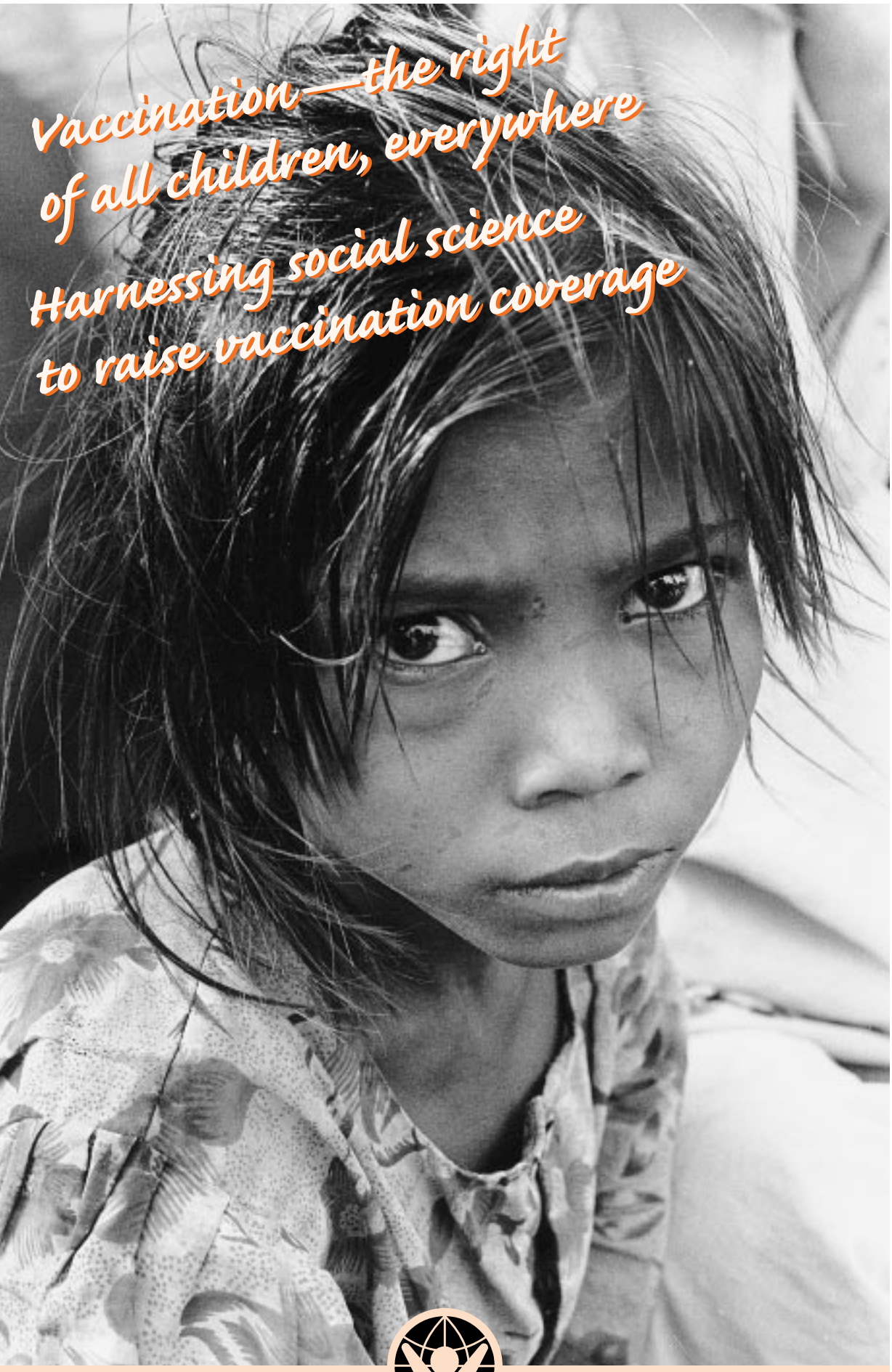
C V I F O R U M



Vaccination—the right of all children, everywhere

Harnessing social science to raise vaccination coverage

Number 17
November 1998

In this issue

CHILDREN'S VACCINE INITIATIVE

Vaccination—now the right of all children

The Children's Vaccine Initiative (CVI) is a global coalition of organizations from the public, non-governmental and private sectors, including the vaccine industry, working together to maximize protection against infectious diseases through the development and utilization of safe, effective, easy-to-deliver and widely available vaccines. The CVI was launched at the World Summit for Children in 1990 and is cosponsored by the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Health Organization (WHO), the World Bank and the Rockefeller Foundation.

Cover photo: UNICEF/Shehzad Noorani

What right does a child have to vaccination? Answer: as basic a right as the right to life. What responsibility does a government have to provide vaccination? Answer: as basic a responsibility as that to defend the lives of its citizens.

Currently, vaccination is estimated to be saving the lives of some three million children a year and preventing disability in a further 750,000. At $15 a child — for children in the poorest countries[1] — its billing as "the world's greatest health bargain" is clearly merited.

Yet, about 25 million children are not getting their share of the bargain. In some places, notably Africa, barely 50 % of infants are fully immunized. Even in some rich countries up to a third of children are not getting all their vaccines. Worldwide, two million children are dying every year from diseases preventable by the basic vaccines and a further five to six million from diseases preventable by newer, more expensive vaccines that are either available now (at least in many industrialized countries) or will be in the near future.

To bring all currently available vaccines to all children, estimates Ralph Henderson, former head of WHO's Expanded Programme on Immunization and until recently WHO Assistant Director-General, would require an extra $700 million —$5 per infant or 12 cents per capita — in donor funding[2]. "How is it possible," he asks, "that something so cost-effective and readily available is not reaching every child?" With over $130 per person being spent on the military machine in a global economy now running close to $30 trillion, the answer, he charges, "is not only a failure of leadership — it is a moral outrage."[2]

A moral outrage that calls for a moral response. That makes vaccination of children more than one medical or technical option among many, more even than one priority among others queuing for resources. That makes vaccination a moral responsibility, even an obligation, for parents and families and all adults, all governments, everywhere, whatever their resources. That makes, in other words, vaccination a right.

