause of death, including injuries which are referred by the ICD scheme as "Accidents and Adverse Effects." This classification scheme includes categories that specify injuries that are clearly intentional, such as those resulting from homicide or child abuse. There are also categories that specify injuries from other causes such as drowning, motor vehicle accidents, etc. Problems arise when the intent of the cause of an injury is unknown or unspecified. As a result, many deaths due to intentional injuries, including child abuse and neglect, are misclassified as either accidents, homicides without indication of parent or care giver, SIDS, or as unknown. In short, when deaths are classified as an "unintentional injury" or accident, little is revealed about the actual nature of the deaths.

Although accidents and other adverse effects are listed as the major cause of death for children ages 1-4, researchers estimate that a substantial proportion of injury fatalities may actually be the result of child maltreatment. *See* Singh et al., *supra* note 22. Those classifying the deaths, such as coroners and medical examiners, are pressured to complete death certificates in a timely manner, often neglecting important details, and some still remain reluctant to implicate children's parents in their deaths. *See* USDHHS, A NATION'S SHAME, *supra* note 742, at 22. Some problems with inaccurate recording of the cause of death arise because some people who fill out death certificates are not medically trained. *Id.* Further, states have different definitions of child homicide, and many deaths are thus not classified as such. Many agencies also have different policies and procedures regarding child death reporting, investigation, and prosecution. As a result, many states have tried to address the issue of low investigation and

term "unintentional injuries" refers to injuries that occur without specific intent of harm, as contrasted with the term"intentional injuries," which indicates that the injury occurred as a result of an intent to harm; since the effects of intentional and unintentional injuries remain similar, it is the underlying cause of the condition and the intentionality of harm that become the distinguishing factors.[830] The challenge in categorization is most profound when dealing with the issue of child abuse and neglect, since the intent to harm is difficult to prove.

Unintentional injuries

Despite inadequate methods to catagorize injuries, unintentional injury is considered the leading cause of death for children ages 1-4 in the United States and is one of the top 6 leading causes of death for children under the age of 1.[831] As many as 3600 children die each year as a result of unintentional injuries, which can be attributed to multiple factors, such as a child's developmental level, a parent's lack of understanding of the child's abilities, and environmental circumstances.[832] Each type of injury has a particular demographic pattern which varies with the child's age and developmental level, the prevalence of threat in the community, access to safety devices, and amount of supervision.[833] Motor vehicle accidents cause the largest number of trauma deaths to children; drowning, especially in swimming pools and bathtubs, fire-related injuries, poisoning, and falls are other leading causes of injury and death, with children under the age of 5 having a higher death rate due to these circumstances than any other age group.[834]

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prosecution rates of abusers by establishing standardized guidelines of identification and investigation of child deaths. With the increasing incidence of child maltreatment and the insistence on a more accurate tracking system, stricter guidelines for ICD-9 coding when dealing with issues of child abuse and neglect have been implemented. *See id.*

[830] E.M. Lewit & L.S. Baker, *Child Indicators: Unintentional Injuries*, 5 FUTURE OF CHILDREN 214-22 (Spring 1995).

[831] Singh et al., *supra* note 22, at 23.

[832] Lewit & Baker, *supra* note 830.

[833] *See generally* S. M. Smith et al., *Injury and Child Abuse*, in FROM DATA TO ACTION, *supra* note 709, at 299.

[834] Rivara & Grossman, *supra* note 828, at 791.

Intentional injuries

Intentional injuries are primarily attributable to child abuse and neglect.[835] Although accidents and adverse effects are listed as the leading cause of death for children ages 1 through 4, research indicates that more children die as a result of abuse and neglect than from any one of the unintentional injuries such as falls, choking, suffocation, fires, drowning, or motor-vehicle accidents. Recent research suggests that approximately 2000 infants and young children die from abuse or neglect by parents or caretakers each year, averaging 5 children killed every day from maltreatment.[836] Other estimates report that more than 5 of every 100,000 children under the age of 4 are killed by abuse and neglect.[837]

Child neglect

Twice as many children are victims of medical and other types of neglect than of physical abuse, a fact even more profound among younger children. Deaths due to medical neglect occur when medically necessary treatment is withheld from disabled infants and children who have

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[835] The National Center on Child Abuse and Neglect identifies a case as child abuse or neglect when "through intentional acts, a parent, guardian, or other adult caretaker causes foreseeable and avoidable injury or impairment to a child under age 18 or worsening of an existing injury or impairment in a child under age 18 years." National Center on Child Abuse and Neglect (1977), *in* USDHHS, A NATION'S SHAME, *supra* note 742, at 144.

[836] National Safety Council (1995), *in* USDHHS, A NATION'S SHAME, *supra* note 742 at xxv, xxiii.

[837] CDC, *Poverty and Infant Mortality*, *supra* note 21, at 922, *in* USDHHS, A NATION'S SHAME, *supra* note 742, at 8. In addition to the number of child-maltreatment fatalities, at least another 18,000 children per year are left permanently disabled, and over 141,000 are seriously injured from maltreatment. In total, there are about 3 million reported cases of child abuse and neglect each year. National Center for Child Abuse Neglect (1991), *in* USDHHS, A NATION'S SHAME, *supra* note 742, at xxv. While these statistics are alarming, recent studies suggest that, as a result of underreporting and misclassification, many more deaths due to child abuse and neglect occur every year. Fatality figures usually only include those deaths that are known to child protective services and do not represent those unknown to the agency at the time of death. *See* USDHHS, CHILD MALTREATMENT 1994: REPORTS FROM THE STATES TO THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (1996) [hereinafter USDHHS, STATE REPORTS ON CHILD ABUSE & NEGLECT]. In 1995, 45 states reported that 996 children were known by child protective services to have died as a result of maltreatment, but estimates from the National Center for the Prosecution of Child Abuse estimate that actually about 2000 children die each year. National Clearinghouse on Child Abuse & Neglect Information, *Frequently Asked Questions About Child Abuse and Neglect* (visited July 16, 1997) <http://www.calib.com.nccanch/pubs/fatality.html>. These underestimates are partly a result of inadequate investigations, inconsistent handling and tracking of cases, poor reporting systems, misclassification of cases, and little accountability by those responsible for investigating child deaths. USDHHS, STATE REPORTS ON CHILD ABUSE & NEGLECT, *supra*, at 19. It has been estimated that due to misclassification and underreporting, a more accurate death rate for children under age 4 from abuse and neglect by a parent or care giver is 11.6 per 100,000 children, rather than 5.4. CDC, *supra*, *in* USDHHS, A NATION'S SHAME, *supra* note 742, at 8. The criteria used to establish the incidence of abuse versus the incidence of neglect differs considerably, placing them into two distinctly different maltreatment categories and requiring separate prevention and treatment strategies.

life-threatening conditions. Victims younger than 4 years old are about 5 times more likely to be neglected than physically abused.[838]

Efforts to understand the various types of neglect have led to increased awareness among parents and caretakers about the dangers faced by unsupervised young children. "Supervision neglect deaths" occur when a child is left unsupervised and sudden danger arises. "Chronic neglect deaths" are a result of problems building over time.[839] Mothers are most often held responsible for deaths due to neglect such as bathtub drowning, dehydration, and starvation.[840] However, often a mother is held accountable for a death even when the father was actually in charge of the child at the time of the incident.[841]

Due to the ambiguous definition of neglect, many deaths resulting from lack of supervision are not classified as child maltreatment, but as the result of an "unintentional injury." For example, a child might have drowned in a bathtub and the death was identified as an accident. But, the fact that the young child was left unsupervised goes unrecorded. In fact, some states do not even collect data on neglect or do not legally define neglect as a type of maltreatment.[842]

Child physical abuse

udies in Oklahoma, Colorado, and Oregon on the causes of death to children as a result of abu eveal that many of the children experienced severe head trauma, the results of severe shaking, or injury to their abdomen or thorax.[843] In a study of Shaken Baby Syndrome, most cases occurred when men became furious about babies' crying. The overlap between domestic violence and child abuse is significant, since children in homes where domestic violence occurs are much more likely to experience physical assault. This correlates with the finding that most physical abuse fatalities are caused by fathers and other male caretakers. As the level of violence in the home increases, the likelihood of fatal injuries to children also increases; events identified

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[838] Administration for Children and Families, *Section 2: 1995 National Findings* (visited July 16, 1997) <http://www.acf.dhhs.gov/programs/cb/stats/ncands/section2.html/1996/nis.html>, at 4.

[839] Colorado Child Fatality Review Committee, *in* USDHHS, STATE REPORTS ON CHILD ABUSE & NEGLECT, *supra* note 837, at 11.

[840] USDHHS, STATE REPORTS ON CHILD ABUSE & NEGLECT, *supra* note 837, at 13.

[841] *Id.* at 14.

[842] Administration for Children and Families, *supra* note 838, at 1.

[843] Colorado Fatality Review Committee, *in* USDHHS, STATE REPORTS ON CHILD ABUSE & NEGLECT, *supra* note 837, at 15.

as triggers include a baby's inconsolable crying, feeding difficulties, failed toilet-training attempts, and other acts of "disobedience."[844]

Child homicides

In 1995, the homicide rate for young children reached its highest point in 40 years.[845] Moreover, 80 percent of homicide is the result of parental maltreatment. Although females are identified more often as perpetrators of maltreatment, males are more likely to be responsible for child abuse fatalities.[846]

5.4. Preventability of child deaths

Many injuries of children aged 1-4 are considered preventable, since their incidence can be reduced by implementing relatively simple strategies. Understanding the factors associated with the occurrence of injuries is critical to developing effective prevention strategies.[847] For example, racial/ethnic minority children and low-income children experience injuries at higher rates than the general population. Living in impoverished environments and not having common safety devices are just two of the reasons behind this disparity.[848] In addition, an estimated 20 percent of the injuries to children under the age of 6 who lack health care coverage go untreated.[849] The racial and socioeconomic disparities in injury-related deaths for children aged 1-4 point to many intervention areas that can be considered, ranging from safe and affordable housing, to universal health care coverage for children under 6, to household economic security.

Children from families with annual incomes below $15,000 were 22 times more likely to experience maltreatment and to be seriously injured than children from families whose incomes exceeded $30,000.[850] In addition to living in poverty, abused children often have parents in their 20s who have not finished high school, are depressed, and are unable to cope with stress.[851]

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[844] USDHHS, STATE REPORTS ON CHILD ABUSE & NEGLECT, *supra* note 837, at 12.

[845] USDHHS, A NATION'S SHAME, *supra* note 742, at xxiv.

[846] Levine et al., *in* USDHHS, A NATION'S SHAME, *supra* note 742, at xxvi.

[847] Lewit & Baker, *supra* note 830.

[848] KIDS COUNT: CHILDREN IN LARGE CITIES, *supra* note 759, at 24.

[849] M.D. Overpeck & J.B. Kotch, *The Effect of U.S. Children's Access to Care on Medical Attention for Injuries*, 85 AM. J. PUB. HEALTH 402, 403 (Mar. 1995).

[850] Administration for Children and Families, *Survey Shows Dramatic Increase in Child Abuse and Neglect, 1986-1993* (visited Dec. 2, 1996) <http://www.acf.dhhs.gov/news/press/1996/nis.html>.

[851] USDHHS, A NATION'S SHAME, *supra* note 742, at 14.

Many abusive parents have also experienced abuse and neglect firsthand at some point in their lives. Substance abuse among parents or caretakers is often a contributing factor. However, every case is different and no single profile fits each situation. Contrary to popular belief, the majority of the child abuse/neglect deaths occur in two-parent households where a male is present.[852]

In addition to an increased risk among poor children, younger children appear more at risk of maltreatment than older children. About 90 percent of all deaths from abuse and neglect are to children under the age of 5; most of these victims are actually under the age of 2, and 41 percent are infants under the age of 1.[853] One of the main reasons is that before reaching school age, young children may have little contact with adults outside the immediate family or household environment who will intervene in abusive situations. A majority of child-abuse cases investigated are the result of reports made by either law enforcement, medicine, social services, or education professionals, who might not have any contact with non-school-age children.[854]

The over-representation of Black families in child-abuse and neglect fatalities, 2 to 3 times the rate seen in other racial groups, is a complex issue. Many researchers believe that the systemic racial bias present throughout the child-protection and judicial system (or society in general) has magnified the issue of race as a predictive factor of abuse; still others believe that the true contributing factor is poverty, which affects large numbers of people of color and results in intense emotional distress, increasing the likelihood of explosive episodes.[855]

- **Prevention of unintentional injuries**

Unintentional injuries are often regarded as accidental, which can be extremely misleading since the word "accident" implies something that is unpredictable and out of one's control. Yet, one-third of all unintentional injuries could likely be prevented through simple safety measures.[856] The use of child restraint devices in automobiles, for example, prevents approximately 71 percent of deaths to children under age 5; similarly, child-resistant packaging has been responsible for the reduction in deaths due to poisoning, and the use of smoke detectors has had significant impact on the prevention of deaths due to fire.[857] Typically, the priority level for the development of prevention strategies for each type of injury is based on the assessment of

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[852] Alfaro, *in* USDHHS, *supra* note 742, at 14.

[853] *Id.* at 16.

[854] Administration for Children and Families, *supra* note 838, at 1-2.

[855] USDHHS, A NATION'S SHAME, *supra* note 742, at 25.

[856] Rivara & Grossman, *supra* note 828, at 795.

[857] *Id.* at 795-96.

the rates of mortality, hospitalization, and disability, as well as the existence of effective safety measures.[858]

- **Prevention of intentional injuries**

A pattern of abuse in the past is the best indicator of the likelihood of future abuse.[859] Policies related to family preservation and reunification should be examined especially in cases of ongoing physical abuse.[860] If intervention strategies were implemented earlier, such as prompt removal from the home or termination of parental rights, and more serious repercussions to perpetrators existed, then it is possible that fewer of these child-maltreatment cases would result in fatalities.

C. United States law and practice

1. Federal law

1.1. Constitutional law

The Constitution of the United States does not provide for the health protection of its people. The United States Supreme Court, for the most part, interprets the Constitution as restricting government from interfering with personal liberties, but not affirmatively obligating government to provide social welfare benefits.[861] Hence, no government, at the federal, state, or local level, is required by the federal Constitution to provide a minimum level of health care for persons in need or to provide health benefits at all. Therefore, under US constitutional doctrine, government provision of health care, and many other social benefits (e.g., housing,[862] welfare,[863] etc.) is discretionary.[864]

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[858] *See supra* note 833, at 299.

[859] USDHHS, A NATION'S SHAME, *supra* note 742, at xxxv.

[860] *Id.* at 116.

[861] Citizens have "no affirmative [constitutional] right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests." DeShaney v. Winnebago County Social Services Dep't, 489 U.S. 189, 196 (1989).

[862] *See* Lindsey v. Normet, 405 U.S. 56 (1972).

[863] *See* Memorial Hospital v. Maricopa County, 415 U.S. 250 (1974).

[864] Kenneth R. Wing, *The Right to Health Care in the United States*, 2 ANNALS HEALTH LAW 161, 186 (1993).

Once a government chooses to establish a health care program, however, the manner in which health benefits are dispensed is subject to constitutional limitations.[865] Specifically, the distribution of benefits may not violate the nondiscrimination and fairness principles underlying the due process and equal protection clauses of the Fifth and Fourteenth Amendments.[866]

The Equal Protection Clause of the Fourteenth Amendment[867] prohibits state discrimination on the basis of classifications such as race and sex in the application of health benefits.[868] Despite the Equal Protection Clause, there are no laws against disparate impact of health benefits or policies at the constitutional level.[869]

Under the Due Process Clause of the Fifth and Fourteenth Amendments,[870] the Constitution guarantees that no one shall be deprived of the right to life without due process of law. This provision has been interpreted, however, to impose no affirmative obligation on government to provide resources to preserve life.[871] The constitutional provision protects individuals against government action which deprives them of life without due process, i.e., fair trial.

1.2. Statutory law and programs

To the extent federal law provides legal rights to medical assistance, those rights are created by statute. Congress has the Constitutional authority to regulate medical care and to establish health benefit programs.[872] Congress has chosen to exercise that power by enacting a

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[865] Maher v. Roe, 432 U.S. 464, 469-70 (1977)

[866] The Equal Protection Clause of the Fourteenth Amendment applies to the states; its principles apply to the federal government through the Due Process Clause of the Fifth Amendment. Bolling v. Sharpe, 347 U.S. 497, 499 (1954).

[867] U.S. CONST., amends. 5 & 14.

