ENSURING THE HIGHEST ATTAINABLE STANDARD OF HEALTH FOR CHILDREN DEPRIVED OF THEIR LIBERTY

murdoch children's research institute

Justice Health Group

FXB Center for Health & Human Rights at Harvard University

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PREFACE

As chair of the United Nations Task Force on Children Deprived of Liberty, I would like to commend Professor Stuart Kinner, Ms Tess Kelly, Mr Alex Campbell, and others in the Justice Health Group for their research on the right to health for children deprived of liberty, which is one of the cross-cutting dimensions of the work of the United Nations Task Force.

Through analyzing current standards on healthcare for children deprived of liberty, this research shines a light on one of the most neglected areas in the protection of children in these settings. Many gaps persist in our knowledge of preexisting complex health conditions that may be further compounded by the experience of being deprived of liberty and health problems experienced by children in connection with deprivation of liberty. Similarly, very little is known about children's health outcomes after being deprived of liberty.

As recommended by the research, States must redouble their efforts to design and implement minimum healthcare standards in all places where children are deprived of their liberty, whilst also urgently increasing investment in the prevention of deprivation of liberty and in promoting alternatives to it.

All children have the right to enjoy the highest attainable standard of health, including mental health. This requires a holistic approach to health and protection from violence, as set out in the Convention on the Rights of the Child and the 2030 Agenda for Sustainable Development.

On behalf of the UN Task Force on Children Deprived of Liberty, I commend this collaborative research involving various universities and institutes, which provides crucial support to evidence-based advocacy to safeguard children's rights.

I look forward to continuing our collaboration.

Najat Maalla M'jid
Special Representative of the Secretary-General on Violence against Children
July 2023

EXECUTIVE SUMMARY

Children who experience deprivation of liberty are distinguished by a high prevalence of complex, co-occurring health needs that necessitate coordinated, high-quality healthcare. Emerging evidence of very poor health outcomes after deprivation of liberty suggests that in addition to ongoing efforts to prevent detention, more should be done to improve the health of these children, both in detention and after they return to the community. Setting and implementing minimum standards for healthcare in detention can help to drive improvements in the quality of care, and thereby improve health outcomes for children who experience deprivation of liberty.

This report identifies, critiques, and synthesises current standards for healthcare for children deprived of their liberty. It considers these standards in relation to the six settings considered by the United Nations Global Study on Children Deprived of Liberty (**Global Study**),[1] including (a) detention of children in the administration of justice; (b) children living in prisons with their primary caregiver; (c) migration-related detention; (d) deprivation of liberty in institutions; (e) detention in the context of armed conflict; and (f) detention on national security grounds. Informed by the UN System Common Position on Incarceration[2], we conclude that there are important gaps and ambiguities in relation to the current international standards for healthcare for children across these settings. The aim of this report is to identify these gaps and assist the United Nations Task Force (**UNTF**) in its efforts to support the implementation of the UN Convention on the Rights of the Child (**UNCRC**) and ensure that all children, including those deprived of their liberty in all settings, achieve the 'highest attainable standard of health.'[3]

ABBREVIATIONS

Bangkok Rules	United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders
Beijing Rules	United Nations Standard Minimum Rules for the Administration of Juvenile Justice
CESCR	Committee on Economic, Social and Cultural Rights
CRPD	United Nations Convention on the Rights of Persons with Disabilities
Global Study	United Nations Global Study on Children Deprived of Liberty
Havana Rules	The United Nations Rules for the Protection of Juveniles Deprived of their Liberty
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
LGBTQ+	Lesbian, gay, bisexual, transgender, queer or questioning
Mandela Rules	United Nations Standard Minimum Rules for the Treatment of Prisoners
Paris Principles	Principles and Guidelines on Children Associated with Armed Forced or Armed Groups
SRSG VAC	Office of the Special Representative of the Secretary General of Violence Against Children
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
UNDRIP	United Nations Declaration on the Rights of Indigenous People
WHO	World Health Organization
WHO HIPP	WHO Health in Prisons Programme

INTRODUCTION

The UN Convention on the Rights of the Child (**UNCRC**) recognises the right of all children to the highest attainable standard of health, and access to health services necessary to achieve this (Article 24.1).[3; pp7] The rights set forth in the UNCRC apply to all children everywhere, without discrimination of any kind (Article 2).[3; pp2] This includes children deprived of their liberty in any setting. However, there is a lack of clarity regarding how this international standard is applied to children deprived of their liberty.