UNICEF/Shehzad Noorani

An individual with a right to protection against disease.

UNICEF/Shahzad Noorani

Children claiming their rights, governments fulfilling their responsibilities, diseases deprived of their victims.

"How is it possible that something so cost-effective is not reaching every child? The answer is not only a failure of leadership — it is a moral outrage."

Dr Henderson puts it this way : "Immunizing children is not a matter of charity, it is a matter of fulfilling a fundamental human right… When something becomes a right, it means that every child is entitled to it, not just those who are easy to reach… not just the first 80 per cent but also the last 20 per cent : institutionalized children, children living on the streets, the hill tribe children in Thailand, the Romanies in Bulgaria and Romania, the isolated villagers in Nigeria."

Many members of the public health community interviewed by *CVI FORUM* for this article believe that giving vaccination the status of a right would lend moral and legal weight to their efforts at defending the health of children around the world and at convincing governments to put national immunization programmes high among the top priorities for resources.

* * *

In fact, vaccination *is* a right, enshrined by implication or explicitly in at least eight legally binding international instruments (see pages 4 and 5). In the text of only one, however — the 1988 "Protocol of San Salvador" — is it explicitly spelled out as a right. In all others, it is inferred as part of the right to health or to protection against disease.

Without doubt the most powerful instrument and the one most pertinent to child immunization is the Convention on the Rights of the Child (CRC), adopted by the UN General Assembly in November 1989. It has certainly been the most widely and most rapidly accepted. Within one year of its adoption, it was ratified by 60 countries and at this writing has been ratified by 191, leaving only two — the U.S. and Somalia — still to ratify (the U.S. has signed but not ratified, and Somalia has no internationally recognized government to sign or ratify.)

Two billion, or 96 %, of the world's under-18-year-olds are covered by the CRC. The Convention does not name immunization as such, but its calls for "the application of readily available technology" to combat disease and for the development of "preventive health care" certainly imply immunization. More explicitly, the UN Committee on the Rights of the Child that monitors progress in observance of the Convention asks governments reporting to it — as the Convention requires them to do at

4.

International treaties and declarations recognizing health or vaccination as a right

1924 — Declaration of the Rights of the Child ("Declaration of Geneva"), endorsed by the League of Nations

❍ *"The child must be given the means requisite for its normal development, both materially and spiritually."* Point 1

1946 — WHO Constitution, adopted by the World Health Assembly

❍ *"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."* Preamble

1948 — Universal Declaration of Human Rights, adopted by the United Nations General Assembly

❍ *"Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including…medical care and necessary social services… …Motherhood and childhood are entitled to special care and protection…"* Art. 25 (1, 2)

1948 — American Declaration of the Rights and Duties of Man, approved by the Ninth International Conference of American States

❍ *"the right to the preservation of…health through sanitary and social measures… to the extent permitted by public and community resources."* Art. XI

1959 — Declaration of the Rights of the Child, adopted by the United Nations General Assembly

❍ *"..the child, by reason of his physical and mental immaturity, needs special safeguards and care…before as well as after birth… The child shall…be entitled to grow and develop in health; to this end, special care and protection shall be provided."* Preamble, Principle 4

1961 — European Social Charter, adopted by the Council of Europe

❍ *"…to prevent, as far as possible epidemic and endemic diseases…"* Art. 11

1966 — International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations General Assembly

❍ *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health…The steps to be taken…to achieve the full realization of this right shall include… the provision for the reduction …of infant mortality and for the healthy development of the child [and] the prevention…of epidemic, endemic…and other diseases."* Art. 12 (a, b)

1981 — African Charter on Human and Peoples' Rights, adopted by the Organization of African Unity

❍ *"the right to enjoy the best attainable state of physical and mental health."* Art. 16

1987 — WHO and UNICEF Declaration of Alma-Ata, adopted by the International Conference on Primary Health Care

❍ *"…health is a fundamental human right and …the attainment of the highest possible level of health is a most important world-wide social goal…"* Art. I

1988 — Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador), adopted by the Organization of American States

❍ *"the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being...and, particularly, to adopt the following measures to ensure that right:…Universal immunization against the principal infectious diseases; Extension of the benefits of health services to all individuals…; Prevention and treatment of endemic, occupational and other diseases;…Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable."* Art. 10 (1, 2b, c, d, f)

1989 — Convention on the Rights of the Child, adopted by the United Nations General Assembly

❍ *"…every child has the inherent right to life…States Parties shall ensure to the maximum extent possible the survival and development of the child…the right of the child to the enjoyment of the highest attainable standard of health…ensure that no child is deprived of his or her right of access to such health care services…shall take appropriate measures to diminish infant and child mortality…to combat disease…through,* inter alia, *the application of readily available technology…To develop preventive health care…"* Art. 6, 26

1990 — World Declaration on the Survival, Protection and Development of Children, adopted at the World Summit for Children

❍ *"There is no cause which merits a higher priority than the protection and development of children…"* Plan of Action, para. 36

1990 — African Charter on the Rights and Welfare of the Child, adopted by the Organization of African Unity

❍ *"Every child shall have the right to enjoy the best attinable state of physical, mental and spiritual health…and in particular shall take measures to reduce infant and child mortality rates…[and] to develop preventive health care…"*

1990 — International Convention on the Protection of the Rights of all Migrant Workers and their Families, adopted by the United Nations General Assembly

❍ *"Members of the family of migrant workers shall…enjoy equality of treatment with nationals…in relation to…access to social and health services…"* Art.43

1993 — Vienna Declaration and Programme of Action on the rights of the child, adopted by the World Conference on Human Rights.