[868] The Supreme Court has provided early decisions that discriminatory application of a law, which on its face is not discriminatory, is a denial of the equal protection of the Fourteenth Amendment. See Yick Wo v. Hopkins, 118 U.S. 356 (1886)

[869] *See* Washington v. Davis, 426 U.S. 229 (1976).

[870] U.S. CONST., amends. 5 & 14.

[871] *See* DeShaney v. Winnebago County Social Services Dep't, 489 U.S. 189, 196 (1989).

[872] Congress is allowed to pass health care legislation via the Commerce Clause, which gives Congress the power to "regulate commerce . . . among the several states . . . ." U.S. Const., Art. I, § 8, cl. 3. Under the Commerce Clause, Congress may regulate any commercial activity that substantially affects interstate commerce. *See, e.g.*, Heart of Atlanta Motel v. United States, 379 U.S. 241 (1964). The provision of medical care is a business

number of laws that establish, in one form or another, legal rights to health care. Various federal programs are targeted to assist the poor and, in particular, poor mothers and children. These programs create legal rights to health care in different forms, other than direct, federal entitlements for individuals.

- **Title XIV: Medicaid**

The Medicaid program is a joint state-federal program that provides federal appropriations and establishes federal guidelines to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services . . ."[873] Medicaid is administered at the state level, and every state has opted to either administer a state Medicaid program or a similar health program under a federal waiver. Federal law mandates that each state Medicaid program must cover certain federally designated eligible groups of individuals and must provide a set of specified benefits.[874] Under this structure, an individual can go to federal court and claim, under 42 U.S.C. § 1983, that a state has deprived that individual of a federally protected right to Medicaid benefits.[875]

Medicaid is the largest public program that focuses on the health care needs of low income people and/or people with high-risk health or social problems. From the mid-1980s, Congress passed legislation that placed increasing responsibility on public programs for the

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with substantial effect on interstate commerce. *See* Summit Health LTD. v. Pinhas, 500 U.S. 322, 329 (1991) (stating that the practice of opthamology at a local hospital affects interstate commerce because: 1) out-of-state patients are treated; 2) medical supplies are purchased from out-of-state; and 3) revenues are generated from out-of-state insurance companies).

[873] 42 U.S.C. § 1396.

[874] The Medicare program creates a legal entitlement to health insurance benefits from the federal government for each individual who is eligible under the program 42 U.S.C. §§ 1396-1395ccc. The program covers hospital care, physician care, and certain other medical services for the aged and certain disabled persons, regardless of financial circumstances. If eligibility for Medicare benefits is denied by the Department of Health and Human Services, and the appropriate administrative reviews are exhausted, an individual may seek federal judicial review of an administrative eligibility determination. 42 U.S.C. § 1395ff(b)(1), (2).

[875] 42 U.S.C. § 1983 states that "[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects or causes to be subjected any citizen . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress." The Supreme Court has held that this statute, stemming from the Civil Rights Act of 1871, may be used to enforce rights under federal statutes, such as the Medicaid statute. *See* Maine v. Thiboutot, 448 U.S. 1 (1980).

provision and financing of health care for women and children.[876] A major purpose of this legislation was to increase women's access to prenatal care and other primary health services in the effort to reduce the infant mortality rate. The rapid reduction in the country's infant mortality rate over the decades slowed considerably by the end of the 1980s, thus, necessitating a change in legislation concerning maternal and infant health.[877]

While many public programs during this period in the late 1980s experienced funding increases and began to concentrate more on concerns about infant mortality, the public program most affected by these changes was Title XIX of the Social Security Act, known as Medicaid. Services are financed by reimbursing designated providers who offer care. Funding for the program is shared by both the federal government, through the Health Care Financing Administration within the Department of Health and Human Services, and state governments, through state health and human service departments.[878]

Medicaid was not adequately equipped to finance timely prenatal care for large numbers of pregnant women who were in need; accordingly, additional funding had to be allocated. Since Medicaid subsidizes approximately one third of all births in the United States,[879] any legislative action impacts millions of pregnant women and infants who depend on its support. While having to comply with federal guidelines, states are given the primary responsibility to design and administer their own Medicaid programs. As a result, wide variations in eligibility, the types of services offered, and the amount of money allocated exist among states.[880]

In the past, nearly all states had set Medicaid income eligibility limits far below the federal poverty level, leaving many low income people who did not meet eligibility criteria

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[876] Important legislation changes to the Medicaid system have occurred since the mid-1980s.

- *Consolidated Budget Reconciliation Act of 1985* gave states the option to offer pregnant women services such as nutritional counseling, psycho-social counseling, case management and health education not otherwise covered by the plan.
- *Omnibus Budget Reconciliation Act of 1987* allowed states to increase income eligibility requirements for pregnant women and infants to 185% of the poverty level.
- *Family Support Act of 1988* provided up to 12 months of added Medicaid coverage for families that leave AFDC due to increased income.
- *Omnibus Budget Reconciliation Act of 1989* mandated that all states have to at least cover pregnant women and children through age 5 years with family incomes below 133% of the federal poverty level, but up to 185%.
- *Omnibus Budget Reconciliation Act of 1990* placed Medicaid workers at health care facilities in order to make it convenient for women to apply for assistance.

WALLACE ET AL., *supra* note 709. *See also* M.B. Carpenter, *The Impact of Legislation Designed to Reduce Infant Mortality*, J. PERINATAL & NEONATAL NURSING 19, 19-30 (June 1995).

[877] Carpenter, *supra* note 876.

[878] *Id.*

[879] *Id.*

[880] R.B. Gold, S. Singh, & J. Frost, *The Medicaid Eligibility Expansions for Pregnant Women: Evaluating the Strength of State Implementation Efforts*, 25 FAM. PLAN. PERSP. 196, 196-206 (Sept./Oct. 1993).

without health care coverage. Women and children, who comprise the largest numbers of Medicaid recipients and only one third of the overall spending, were often those most affected. Traditionally, enrollment in AFDC,[881] the government's cash assistance program, was the primary way for women and children to become eligible for Medicaid. However, many pregnant women, infants and children were left without health care coverage during the most vulnerable times of their lives, simply because they did not meet AFDC's stringent income eligibility requirements.[882]

The traditional link between Medicaid and the AFDC program was severed in 1986 as Congress extended Medicaid coverage to pregnant women, infants and children up to age 5 years who had family incomes above the AFDC level, but below the federal poverty level. The Omnibus Budget Reconciliation Act of 1986 was met with tremendous response from states which, within just 2 years, increased income eligibility limits of Medicaid programs, beginning the trend of more liberal eligibility requirements. In addition, the application process known to be a huge deterrent to enrolling in the program was shortened for pregnant women. Pregnant women could also remain enrolled in Medicaid throughout their pregnancy and 60 days postpartum without having to reapply.[883]

By the early 1990s, congressional legislation had resulted in income eligibility levels for Medicaid two to three times higher than in the past. Expansion in eligibility to pregnant women and children greatly improved the health insurance status of low income people on and off welfare.[884] The changes in the way health care for low income pregnant women was financed began to alter the traditional face of Medicaid. It was no longer a welfare-based system, but one that provides access to high-quality, comprehensive prenatal care and other health services to as many eligible people as possible.[885] As discussed later, however, welfare reform legislation in the mid-1990s has had a significant impact on public programs targeting women and children.

- **Aid to Families with Dependent Children (AFDC) and Temporary Assistance to Needy Families (TANC)**

In 1996, changes in public welfare policies called for the replacement of AFDC (commonly referred to as welfare) with the Temporary Assistance to Needy Families program, a discretionary block grant program providing time-limited cash benefits for needy families with

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[881] *See infra* pp. 201-02.

[882] Carpenter, *supra* note 876.

[883] *Id.*

[884] *Id.*

[885] Gold et al., *supra* note 880.

children.[886] The new program mandates that parents find work, go to school, or do community service in order to continue receiving federally-funded cash welfare benefits. Although this program does not involve the direct provision of health benefits, the theory behind the legislation indicates a perceived relationship between legal rights to benefits and healthy children. The law concludes that the new conditions placed on receipt of benefits will lead to less teenage and out-of-wedlock births, which will lead to healthier babies and a drop in infant mortality.[887]

Prior to the policy changes, for 60 years, AFDC has been the primary cash assistance program targeting poor families with children. The federal government provided funding and monitoring of the program and the states were responsible for administering AFDC and establishing qualifications for recipients. A monthly cash grant taking into account family size, earned income, and expenses was provided to those who meet the eligibility criteria. Although the limited assistance offered by AFDC was not enough to pull families out of poverty, it helped to meet primary needs that might otherwise be left unmet. Individuals in single-parent families were the major group covered by AFDC. In 1992, 5 percent of the total U.S. population received AFDC while 15 percent of the nation's children received benefits.[888]

In addition to cash assistance, families who qualified for AFDC were also eligible for other benefits such as Medicaid and food stamps. The food stamp program provides coupons to individuals to redeem for food. Since the majority of AFDC recipients also received food stamps, families had additional money to spend on items other than food. The Thrifty Food Plan, a low cost diet plan, helps to determine the allotment of Food Stamps. Federal feeding programs were developed in response to advocacy efforts to address childhood hunger in the United States. Programs such as food stamps have been instrumental in addressing the issue of childhood hunger on a large scale.[889]

- **Title V: Maternal and Child Health Services Block Grant Program**

Under Title V, the federal government operates a Maternal and Child Health (MCH) Services Block Grant Program which provides matching funds to states.[890] One of the main purposes of this program is to enable states "[t]o provide and to assure mothers and children (particularly those with low income or with limited availability of health services) access to

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[886] Personal Responsibility and Work Opportunities Reconciliation Act, Pub. L. No. 104-93, 110 Stat. 2105.

[887] *Id.* § 101(8)(C), (9)(D).

[888] S.B. Page & M.B. Larner, *Introduction to the AFDC Program*, 7 FUTURE OF CHILDREN 20, 20-27 (Spring 1997).

[889] E.M. Lewit & N. Kerrebrock, *Childhood Hunger*, 7 FUTURE CHILDREN 128, 128-37 (Spring 1997).

[890] 42 U.S.C. § 701-710.

quality maternal and child health services."[891] The programs are operated under broad federal requirements, restrictions, and reporting obligations, but an individual has no general federal entitlement or legal right to receive benefits. The funds are used by state and local governments, nonprofit human services agencies, colleges and universities, public health agencies, and other groups to conduct activities to reduce infant mortality, provide preventative and primary services for low income children, and numerous other functions. Examples of projects funded under the program are the operation of maternal and child health centers, maternal and child health programs to service rural areas, and outpatient and community-based services programs.

Title V and Medicaid have historically had to work together to develop comprehensive health care programs for women and children. Agencies receiving Title V funds have a role in assisting Medicaid in performing outreach and health education to families and enlisting appropriate providers into the system. While Medicaid focuses on offering primary and acute care to families, MCH programs help to establish larger systems of care, by providing statewide leadership in developing health service policies and standards and assuring high quality care for all mothers and children. Medicaid programs have relied a great deal on Title V agencies to help develop and implement new policies and initiatives targeting infant mortality reduction.[892]

Together with the expansion in Medicaid financing in the late 1980s, other federal maternal and child health programs such as Title V were expanded in order to meet the health care needs of women and children. Title V of the Social Security Act of 1965, was created as a federal-state partnership to administer maternal and child health services, especially to those with low incomes and who lack access to care.[893] Title V programs seek to integrate resources in both the private and public sector to target the MCH population. Federally, Title V is administered by the Maternal and Child Health Bureau within the Department of Health and Human Services and locally, it is administered within state health departments.[894]

In 1981, new legislation consolidated seven MCH programs into one Maternal and Child Health Block Grant, which allowed states to develop their own programs to reduce infant mortality and assure access to care for mothers and children.[895] States must provide a three dollar match for every four dollars that the federal government allocates. As with Medicaid, Title V services, coordination, and standards began to vary within each state and problems occurred with how to transfer responsibility to states. After facing budget cuts in the early 1980s, coordination

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[891] 42 U.S.C. § 701(a)(1)(A).

[892] Gold et al., *supra* note 880.

[893] WALLACE ET AL., *supra* note 709.

[894] Carpenter, *supra* note 876.

[895] *Id.*

of state Title V services was accomplished. In 1998, the Maternal and Child Health Block Grant appropriation from Congress was $684 million.[896]

- **Special Supplemental Food Program for Women, Infants and Children**

The Special Supplemental Food Program for Women, Infants, and Children (WIC) program provides food, nutritional screening, nutrition education, and referrals to health and social services for low-income pregnant and postpartum women and children up to age 5.[897] The program does not provide an entitlement to benefits; it is designed to provide funding for supplemental foods and nutrition through any eligible local agency that applies for participation. The intent is that WIC shall "serve as an adjunct to good health care, during critical times of growth and development, to prevent the occurrence of health problems . . ."[898] Eligibility for benefits under WIC is based on income and evidence of medical or dietary risks.

One out of every three babies born in the United States participates in the Supplemental Food Program for Women, Infants, and Children (WIC). Maternal participation in WIC has been shown to be effective in reducing infant mortality and improving birth outcomes. Although funding increased to about $3.5 billion in 1995, there are still many pregnant women who are eligible for WIC services but do not receive them.[899]

WIC was established by Congress in 1972 based on the knowledge that the nutritional status and practices of a mother can affect the outcome of her pregnancy. Research had shown that hunger was a problem among childbearing women, infants, and young children. A recent report on world hunger by the Bread for the World Institute estimates that 13.6 million children in the United States are hungry or at risk of hunger.[900]

- **Title X: Family Planning and Reproductive Health Care Services**

Each year over 4 million women and adolescents receive services at Title X funded family planning and reproductive health care clinics. The majority of these patients are young and poor, with African-Americans disproportionately represented in the clinic populations. For 83 percent of the women who receive care, Title X clinics are their only source of family planning services. About one-third of the clinic populations are adolescents, who are served on a

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[896] Maternal & Child Health Bureau, *Maternal and Child Health Bureau Programs* (visited June 26, 1997) <http://www.os.dhhs.gov/hrsa/mchb.html>.

[897] 42 U.S.C. § 1786.

[898] 42 U.S.C. § 1786.

[899] Carpenter, *supra* note 876.

[900] Bread for the World Institute, *What Governments Can Do: Hunger 1997*, *supra* note 753.

confidential basis and regardless of their ability to pay. Outreach and preventive educational services are also provided to young people in diverse communities.[901] However, it must be noted that only 2 percent of all Title X family planning clinic patients are males, which stresses the continuing need for outreach in regard to male responsibility in family planning.[902]

The goal of this federal program is to reduce unintended pregnancy by providing contraceptive and other reproductive health care services to those in need. Through supporting the operation of family planning agencies in the United States, Title X is dedicated solely to funding family planning related services. Depending on the state, Title X money is administered through either the state health department, Planned Parenthood affiliates, hospitals, regional or local family planning councils, or community organizations.[903]

A minimum standard of care is enforced in Title X funded agencies. The law guarantees that people are given a choice of medical or non-medical contraceptive methods. However, no one should be coerced into a method of contraception. In addition, patients are to be charged on a sliding fee scale based on income. This approach means that if someone is at or below 100 percent of the federal poverty level, then all of their reproductive health care services are subsidized. No Title X money is to be used to pay for abortions. In the event of an unintended pregnancy, non-directive counseling on available options is to be provided to the woman. Title X funding also is to pay for training of health care professionals, the provision of public information and outreach, and the evaluation of the effectiveness of the services provided.[904]

In addition to the receipt of contraceptive methods, comprehensive family planning services and counseling is provided by clinics. They also provide preventive health care services that are critical to reproductive and sexual health, such as Pap tests, breast exams, testing for anemia, blood pressure and diabetes, sexually transmitted disease screening, and safer sex counseling.[905]

Since Title X is a federally administered program, states are not allowed to impose their own restrictions on the type and quality of services offered.[906] When this Title X money is block granted to states, however, cuts in funding for particular services would dramatically affect the

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[901] Planned Parenthood, *Planned Parenthood Fact Sheet, America's Family Planning Program: Title X.* (visited July 20, 1997) <http://www.ppfa.org/ppfa/titlex.html>.

[902] INSTITUTE ON MEDICINE, THE BEST INTENTIONS, *supra* note 767, at 219.

[903] Planned Parenthood, *supra* note 901.

[904] *Id.* at 1.

[905] *Id.* at 2.

[906] INSTITUTE ON MEDICINE, THE BEST INTENTIONS, *supra* note 767, at 278.

health care and status of a state's population, similar to the affects of federal cuts to welfare or other funding.