Children who experience deprivation of liberty are distinguished by complex and co-occurring health problems, including high rates of mental illness, risky substance use, neurodevelopmental disability, and communicable and non-communicable disease.[4] Although the health and social profiles of these children vary between settings, evidence suggests that the prevalence of most health problems is higher among children deprived of liberty than among their peers in the surrounding communities.[5-7] At least with respect to children who have contact with the child justice system, there is also good evidence that certain health conditions (notably including mental illness and neurodevelopmental disability) are important risk factors for subsequent justice involvement and detention.[8] These health problems, many of which are preventable or treatable, tend to co-occur in a syndemic fashion such that multimorbidity is normative, and is typically set against a backdrop of entrenched, intergenerational disadvantage.[6,9,10]

Some health conditions may be exacerbated by being in detention, and some health conditions may develop as a result of deprivation of liberty. However, children who experience deprivation of liberty often enter detention with pre-existing, complex health needs, and many continue to have significant health needs after release from detention. As such, although every effort should be made to prevent children from being deprived of their liberty in the first place, while this practice continues to occur it can provide an opportunity (albeit a regrettable one) to identify and initiate appropriate healthcare for vulnerable and marginalized children. The standard of healthcare for children deprived of liberty is therefore an important public health and health equity issue.

The issue of physical and mental health needs and rights of children deprived of liberty received renewed attention in 2019, when the findings of the UN Global Study on Children Deprived of Liberty (Global Study) were presented to the UN General Assembly. The Global Study found that at least 7.2 million children are de facto deprived of their liberty globally each year in diverse settings including in the administration of justice, living with a parent in prison, in migration related detention, in the context of armed conflict or national security, and in institutions (including residential institutions or for notionally therapeutic reasons). The cross-cutting health theme in the Global Study summarised the global evidence on the health of children deprived of liberty in these settings. A subsequent series of papers in Lancet journals[6,8,12] expanded on the health status and healthcare needs of children in the child justice system, highlighting concerns that children deprived of their liberty frequently receive inadequate healthcare during detention, notably including inadequate mental healthcare.[13-16]

A life-course perspective

Both the Global Study and a subsequent WHO Policy Brief on Health Concerns among Children Deprived of Liberty[17,18] adopted a life-course perspective – recognising that detention is a setting through which children – typically vulnerable and marginalized children – pass. A life-course perspective recognises that children transitioning from communities into detention often come with pre-existing health concerns and healthcare experiences and that, when these children return to the community, they are likely to have significant on-going health-related needs. Understanding the health-related trajectories of these children from a life-course perspective points to the necessity for the provision of high-quality, coordinated, and continuous healthcare, before, during and after detention, thereby creating meaningful and sustained change in the lives of vulnerable children.

Not enough is known about the 'upstream' health determinants of deprivation of liberty, although it is clear that many children who experience deprivation of liberty have significant, pre-existing, and often under-treated health needs. With respect to detention in the child justice system, immigration detention, and institutional care, recent reviews have found that neurodevelopmental disability, mental health issues, trauma and maltreatment increase the risk of subsequent detention, although most of the evidence so far has come from cross-sectional studies of children already in detention. These findings underscore the importance of 'upstream' efforts to prevent deprivation of liberty, including through policies that reduce inequalities at the population level.

Children who experience deprivation of liberty are distinguished by complex and co-occurring health problems, including high rates of mental illness, risky substance use, neurodevelopmental disability, and communicable and non-communicable disease.

The health chapter in the Global Study provided a comprehensive review of the available evidence regarding the health of children deprived of liberty in all settings. Although the evidence was again limited – and predominantly focussed on high-income countries – it is abundantly clear that the burden of disease among children who experience deprivation of liberty is markedly higher than in the communities from which they come, and to which they return. Particularly with respect to detention in the child justice system, the evidence suggests that most children in detention have multiple, co-occurring health problems, necessitating coordinated, multi-sectoral care.[6] A recent global review of this evidence found that among those detained in the child justice system, between 12% and 65% have a history of self-

harm, between 22% and 96% have a substance use disorder, and between 32% and 50% have experienced a traumatic brain injury. Rates of mental illness, neurodevelopmental disability, infectious disease, and sexual and reproductive health problems are also markedly elevated.[4]

Although the majority of those detained in the child justice system are male, the prevalence of many health conditions – notably including mental illness – is significantly higher among girls than among boys.[6,22-24] Girls detained in the child justice system are a particularly traumatised and vulnerable group, and require coordinated care that is age appropriate, gender sensitive, and trauma informed.[25] Very little is known about the healthcare needs and experiences of lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ+) children deprived of their liberty, but the available evidence indicates that these children, too, are often particularly traumatised and struggling with social exclusion and dual stigma related to their LGBTQ+ status, and detention.[26] This manifests in multiple ways including violence victimisation, bullying, mental disorder, and increased rates of self-harm.[27]