❍ *"National and international mechanisms and programmes should be strengthened for the defence and protection of children…underlines the importance of major national and international efforts…for promoting respect for the rights of the child to survival, protection, development and participation…particular priority should be placed on reducing infant and maternal mortality rates…"* Part I, 21; Part IIB, 4

1997 — Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, adopted by the Council of Europe

❍ *"Parties… shall take appropriate measures with a view to providing… equitable access to health care of appropriate quality."* Art. 3

1998 — Declaration on the Right of the Child to Health Care ("Declaration of Ottawa"), adopted by the World Medical Association

❍ *"Every child has an inherent right to life, as well as the right of access to the appropriate facilities for health promotion [and] the prevention...of illness...Every effort should be made to protect to the maximum extent possible the survival and development of the child...to secure for every child the provision of adequate...health care...with emphasis on primary health care...[and] to develop preventive health care..."* Art. 4, 4 (i, v, viii)

regular intervals — to include a description of the measures they have taken "to diminish infant and child mortality [and] to ensure a universal immunization system."[3]

Human, healthy and immunized

Human rights really took off in the mid-1940s, starting with political and civil liberties, then taking in social and economic rights and more recently embracing environment and broad development issues.

Nine years ago, children got their very own rights instrument with the adoption of the Convention on the Rights of the Child. In 1990, a world summit gave special focus to children's health issues and sparked the creation of the Children's Vaccine Initiative later the same year.

and both refer to health as a human right. Since then, health has been woven into most international human rights instruments.

Interestingly, the Declaration of Alma-Ata, which in 1987 launched WHO's pivotal primary health care policy, emphasizes human dignity, participation, equality and concern for vulnerable population groups — four underpinnings of the human rights movement. Legal or linguistic purists aside, few people today flinch at the expression, "the right to health" or feel the need to spell out its full meaning as, for example, "the right to health services."

As one group of human rights activists[5] notes, health and human rights have developed "an inextricable relationship [with] enormous practical consequences." One such

UNICEF/Francene Keery

The right to vaccination to enjoy the right to survival to enjoy the right to moments like this.

By the mid-1990s, many organizations, both governmental and non-governmental, had taken up the child rights banner (interestingly, of the 558 organizations listed by UNESCO as dealing with early childhood in Europe and North America, one quarter now have child rights on their agendas[4]).

Whether by chance or design, the two instruments generally accepted as the canons of, respectively, human rights and health — the Universal Declaration of Human Rights and the WHO Constitution — both appeared on the scene within a few years of each other

consequence is that "the extent to which human rights are realized may represent a better and more comprehensive index of well-being than traditional health status indicators." The converse is already in almost daily use: the committee set up to monitor implementation of the CRC uses health as an indicator of respect for children's rights.

"Immunization is such a doable, cost-effective intervention, with a tremendous impact on health. If a child isn't at the very least receiving immunization, it's a first indicator that a government is not as committed to children and their health rights as it should be."

Every human being, rich or poor, young or old, has the right to vaccination.

Even more inextricable is the relationship between health and immunization. Over the first half of this century, immunization progressively graduated from an emergency response to epidemics to become an integral part of preventive health services. Indeed, a recent international expert study[6] concluded that "immunization… [is] the most cost-effective essential public health function." The WHO ranks immunization as the fifth of the eight essential components of primary health care (after health education, proper nutrition, safe water and sanitation, and maternal and child health care) and since 1979 has used immunization coverage as an indicator of countries' progress in achieving the "global health-for-all" strategy[7]. This year, for the first time, the WHO will use immunization coverage rates in conjunction with the human development index[8] as an indicator of the funds a country needs to strengthen its health services.

Paediatrician Nafsiah Mboi, rapporteur of the Committee on the Rights of the Child and a former official of the Indonesian health ministry, is the only representative of the health sector among the Committee's ten members. "We always ask the WHO," she says, "to provide information about immunization in the countries scheduled for review by the Committee and if we have information that coverage is low, we ask the government concerned to do something about it, as part of an overall improvement of the country's health system."

At the Convention's secretariat in Geneva, Paulo David points out that the Committee's interest in immunization data focuses not so much on the percentage of children vaccinated but more on those not vaccinated. "Who are they? The handicapped, the unregistered, the migrant children? That's what the Committee looks for. We distrust classical indicators."

There is, moreover, evidence that immunization coverage, suitably broken down ("disaggregated") may be a good barometer of social and economic equity, a central tenet of human rights. One example is the finding of a U.S. national vaccination survey that, in 1996, coverage levels for routine vaccination were 4 to 11 percentage points lower for children living below the poverty level than for those above it[9]. Moreover, surveys conducted by the Demographic and Health Surveys programme (a project funded by the United States Agency for International Development) in 28 developing countries between 1990 and 1994 showed vaccination coverage rates to be significantly lower in rural vs. urban children, in children with uneducated vs. educated mothers, in children of higher vs. lower birth order (higher birth order — fourth child or higher — is associated with low socioeconomic status) and in children living in households with no radio (a reflection of low socioeconomic status) vs. in households with a radio (and a higher socioeconomic status).[10]

"The Convention on the Rights of the Child lends credibility and objectivity to our attempts at raising the importance of vaccination in the minds of government officials. It helps us convince them that vaccination is not only highly cost-effective but also an essential service and deserves a specific budget line."

"Twenty-three percent of the world's children under 12 months of age are not immunized against measles and are thus being denied their "fundamental right to health care."

World Bank health specialist Amie Batson believes that coverage of the child population by national immunization programmes is an excellent indicator of government responsiveness both to child health and to equity: "Immunization is such a doable, cost-effective intervention, with a tremendous impact on health. If a child isn't at the very least receiving immunization, it's a first indicator that a government is not as committed to children and their health rights as it should be. Immunization status is also one of the most basic, universal and measurable indicators, whether a child is in the jungle or the desert or a high-tech physician's office. So in and of itself, immunization is both equitable and a quintessential indicator of equity."