- **Supplemental Security Income**

The Supplemental Security Income (SSI) program was implemented under the Social Security Act of 1965 in order "to assure a minimum level of income for people who are age 65 or over, or who are blind or disabled." SSI, administered by the Social Security Administration, helps to maintain a minimum standard of living for those who do not have sufficient income and resources. For the purposes of our discussion, SSI will be mentioned only in terms of how it applies to disabled infants, especially to those born premature and with low birth weight--the key factors linked to infant mortality.[907]

In assessing whether an infant is eligible for SSI, the impairment must be expected to "substantially reduce the ability to grow, develop or mature physically, mentally or emotionally and, thus, to engage in age-appropriate activities of daily living (Sec. 416.924a(c)(2))." Age-appropriate activities of a child are described in terms of developmental milestones, which refer to a child's expected developmental achievements at particular points in time. Developmental milestones are the best indicators of impaired functioning for infants.[908]

SSI assists preterm infants, who are considered to be younger than their chronological age. Preterm infants who weigh less than 1200 grams at birth are considered disabled until attainment of the chronological age of 12 months (Sec. 416.926a(d)(10)). Small gestational age infants, with weights of less than 2000 grams, are also considered disabled (Sec. 416.926a(d)(11)). The younger an infant or child, the greater the impact of the impairment on their ability to grow and develop.[909]

An individual functional assessment (IFA), an evaluation of SSI eligibility based on age-appropriate functioning, was developed as a result of legislation passed in 1990. IFAs are performed on newborns and young infants to assess cognitive, communicative, motor, and social development. Between 1990 and 1996, the number of children eligible for SSI increased from 350,000 to 965,000. About one-third of this increase was attributed to the advent of the individual functional assessment.[910] However, the definition of disability for children has been

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[907] Social Security Administration, *Welfare Reform and SSI Childhood Disability* (visited June 26, 1997) <http://www.ssa.gov/welfare/welfare.html>.

[908] *Id.*

[909] Children's Defense Fund, *Health Provisions in the Welfare Law* (visited June 27, 1997) <http://www.childrensdefense.org/welfarehealth.html>.

[910] Social Security Administration, *Welfare Reform and SSI Childhood Disability*, *supra* note 907.

greatly altered by the recent Welfare Reform Act of 1996. These legislative changes and their affect on infants and children with disabilities will be discussed later on in this report.

- **Comprehensive Perinatal Care Program**

The Comprehensive Perinatal Care Program (CPCP) of 1987 awarded additional grants to community and migrant health centers, which greatly increase access to prenatal care services and has made infant mortality reduction a high priority in local communities, to support initiatives to improve birth outcomes.[911] Community and migrant health centers are multi-service centers that receive funding from the Department of Health and Human Services to offer preventive and primary care to the medically undeserved. These health centers, usually located in low income neighborhoods, offer a range of primary health and social services.

- **National Commission to Prevent Infant Mortality**

The National Commission to Prevent Infant Mortality was established by Congress in 1987 in order to address the issue of infant mortality. In August 1988, the Commission issued a report, *Death Before Life: The Tragedy of Infant Mortality*. The Commission has focused since then on implementing the recommendations contained in the report, more specifically on making the health of mothers and babies a top priority and providing all pregnant women with access to preventive health care. Much of the Commission's work has been focused on education and public awareness activities and addressing the major barriers to accessing care.[912]

- **Healthy Start Program**

The Healthy Start Program is a presidential initiative established by the Public Health Service Act in 1989. This initiative, implemented by the Maternal and Child Health Bureau, has as its goal the reduction of infant mortality by 50 percent in 5 years within 22 high risk communities.[913] Both the public and private sector have contributed resources to develop innovative approaches to reducing infant mortality. A holistic approach to the care of pregnant women has been identified consisting of comprehensive medical, social, and educational services. Collaboration with other programs such as Medicaid and WIC has been an important aspect of the initiative. In 1997, $96 million was allocated to the Healthy Start program.[914]

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[911] Carpenter, *supra* note 876.

[912] WALLACE ET AL., *supra* note 709.

[913] *Id.*

[914] Maternal and Child Health Bureau, *supra* note 896.

- Child abuse and neglect prevention programs

A number of important initiatives have been enacted to address child abuse and neglect. Child Death Review Teams have become a significant intervention on the crisis of fatalities due to child abuse and neglect. These multidisciplinary teams are instrumental in identifying weaknesses in the child protection system and identifying more effective prevention strategies.[915] In addition, the National Center on Child Abuse and Neglect (NCCAN), part of the Administration for Children and Families, allocates child abuse and neglect funds appropriated by Congress and coordinates the federal government's activities in this area of concern. Funding is available to states through four grant programs whose primary aim is prevention and coordination of services.[916] These programs are as follows:

- Community-Based Family Resource Program Grants support statewide networks of local child-abuse and neglect prevention and family-resource programs. In fiscal year 1996, $23 million was available.

- The Basic State Grants provide assistance in developing, strengthening, and implementing child abuse and neglect prevention and treatment programs. In fiscal year 1996, $18 million was available.

- The Children's Justice Act of 1986 provides grants that help to develop, establish, and operate programs designed to improve the following: the handling of child abuse and neglect cases, particularly cases of child sexual abuse and exploitation, in a manner which reduces additional trauma to the child; the handling of cases of suspected child abuse or neglect fatalities; and procedures for the investigation and prosecution of child abuse and neglect cases, particularly in cases of child sexual abuse and exploitation. In fiscal year 1996, $8.5 million was available.

- Medical Neglect/Disabled Infants State Grants help states respond to reports of medical neglect, including the withholding of medically indicated treatment from disabled infants with life-threatening conditions. In fiscal year 1996, $3 million was available.

- **Hill-Burton Act**

The Hill-Burton Act[917] created a program which grants funds to hospitals for construction purposes under the condition that the hospitals receiving the federal monies furnish a reasonable

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[915] USDHHS, *supra* note 742, at 77.

[916] Administration for Children and Families, *Child Abuse and Neglect Fact Sheet* (visited Dec. 2, 1996) <http://www.acf.dhhs.gov/opa/facts/abuse.html>, at 1-2.

[917] 42 U.S.C. §§ 291-2910.

amount of medical care for those unable to pay.[918] While an indigent person may be eligible to receive care under the requirements of this statute, no legal right is created for any individual.[919]

- **Civil Rights Act**

A legal guarantee to non-discrimination in receipt of medical care is found in the Civil Rights Act.[920] This Act bars intentional discrimination, on the basis of race, in providing access to public or private facilities. The Act has been applied to medical facilities.[921] Therefore, federal law protects the rights of everyone to equal access to public or private health facilities.

1.3. Federal policy

- **The Healthy People 2000's Infant Health Objectives**

In 1990, the United States government adopted a national initiative, Healthy People 2000, which set specific objectives for achieving health for all US residents.[922] While major improvements in health among US residents were achieved during the 1980s, Healthy People 2000 places greater emphasis on reducing the persistent health *disparities* between those who bear the disproportionate burdens of illness and death and the population at large. Healthy People 2000 sets three broad public health goals for the 1990s:

- Increase the healthy life span for all US residents;
- Achieve access to preventive health services for all US residents; and
- Reduce the disparities in health among US residents.

The Healthy People 2000's (Maternal and) Infant Health Objectives acknowledge the country's gross disparities in infant mortality that are associated with racial and ethnic background, as well as gender and socioeconomic status of various population groups.

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[918] KATHLEEN S. SWENDIMAN, CONSTITUTIONAL AND STATUTORY RIGHTS TO HEALTH CARE 94-64A (Congressional Research Service, Jan. 31, 1994).

[919] *See* Newsom v. Vanderbilt, 653 F.2d 1100, 1121 (6th Cir. 1981) (no individual person has a right to receive health care under the program because the hospitals are allowed discretion in allocating care for indigents as a group).

[920] "All persons within the jurisdiction of the United States shall have the same right in every state . . . to make and enforce contracts . . . and to the full and equal benefit of all laws for the security of the persons and property as is enjoyed by White persons, and shall be subject to like punishments, pains, penalties, taxes, licenses, and exactions of every kind, and to no other." 42 U.S.C. § 1981.

[921] *See* Cypress v. Newport News General and Nonsectarian Hospital Ass'n, 375 F.2d 648 (4th Cir. 1967).

[922] This national initiative succeeds the efforts of the previous decade (1980s), following the 1980 publication of the *U.S. Surgeon General's Report on Health Promotion and Disease Prevention.*

Measurable objectives are set for reducing overall infant mortality, addressing the growing social and racial disparity in infant health, and improving maternal health and pregnancy. To reduce the disparity in infant mortality, the plan identifies low birth weight reduction and increasing access to prenatal care as specific strategies subject to measurable objectives.

Progress to date has been mixed, with some improvement for all groups and a deterioration in the health condition of some disadvantaged groups. The status of Black infants as compared to White infants is an apt illustration. Use of prenatal care has improved for both Blacks and Whites, but remains much higher for Whites. The incidence of low birth weight has remained stable for Whites and has worsened for Blacks. The disparity in Black and White infant deaths rates is *growing*. It now appears unlikely that the main objectives in reducing racial disparities in infant health can be achieved by the target year (see Table 6.10).

Table 6.10. Progress toward 2000 maternal and infant health objectives for U.S. children by race

Health Objectives	1987 baseline rates	1996 "midcourse" rates*	2000 target rates
Infant Mortality Rate (Deaths per 1000 live births)			
Blacks	18.8	15.8	11
Whites	8.6	6.6	7 or less
US	10.1	8	7 or less
Prenatal Care in First Trimester (%)			
Blacks	60.8	64	90
Whites	80	81	90
US	76	80	90
Low Birth Weight Rate (%)			
Blacks	13	13.3	9
Whites	5.7	5.7	5 or less
US	6.9	7.1	5 or less

*Data for "midcourse" rates for Whites and Blacks reported in 1996, but collected from 1994 for infant mortality rates; 1992 for prenatal care; and 1990 for low birth weight rates.
Source: Healthy People 2000 Midcourse Review and 1995 Revisions; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, TRENDS IN THE WELL-BEING OF AMERICA'S CHILDREN AND YOUTH (1996); NATIONAL CENTER FOR HEALTH STATISTICS (1996).

Efforts to reduce infant deaths in the United States today are centered on two main goals, both of which relate to low birth weight and preterm birth: 1) *improving survival of infants born at low birth weights*, and 2) *preventing low birth weight and preterm delivery*.[923] The overall decrease in infant mortality in the United States over the last two decades has been largely due to

[923] Shiono & Berhman, *supra* note 730, at 4.

successes with the first goal—keeping infants alive who are born prematurely and at low birth weights.[924]

The United States has not, however, made significant progress toward the second goal—*preventing* low birth weight and preterm delivery. Despite prevention efforts, the rates of preterm birth /low birth weight have remained stable over time. Disorders from these conditions remain a leading cause of infant mortality and are responsible for the disproportionately higher death rates for Black infants.[925] They remain an enormous challenge to this country. Experts highlight the need for direct attention to these problems and for strategies that focus less on "high tech" medical interventions, such as those used in neonatal intensive care units, and more on preventive services[926] and social and economic disparities associated with health.[927]

Section 1.3 of this chapter examines medical and public health strategies and steps taken in the United States to reduce infant mortality and, more specifically, to address low birth weight and preterm birth. This section also discusses public policy approaches which focus on ameliorating the social and economic conditions of disadvantaged children through public benefits. In light of dramatic changes in public benefits in health care and social welfare, the government must ensure that the survival and well-being of the country's disadvantaged children are not further undermined. While strategies for reducing infant mortality have had mixed success in the last two decades, "reforms" in the social and health delivery systems must be carefully scrutinized to safeguard the significant gains so far, and to minimize the risk of further deterioration in the infant and child health differentials between children in different socioeconomic classes.

- **Medical interventions**

In the United States today, what has been labeled a "perinatal paradox" exists between the capacity to bring to bear a vast array of costly, technology-driven treatments for an individual infant to improve survival *and* the failure to address the broader social issues linked to the relatively poor overall health status of infants.[928] Critics point to the shortcomings of

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[924] Shiono & Berhman, *supra* note 730, at 5; MacDorman et al., *supra* note 709, at 239-40.

[925] Black infants die from disorders due to low birth weight and short gestation (preterm birth) at 4.5 times the rate of Whites. *See supra*, part B.2.2 (Racial and ethnic disparities), and part B.5.1 (Causes of infant deaths).

[926] Kliegman, *supra* note 733, at 911; Shiono & Berhman, *supra* note 730, at 10.

[927] CDC, *Poverty and Infant Mortality*, *supra* note 21; Lee et al., *supra* note 733, at 302.

[928] *See* R.A. Rosenblatt, *The Perinatal Paradox: Doing More and Accomplishing Less*, 8 HEALTH AFF. 8, 158 (1989).

overemphasizing the success of the "technology driven" reductions in infant mortality.[929] Relative improvements in the survival of infants born too small and too early are due mainly to the increased operation of neonatal intensive care units (NICUs) and use of exogenous surfactant therapy, which facilitates respiration in infants with underdeveloped lungs.[930] Although the use of surfactants has increased the chance of survival for many preterm and/or low birth weight infants, these infants often suffer subsequent chronic health problems.[931] For Black infants the leading cause of death is still attributable to preterm and low birth weight, and up to 92 percent of deaths to Black infants may have occurred among those born with low birth weights.[932] These facts suggest the limitations of strictly medical interventions to mitigate racial disparities in infant mortality.

There are new threats to child health such as HIV/AIDS, rising levels of child poverty, and the alarming rise in the incidence of child ill-treatment and homicide. These factors point to another dilemma: whether or not the United States is improving survival of infants only to launch them into an unhealthy and dangerous environment. These problems have refocused the interest in and discussion of strategies that, in addition to medical interventions, include the broader social and economic issues such as poverty, access to quality health and education, affordable housing, job training, and employment opportunities with livable wages. Today, a more balanced and holistic approach is needed that reduces infant mortality and improves the well-being of surviving children.

- **Public health strategies**

Efforts to prevent low birth weight and preterm births[933] have focused on such public health measures as:

- *Behavioral (or lifestyle) change strategies*: aiming at changing individual behaviors that have negative effects on a fetus and infant such as cigarette use and nutrition;[934]

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[929] Kliegman, *supra* note 733, at 909.

[930] Shiono and Berhman, *supra* note 730, at 5.

[931] Kliegman, *supra* note 733, at 909.

[932] USDHHS, *Infant Mortality-United States, 1990*, 42 MORTALITY & MORBIDITY WKLY. REP. 161, 164 (Mar. 12, 1993).

[933] *See supra* section B.5.

[934] *See supra* ch. II (discussing correlation of these behaviors with child mortality).

- *Prenatal care*: increasing the number of women who use prenatal care and encouraging initiation of care early in the pregnancy;[935] and

- *Family Planning*: enabling women to make healthy reproductive choices.[936]

Nonetheless, the strategy to reduce the rate of infant mortality by preventing low birth weight and preterm birth, appears to have had little effect.[937] Public health and medical experts claim that marginal success to date is not surprising since, despite extensive research, knowledge about what causes these poor birth outcomes remains incomplete.[938]

- **Community Participation**

The U.S. Public Health Service,[939] in partnership with a wide range of public and private entities, is working to promote efforts for healthy communities and cities throughout the country. Cities and communities nationwide are now engaged in planning and implementing their own health objectives, with assistance from the American Public Health Association and the CDC.[940] (see Box 6.7).

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[935] *See supra* part B.4.5 (discussing inadequate prenatal care and its effect on child mortality). Over time, greater proportions of the U.S. population have utilized prenatal care services. Trends showing increased use of prenatal care, however, have not had the expected result of lowering the rates of low birth weight and preterm birth. These trends may be obscured by changes in the underlying risks of the U.S. population like the incidence of cigarette use. Shiono & Berhman, *supra* note 730, at 9.

[936] With the advent of federally funded family planning programs, low-income women finally gained access to needed reproductive health care services. Since 1965, these family planning programs have been aimed primarily at reducing in the number of unintended pregnancies. With the expansion in family planning-related services, greater emphasis is now given to identifying and reducing the risks of poor pregnancy outcomes. Pre-pregnancy consultation care, through family planning services, is a significant contribution to reducing low birth weight and identifying the other risks associated with poor pregnancy outcome. USDHHS, FROM DATA TO ACTION, *supra* note 709, at 25-26.

[937] Shiono & Berhman, *supra* note 730, at 5. In the United States, the percentage of infants born at a low birth weight declined by only 8 percent from 1950 to 1990, while the infant mortality rate dropped over 30 percent. MacDorman et al., *supra* note 709, at 239. Furthermore, the incidence of low birth weight increased among Blacks between 1960-1983. *Id.*

[938] Shiono & Berhman, *supra* note 730, at 8. *See also* Alexander & Korenbrot, *supra* note 777.