Adding value to common sense

The logical link between human rights, health and immunization is clear. But what, apart from logic, is the point or added value of hoisting child vaccination onto the human rights bandwagon? Of declaring vaccination the right of each and every child?

For one thing, it makes moral sense. The dictionary defines a right as *that which is morally or socially correct or just or good or proper.* It is the sense of Dr Henderson's "moral outrage" at the exclusion of millions of children from the benefits of immunization.

It also makes legal sense. The dictionary gives a second definition of a right as *something to which one has a just or fair claim.* "What is revolutionary for organizations like UNICEF and WHO," says the CRC's Mr David, "is that making health and immunization part of a legal convention takes them out of the domain of charity. This hits at the very root of the problem."

The legal and social implications of the CRC have been the subject of much debate. Some question the feasibility of making children, ie. legal minors without legal responsibility, the subjects of a legal covenant. In fact, the 1990 African Charter on the Rights and Welfare of the Child is one of the few — if not the only — legal treaty to include in its articles the responsibilities of the child (Article 31).

However, Sev Fluss, formerly WHO Programme Manager for Human Rights and prior to that chief of health legislation with the organization, points out : "An international treaty, like the Convention on the Rights of the Child, clearly places the responsibility on the State for meeting its terms and for enacting legislation that implements those terms."

UNICEF Deputy Director Stephen Lewis, who has no doubts about the usefulness of the Convention, even makes a virtue of its mix of modes: "It is the only binding international convention [in] which… every single right is equal: traditional economic, social, cultural, political, and civil. The rights to health and to education are equal in every respect to the rights to freedom of religion or freedom of speech."[11] Dr Mboi is even more emphatic: "The very thing that makes the Convention so special and so powerful is its indivisible and interdependent nature. It's not just a list of rights. It regards the child as a whole, and gives the child a new status as an actor in life, as the subject of his or her actions, not just the object of actions by others."

Above all, though, giving immunization the status of a right does makes common sense. What self-respecting government would deliberately deprive a child of a simple, effective method of protection against a lethal or crippling disease? What government would fail to make sure that this method was made available to all the children for whom it is responsible — especially a government that has signed and ratified a legally binding commitment to that effect? Well, a look at immunization coverage data suggests that there are governments who do fail to live up to this responsibility and commitment for a variety of reasons — among them, inertia or inadvertent negligence, and lack of awareness that immunization tops the list of cost-effective health interventions[16] and should therefore be given top priority for allocation of limited resources.

Lack of resources is a common reason given by governments, especially of poor countries, for not ensuring immunization of all the children they are responsible for. The CRC does state that countries should implement its terms relating to economic, social (including health) and cultural rights "to the maximum extent of their available resources…" At the same time, the CRC Committee makes it clear that "…lack of financial resources cannot be used as a justification for neglecting to establish social security programmes," [12] that " priority be given in budget allocations to the realization of the economic, social and cultural rights of children, with particular emphasis on health and education…"[13]

Inside the Convention on the Rights of the Child

The Convention on the Rights of the Child is unique in the way governments have responded to it: no other human rights instrument has been ratified so quickly by so many. Within nine months of its adoption in 1989 by the UN General Assembly it had garnered the 20 ratifications needed to become part of international law. Today it has 191 "states parties", leaving only two holdouts: the U.S. (that has signed but not ratified) and Somalia. (In the roster of human rights treaties, the Convention on the Elimination of All Forms of Discrimination Against Women, adopted in 1979 and now with 161 states parties, comes a fairly close second.)

What explains its success? Nafsiah Mboi, paediatrician and member of the Convention's monitoring committee, gives six reasons :

❍ Children are special "and not many governments want to be accused of not caring about them."
❍ The process of drafting the Convention was done slowly and carefully (it took ten years) and resulted in a document acceptable to all cultures and systems.
❍ It came at the end of a 40-year discourse on human rights (since the 1948 Universal Declaration) and people were suitably "primed".
❍ Compared with many other treaties, it is not so legally threatening to governments and emphasizes more its use as a tool for achieving progress through dialogue and persuasion.
❍ It is seen by many governments, particularly of poor countries, as a tool for putting pressure on international organizations to provide aid, not out of charity but as an obligation.
❍ It was championed by UNICEF, particularly by its former Executive Director, the late James Grant, who "bulldozed" many of the participants at the 1990 World Summit for Children into signing it.

What about the two laggards? Somalia's reason for not signing is that it doesn't have an internationally recognized government. For the U.S. there are three main reasons. One is that no other treaty involves family law or family life so extensively and intimately. The second is virulent opposition by a militant minority[21]. The third is a strongly federalist political system, the fact that family life is traditionally within state purview and the political responsiveness of a number of states to the arguments of the militant minority. The three reasons combined result in political inertia.

The Convention's 54 articles, which its proponents insist should be taken as a whole, centre on four basic rights — to life, survival, development and expression of opinion. (Opponents to the Convention who fear that it condones juvenile mayhem may not have read Article 5, which urges states parties to respect the responsibilities of parents "to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of [his or her] rights…")

Most of the "dialogue and persuasion" that the Convention favours is the work of its monitoring committee, more formally entitled "Committee on the Rights of the Child." The Committee is made up of ten individuals — currently, four men and six women — elected every two years in their individual capacities from a list of nominees put forward by all the states parties. Committee members come from all continents and many walks of life — law, medicine, politics, journalism, development, social science, and so on.

The Committee's job is to monitor implementation of the Convention. It does this through a number of tools and procedures. The basic tool is a report that each government has to submit to the Committee within two years of ratifying the Convention and every five years thereafter. This report should show the Committee what the government is doing to implement the Convention in the different areas it covers.

The Committee meets for three four-weekly sessions a year at its Geneva headquarters. Three of the four weeks are devoted to a discussion of several, usually three to six, country reports. The discussion takes place between the Committee and representatives of the reporting countries. It is public and often attended by the media and other interested bodies (WHO, UNICEF, etc.). At the end of the third week, the Committee produces its "concluding observations and recommendations." The fourth week of the session is devoted to a so-called "pre-sessional" or preliminary discussion of country reports that will be considered fully at the next main session of the Committee. The pre-sessional discussion is not public and takes place between the Committee members, UN agencies and interested non-governmental organizations (NGOs). It is at the pre-sessional discussion that the Committee often learns from knowledgeable sources working within the country about gaps in a government's country report. Dr Mboi gives an example of how the dialogue can take an awkward turn. "The Committee has learned," the chairperson addresses the country's representatives, "that your measles immunization coverage rate has fallen from 65 % to 40 % in the past two years. Can you explain this?" The government officials, Dr Mboi says, "may be flabbergasted: 'How do you know this?' they may ask." (The information may have come from an NGO, during a pre-sessional discussion.) The next question from the Committee could well be: 'What action are you going to take?' During pre-sessional discussions the Committee may also learn about progress the country is making in addressing child rights or about stumbling blocks that could account for lack of progress in some areas.

At this writing, the Committee has received 125 country reports and has considered 89 of them. The backlog and resulting delay often allow countries to rectify problems and address concerns.

Generally, countries are " very collaborative," Dr Mboi notes. "But some obviously don't have any interest at all in children's rights. And that's when we point to the Convention and say: 'But you've signed this. You've ratified this. What are you going to do about this violation?' And believe it or not, they generally always back down and agree, at least verbally, to take action. But the important thing is: the dialogue has started, the process of making countries publicly accountable is under way and progress in their implementation of the Convention becomes possible."

"For the first time States become internationally and publicly accountable for their treatment of children."

"Some countries don't have any interest in children's rights. That's when we point to the Convention and say: 'But you've signed this. You've ratified this. What are you going to do about this violation?' And believe it or not, they generally always back down and agree to take action. But the important thing is: the dialogue has started, the process of making countries publicly accountable is under way."

and that "the best interests of the child is a guiding principle… ensuring that the maximum extent of resources are made available for children's programmes, in reviewing budget allocations…" [14]

For the late Jonathan Mann, U.S. human rights activist and AIDS expert, and his colleagues at the François-Xavier Bagnoud Center for Health and Human Rights at the Harvard School of Public Health in Massachusetts, "the rights approach… implies rejection of a solely market-based approach to the social good of health care and health status. Cost-containment and cost-benefit analyses in health care allocation remain important but need not be determinative in matters of social goals relating to health." [15]

Virginia A. Leary, Distinguished Service Professor of Law at the State University of New York in Buffalo, points out that "the correlation between a lack of resources and poor national health does not always exist: certain low- and middle-income countries show considerably better health statistics than other developing countries." She cites Sri Lanka, with a life expectancy at birth (73 years for 1997) only a few years short of many industrialized countries (and, she could have added, immunization coverage rates for the basic vaccines well above those of some rich countries).[15]

It clearly also makes economic sense to regard vaccination as a right. Peter Newell, who chairs the Council of the UK's Children's Rights Development Unit and is co-author of an *Implementation Handbook for the Convention on the Rights of the Child,* says: "If only in economic and social terms, it pays countries to be attentive to the needs of children. If they don't, the costs will rise in a multitude of areas as their neglected children get older." The World Bank pointedly suggests that "governments in developing countries should… double or triple spending on basic public health programs such as immunization…" and should forego spending on less cost-effective interventions within or outside the health sector.[16]

A stamp of moral authority

Officials of public- and private-sector organizations devoted to fostering public health welcome the CRC as a moral goad with which to prod governments into more energetic action in favour of child health and vaccination.

CVI Coordinator Roy Widdus, for example, says "it lends credibility and objectivity to our attempts at raising the importance of vaccination in the minds of government officials in countries. It helps us convince them that vaccination is not only highly cost-effective but also an essential service and deserves a specific budget line. It allows us to say: 'Look, you signed this covenant. How are you going to reflect your acceptance in your national laws and their implementation?' It also gives us access to a wider range of officials in different sectors of government — social, financial, economic, educational — than we have with immunization as a purely health measure within the specific domain of the health ministry."

UNICEF's Stephen Lewis concurs: "It allows us to place national immunization… before a government, not as a necessary requirement for children, but as an obligation under the Convention. It also allows us to go to a government like Angola or to the warring factions in Afghanistan… or in Sri Lanka, and ask them to lay down their arms for a period of time and to create a corridor of peace through which the immunization of children can be delivered. All in the name of the right, which is conferred by the Convention, and which we now use time and time again." [11]

This year being the 50th anniversary of the Universal Declaration of Human Rights, UNICEF, which recently integrated child rights into its mission statement and its country programmes, gives exceptional prominence to the CRC in its major annual publications. Its *Progress of Nations*[2] for 1998 charges that every year about 40 million births are not registered: that means that those unregistered children could be deprived of their basic vaccines if they live in the eight countries of the world where a birth certificate is required for immunization. The UNICEF report also notes that 23 % of the world's children under 12 months of age are not immunized against measles and are thus being denied their "fundamental right to health care." In its *Annual Report,* UNICEF Executive Director Carol Bellamy urges progress "to a new global agenda for children in the 21st century — an agenda solidly rooted in child rights" and calls for "a culture of rights reaching from the top layers of government to every household."