[939] *The Healthier Communities and Cities Coalition*, working under the umbrella of the USPHS, is working with participating communities to ensure that resources and tools are available for addressing health issues at the local level.

[940] *Healthy Communities 2000: Model Standards* and *A Guide to Implementing Model Standards*, developed jointly by the APHA and CDC, are available to participating communities by contacting APHA, 1015 Fifteenth Street NW, Washington, DC.

Box 6.7. City of Indianapolis: A Community-Centered Approach to Reducing Infant Mortality by the Marion County Health Department

The Marion County Health Department (MCDH), concerned with the persistently high rates of infant mortality and large discrepancies in rates between Blacks and Whites, has implemented a promising new approach to reducing infant mortality and the mortality disparities in Indianapolis and the county. The underpinnings to this approach entail community participation, intersectoral collaboration, and a comprehensive position on infant mortality that encompasses the biological, social and economic dimensions. In 1987, more than 13 out of every 1000 infants born alive died within the first year of life. By 1995 the rate was still nearly 10 infant deaths per 1000 live births; Black infants still died at a rate almost twice that of Whites.

MCHD conducted a community needs assessment in 1995, which helped to refocus priorities and to shift to a more comprehensive approach to reducing the infant mortality rate. The survey results indicated that community members were more concerned with social and economic problems such as: 1) increasing teenage pregnancy; 2) increasing violence inside and outside the home; 3) poverty; 4) overall community safety; and 5) increasing drug trafficking. As a result, MCHD now views infant mortality as a community-wide issue that needs a comprehensive solution. Many of the new programs in MCHD are geared toward drawing women [of child-bearing age] into the [social and health] system and toward improving the system for women. Most importantly, potential solutions now also focus on strengthening the social, economic, and political fabric of the community.

An important new strategy is to *increase collaboration among multiple sectors of the community* including churches, private and public sectors, the judicial system, and health care providers. The multi-sectoral collaborative relationships are essential for maximizing resources, avoiding duplication of services, connecting women and families with appropriate services, and coordinating child health care. In turn, these collaborative efforts have enhanced the appropriateness and effectiveness of existing health and social systems within the county. Another strategy is *to focus on building upon the strengths and resources in the community*. Finally, outreach activities are carried out by various representative organizations of the collaborative effort, such as home visits to pregnant women, mothers, and infants. Some key programs and initiatives to improving infant and child health in Marion county today include: 1) *the use of Community Health Outreach Worker;* 2) *address drug use by pregnant women; 3) improve prenatal care and healthy parenting;* 4) *Infant Mortality Review Project; and,* 5) *Sisterfriend: A Support Program for teen mothers*.

MCHD has made progress in tackling infant mortality through building collaborative relationships, reaching out to disparate populations, and encouraging community ownership and participation. The community itself now acknowledge the complexity of health issues and the need for strengthening and building healthy communities as a pre-requisite to fostering healthy children. Some important lessons learned include: 1) collaboration and outreach efforts can improve access to and utilization of the health care system; 2) health and volunteers from other sectors play a vital role in reshaping the way in which public health works in Indianapolis; and 3) effective collaboration between public and private organizations lead to cost-effective and appropriate roles and responsibilities.

Source: Personal communications with Ms. Bobbie Brown, Coordinator, Maternal and Child Health/CityMatCH, Marion County Health Department; 1995 MCHD community needs assessment and other secondary sources; City KIDS COUNT, 1997.

The underlying principles guiding these state and local efforts, notes the USPHS in the 1995 Midcourse Review of Healthy People 2000, include "use of a broad definition of health, including overall well-being and quality of life issues; working to change the structure of communities with the understanding that how communities are organized can enhance or harm health; and striving for broad participation at the community level as a means of achieving health-supporting structural change."

Philanthropies and businesses play an important role in issues affecting maternal and child health by providing expert advice, technical support, and funding to programs. More than 34 million working women between the ages of 20 and 44 may become pregnant during their careers. Coalitions of businesses established in various states are taking the initiative to discuss maternal and child health issues, such as maternity care related issues of employees. Business

communities realize that money spent on prevention could save the health care system as well as their business large amounts of money in the long run.[941]

While a call for greater community participation in promoting health is necessary, cities and communities nationwide are still grappling with much broader and more intractable problems such as rising child poverty, deterioration of the family, urban neighborhood decay, and shrinking public benefits.

- **Public benefits**

Because of numerous findings that show a strong relationship between socioeconomic status and child health, many of the social programs related to poverty and improving health among women and children in the United States are aimed at increasing access to health and medical care for pregnant women and at decreasing the incidence and effects of poverty.[942] The key social programs implemented in the United States to reduce the effects of poverty include Medicaid, WIC, and AFDC.

Since the Congressional passage of the Omnibus Budget Reconciliation Act of 1986—which aimed at reducing infant mortality by expanding Medicaid coverage to all pregnant women, infants and children up to age five with household income below the federal poverty level—many initiatives have been implemented to confront the problem. Addressing infant mortality and improving perinatal outcomes have been the focus of many recent policies and programs. Although the private sector has played an important role in providing expert advice, technical support, and funding to programs, changes in public policies have had substantial impact upon the health of mothers and infants.

Maternal and child health (MCH) programs have reacted quickly to legislative changes by enhancing medical and support services and establishing community-based outreach efforts to pregnant women and their families. Although the impact of these initiatives has not been adequately measured and evaluated, comprehensive services aimed at improving the health and well-being of women and children have been developed and access to primary health care has been expanded.[943]

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[941] WALLACE ET AL., *supra* note 709.

[942] Shiono & Bergman, *supra* note 730, at 10. SES is typically a measure of a combination of education, income, and occupation, because the three variables add different information about an individual's status. J.L. Kiely, K.M. Brett, S. Yu, & D.L. Rowley, *Low Birth Weight and Intrauterine Growth Retardation, in* USDHHS, FROM DATA TO ACTION, *supra* note 709, at 185.

[943] Carpenter, *supra* note 876, 19-30.

New legislation to "reform" the social welfare system in the United States is anticipated to force an additional 1.1 million children below the poverty line.[944] Moreover, in a comparison of 17 industrialized nations, the United States ranks last in terms of government assistance and benefits to reduce child poverty.[945] The percent reduction in child poverty achieved by governments in Sweden and Canada was 84 percent and 39 percent, respectively; whereas in the United States, the child poverty rate dropped only 15 percent after government assistance and benefits to lift disadvantaged children out of poverty.

Although the positive health outcomes of pregnancy and birth (particularly those related to a reduction in infant mortality rates and in racial and social disparities among population groups) can not be specifically attributed to social programs such as AFDC, WIC and Medicaid, policy considerations to abandon or reduce funding to such programs must be based on a broader view of efficacy so as not to underestimate potential benefits. The values of these social programs can not be measured solely by progress in health, e.g., reducing incidence of low birth weight or infant death. Rather, it is equally or more important to consider the impact of social policy changes on the overall quality of life of the family and community, especially in an era of widening socioeconomic disparities in the United States.

- **Current changes in public benefits**

Welfare reform legislation

Since the passage of legislation such as the Family Support Act of 1988, the federal government has been rethinking the structure of the welfare system. A conflict exists between whether to the Act assures families enough income to support children or discourages parents from working. New legislation has shifted the focus from welfare to work programs with the hope that the new focus will lead to a reduction of the dependence on welfare. However, the effect of welfare reform legislation upon the lives of children can not be evaluated until the new laws have been fully implemented. Many economists and child welfare advocates believe that families will have great difficulty in providing adequately for children in the low wage job market.[946]

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[944] Urban Institute estimate, *in* Bread for the World, *What Governments Can Do: Hunger 1997*, *supra* note 753.

[945] *Id.*

[946] S.W. Blank & B.B. Blum, *A Brief History of Work Expectations for Welfare Mothers*, 7 FUTURE OF CHILDREN 28, 28-38 (Spring 1997).

Temporary Assistance to Needy Families

The Personal Responsibility and Work Opportunities Act of 1996 marks the elimination of the uncapped federal cash assistance program, AFDC. The program replacing AFDC is called Temporary Assistance to Needy Families (TANF) and is a time-limited state block grant program. This program will have repercussions for the many low income families who will be denied coverage. States have the authority to set eligibility requirements and the level of assistance and therefore, TANF programs will vary greatly among states.[947] In order to receive TANF grants, States must submit plans for how they will be used to the Federal government and the Federal officials must approve the plans. The time lines for States to submit their plans varies, but new legislation is estimated to take effect sometime in mid to late 1997.

Under TANF, there is no guarantee of assistance. Work requirements and a 5 year lifetime limit for coverage are significant aspects of the program. A state may provide hardship exemptions to the five year limit for 20 percent of its caseload. However, once a family reaches its time limit, the Act provides no non-emergency assistance to help meet the needs of children.[948]

The new law forbids undocumented and in many cases, documented immigrants from receiving public assistance except as considered necessary to protect life and safety. Immigrants already in the United States and currently receiving benefits, will continue to receive benefits until their cases are redetermined within the first year. Only certain "qualified aliens" present in the United States before the new law took effect will be eligible for public assistance. However, under the new law, the majority of qualified immigrants are actually excluded from receiving most benefits.[949] Individuals who are still eligible for assistance are:[950]

- Refugees, asylees, and persons granted withholding of deportation, but only for their first five years in the United States.
- Veterans and active duty armed service personnel lawfully residing in the United States as well as their spouses and unmarried children under 21.
- Any qualified immigrant who has worked over 10 years and have not received any benefits after 12/96.

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[947] Page & Larner, *supra* note 888.

[948] M.V. Larner, D.L. Terman, & R.E. Behrman, *Welfare to Work: Analysis and Recommendations*, 7 FUTURE OF CHILDREN 4 (Spring 1997).

[949] Children's Defense Fund, *supra* note 909, at 5.

[950] S.A. Koberstein, *Welfare Reform Briefing* at Minnesota Council of Nonprofits (Aug. 26, 1996).

New legal immigrants are barred from receiving any benefits, which include TANF, food stamps, SSI and Medicaid for 5 years and then their eligibility will be determined by states. At the time of redetermination, the income of the sponsor will be calculated into the income of the immigrant. As a result, many poor immigrants will be denied help based on the higher incomes of their sponsors.[951]

Unmarried adolescent parents will also feel the affects of the new legislation. In order to receive assistance, teen parents are required to live with a responsible adult or in an adult-supervised living situation. Assistance is also dependent upon whether they participate in educational and training activities.[952] Children will be the most affected by a parent's refusal to follow the above requirements. In addition to this punitive approach to teenage pregnancy, the government is also concentrating on prevention issues. Increased funding for pregnancy prevention programs and education will be allocated.

Changes in Medicaid

The Medicaid program has not been as drastically affected by welfare reform, but the program will certainly feel the affect of the changes. Unlike with AFDC, states are not required to provide Medicaid to all TANF recipients, but many may opt to develop a linkage. Families who meet AFDC eligibility criteria before welfare reform, whether or not they are eligible for TANF, are guaranteed an extension in Medicaid benefits for 12 months. Changes in application procedures may cause unnecessary confusion and result in harmful gaps in health care coverage.[953]

Congress has attempted to secure Medicaid for those who do not qualify for cash assistance, especially pregnant women and children. For example, states can deny Medicaid to adults who lose assistance for refusal to find work. However, pregnant women and children remain exempt from this rule and thus, their access to Medicaid has been protected. The law that expanded Medicaid coverage to children under age six in families with incomes up to at least 133 percent of the federal poverty level still remains in effect.[954]

Under the new changes, immigrants will lose Medicaid coverage. To further complicate the matter, sponsor-deeming rules now will apply to Medicaid, meaning the income of the

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[951] Children's Defense Fund, *supra* note 909, at 6.

[952] Administration for Children and Families, *Section 2: 1995 National Findings* (visited July 16, 1997) <http://www.acf.dhhs.gov/programs/cb/stats/ncands/section2.html>.

[953] Children's Defense Fund, *supra* note 909, at 1.

[954] *Id.* at 3.

sponsor is added to the resources of the immigrant upon determining eligibility.[955] States have the option to provide benefits to unqualified immigrants with state funds, but first legislation must be passed. Both unqualified and qualified immigrants are still allowed certain forms of support such as emergency Medicaid, non-cash disaster relief, immunizations, treatment for communicable diseases, and social security benefits under limited circumstances. Although a long and tedious process, becoming U. S. citizens is the only way for immigrants to escape these stringent requirements.[956]

Changes in food stamps

Although the food stamp program is still an individual entitlement, cuts in the program over the next six years and more stringent requirements for the receipt of food stamps will add to the difficulty of supporting a family. About 70 percent of the cuts will be to families with children and about 300,000 immigrant children will lose food stamp benefits.[957] Nutritional support for women and children will be greatly affected, thus, increasing the likelihood of health problems related to malnutrition.

SSI and children with disabilities

The SSI standards for childhood disabilities have changed under the new legislation. Children are now not considered disabled unless they suffer from a "medically determinable, marked, and severe functional impairment" which can be "expected to result in death or which has lasted or can be expected to last for at least 12 months."[958] The Social Security Administration has a listing of disability conditions that qualify children for SSI benefits. This list will be modified to fit the more limited, stricter definition of disability. Under the new law, the individual functional assessment will no longer be performed.[959]

Estimates are that 315,000 children will lose SSI benefits as a result of these changes.[960] Infants whose family incomes are below 133 percent of the federal poverty level are still guaranteed Medicaid, which provides coverage for most of their high medical expenses. The majority of children losing SSI are thought to be those with "maladaptive behavior" such as mood disorders, mental retardation, developmental disabilities, schizophrenia, and attention

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[955] *Id.* at 6.

[956] Koberstein, *supra* note 950.

[957] Lewitt & Kerrebrock, *supra* note 889, at 129.

[958] *See supra* note 886 and accompanying text.

[959] Children's Defense Fund, *supra* note 909, at 3-4.

[960] *Id.*

deficit disorder—conditions that are not usually associated with infants.[961] However, stricter requirements may result in the failure of infants to be covered early enough or not at all by SSI benefits. To begin with, assessing the functional level of an infant can be a difficult task, but without an individual functional assessment it may become even harder. There may not be sufficient time to determine whether or not an infant has a severe functional impairment to receive the necessary benefits and resources for survival. The impact of a disability can be more profound on a child's growth and development if the child was born with or developed the condition early in life.

The impact that this welfare reform legislation will have on the well-being of women and children is not yet known. Immigrants who have no safety net upon entering this country may not have any chance to succeed. Women with children having significant health problems may be discouraged from finding a job because of the potential loss of health care coverage. Due to new SSI changes, preterm and low birth weight infants may not be considered severely impaired to receive adequate assistance. The uncertainty of finding work, the low wage job market, and the instability of public assistance will most likely take a toll on the health of women and children. The question is whether single women will be able to meet their family's basic needs for food, shelter and safety in the low wage job market. Despite welfare cuts, assuring the availability of other forms of assistance such as food stamps, Medicaid and housing subsidies will be important in helping to maintain the health of low income women and children.[962]

Health care reform

Over the last century infant mortality has received considerable attention from the public health and medical sectors of the United States. Federal, state, and local governments collect information about infant mortality in order to do surveillance, identify problems, and develop, implement, and evaluate programs and policies. Furthermore, public health and medical researchers have conducted most of the research in this area and are, in large part, the major contributors to the current state of knowledge. Although the approach to understanding and reducing the problem of infant mortality has included contributions from a number of disciplines, responsibility for the problem has rested largely with the public health and medical sectors.

Now in the midst of health care reform, questions concerning the roles of both public health and the private medical care system are emerging. Much of this is driven by the creation of managed care organizations (MCOs) and the growing enrollment of Medicaid clients in MCOs. Because of the complex nature of problems like infant mortality, the privatization of health care services troubles public health experts. Unlike diseases and medical conditions which are the typical purview of medical practice, problems like infant mortality have etiologies that are more complex and often involve non-biological factors such as poverty and marital

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[961] *Id.*

[962] Larner et al., *supra* note 948.

status. These problems also affect race/ethnicity groups differently as demonstrated by the disparity in the rate of infant deaths between Black and White U.S. residents. Concerns of public health experts include questions about the capacity of private health care organizations to effectively address these problems and the populations that suffer disproportionately from them and concerns regarding data privacy issues.

2. State laws

2.1. State constitutional law

Rights granted under state constitutions may be more expansive than the rights provided under the federal Constitution or the Bill of Rights. In the area of health care, 15 states have constitutional provisions which either authorize or mandate the provision of medical care for the poor.[963] This section reviews the state constitutional (and statutory) provisions in five states subject to the case study: Illinois, Indiana, Michigan, Minnesota, and Wisconsin.[964]

Only one of the five states has a constitutional provision which requires the state to support public health. The Michigan Constitution declares that "[t]he legislature shall pass suitable laws for the protection and promotion of the public health."[965] The word "shall" denotes a mandatory obligation; it is reasonable to interpret the provision to mean that the Michigan legislature is constitutionally required to enact suitable public health laws. However, the Michigan Supreme Court has not interpreted this constitutional language as an individual entitlement. In the only case to interpret this constitutional language, the court seized on the word "public" and ruled that the provision operates as a limitation on the power of the government to pass laws or take actions for private purposes.[966] Therefore, the Court's interpretation limits the state's obligation to protect the right to health for all. As yet, there is no legal authority explaining what degree of regulation is needed to be constitutionally "suitable." However, courts in other states have interpreted similar constitutional provisions to require that the state provide greater benefits than the state's statutory law would require.[967]

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[963] M. DOWELL, NATIONAL HEALTH LAW PROGRAM MANUAL ON STATE AND LOCAL RESPONSIBILITY TO PROVIDE MEDICAL CARE FOR INDIGENTS (1985).

[964] This report highlighted Chicago, Detroit, Indianapolis, Minneapolis, and Milwaukee.

[965] MICH. CONST. art. IV, § 51.

[966] *See* Gregory Marina, Inc. v. City of Detroit, 144 N.W.2d 503 (1966).

[967] *See* Graham v. Reserve Life Insurance Co., 274 N.C. 115, 161 S.E. 2d 485 (1968); Tucker v. Toia, 43 N.Y.2d 1, 371 N.E.2d 449 (1977).

2.2. State statutory laws and programs

Each of the five states reviewed in this report has statutory laws that articulate some degree of legal right to medical assistance. Some statutes have extremely broad entitlements; others authorize specific benefits for a defined group of eligible persons. In many states, courts have interpreted the scope of services that must be provided under the statutes and the ability of individuals to enforce the laws, as well as the due process guarantees that must be provided to eligible beneficiaries.[968]

- **Illinois**

Illinois law "declares it to be the public policy of this state that all citizens . . . are entitled to lead healthy lives."[969] This extremely broad language has never been interpreted to require government support for a universal minimum level of health. Illinois has, however, created various programs and passed a number of statutes directly affecting child mortality.

Medicaid

Illinois' Medical Assistance (Medicaid) program is intended "to provide . . . essential medical care . . . for persons receiving [welfare benefits] . . . and for other persons who are unable, because of inadequate resources, to meet their essential health needs."[970] Medical benefits under that program "*shall* be available to any [eligible persons]" (emphasis added).[971] The obligation to provide medical assistance to eligible individuals may be judicially enforced.[972] The Medicaid program guarantees certain medical services to eligible persons. Covered services are defined broadly in the statute, and would include basic maternal and child health services. Eligible beneficiaries include women and children up to 6 years of age whose incomes and resources are insufficient to meet the costs of medically necessary care under Title IX of the Social Security Act. In addition, pregnant women who are at or below 133 percent of the official poverty line are eligible for ambulatory prenatal care under the program.

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[968] *See* M. Dowell, *State and Local Government Legal Responsibilities to Provide Medical Care for the Poor*, 3 J. L. & HEALTH 1 (1988-89).

[969] ILL. ANN. STAT. ch. 20, para. 5/6.06 (Smith-Hurd 1993 & Supp. 1997).

[970] ILL. ANN. STAT. ch. 305, para. 5/5-1 (Smith-Hurd 1993 & Supp. 1997).

[971] ILL. ANN. STAT. ch. 305, para. 5/5-2 (Smith-Hurd 1993 & Supp. 1997).

[972] St. John's Hospital v. Town of Capitol, 220 N.E.2d 333 (Ind. Ct. App. 1966).

Infant Mortality Reduction Act

Infant Mortality Reduction Act (INMRA)"provide[s] for the establishment of a... program designed to fund programs which are targeted toward those areas of the State which experience high rates of infant mortality."[973] This legislation explicitly endorses the idea that resources should be targeted to areas of greatest need.

Under the INMRA, grants are awarded through the Illinois Department of Public Health to units of local government, public health agencies, and private nonprofit health or human services agencies to develop or expand the following: 1) prenatal services; 2) perinatal services; 3) infant follow-up services in the first year of life; and 4) adolescent pregnancy services. The regulations implementing the program state that "all applicant agencies shall be subject to the planning, promotion, and coordination of such services by the Division of Family Health."[974]

A significant percentage of the funds are allocated to the University of Illinois Division of Specialized Care for Children for programs relating to child mortality, and priority is also given to federally qualified health centers. Except for the University funding, the formula used to distribute funds under the program must give weight to the following factors: 1) number of reported live births within each county; 2) number of reported infant deaths within each county; 3) the infant mortality rate within each county; 4) the population of each service area; 5) per capita income level of each service area; and 6) any other factors relating to the incidence of infant mortality as determined by the Director of the Department of Public Health.

An Infant Mortality Reduction Advisory Board ("Board") is created within the Department to help implement the program. The Board is to advise the Director on efforts to reduce infant mortality and make recommendations regarding the funding formula. The Board also publishes an annual report listing activities taken to address infant mortality.

Prenatal and Newborn Care Act

The Prenatal and Newborn Care Act (PNCA) provides for a grant program to local health authorities or private nonprofit agencies to deliver services including prenatal care, one postnatal medical visit, and two periodic medical screenings.[975] There are income eligibility requirements for the program, and no person who receives benefits under the State's Medical Assistance (Medicaid) program is eligible.

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[973] ILL. ANN. STAT. ch. 410, para. 220. (Smith-Hurd 1993 & Supp. 1997).

[974] ILL. ADMIN. CODE tit. 77, § 630.20(a)(3) (1996).

[975] ILL. ANN. STAT. ch. 410, para. 225 (Smith-Hurd 1993 & Supp. 1997).

Two separate entities are charged with coordinating the PNCA program along with other state programs. First, the Department of Public Health is ordered to consult with the Infant Mortality Reduction Advisory Board regarding implementation of the Prenatal and Newborn Care Act; and the Board must advise the Department on the coordination of services provided under this program with services provided under the Infant Mortality Reduction Act and the Problem Pregnancy Health Services and Care Act. However, the regulations implementing this program state that it is the responsibility of each project director to coordinate the services provided with other sources of care in the community such as: (1) Illinois Medical Assistance Program; (2) local health departments; (3) neighborhood health centers; (4) local child development clinics; (5) division of services for crippled children; (6) local hospitals; (7) local children and family services programs; (8) local schools; (9) vocational rehabilitation centers; (10) regional perinatal centers; (11) local early intervention programs for infants and toddlers with handicaps; (12) other related social services agencies.

Problem Pregnancy Health Services and Care Act

The Problem Pregnancy Health Services and Care Act (PPHSCA) authorizes funds to be used by grantees for any number of coordination, education, training, and assistance functions, including: 1) programs to link services; 2) assistance with problem pregnancies; 3) technical assistance to other communities and programs; 3) training; 4) establishing a comprehensive network of well-coordinated services in a single setting.[976]

SIDS Autopsies

The SIDS Autopsies law states that where an infant under 2 years of age has died suddenly and unexpectedly and the circumstances concerning the death are unexplained, an autopsy shall be performed by a licensed physician with a specialty in pathology. In addition, any time a child dies mysteriously, the coroner is to secure the services of a pathologist.[977]

Abused and Neglected Child Reporting Act

Under the Abused and Neglected Child Reporting Act, a great number of officials and other persons, from recreational personnel to coroners, are ordered to report to the Department of Public Health any incidence of believed child abuse.[978]

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[976] ILL. ANN. STAT. ch.410, para. 230/2-100 (Smith-Hurd 1993 & Supp. 1997).

[977] ILL. ANN. STAT. ch. 55, para 5/3-3016 (Smith-Hurd 1993 & Supp. 1997).

[978] ILL. ANN. STAT. ch. 325, para. 5/4 (Smith-Hurd 1993 & Supp. 1997).

Healthy Kids Program

The Healthy Kids Program authority is in the form of a means-tested legal entitlement.[979] It states that "any child under . . . 21 eligible to receive Medical Assistance [under Medicaid] shall be eligible for Early and Periodic Screening, Diagnosis and Treatment services."

Center for Minority Health Services

The Center for Minority Health Services includes an advisory panel on minority health.[980] This panel advises the Department of Public Health on health problems faced by minorities, finds ways to coordinate services to minorities, improves the collection and reporting of data on minority health problems, and recommends legislative changes, among other functions.

Also regarding minority health concerns, the Department of Public Health is directed to provide information to Hispanics, Blacks, and other population groups residing in areas which experience high rates of infant mortality.[981] The information shall inform these groups about the causes of infant mortality and the steps which may be taken to reduce the risk of early infant death.

- **Indiana**

Indiana law provides for certain health care services relevant to child mortality in that state. The law states that the Indiana Department of Health "shall supervise the health and life of the citizens of Indiana."[982] As a part of that task, the Department "shall cooperate with the United States Department of Labor to . . . extend and improve services for the promotion of the health of mothers and children."[983] Although this language could be read to imply that the department is required to ensure that maternal and child health services are improving within the state, it is doubtful that a court would interpret the statute in that way.

There is also a mandatory and judicially enforceable duty to provide care to indigent persons.[984] In the *Washington Township* case, the township was ordered to pay the hospital bill

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[979] ILL. ANN. STAT. ch. 305, para 5/5-19 (Smith-Hurd 1993 & Supp. 1997).

[980] ILL. ANN. STAT. ch. 2310, para. 55.62a (Smith-Hurd 1993 & Supp. 1997).

[981] ILL. ANN. STAT. ch. 20, para. 2310/55.50 (Smith-Hurd 1993 & Supp. 1997).

[982] IND. CODE ANN. § 16-19-3-1 (West 1995 & Supp. 1996).

[983] IND. CODE ANN. § 16-35-1-2 (West 1995 & Supp. 1996).

[984] IND. CODE ANN. § 52-148;(West 1995 & Supp. 1996). *See also* Washington Township of Allen County v. Parkview Memorial Hospital, 246 N.E.2d 391 (Ind. Ct. App. 1969).

for the care of a woman who had developed gangrene and eventually died. Even though the woman's husband was employed, the family could not make ends meet and could not afford to pay the hospital bill. Thus, the woman qualified for assistance under the statute.[985] Indiana courts have clearly stated that the poor must receive necessary medical care, but the nature and extent of the care is largely at the discretion of each township.[986]

All hospitals licensed in Indiana are also required to provide emergency hospital services to victims of sex crimes who apply for emergency services related to injuries or trauma resulting from the alleged crime.[987] The hospital must provide counseling services for the victim, as well as the appropriate emergency medical care.[988]

Indiana also operates the following programs related to the delivery of medical care for children and families:

Medicaid

Under a county-administered Medicaid program, Indiana mothers and children who receive basic welfare benefits are eligible for medical services and are automatically eligible for Medicaid without application.[989] In addition, all "qualified" pregnant women and children under the federal guidelines are also eligible. If the family income is under 150 percent of the federal poverty guideline, a woman may be eligible for pregnancy services, including pre-natal services, delivery, and postpartum services for 60 days. An infant under age one is also eligible if the family income is under 150 percent of the federal poverty level. Children ages 1-6 are eligible if the family income is under 133 percent of the federal poverty level.

Community Health Centers

To carry out its responsibility for providing adequate and proper health services through local boards of health, Indiana administers grants to community health centers and maternal and child health clinics that are seeking physician services.[990]

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[985] Washington Township of Allen County v. Parkview Memorial Hospital, 246 N.E.2d 391, at 393.

[986] State *ex. rel.* Van Buskirk v. Wayne Township, 418 N.E.2d 234 (Ind. Ct. App. 1981).

[987] IND. CODE ANN. § 16-21-8-1 (West 1995 & Supp. 1996).

[988] IND. CODE ANN. § 16-21-8-3 (West 1995 & Supp. 1996).

[989] IND. CODE ANN. § 12-15 (West 1995 & Supp. 1996).

[990] IND. CODE ANN. § 16-46 (West 1995 & Supp. 1996).

Maternity Assistance Development Fund

The Maternity Assistance Development Fund provides grants to maternity homes for pregnant women.[991] To be eligible for the grants a home must provide educational assistance, prenatal child care and parenting class, job training, and a temporary residence for pregnant women. The funds are targeted for women who do not have access to other prenatal services.

Toll Free Assistance Line

The state Health Department must maintain a telephone line to provide information, referrals, follow-up, and personal assistance concerning federal, state, local, and private programs that provide services to children less than twenty-one years of age with long term health care needs.[992]

Children with Special Health Care Needs

Indiana creates county funds to provide health care to children with special needs.[993] The funds are generated by a tax levy on property, taxes on financial institutions, and private donations.

Step Ahead Comprehensive Early Childhood Grant Program

The Step Ahead Program provides grants for preschool developmental child care. [994] The program is designed to enhance readiness for school and facilitate early identification of developmental problems.

- **Michigan**

Michigan's state law requires general medical assistance to the poor which can indirectly affect child mortality. Each Michigan county "shall administer a public welfare program" and such program will include medical care in a county medical facility."[995] The appropriation of funds to pay for this county assistance program is, however, "within the discretion" of each

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[991] IND. CODE ANN. § 16-26 (West 1995 & Supp. 1996).

[992] IND. CODE ANN. § 16-19-3-23 (West 1995 & Supp. 1996).

[993] IND. CODE ANN. § 35-3 (West 1995 & Supp. 1996).

[994] IND. CODE ANN. § 20-1.8 (West 1995 & Supp. 1996).

[995] MICH. COMP. LAWS ANN. § 400.55 (West).

county board of supervisors.[996] In one instance, a county board failed to appropriate sufficient funds to maintain the general assistance program for the entire fiscal year, and consequently suspended the program for a number of weeks. The case brought to issue the contradiction between the mandatory language requiring each county to administer a program and the discretionary ability of the county board to appropriate funds. A Michigan Court of Appeals ruled that the general assistance program may not be suspended even when appropriations are insufficient to pay for the services.[997] The court stated that the board has discretion to fund the program at a higher level than is necessary.[998] The board also has discretion to appropriate funds for program administration at any level the board desires.[999] But the Board does not have discretion to render meaningless the legislative mandate to provide general medical assistance services to the indigent.[1000]

The Michigan Department of Social Services operates a Medicaid program for the medically indigent.[1001] A number of medical services are available to eligible citizens, including hospital care, physician services, nursing home services, psychiatric care, and home health services, among others.

- **Minnesota**

Minnesota law declares that it is "the policy of this state that persons unable to provide for themselves and not otherwise provided for by law . . . are entitled to receive grants of assistance necessary to maintain a subsistence reasonably compatible with decency and health."[1002] The Minnesota Maternal and Child Health and Nutrition Programs are intended to "reduce infant mortality" and "assure access to quality maternal and child health services for mothers and children, especially those of low income and with limited availability to health services."[1003]

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[996] MICH. COMP. LAWS ANN. § 400.70 (West).

[997] King v. Director of the Midland County Dep't of Social Services, 251 N.W.2d 270 (Mich. Ct. App. 1977).

[998] King v. Director of the Midland County Dep't of Social Services, 251 N.W.2d 270, at 274.

[999] King v. Director of the Midland County Dep't of Social Services, 251 N.W.2d 270, at 274.

[1000] King v. Director of the Midland County Dep't of Social Services, 251 N.W.2d 270, at 274.

[1001] MICH. COMP. LAWS ANN. § 400.105 (West).

[1002] MINN. STAT. ANN. § 256D.01 (West 1995 & Supp. 1996).

[1003] MINN. STAT. ANN. § 145.88 (West 1995 & Supp. 1996).

Minnesota programs to provide health services to Minnesota citizens include the following:

Medical Assistance and Minnesota Care

The Medical Assistance and Minnesota Care program provides health care insurance for uninsured and underinsured residents of Minnesota.[1004] Both the covered services and eligibility requirements are favorable to pregnant women and infants. An infant of less than 2 years of age or a pregnant women is eligible for medical assistance if family income is equal to or less than 275 percent of the federal poverty guideline, and no asset standards apply. Covered services include inpatient hospital services, physician services, clinic services, laboratory services, and drugs, among others.