Bjørn Melgaard, head of the WHO's Global Programme on Vaccines and Vaccination (GPV), believes "the really important thing is that the Convention compels governments to

advocate and provide vaccination to all children. But it is not a legal instrument to force parents to immunize children or to punish parents who don't. At the same time, for the moral force of the Convention to have any impact on the ground, its terms must be a part of a country's national public health laws. Generally speaking, however, the countries most in need of a boost to their vaccination efforts have the least capacity to develop these laws and put them into practice."

Indeed, a pilot study[17] conducted last year by a WHO team in 37 selected countries spanning the development spectrum suggested that nearly half of them had no capacity for public health law. The study looked especially at countries' capacity to provide education and training in developing public health law. It is true that in certain countries the Convention is "self-executing": when a country ratifies it, it automatically becomes the country's law of the land. Some countries have legal systems, however, that require an active process of incorporation of the Convention in their national laws. As Aude L'hirondel, who is a WHO legal officer and ran the pilot study, points out, "in practice, if the Convention has to have any impact, governments must first incorporate it into their national legislation, then create the mechanisms for implementing it and finally make sure that it is enforced."

How effective a tool ?

In the last analysis, though, surely the important question is : Do rights work?

Dr Mboi is decidedly upbeat : "For us in the Committee on the Rights of the Child, this instrument is definitely making a difference. More and more countries are reviewing their domestic laws to bring them into line with the Convention's terms. More and more governments are engaging in a dialogue with us, with international multilateral organizations, with non-governmental organizations, and are, sometimes for the first time, paying attention to the state of children in their countries and are even learning about some of the abuses their children have been suffering that they didn't know or want to know about. For some countries, like mine, Indonesia, subjects like child prostitution, street children, child labour, were never mentioned before the Convention existed. Now, surveys provide statistics on these issues and we can speak about them openly, publicly."

There is also evidence that countries are creating national "structures" devoted to protecting children's rights. The Office of the High Commissioner for Human Rights (OHCHR) notes that "National commissions and inter-ministerial committees for children, national plans of action, agendas and strategies for children, child impact assessment [projects]…are becoming the rule rather than the exception. The CRC also requires all countries to review their constitutions and laws and several have developed children's rights codes or statutes."[18]

Perhaps most effective of all is the CRC's process of reporting, examining and widely disseminating much of the information its Committee receives and the observations it makes. "For the first time States become internationally and publicly accountable for their treatment of children," says the OHCHR.[18] Certainly, many of the CRC Committee's observations are acted upon: a preliminary survey conducted by the CRC secretariat found that UN agencies, including the OHCHR, UNICEF, the WHO, the World Bank and other specialized UN agencies, had begun or completed more than 300 actions directly or indirectly in response to recommendations for technical assistance made by the Committee since 1993.

Governments too are showing signs of greater commitment to vaccination: at this writing, 26 % of the poorest countries were paying a quarter of the costs of their own vaccines to an extent commensurate with their population size and gross national product (their pre-agreed "vaccine self-sufficiency target") vs. only 2 % in 1990. All other developing countries were paying 62-100 % of their vaccine costs vs. 49-80 % in 1990. The CVI's Dr Widdus is convinced that "in many developing countries health ministry officials are starting to use the Convention and similar instruments to convince the government's finance people to add a specific vaccine line to their national budgets."

* * *

When all's said and done, though, perhaps even asking if a right works is besides the point.

In the year the CRC was adopted by the UN General Assembly, Ruth Roemer, Professor Emerita of Health Services at the University of California Los Angeles School of Public

The Convention on the Rights of the Child is unique in the way governments have responded to it: no other human rights instrument has been ratified so quickly by so many.

UNICEF/Roger Lemoyne

"A ray of hope" that universal vaccination will free children everywhere, in every home, in every land, from the needless dangers of disease.

"For the parents who fear for the lives of their unvaccinated children, perhaps publicly acclaiming vaccination as a human right could offer a ray of hope."

Health, wrote[19] : "The principal function of a constitutional provision for the right to health care is usually symbolic. It sets forth the intention of the government to protect the health of its citizens…". Most advocates of vaccination would endorse that view of the "added value" of a right.

Does a symbol "work"?

Perhaps South African president Nelson Mandela is close to the point: "The Universal Declaration [of Human Rights] was adopted… only a few months after the first government which was determined to apply a policy of absolute apartheid came to power in South Africa. For all the opponents of this pernicious system, the simple and noble words of the Universal Declaration were a sudden ray of hope at one of our darkest moments."[20]

For the parents who fear for the lives of their unvaccinated children, perhaps publicly acclaiming vaccination as a human right could also offer a "ray of hope."

Notes

1 The $15 covers the UNICEF $1 cost of the basic vaccines, ie. against tuberculosis, polio, tetanus, diphtheria, whooping cough and measles, and the $14 for their administration, delivery and other logistic expenses.

2 *The Progress of Nations* 1998, UNICEF.

3 *General Guidelines Regarding the Form and Contents of Periodic Reports to be Submitted by States Parties Under Article 44, Paragraph 1 (B), of the Convention,* United Nations, CRC/C/58, 1996.

4 *Early Childhood Care & Education: Directory of Organizations in Europe and North America,* UNESCO, 1998.

5 J. Mann *et al.*, *Health and Human Rights,* Vol.1, No.1, Fall 1994.

6 Essential public health functions: results of the international Delphi study. *World Health Statistics Quarterly,* WHO, 51 (1), 44-55, 1998.

7 *Evaluation of the Implementation of the Global Statistics for Health for All for 2000:* 1979-1996, WHO, 1996.

8 Developed by the United Nations Development Programme (UNDP).

9 *Journal of the American Medical Association,* 278 (20), 1655-1656, 1997.

10 *DHS Comparative Studies 22, Childhood Immunization:* 1990-1994, Macro International Inc., Claverton, MD, USA.

11 Mr Lewis was speaking at the Second International Conference on Health & Human Rights held at Harvard University, Cambridge, Massachusetts, USA, in October 1996.

12 Concluding observations of the Committee on the Rights of the Child on the initial report of Nigeria. *Implementation Handbook for the Convention on the Rights of the Child,* UNICEF, 63, 1998.

13 Concluding observations of the Committee on the Rights of the Child on the initial report of the Syrian Arab Republic. *Implementation Handbook for the Convention on the Rights of the Child,* UNICEF, 64, 1998.

14 Concluding observations of the Committee on the Rights of the Child on the initial report of Pakistan. *Implementation Handbook for the Convention on the Rights of the Child,* UNICEF, 64, 1998.

15 *Health and Human Rights,* Vol.1, No.1, Fall 1994.

16 *World Development Report* 1993, The World Bank, Oxford University Press, 7, 1993.

17 Supra note 6, pp. 79-87.

18 *Children's Rights: Creating a Culture of Human Rights,* Office of the High Commissioner for Human Rights, United Nations, Geneva, 1998.

19 Hernan L. Fuenzalida-Puelma and Susan Scholle Connor, eds., *The Right to Health in the Americas* (Pan American Health Organization, Scientific Publication No. 509, Washington, DC) 1989.

20 *Amnesty International Report 1998,* Amnesty International Publications, 2, 1998.

21 S. Kilbourne, *Child and Family Law Quarterly,* 10 (3), 243-256, 1998.

Can social science help overcome barriers to vaccination?

National immunization programmes around the world are currently reaching about 80% of the world's children, but in some places not even half the child population is being protected with the basic vaccines. That has been the situation now for nearly half a decade. What is stymieing efforts to raise those coverage figures? Findings from a project presented at a meeting held in May in Woudschoten in the Netherlands suggest that social science may offer clues.

The *Social Science and Immunization Research Project,* as it is called, was launched five years ago by a team of Dutch and U.S. researchers with financial support mainly from the Dutch and Danish governments, and the Rockefeller Foundation. Over the past two years teams of social scientists used surveys, focus group discussions, case studies and other social science techniques to explore how people in different cultures and socioeconomic settings perceive vaccination and why they accept vaccination or, more pertinently to the ultimate aim of the project, why they do not accept vaccination.

The teams worked in six countries — Bangladesh, Ethiopia, India, Malawi, the Netherlands and the Philippines[1]. So that the overall findings could be collated and compared on completion of the project, all the teams sought answers to the same basic questions. In all five developing countries, the teams gathered information from areas with high and others with low vaccination coverage rates. In addition, three "transnational" teams investigated broad crosscutting topics — respectively, social demand for vaccination and the quality of vaccination services, immunization and the State, and global EPI[2] programming and technology development.

A major problem identified by the project teams was tension between health workers and parents.

"Knowledge about acceptance and non-acceptance of vaccination is an important addition to immunization coverage data, which are often unreliable and do not give information about future prospects of vaccination efforts," project director Pieter Streefland told the meeting. Hence the need, he said, to gather information about how people experience vaccination in order to understand what makes them accept or refuse it. Dr Streefland is professor of applied development sociology at the University of Amsterdam.

UNICEF/Sean Sprague

Removing barriers to vaccination creates barriers to disease.

"The studies show that social science can provide fresh perspectives for the managers of national immunization programmes."

UNICEF/Sean Sprague

A heavy workload can mean no time and no energy to bring children in for vaccination.

Summarizing the project's findings to date, he listed among the reasons why mothers do not bring their children in for vaccination: a heavy workload, sickness, flooding, and poorly functioning or discourteous immunization staff. Mothers in some places, he noted, harbour misconceptions about vaccination ("vaccines can cure malaria") or about the cause of a disease and its spread ("measles is caused by a shortage of blood and transmitted by flies and mosquitoes," "eating meat or dehydration can cause tetanus"). A major problem identified by the project teams in all the developing countries, with the exception of the Philippines, is tension between health workers and parents, due in some places to failure of health workers to turn up in time or at all, and in others to staff rudeness. Immunization programme staff often fail to keep proper vaccination records or to follow up drop-outs from the programme. Not surprisingly, immunization coverage data are often inaccurate and in some countries mask wide divergence of vaccine coverage rates between different provinces or districts.

Other findings of the project that could account for low vaccination coverage rates included: poor training and supervision of immunization programme staff resulting in a lack of technical competence and interpersonal skills; under-staffing of health centres and institutions; poor understanding by health workers of contraindications to vaccination; staff forcing parents to accept vaccination for their children as a condition for curative treatment; inadequate attention by staff to safety of injections (eg. syringes and needles not replaced or sterilized after each session or vaccines administered in doses up to tenfold the prescribed dose or stocked in refrigerators above the recommended temperature); poor communication by staff of vaccination information to parents, particularly regarding the risk of side-effects; shortage of supplies (vaccines, syringes, thermometers, vaccination cards, fuel to run refrigerators); and lack of health education materials.

One limitation of the project, Dr Streefland admits, may be its failure to show a measurable correlation between the study findings and non-acceptance of vaccination, despite the fact that the study teams worked in reportedly high- and low-coverage areas of the developing countries. "The problem," he says, "was that reported immunization coverage figures were found to be inaccurate and made it impossible for us to obtain statistically significant comparisons between different areas." The main thrust of the studies, though, Dr Streefland points out, was "qualitative" and aimed to provide "an

understanding of the complex social and cultural contexts of vaccination programmes." Through this approach, he adds, the project "clearly elucidated a number of problems these programmes face."

CVI Coordinator Roy Widdus agrees: "The studies show that social science can provide fresh perspectives for the managers of national immunization programmes. The CVI Secretariat together with its partners will explore how social and behavioural research could help with specific high-priority problems, like how to reach the hard-to-reach, how to improve the quality of contact between providers and parents, and, in particular, how to make better use of this contact with parents to educate them about health and vaccination and gain their confidence in the safety of vaccination."