The Minnesota Care program will cover some women and children who are not eligible under the medical assistance program. Eligible beneficiaries must pay a premium under the Minnesota Care program. The eligibility requirements for pregnant women and children are the same as for the medical assistance program (275 percent of the poverty line). Pregnant women and children under age two are exempt from the statutory provisions requiring disenrollment for failure to pay the required premium.

Maternal and Child Health and Nutrition Program

The Maternal and Child Health and Nutrition Program distributes federal funds from the Maternal and Child Health Services Block Grant program to qualified organizations and community health service areas to conduct programs and provide services to mothers and children, particularly in high-risk areas.[1005] Allocation is in accordance with a statutory formula that takes into account areas of high infant mortality and high risk factors. There exists a Maternal and Child Health Advisory Task Force which reviews all grant applications and provides advice on the use of the federal monies. This Task Force produces annual reports on the use of federal money and provides recommendations to reduce infant mortality.

There also exists a nutritional supplement program for individuals who are not receiving any similar services under other federal, state, or local programs and who are nutritional risks and don't have the means to provide necessary nutritional supplements for themselves.

Child Mortality Review Panel

The Child Mortality Review Panel is established under the authority of the Commissioner of Human Services to review the deaths of children in Minnesota, including deaths attributed to

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[1004] MINN. STAT. § 256.935, § 256B.

[1005] MINN. STAT. § 145.88 - 145.90.

maltreatment or in which maltreatment may be a contributing cause.[1006] The purpose of the panel is to make recommendations to agencies for improving the child protection system.

Early and Periodic Health and Development Screening Programs

The Commissioner of Health is authorized to provide instruction and advice to expectant mother and fathers during pregnancy and to mother, fathers, and their infants after childbirth. Under this authority, the Department of Health has established a program in which children are screened once before they enter kindergarten.[1007]

Maternal and Child Service Program for Alcohol and Drug Abuse

The Maternal and Child Service Program for Alcohol and Drug Abuse helps to improve the health and functioning of children born to mothers using alcohol and controlled substances.[1008] It includes intervention, treatment, and coordination of medical, educational, and social services through a child's preschool years. Research and evaluation projects are authorized to identify effective methods of improving outcomes among this high-risk population.

Investigations into the Deaths of Children

In Minnesota, the coroner must investigate and may conduct inquests into all violent deaths.[1009] Additionally, if a child under 2 years of age dies suddenly and unexpectedly under circumstances indicating that the death may have been caused by sudden infant death syndrome, the parents are to be notified that an autopsy is essential to establish the cause of death as sudden infant death syndrome.

Community Health Center Program

The Community Health Center Program provides grants to communities for planning and establishing community health centers in rural shortage areas.[1010]

[1006] MINN. STAT. § 256.01, subd. 12.

[1007] MINN. STAT. § 144.06; MINN. R. 4615.0900 (1995).

[1008] MINN. STAT. § 254A.17.

[1009] MINN. STAT. § 390.11.

[1010] MINN. STAT. § 144.1486.

Way to Grow/School Readiness Program[1011]

The Way to Grow/School Readiness Program is a grant program under the Commissioner of Children, Families, and Learning which is authorized to work with other agencies and community organizations to build a coordinated and improved continuum of necessary services for children from prebirth to age six. Eligible grantees are local units of government, community action agencies, and nonprofit organizations. An advisory committee reviews grant applications.

In Fiscal Year 1993 there were 5 Way to Grow programs, including a Minneapolis program. The programs focus on providing linkages between families and needed services. They provide: (1) staff training; (2) neighborhood oriented, culturally specific social support, outreach, and information; (3) strategic outreach to pregnant women and families with young children; (4) collaboration and coordination of a continuum of neighborhood health and social services.

- **Wisconsin**

Wisconsin's Department of Health and Family Services, in operating the state Medicaid program, "shall administer medical assistance, rehabilitation and other services to help eligible individuals and families attain or retain capability for independence or self-care . . ."[1012] Wisconsin also provides each county with a relief block grant for general assistance purposes.[1013] The county or municipality is obliged to pay a hospital for the provision of medical care to eligible poor individuals, and this obligation to fund medical care for the poor will be upheld in state courts.[1014] A municipality may not obstruct a hospital's ability to provide care to the poor by imposing on the hospital a requirement to investigate the financial circumstances of apparently eligible persons.[1015] The obligation to engage in such an investigatory function would undermine the hospital's ability to provide the necessary care.

Wisconsin also operates the following programs:

[1011] MINN. STAT. § 121.835

[1012] WIS. STATE. ANN. § 49.45 (West 1997).

[1013] WIS. STAT. ANN. §§ 49.001-49.178 (West 1997).

[1014] *See* Trinity Memorial Hospital of Cudahy, Inc. v. County of Milwaukee, 295 N.W.2d 814 (Wis. Ct. App. 1980).

[1015] *Id.*

Medicaid

Wisconsin's Medicaid program provides services for pregnancy and any pregnancy-related conditions to women who qualify.[1016] The statute also provides family planning services and school medical services. Pregnant women and children who meet income requirements need not pay recipient costs. Medicaid eligibility is automatic for individuals receiving basic welfare benefits. Pregnant women qualify if their family income is less than 133 percent of the federal poverty level. The same eligibility requirement applies to children under six years of age.

Child and Maternal Health Program

The Child and Maternal Health Program provides reproductive health services, family planning, pregnancy related services through postpartum including information, referral, and follow-up. The program also provides early identification of pregnancy and prenatal care, infant and preschool health services, child and adolescent health services, oral health nutrition, health education, childhood and adolescent injury prevention, and family health benefits counseling.[1017]

Funds are allocated to provide community based family planning, including counseling, information and referrals. Specific programs receiving funding include cancer screening, sexually transmitted disease control programs, pap tests for low income women, and pregnancy counseling.

Wisconsin also requires reporting for adverse neonatal outcome babies. These conditions include low birth weight, serious problems such as nervous system defects, low apgar scores, serious birth defects, and developmental disabilities. Infants must also be tested for congenital and metabolic disorders. The state will provide services to the family such as tests, counseling, dietary treatment and evaluation as a minimal fee.

The state also provides outreach to low-income pregnant women to inform them of the importance of pre-natal care and the availability of benefits through Medicaid. This program will make referrals and follow-up contacts with women. These services are funded by the Maternal and Child Health Services Block Grant.

Statewide Immunization Program

All elementary schools are required to ensure that students have the appropriate vaccinations.[1018]

[1016] WIS. STAT. ANN. §§ 49.45 - 49.47 (West 1997).

[1017] WIS. STAT. ANN. § 253 (West 1997).

[1018] WIS. STAT. ANN. § 252.04 (West).

Alcohol and Drug Treatment

Wisconsin provides grants to counties and non-profit agencies who provide drug and alcohol treatment to pregnant women and women with children under age 5.[1019] The state provides grants to home-based, community-based, and residential family-centered programs. In order to be eligible for funding, the program must provide treatment for alcohol and drug abuse, parent education, support services for children, and vocational and housing assistance.

Early Education Services

Under the Early Education Services program, the state contracts with early childhood education providers, who must reserve 75 percent of their spaces to children of parents who are eligible for day care or child care funds through the state, and children with exceptional educational needs.[1020] The statute also requires developmental day care delivery and staff ratios and hour requirements.

D. International Legal Obligations of the United States

1. Framework for the United States' international obligations

The following international instruments define the United States' international legal obligations, as discussed in chapter II, and provide a framework for the United States' compliance obligations relevant to child health and survival:

[1019] WIS. STAT. ANN. § 46.86 (West 1997).

[1020] WIS. STAT. ANN. §§ 119.72- 119.73 (West).

Box 6.8. International instruments regarding child health and survival applicable to the United States

Universal Declaration of Human Rights (UDHR)	adopted Dec. 10, 1948
International Covenant on Civil & Political Rights (ICCPR)	ratified by U.S. June 8, 1992
International Covenant on Economic, Social & Cultural Rights (ICESCR)	signed by U.S. Oct. 5, 1977
Convention on the Rights of the Child (Children's Convention)	signed by U.S. Feb. 16, 1995
Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention)	signed by U.S. July 17, 1980
Convention on the Elimination of Racial Discrimination (ICERD)	ratified by U.S. Oct. 21, 1994
American Declaration of the Rights and Duties of Man (American Declaration)	adopted 1948
American Convention on Human Rights (American Convention)	signed by U.S. June 1, 1977
WHO Constitution	accepted by U.S. June 21, 1948

The United States has ratified or accepted five of the principal international instruments relevant to child health and survival (see Box 6.8), indicating that it will uphold the rights and duties provided in these instruments. The U.S. has also signed, but not yet ratified , four of the other listed instruments. Under U.S. law, treaties that have been signed but not yet ratified may be rejected by a future administration or Congress. By signing the treaties, however, the government has expressed consent to abide by their provisions.[1021]

The U.S. Constitution states that all treaties are the supreme law of the land and prevail over inconsistent state constitutions and laws.[1022] Under U.S. law, however, subsequent federal statutory law can override a treaty obligation if it is found to be in conflict with the treaty.[1023] But, wherever possible a construction that gives effect to both the treaty and statute is generally preferred.[1024]

[1021] Vienna Convention on the Law of Treaties, art. 11, *supra* note 166.

[1022] U.S. CONST. art. VI, § 2.

[1023] *See* Asakura v. Seattle, 265 U.S. 362 (1924). An example of federal law that may override treaty obligations is the recent welfare reform statutes.

[1024] *Id.*

Despite the constitutional provision on the supremacy of treaty law, most, but not all of the human rights treaties ratified by the United States have been accompanied by a declaration that it considers the substantive provisions of those treaties not self-executing.[1025] This non-self executing status is generally applied where courts could imply a private cause of action from treaty provisions.[1026] Such treaties must include implementing legislation. The treaties listed above, however, have not been the subject of such legislation.[1027]

Under the treaties and other instruments the United States has ratified or accepted, the U.S. government has both obligations of conduct and result[1028] in regard to the right to health and survival. As provided in instruments such as the ICCPR and ICERD, the United States' obligations of conduct include protecting the right to life, ensuring non-discrimination in the application of laws and practices, and monitoring and reporting on its compliance.

Although the United States is not legally bound by treaties it has not ratified or accepted, as a signatory to treaties such as the ICESCR, the U.S. government has expressed its intent to abide by their obligations. Under the ICESCR, obligations of result include "tak[ing] all effective and appropriate measures" with a "view to achieving progressively the full realization" of the right to health protection and child survival.[1029] In addition, the U.S. is obligated to utilize to the maximum extent its available resources to undertake such measures,[1030] and to do so without discriminating among children on the basis of race, sex, religion, ethnic or social group, or other status. The concept of "progressive realization" takes into account that certain of the U.S. obligations related to health and child survival may not be able to be achieved

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[1025] *See* FRANK NEWMAN & DAVID WEISSBRODT, INTERNATIONAL HUMAN RIGHTS: LAW, POLICY, AND PROCESS 22 (2d ed. 1996).

[1026] *Id.* at 22-23.

[1027] The one exception is the United States' extradition implementation legislation of the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment.*

[1028] *See Maastricht Guidelines, supra* note 175. *See also* discussion *supra* ch. III, part A.2.

[1029] ICESCR, *supra* note 161, art. 2 ("Each State Party . . . undertakes to take steps . . . with a view to achieving progressively the full realization of the right . . . ."); Women's Convention, *supra* note 197, art. 14(2) ("States . . . shall take all appropriate measures and shall ensure . . . access to adequate health care . . . ."); Children's Convention, *supra* note 162, art. 24(2) ("States . . . shall take appropriate measures to diminish infant and child mortality . . . [and] to ensure provision of medical assistance and health care to all children . . . .").

[1030] ICESCR, *supra* note 161, art. 2 ("Each State Party . . . undertakes to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant . . . ."); Children's Convention, *supra* note 162, art. 4 ("With regard to economic, social, and cultural rights, States Parties shall take undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international cooperation.").

immediately.[1031] But it also "imposes an obligation to move as expeditiously and effectively as possible towards that goal."[1032]

The obligations of conduct and result require the U.S. to adopt legislative, judicial, social, educational, administrative, economic, and other measures for the protection of children's health and survival rights.[1033] The U.S. must take immediate steps to eliminate discrimination in the enjoyment of the right to health protection, and progressive measures to reduce preventable child mortality and ensure the survival, development, and adequate standard of living of children.[1034] These measures must provide particular attention to the specific health needs of mothers and children.[1035]

1.1. Obligation to monitor and report accurately

The United States' international obligations require the government to monitor and provide reports detailing the extent to which its international obligations are being met. Under the ICERD, the U.S. reporting requirements include submissions to the Committee on the Elimination of Racial Discrimination every two years.[1036] As indicated by the ICERD, and other international instruments to which it is a party, the U.S. reports should include conditions relating to health and child survival; the measures it has adopted in regard to health and children's rights; and its progress or limitations in alleviating health concerns and furthering health protection.[1037] Such reports should also include a comprehensive review of its national legislation, administrative rules and procedures, and practices to ensure adequate monitoring of the actual health situation.[1038]

[1031] General Comments, *supra* note 176.

[1032] *Id.*

[1033] Article 2 of the ICESCR requires that States Parties take steps to fully realize the rights in the Covenant "by all appropriate means, including particularly the adoption of legislative measures." ICESCR, *supra* note 161. Article 4 of the Children's Convention also provides that "States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention." Children's Convention, *supra* note 162.

[1034] *See supra* ch. III, part A.2.

[1035] *See supra* ch. III, part B.2.

[1036] ICERD, *supra* note 186.

[1037] ICESCR, *supra* note 186, pt. IV. *See also* General Comments, *supra* note 176, at 50-52.

[1038] General Comments, *supra* note 176.

1.2. Right to non-discrimination

Non-discrimination is a fundamental principle for the full realization of children's health and survival rights. According to the WHO Constitution, which the United States accepted in 1948, "the enjoyment of the maximum level of health that can be attained is a fundamental right for all without distinction of race, religion, political ideology, or economic and social condition."[1039] Similarly, the ICESCR recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[1040] Along with the non-discrimination provisions in the general human rights treaties,[1041] the ICERD and the Women's Convention specifically provide for measures to prohibit discrimination, particularly with regard to health care.[1042]

Under these instruments, discrimination in the availability, accessibility, affordability, and quality of health services constitutes a direct denial of the right to health.[1043] Therefore, the United States' obligations extend not only to discriminatory policies or practices, but also to discriminatory impact or effects which impair the right to health.[1044] The ICERD and Women's Convention, as well as other international instruments, impose an affirmative duty on the U.S. government to incorporate the right to non-discrimination in its laws and policies, as well as ensure non-discrimination in the application and impact of its programs.

1.3. Guarantee of life, health, and adequate standard of living

Under the ICESCR and the Children's Convention, the right to life, to health, and to an adequate standard of living are necessarily interlinked for the survival and development of children.[1045] Without adequate nutrition, housing, health and other services, children and their families can not attain the highest standard of health or ensure survival. Therefore, to meet its international obligations for the health, development, and survival rights of its children, the U.S. must not only promote health-related programs, but must also ensure the appropriate socioeconomic conditions to attain an adequate standard of living.

[1039] WHO Constitution, *supra* note 142.

[1040] ICESCR, *supra* note 161, art. 12(1).

[1041] *See supra* ch. III, part B.

[1042] ICERD, *supra* note 186, art. 5 (e)(iv); Women's Convention, *supra* note 197, art. 11(1)(f).

[1043] Gruskin & Sullivan, *supra* note 176.

[1044] *Id.*

[1045] ICESCR, *supra* note 161, arts. 11, 12; Children's Convention, *supra* note 162, arts. 24.27.

2. United States customary international law obligations

Along with treaty obligations, the law of the United States includes customary international law, which is considered a part of federal common law.[1046] Thus, the U.S. may be considered bound by relevant provisions of the Universal Declaration of Human Rights (which is not a treaty), to the extent that those provisions have become authoritative customary law.

3. Assessment of United States compliance

Despite being one of the wealthiest countries in the world, and having the capacity to protect children in all segments of society, the United States' compliance with international obligations to uphold the health and survival rights of children has been limited. U.S. reservations on significant human rights provisions in international instruments, as well as U.S. federal laws and policies related to these reservations, place disadvantaged children, particularly those who are poor or of color, at higher risk of preventable deaths.

The United States has issued specific reservations related to non-discrimination.[1047] In its reservation to the ICERD, the U.S. government distinguishes between public conduct, which is subject to governmental regulation, and private conduct, which is not. This reservation may potentially have an impact on factors significant to child mortality, such as domestic violence and family planning.

United States federal law, both constitutional and statutory, does not adequately prohibit discrimination. U.S. federal law does not meet the disparate impact requirements of the ICERD. There is simply no constitutional or statutory prohibition against discriminatory impact in the provision of health or other protections. To ensure that this obligation will be made effective in law and practice requires implementing legislation, particularly with regard to child mortality.

In addition, U.S. federal and state law do not provide affirmative protections of the right to life. The limited interpretation given the 5th and 14th Amendments Due Process Clause as

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[1046] *See* The Paquete Habana, 175 U.S. 677 (1900):

> International law is part of our law, and must be ascertained and administered by the courts of justice of appropriate jurisdiction...For this purpose, where there is no treaty, and no controlling executive or legislative act or judicial decision, resort must be head to the customs and usages of civilized nations. . . ."

See also First National City Bank v. Banco Nacioal de Cuba, 406 U.S. 759 (1972).

[1047] The Vienna Convention on Treaties allows a state to formulate a reservation, when signing, ratifying, accepting, approving or acceding to a treaty. Vienna Convention on the Law of Treaties, art. 19, *supra* note 166. The United States has issued reservations in regard to the ICCPR and ICERD non-discrimination provisions. The reservation to the ICCPR related to the U.S. practice of permitting distinctions based on various characteristics for legitimate government purposes.

applied to the right to life fails to meet the standards of the ICCPR as interpreted by the HRC in regard to child mortality. Although some state constitutions and laws have specific protections for the right to life and health, interpretations have not implied affirmative obligations on the part of state and local governments to reduce child mortality, or disparities of resources leading to child mortality.

While both the federal and state governments provide a number of health and social programs, persistent socioeconomic barriers for people in poor communities, and those in racial/ethnic minorities, increase the likelihood of unhealthy, unstable circumstances for child health. Recent legislative "reforms" and changes in public benefits and health care threaten child health protections among these disadvantaged groups. Without increased investments within these communities and more effective protections for women and families, disadvantaged children in the U.S. will likely not receive adequate nutrition, housing, or education for healthy development.

VII. CONCLUSION

As this report outlines, global child survival requires the protection and promotion of fundamental human rights worldwide. Assuring child survival is an obligation of all governments by virtue of their responsibility to comply with international human rights standards. The case studies examined in this report—Uganda, Mexico, and the United States—reveal that preventable child mortality in both developing and developed countries violates the basic human rights of children.

The research, findings, and recommendations presented in this report provide the basis for an ongoing campaign to assure the rights to survival and health of the world's vulnerable children. Minnesota Advocates for Human Rights urges policymakers, development professionals, and health and human rights advocates to consider the findings and recommendations contained in this report. A commitment to the protection of the full range of human rights by governments and the international community is critical to ensure that every child has an equal chance to survive, develop, and enjoy a healthy life.

Minnesota Advocates encourages comment on this report and collaboration on campaign actions. To all the individuals and organizations working to protect human rights and promote the survival of children we extend our profound and heartfelt appreciation.

A. General findings and recommendations

1. Findings

- A high incidence of child mortality is a result of the violation of the following, and other, basic human rights:
  - right to non-discrimination;
  - right to life;
  - right to health;
  - right to an adequate standard of living, which includes:
    - sufficient food
    - appropriate housing
    - safe water and sanitation
    - adequate medical services; and
  - right to education.

- High and disparate levels of preventable child deaths reflect a failure on the part of governments to respect and ensure the rights essential to child survival. Child survival is a predicate to the enjoyment of all other human rights.

- Global child survival has improved since the 1950s but the advances reach only a portion of the world's children. Those most likely to die before reaching age five are in developing countries.

- Within both developing and developed countries, the poor, racial and ethnic minorities and indigenous groups have disproportionately higher rates of child mortality.

- Data on issues critical to child mortality are inadequate and are not disaggregated in a way that is helpful to policy making and programming. Overall child mortality rates mask important variations within a country.

Children under-five are primarily dying from preventable causes that include biological, behavioral, and socioeconomic determinants. In developing countries, child deaths are caused largely by the "diseases of poverty" such as immunizable childhood diseases and malnutrition. The low socioeconomic status of mothers, unsafe water, lack of nutritious food, and punitive government policies also contribute to excessive child deaths. In industrialized countries, children often die from low birth weight and preterm births, abuse and neglect, and accidental injuries. As in non-industrialized countries, socioeconomic factors impact child survival in industrialized countries. The disparities in these factors among population groups generally parallel the disparities in the child death rates.

- Structural factors which have had a damaging effect on child mortality include absolute poverty, lack of satisfaction of basic human needs, gender and other forms of discrimination, unbalanced macroeconomic policies, and unsustainable external debts.

- Ameliorative measures are available and affordable. A global strategy to promote "Health for All by the Year 2000," which was proposed at the 1978 Alma-Ata International Conference on Primary Health Care and adopted by the World Health Assembly in 1981, provides a practical framework for improving child health and survival worldwide. The 20:20 initiative endorsed by such U.N. agencies as UNICEF, UNFPA, WHO, UNDP, and UNESCO suggests a strategy through which aid donors and governments can earmark 20 percent of their budgets towards meeting the social goal of universal access to primary health care and nutrition, reproductive health, water and sanitation, primary education, and other basic social services.

2. Recommendations

2.1 To governments

- Take all necessary steps to assure all internationally recognized human rights.

- Fully comply with human rights treaties and instruments, in particular the Convention on the Rights of the Child.

- Comply with obligations under international human rights law to assist poorer countries in realizing the rights essential to the survival and health of children.

- Observe the Alma-Ata principles of primary health care by ensuring equity, universality, community participation, and intersectoral collaboration in health policies and programs. All segments of the population must be enabled to define and guide their own well-being.

- Adopt a cohesive strategy for child survival that promotes long-term investments and solutions, and de-emphasizes short-term measures.

- Take legal and policy measures to ensure that the status and role of women will improve the quality of their life as well as the health and welfare of their children and family.

- Accede to the United Nations' 20:20 initiative that calls for a prioritized resource allocation towards basic health and social development: a minimum allocation of 20 percent of governmental budgets and 20 percent of donor countries' official development assistance.

- Develop an organized public education and advocacy program to heighten awareness of the need to improve maternal and infant health that should be directed toward the general public, women of childbearing age, families, teachers, and employers.

2.2 To international financial institutions

- Ensure that finance and economic development programs do not disadvantage poor, rural, and agrarian regions by focusing only on urban centers and the global market.

- Continue the joint initiative of debt relief and poverty reduction in development policy and program planning. A more progressive debt reduction plan must be considered for all poor countries, particularly indebted countries that have a demonstrated commitment to the social sector, institutional and human capacity building, poverty alleviation, and development of a democratic and civil society.

- Apply a social conditionality on future loans as a strategy to compel loan-recipient countries to mobilize greater national resources specifically for health and social development.

2.3 To U.N. specialized agencies and international health/development non-governmental organizations

- Emphasize ratification and observance of human rights treaties, especially those which guarantee rights related to child health and survival, including:
  - International Covenant on Political and Civil Rights;
  - International Covenant on Economic, Social, and Cultural Rights;
  - International Convention on the Elimination of All Forms of Discrimination;
  - Convention on the Rights of the Child; and
  - Convention on the Elimination of All Forms of Discrimination Against Women.

- Continue active involvement in the monitoring of global child survival and health. Facilitate the work of the Convention on the Rights of the Child, the International Covenant on Economic, Social and Cultural Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women. Improve the selection and collection of appropriate (disaggregated) social and health indicators to measure more accurately the impacts of policies and programs.

- Facilitate and improve the linkages between U.N. specialized agencies, international health and development (non-governmental) organizations, governments, and international financial institutions to improve child survival through national planning and implementation.

- Promote primary health care objectives that are low-cost, high-impact, and appropriate to local situations. Support long-term, grass-roots development that improves social conditions and human capacity in a sustainable manner.

B. Country-specific recommendations

1. Uganda

1.1. Findings

- Uganda's under-five child mortality rate of 147 deaths per 1000 births is one of the world's worst. Ugandan children still die from largely preventable diseases. Malaria is the leading killer, responsible for one in five child deaths. More than a quarter of all under-five deaths are attributable to measles, diarrheal diseases and respiratory infections. AIDS is now the fifth leading cause of death for children under age five. The AIDS epidemic continues to have an adverse impact not just on the children directly, but also on the family and community, as reflected in the rising numbers of AIDS orphans.

- The health and well-being of Ugandan children is harmed by the ethnic and regional tensions between north and south, the ongoing insurgency, and the legacy of social and economic disruption from decades of armed conflict, civil strife, and displacement. Uganda remains one of the world's poorest countries.

- Child survival in Uganda remains under-funded, while the debt burden, defense spending, and an unwritten commitment to low-impact, tertiary health care supersede basic child survival strategies.

- The low social status and high illiteracy of women in Uganda undermine the health of children as well as women. Mortality and morbidity indicators demonstrate dramatically higher risk for rural children and women.

- Uganda has failed to carry out its plans to improve child survival by moving resources away from curative, hospital-based programs and toward primary and preventative health care.

- The health and social service systems that implement Uganda's law are in transition during the ongoing process of decentralization. The Local Governments Act passed in 1997 devolves authority for providing medical and health services to the local district councils, subject to minimum, centrally-set health standards. Control of most resources has not yet devolved to the district level. Poor rural districts in particular lack the resources to carry out their new responsibilities. Current cost-sharing programs for the health sector have proven to be ineffective sources of revenue, and have made health services even more inaccessible to the very poor.

- Uganda's law places a priority on child welfare and generally appears to address Uganda's international obligations (with the exception of the anachronistic Public Health Act), however, legal and resource limitations hinder the protection of children's rights. The 1995 Constitution of Uganda recognizes and protects the right to life, but contains no explicit guarantee of the right to health. In addition, the enforcement provisions of the Constitution do not apply to the right to health. The Children's Statute of 1996 specifies children's rights and places shared responsibility for ensuring those rights on the nation, parents, extended families, and local authorities. In practice, the country faces the enormous challenge of marshaling adequate human and financial resources to implement these guarantees.

1.2. Recommendations

- Comply with all human rights obligations under treaties and instruments to which Uganda is a party. Promote and protect children's rights, in particular those related to child health and survival, through adequate programs and funding.

- Continue legislative efforts as well as target social spending to promote the rights and status of women. Government funds should support the implementation of a massive women's literacy campaign.

- Repeal or update provisions of the Public Health Law that are inconsistent with the Local Governments Act. Increase the resources available to the Ministry of Health and Local Councils to guarantee the implementation of reasonable minimum health standards regardless of the wealth of the various districts. The cost sharing scheme for the health sector should be re-examined and modified to ensure accessibility to the poor.

- Provide funds to support high-impact primary health care strategies as a national priority, including the required human capacity resources outlined in the Uganda National Plan of Action for Children reform program. Funds made available from the current IMF and World Bank debt relief initiative provide an excellent opportunity to invest in the Uganda National Plan of Action for Children primary health care package.

- Use debt relief funds effectively and sustainably to increase child survival. After demonstrating the impact of debt relief on child survival, more IMF and World Bank debt should be forgiven.

- Target rural communities in the provision of health and social service funds.

2. Mexico

2.1. Findings

- Mexico has made significant progress in reducing overall child mortality, but disparities in child survival are increasing between urban and predominantly rural areas. Socio-economic inequities make children who are in Mexico's poor and rural areas, and those who are indigenous, more vulnerable to preventable deaths before reaching age five than children in urban centers.

- Persistent socioeconomic inequities are exacerbated by economic and structural adjustment policies. Government economic policies have been biased toward urban centers at the expense of marginalized areas. In the past decade, the Mexican government has systematically pursued austerity and structural adjustment programs in accordance with World Bank and IMF specifications. The process has aggravated inequities in socioeconomic development between urban and rural areas. Under the structural adjustment programs, the Mexican government has considered poverty and disparity as by-products of the country's economic development, rather than as violations of economic, social, and cultural rights. As a result, issues such as child mortality are treated as inevitable rather than preventable.

- The Mexican government's response to preventable child mortality in marginalized areas remains inadequate, in law and practice. Mexico's domestic laws, institutions, and administrative programs embrace the discourse of the Alma-Ata primary health care approach, but in practice they create social dependency rather than social empowerment. Government programs to address child mortality are framed in terms of short-term poverty alleviation or social assistance rather than long-term investments, solutions and priorities. Health and social programs are often politicized and do not adequately address the disparity in child survival nor the underlying socioeconomic conditions which threaten the health and survival of children.

- Although the Mexican government has ratified or adopted international instruments relevant to child health and survival, Mexico has not effectively complied with its international obligations for right to life, health, and non-discrimination. The continued and increasing socioeconomic and child survival disparities constitute a discriminatory impact in marginalized communities in violation of international law.

2.2. Recommendations

- Comply with all human rights obligations under treaties and instruments to which Mexico is a party. Promote and protect children's rights, in particular rights related to child health and survival, through adequate programs and funding.

- Adopt a cohesive strategy for child health and survival which promotes long-term investments and solutions to alleviate underlying socioeconomic disparities in marginalized areas. Combat preventable childhood deaths and diseases among all segments of the population as a national health priority to which the maximum available resources must be allocated.

- Observe the Alma-Ata principles of primary health care by ensuring equity, universality, community participation, and intersectoral collaboration in health policies and programs. All segments of the population must be enabled to define and guide their own well-being.

- Improve the productive life and health of women, particularly rural women, as well as the welfare of their children and families.

- Target resources to poor and rural communities, and implement urgent measures to ensure balanced and equitable economic growth in both urban and rural areas.

- Correct inconsistencies in child health data, with particular attention to issues of validity and reliability, and utilize disaggregated indicators for vulnerable populations. Consult nongovernmental organizations and consider their information and recommendations in health policies and programs.

3. United States of America

3.1. Findings

- The United States has seen dramatic improvements in child survival in the past century. Important strides in living conditions, public health, and medicine have largely eliminated many health threats posed by a vast array of deadly but preventable childhood diseases. Nonetheless, the United States has an *infant mortality rate* that is worse than 20 other industrialized countries.

- Eight in ten deaths to children under age five in the United States occur in the first year of life. There is more information available about *infant deaths* than deaths to children aged 1 through 4 years because U.S. data collection, reporting, and research focuses on the infancy period.

- Gross disparities in infant and child mortality rates persist among different groups in the country. Poor children and Black children are the most vulnerable. Black infants die at more than twice the rate of White infants. The mortality rate among infants from poor families is 60 percent higher than for infants above the poverty level. These disparities are growing in terms of both race and poverty.

- Child mortality rates in the United States are linked to biological, behavioral, social, and economic factors including maternal health, socioeconomic conditions, public health practices, and access to quality health care and social services. The disparities in these factors among population groups generally parallel the disparities in the death rates.

- In its failure to address socioeconomic and racial disparities in mortality rates and underlying causes of death, the United States has failed to live up to international standards to protect equally all of its infants—no matter their race or economic status—and to provide conditions adequate for survival and healthy development.

3.2. Recommendations

- Ratify the Convention on the Rights of the Child, the International Covenant of Economic, Social and Cultural Rights, and the Convention on the Elimination of All Forms of Discrimination Against Women.

- Ensure implementation and compliance with all human rights obligations under treaties and instruments to which the U.S. is a party. Promote and protect children's rights, in particular rights related to child health and survival, through adequate programs and funding.

- Achieve further reductions in the disparity in infant mortality and morbidity. Such reductions require changes in social and economic barriers to healthy pregnancy and birth outcome. Both the public and private sectors should increase their investment in health care coverage, child care, education, and training.

- Ensure that the changes in public benefits and health-care delivery do not further threaten child health and survival.

- Implement strategies that minimize the risks of unintentional injuries and violence toward children. Prevention of child abuse and neglect should focus on the millions of high-risk families who are living below the poverty line or are plagued by domestic violence and substance abuse—major risk factors for child ill-treatment.

- Adopt an integrated policy on children's health and well-being in both the federal and state governments, addressing not only the medical needs of all expectant mothers and newborns, but also investing in broad-based preventive approaches. Strengthen coordination between state and federal programs and social and health services for women and their children. A comprehensive service delivery system is needed, offering perinatal clinical services and linkages between community-based health care and social services.

- Increase funding at the state and federal level for monitoring, data collection, and research on the status of children's health and well-being.

GLOSSARY

Absolute poverty level. The income or expenditure level below which a minimum, nutritionally adequate diet plus essential non-food needs is unaffordable and unmet.

Basic human necessities. Requirements for assuring health and well-being which include food, water and sanitation, shelter, primary health care, education, and employment.