Recommendations agreed at the Woudschoten meeting included the following:

❍ Immunization programmes should pay greater attention to local concepts of disease causation.

❍ Health reform, particularly decentralization of the health system, should be undertaken hand-in-hand with social science findings in order to avoid detrimental effects on well-established immunization programmes that are vulnerable to radical changes in the health system.

❍ Health workers should be trained in proper monitoring and record-keeping and encouraged to focus more on tracking a child's contacts with immunization services rather than on trying to reach pre-determined coverage targets (and thus being tempted to falsify data).

❍ Health workers should monitor not only vaccination data but also all births, in order to link vital data with immunization registers and provide an accurate baseline for assessing coverage rates.

❍ Health workers should be given more systematic training that focuses not only on the administration of vaccines and maintenance of the cold chain but also on interpersonal skills that instil empathy and respect. They also need to appreciate the need to communicate information about the benefits and risks of vaccination.

❍ Methodologies for assessing the quality of care provided to parents and children by immunization services should be developed in order to monitor the technical competence and interpersonal skills of health workers.

❍ Supervision of health workers should be established where it is lacking and should be based on a supportive system of incentives that provides greater motivation for accurate reporting and efficient performance at all levels, including attention to safety of injections and injection device disposal.

❍ Immunization programmes should be encouraged to employ front-line health workers rooted in the community and in direct, frequent contact with parents and children, as well as with government health services (examples are the 'anganwadi workers' in India and the 'barangay health workers' in the Philippines).

❍ A system for reporting adverse events related to vaccination and for compensating patients who experience such events should be instituted in every country.

❍ The assumption that mass immunization campaigns to eradicate a disease are beneficial to routine immunization services should be critically assessed.

❍ International agencies should be responsible for meeting the needs for funding and vaccine supplies when national systems fail to do so because of unforeseen disruption caused by, for example, political and social instability, civil unrest and withdrawal of donor aid.

Notes

1 The following institutions participated in the project: Research and Evaluation Department, Bangladesh Rural Advancement Committee (BRAC), and the International Centre for Diarrhoeal Diseases Control, Bangladesh; Department of Community Health, University of Addis Ababa, Ethiopia; Department of Sociology and the Centre for Development Economics, Delhi School of Economics, University of Delhi, India; Centre for Social Research, University of Malawi, Malawi; Medical Anthropology Unit, University of Amsterdam, and the Royal Tropical Institute, Netherlands; Social Development Research Centre, De la Salle University, Philippines; Centre for International Rural and Environmental Health (CIREH), University of Iowa, USA.

2 EPI in this context refers to national routine immunization programmes developed in conjunction with the WHO's Expanded Programme on Immunization.

Supervision of health workers should be based on a supportive system of incentives that provides greater motivation for accurate reporting and efficient performance at all levels, including attention to safety of injections and injection device disposal.

CVI award winners

This year, the CVI's biennial awards go to researchers and distinguished public health figures from Australia, Japan and the United States. The awards will be given at the meeting of the CVI's Consultative Group, to be held this year in November in Geneva, Switzerland. The Consultative Group is a biennial meeting of "partners" in the CVI. It is attended by representatives of multilateral and bilateral development and health agencies, the vaccine industry, the vaccine research community and public health institutions, national immunization programme managers, and other concerned organizations and individuals.

These are the winners of the 1998 CVI awards:

❍ Japanese researchers Yuji Sato and his wife Hiroko Sato share the CVI lifetime achievement award for "their outstanding contributions to the control of pertussis in children." Nearly 20 years ago, while working for the National Institutes of Health in Tokyo, Dr Sato and his wife developed in Japan the first acellular pertussis vaccine, which uses purified proteins of the pertussis organism (*Bordetella pertussis*), instead of the whole bacterial cell used for the traditional "whole-cell" pertussis vaccine. The newer acellular vaccines have about the same efficacy but fewer of the side-effects linked to the whole-cell vaccine, which they have almost entirely replaced in some industrialized countries. The CVI lifetime achievement awards are given "for outstanding and innovative contributions to vaccine development and dedication to expanding protection of the world's children against infectious diseases."

❍ Australian researcher Ruth F. Bishop and two U.S. researchers Roger I. Glass and Albert Z. Kapikian, share the CVI Pasteur award for their "outstanding work leading to the development of vaccines against rotavirus disease and the potential for improved control of this disease." Dr Bishop is at the Royal Children's Hospital in Melbourne, Dr Glass at the Centers for Disease Control in Atlanta, Georgia, and Dr Kapikian at the National Institute of Allergy & Infectious Diseases, part of the National Institutes of Health, in Bethesda, Maryland. The CVI Pasteur award honours outstanding recent contributions to vaccine development.

❍ Ralph H. Henderson will receive the CVI Jenner award "for his remarkable achievement in establishing the WHO's Expanded Programme on Immunization (EPI), that is now preventing the premature deaths of an estimated three million children and disability in a further three quarters of a million children annually." After heading the EPI for a decade (1979-1989) — a decade of incredible growth for the EPI — Dr Henderson became a WHO Assistant Director-General. In June this year, he joined the team of advisers to the WHO's new director-general, Gro Harlem Brundtland. The CVI Jenner award honours outstanding recent contributions to immunization.

Swiss generosity for CVI Consultative Group meeting

The CVI wishes to thank the government of Switzerland, in particular the Swiss Agency for Development and Cooperation and the Swiss Federal Office of Public Health, for their support and hospitality as hosts to the CVI's Consultative Group meeting, held this year (in November) in Geneva.

CVI FORUM is published three times a year by the Children's Vaccine Initiative (CVI).

Editor: John Maurice

Editorial office:
CVI FORUM
CVI Secretariat
c/o World Health Organization
1211 Geneva 27,
Switzerland

Telephone:
+41 (22) 791 4799

Fax:
+41 (22) 791 4888

e-mail:
cvi@who.ch