Causal chain of under-five child mortality.

Biological causes. The immediate or proximate causes of child death such as malnutrition, diarrhea, malaria, and acute respiratory infections.

Behavioral factors. Intermediate factors affecting the child's exposure to the biological causes of death such as child care practices.

Structural (or socioeconomic) factors. Fundamental, underlying social, economic, and cultural determinants through which biological and behavioral factors influence children's well-being.

Debt forgiveness. Initiatives by lenders to forgive, partially or entirely, the sum of principal and interest on total long-term debts.

GOBI-FFF. Basic child survival package promoted by UNICEF which includes: Growth monitoring, Oral rehydration therapy, Breast-feeding, Immunization, Food supplementation, Family planning, and Female education; these techniques are augmented to include the following: provision of safe water and sanitation, maternal health and survival, elimination of micronutrient deficiencies, control of acute respiratory infections and epidemics such as AIDS and malaria, and protection of children in especially difficult circumstances such as war and child labor.

Health care access. Adequate local health services that can be reached by local means of transportation or on foot in no more than one hour.

Maternal mortality. Death of women from any cause related to or aggravated by the pregnancy or its management, but not from accidental causes.

Primary health care. Comprehensive approach to health which recognizes the significant interplay between the health and socioeconomic environments, and which identifies the existing barriers to health as essentially political, social, and economic. Primary health care measures emphasize full participation, equal access, reallocation of resources, and priority concern for vulnerable segments of society such as women and children.

Safe water and sanitation access. The percentage of the population that have reasonable access to treated or uncontaminated water sources and to sanitary means of waste disposal including latrines and composting.

Social development. Development defined more broadly than mere economic objectives to include the basic necessities of populations by addressing priority challenges of social inequity and poverty reduction, with the highest priority placed on development of the well-being of vulnerable groups.

Under-five child mortality. For the purpose of this report, the terms "under-five child mortality" and "child mortality" are used interchangeably to describe all deaths occurring in children under the age of five years. Deaths occurring specifically in children aged 1-4 is denoted as "mortality of children aged 1 through 4" or "1-4 child mortality." This distinction is made in the U.S. and Mexico case studies where the majority of under-five deaths occurs during the infancy period.

Infant mortality. Death within the first year of life.
Neonatal mortality. Death occurring from birth through the first 28 days of life.
Post-neonatal mortality. Death occurring from 29 days through the first year of life.
Mortality of children aged 1 through 4 (or "1-4 child mortality"). Death occurring from the first year through the fourth year of life.

Under-five child mortality rate (or "child mortality rate"). Death (or the probability of dying) between birth and under five years of life expressed per 1,000 live births.

APPENDIX A

Specialized agencies, funds, programs, and financial institutions relevant to health protections

International and regional agencies, funds, programs, and financial institutions provide assistance and guidance for health policies and programs, and socioeconomic development, particularly as related to child survival. Intergovernmental and other organizations aid states through funding for development efforts, monitoring of progress in promoting health protections, and technical assistance for implementation of policies and programs. The following are key agencies or organizations focusing on such efforts:

1. UNICEF

As the only U.N. agency exclusively dedicated to children, UNICEF's policies and programs specifically seek to reduce child mortality. The Executive Board of UNICEF describes its mission by saying that UNICEF "is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behavior towards children."[1] UNICEF focuses on community-based services in primary health care, basic education, safe water, and sanitation in over 140 developing countries.

In 1990, UNICEF held the World Summit for Children which resulted in the World Declaration of the Survival, Protection and Development of Children and a Plan of Action.[2] Both documents specifically addressed the prevention of infant and child mortality through health and education, and the Declaration stated that Summit participants have made a "solemn commitment to give high priority to the rights of children, to their survival and to their protection and development."[3] The Declaration focused on children's lack of nutrition and health care, particularly in developing countries, providing statistics on preventable diseases and the related child deaths. The document advocated a transfer of medical resources from developed countries to less developed areas and articulated a ten-point program to improve the situation of children around the world. Goals of the ten-point program relate to, among other things, clean water, sanitation, hunger, malnutrition, primary health care, immunization, and poverty.

Given the broad goals of the Declaration, the Summit also produced a Plan of Action to guide policy-making at the country level. The Plan created several overall goals related to child

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[1] UNICEF, *Mission Statement* (visited Feb. 13, 1997) <http://www.unicef.org/about/>.

[2] *World Declaration on the Survival, Protection and Development of Children, Plan of Action for Implementing the Declaration in the 1990s* (New York, Sept. 30, 1990), *in* UNICEF, THE STATE OF THE WORLD'S CHILDREN 1991, annex at 51.

[3] *Id.*

mortality that countries should strive to meet by the year 2000. The primary goal is the reduction of child mortality rates by one-third, or to 70 per 1000 live births.[4]

Since the Summit, UNICEF has assisted implementation of the Plan of Action by aiding countries in the formulation and execution of national programs of action based on the World Summit. By 1996, 104 countries had finalized their national programs of action and, according to a UNICEF progress report on the World Summit, those programs will result in an estimated 2.5 million fewer child deaths in 1996 than in 1990.[5]

2. World Health Organization (WHO)

WHO has a significant role to play in the process of informing treaty bodies about progress in the area of health, which has been only partially realized.[6] The agency has the authority to report to the Economic and Social Council (ECOSOC) and the ESC Committee on the health situation in specific countries.[7] Critics have charged that WHO, in comparison to ILO or UNICEF, has failed to involve itself in the process of monitoring the realization of the right to health. One commentator has observed that,

> [u]nlike the ILO, the WHO does not have a tradition of standard-setting through international agreements or of monitoring country progress . . . . WHO has submitted one report pursuant to Resolution 1988 (LX) of the Economic and Social Council, which calls on the specialized agencies to submit reports on progress toward achieving the goals of the Economic Covenant. . . . The WHO's report merely covers those very issues of "generic implementation" . . . and ignores the kind of country-specific data which Article 18 calls for from specialized agencies and which the ILO has provided.[8]

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[4] *See supra* ch. II, tbl. 2.8.

[5] UNICEF, Progress Report on Follow-Up to the World Summit for Children, E/ICEF/1996/15 (Apr. 8, 1996).

[6] *Id.*

[7] This interpretation is implicit in the language of Article 18 of the ICESCR which allows specialized agencies to make reports to the Economic and Social Council including "particularities." Trubek, *Economic, Social, and Cultural Rights*, at 220-21. The Chair of the Committee on Economic, Social and Cultural Rights, has observed that "specialized agencies have a fundamental responsibility to promote realization of human rights" and that "the primary thrust of the [ICESCR's] implementation procedure is directed at the agencies." *Id.* To date, WHO has rarely taken advantage of this opportunity. By contrast, the International Labor Organisation (ILO) has become actively involved in monitoring individual states' progress in the area of employment. *Id.* For a detailed discussion of ILO practices, see Meron, at 231. *See also* Virginia Leary, *Lessons from the Experience of the International Labor Organization, in* THE UNITED NATIONS AND HUMAN RIGHTS: A CRITICAL APPRAISAL 580 (Phillip Alston ed., 1992).

[8] Leary, *supra* note 7, at 580.

affected child mortality.[16] To date, in some circumstances, World Bank policy has actually undermined the achievement of hu[illegible] rights. The World Bank now recognizes the adverse consequences of such programs an[illegible]e fact that at least one-third of its programs have failed in terms of repayment or adverse social and environmental consequences.[17] According to the World Bank:

> The stakes have changed over the years. The Bank group has learned from experience, and been led to shift its development approach. . . . Whereas we initially thought growth would eventually filter down to the poor by osmosis, we have now realized that curbing poverty also requires taking measures to aid the most disadvantaged and most vulnerable groups.[18]

After realizing that investment in human capital is critical for development, the Bank has announced its intention to "increase its contribution to the social sectors by some 50 percent over the following three years."[19] Current World Bank President, James Wolfensohn, recently proposed a plan to reorganize the Bank and improve "performance in promoting the economic development of poor nations."[20] Wolfensohn plans to move the Bank's emphasis away from traditional infrastructure construction projects like power plants and bridges, which are increasingly being financed by the private sector.[21] If the Bank's board approves Wolfensohn's plan, the new focus will be on establishing banking systems and health, education, and other social welfare programs.[22]

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[16] For structural adjustment programs and child mortality, see *supra* notes 94-95 and accompanying text. *See also* The Realization of Economic, Social and Cultural Rights, Final Report Submitted by the Special Rapporteur, June 28, 1996, U.N. Doc. E/CN.4/Sub.2/1996/13, at 19. Critics have charged that Bank policy has actually undermined human rights. *See, e.g.*, Oloka-Onyango, *supra* note 14, at 19. With respect to economic and social rights, critics of the Bank have charged that the Bank's response has been limited to increasing the amount of development assistance without developing a human rights framework. With respect to civil and political rights, the Bank considers these rights to be outside the purview of its mandate and does little to promote these fundamental freedoms. *Id.*

[17] Oloka-Onyango, *supra* note 14, at 19.

[18] Oloka-Onyango, *supra* note 14, at 20.

[19] *Id.*

[20] *See* Richard W. Stevenson, *World Bank Chief Asks Slimmer Staffs and Better L*[illegible]*g*, N.Y. TIMES, Feb. 21, 1997, at C1.

[21] *Id.*

[22] *Id.*

5. International Monetary Fund (IMF)

In conjunction with the World Bank, the IMF's policies and programs have also had detrimental effects on child health and survival. The IMF, which was designed to promote international monetary cooperation and stability in foreign exchange, provides assistance on balance-of-payment problems, including structural adjustment assistance.[23] However, it does not provide assistance for economic development.[24] The conditions the IMF institutes on borrower countries include increased taxes, decreased subsidies, and devaluation of currency, which often negatively impact populations in poor and marginalized areas. Some critics argue that the IMF's austerity programs have reduced the IMF's ability to influence change in debt-laden countries.[25]

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[23] BARRY E. CARTER & PHILLIP R. TRIMBLE, INTERNATIONAL LAW 528-529 (2d ed. 1995).

[24] *Id.*

[25] *Id.*

APPENDIX B

International conferences relevant to child survival and health

Conferences and summits sponsored by WHO and UNICEF, as well as a series of international conferences sponsored by the United Nations over the past few years have addressed issues relevant to child mortality, including primary health care, women, populati and development, social development, as well as human rights generally. The United Natic has established follow-up mechanisms for five-year reviews of implementation at the natio level of the commitments made at the U.N. sponsored conferences. Summaries of these international conferences are discussed below.

1. Alma-Ata International Conference on Primary Health Care

The 1978 International Conference on Primary Health Care at Alma-Ata, jointly sponsored by WHO and UNICEF, resulted in a Declaration that emphasized a participatory, non-discriminatory approach to health and development. The Alma-Ata Declaration was critical in establishing a primary health care approach that treats health as a "most important worldwide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector."[1] The Declaration recognized that "[g]overnments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures."[2] It affirmed the centrality of economic and social development, and the related principle of popular participation:

- The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable.
- Economic and social development [i]s of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries.
- The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.[3]

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[1] Declaration of Alma-Ata, Alma-Ata International Conference on Primary Health Care (1978), *reprinted in* P.F. Basch, *Primary Health Care, in* TEXTBOOK OF INTERNATIONAL HEALTH 200 (1990).

[2] *Id.*

[3] *Id.*

2. World Conference on Human Rights

The 1993 World Conference on Human Rights in Vienna recognized the relationship between human rights, development, and child morality in its Declaration and Programme of Action.[4] In stating that "the human person is the central subject of development," the document recognized that, "[w]hile development facilitates the enjoyment of all human rights, the lack of development may not be invoked to justify the abridgement of internationally recognized human rights."[5] The Vienna Declaration and Programme of Action further called on states in their national action plans to place "particular priority . . . on reducing infant and maternal mortality rates, reducing malnutrition and illiteracy rates and providing access to safe drinking water and to basic education."[6]

3. International Conference on Population and Development

The 1994 International Conference on Population and Development (ICPD) in Cairo[7] produced a Programme of Action which detailed internationally-accepted components of reproductive health care and family planning services. The Programme of Action mirrored the WHO's definition of health[8] by defining reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[9] The Programme also provided some content to the right to reproductive health by stating:

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[4] *See generally* Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, June 14-25, 1993, U.N. Doc. A/CONF.157/23 (July 12, 1993).

[5] *Id.* ¶ 10.

[6] *Id.* ¶ 47. The Declaration and Programme of Action applauded UNICEF for "promoting respect for the rights of the child to survival, protection, development and participation." *Id.* ¶ 45.

[7] One hundred seventy-eight states and regional economic integration organizations were represented at the ICPD. United Nations, *Report of the International Conference on Population and Development*, U.N. Doc. A/CONF.171/13 (Oct. 18, 1994).

[8] As early as 1948, WHO developed a broad definition of health in the Preamble to its Constitution which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Constitution of the World Health Organization, opened for signature July 22, 1946, pmbl., 14 U.N.T.S. 185. The Preamble also identifies health as a fundamental right of every human being "without distinction of race, religion, political belief, economic or social condition." The WHO Constitution states that the "healthy development of the child is of basic importance." *Id.*

[9] The United Nations General Assembly endorsed the Programme of Action, making it a general expression of international commitment to the principles embodied within the action plan. *See* G.A. Res. 49, U.N. GAOR, 29th Sess., U.N. Doc. A/RES/49/120 (1994).

> Reproductive health care in the context of primary health care should, *inter alia*, include: family planning counseling, information, education, communication and services; education and services for post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and management of the consequences of abortion; treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions; and information, education and counseling, as appropriate, on human sexuality, reproductive health and responsible parenthood.[10]

The Cairo Programme of Action reflected an understanding that family planning allows women to more fully and freely choose the size of their families, a view that is consistent with the finding of the UN Population Fund that women who make reproductive choices more freely "tend to have fewer children and can keep them healthier and better educated."[11]

4. Fourth World Conference on Women

The 1995 United Nations Fourth World Conference on Women in Beijing reaffirmed the international community's commitment to improving women's health. The Beijing Declaration and Platform for Action that emerged from the conference contained an extensive discussion of women's health, which asserted that "[c]omplications related to pregnancy and childbirth are among the leading causes of mortality and morbidity of women of reproductive age in many parts of the developing world."[12] Because infant mortality is strongly associated with maternal mortality,[13] the international commitment to improve women's health may help reduce child mortality as well.

5. World Summit on Social Development

The 1995 World Summit on Social Development in Copenhagen underscored the importance of economic, social and cultural rights, including the right to health and survival. The Copenhagen Declaration on Social Development and Programme of Action recognized that "social development and social justice cannot be attained in the absence of peace and security or

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[10] ICPD Programme of Action, *in Report of the International Conference on Population and Development*, *supra* note 7, ¶ 7.6.

[11] United Nations Population Fund (UNFPA), *The State of World Population, Appendix: Follow-up to the ICPD* (visited July 24, 1996) < http://web.unfpa.org/apdx96.html>, at 1. *See also* ch. II, part A.3.3, subsection "Lack of comprehensive reproductive health services."

[12] Platform for Action *in* Report of the Fourth World Conference on Women, Beijing (4-15 September 1995), U.N.Doc. A/Conf.177/20, ¶ 98 (1995).

[13] *See* ch. II, part A.3.3, subsection on "Maternal health and mortality."

in the absence of respect for all human rights and fundamental freedoms."[14] The Declaration and Programme of Action also stated:

> The goals and objectives for social development require continuous efforts to reduce and eliminate major sources of social distress and instability for the family and for society. [The heads of State and Government] pledge to place particular focus on and give priority attention to the health, safety, peace, security and well-being of our people. Among these conditions are chronic hunger; malnutrition; illicit drug problems; organized crime; corruption; foreign occupation; armed conflicts; illicit arms trafficking; terrorism; intolerance and incitement to racial, ethnic, religious and other hatreds; xenophobia; and endemic, communicable and chronic diseases.[15]

Among the commitments of the Summit were: creating an economic, political, social, cultural and legal environment that will enable people to achieve social development; eradicating poverty; promoting non-discrimination; promoting equality and equity between women and men; and promoting and attaining the goals of universal and equitable access to quality education, the highest attainable standard of physical and mental health, and access of all to primary health care.[16]

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[14] Copenhagen Declaration on Social Development and Programme of Action of the World Summit for social Development *in Report of the World Summit for Social Development* (Copenhagen, 6-12 March 1995), ¶ 5, U.N. Doc. A/Conf.166/9 (1995) [hereinafter Copenhagen Declaration and Programme of Action].

[15] *Id.* ¶ 20.

[16] *Id.* at 68, 9-15.