At a population level it is well established that the most disadvantaged individuals – those most in need of high-quality, coordinated, and continuous healthcare – are least likely to receive it. This phenomenon is often referred to as the 'inverse care law.'[28-30] Although not enough is known about the scope or quality of healthcare in most settings where children are deprived of liberty, the available evidence suggests that the inverse care law also applies in these settings. This unfortunate reality has a disproportionate impact on First Nations children, who are over-represented in child justice settings in most if not all colonised countries.[31] For example, in Australia First Nations children comprise 5.8% of young people aged 10-17 years, but account for 53% of children in criminal justice detention. First Nations children in Australia are over-represented in criminal justice detention by a factor of 18, and this over-representation is even higher among those aged 10-13.[32] Consequently, reducing health disparities between First Nations children and other children at the population level requires both ongoing efforts to prevent incarceration among First Nations children, and ensuring high-quality, culturally capable healthcare in all places where children are deprived of liberty.[33] As the Global Study highlighted, this situation is not unique to First Nations children. Indeed, children from racial and ethnic minorities are overrepresented in detention settings around the world.[1; pp288]

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As such, further research and routine monitoring are urgently required to assess the scope and quality of healthcare, including mental healthcare, in all places where children are deprived of liberty, and in turn to drive improvements in the quality and scope of care for these children.

The COVID-19 pandemic has placed additional strains on the administration and provision of healthcare in places where children are deprived of liberty, notably including youth detention, immigration detention, and institutional care settings. UNICEF has reported that in the period from March 2020 to November 2021, 54 countries released over 45,000 children from incarceration in justice settings, to reduce the risk of SARS-CoV2 infection and to account for pandemic-related staff shortages.[34] This included one third of countries implementing alternative measures to deprivation of liberty in the child justice system, such as conditional release and reductions in new incarcerations of children. The COVID-19 pandemic has also had significant adverse impacts in immigration detention, including longer processing times, increasing length of detention, increased overcrowding, and increased difficulties accessing basic healthcare.[35] One study observed a six-fold increase in the proportion of unaccompanied minors in Paris seeking mental health consultations each week during a COVID-19 related lockdown.[36] Although this preliminary evidence is concerning, and highlights the significant health-related impacts of the pandemic on children deprived of liberty, further evidence is urgently required to inform a coordinated response. Not enough is known about the impact of COVID-19 on the health of children deprived of liberty, health services in places of detention since the onset of the pandemic, or health outcomes for these children after they return to the community.

In parallel with efforts to keep vulnerable children out of detention, the provision of high-quality, evidence-based, trauma-informed, culturally appropriate, and age- and gender-appropriate healthcare in all places of detention is critical to optimising health outcomes and ensuring that these children can reach their full potential and enjoy the highest attainable standard of health.[37] It is also crucial that children with specific requirements, such as those with disabilities, receive care that is responsive to these requirements and promotes their right to the highest attainable standard of health. Efforts to prevent children from being deprived of their liberty need not, and must not, come at the expense of investment in the best possible care for those who do experience deprivation of liberty.[12] As noted above, this is particularly important for First Nations children, given their over-representation in places of detention. Failure to uphold the highest standard of health for all children deprived of liberty will almost certainly compound health inequalities.[38]

Although almost all children who experience deprivation of liberty return to the community, remarkably little is known about their health outcomes *after* detention. This is a critical gap in the evidence base.[39] However, at least with respect to children in the child justice system, there is growing evidence of extremely poor long-term health outcomes including elevated rates of mental illness, substance use disorder, functional impairment, HIV, and preventable death due to drug overdose, suicide, and homicide.[40-45] Much of the evidence comes from

one prospective cohort study in Chicago, USA, that followed 1829 children released from detention between 1995 and 1998. After release from detention more than one in five of these young people exhibited marked functional impairment requiring coordinated care, and 7% required intensive support.[40] More than half of males (58%) and females (53%) had a diagnosable mental disorder, most commonly a substance use disorder.[43] Most had engaged in multiple HIV risk behaviours, including unprotected sex with multiple partners, and these risk behaviours were most common among youth with a substance use disorder and/or mental illness.[41] By 28 years of age 91% of males and 79% of females had ever had a substance use disorder.[44] Sixteen years after release from detention 111 of these children had died; the rate of death among girls was almost five times higher than in the general community. Among boys, 91% of deaths were due to homicide (86% gun homicide).[42] A more recent study from the US found that among 3645 children released from criminal justice detention in Ohio, the rate of death was 5.9 times higher than among community peers; the leading cause of death was again homicide (56% of deaths).[46]

Although these findings are deeply concerning, they relate to children released from criminal justice detention in one country. Recent research from Australia confirms that children released from criminal justice detention are at increased risk of preventable death, although from different causes. One study of 2849 children released from detention in Victoria, Australia between 1988 and 1999, and followed for an average of 3.3 years, found that the rate of death for males was 9.4 times higher than among the age- and sex-matched general population, and 41.3 times higher for females. In this cohort, most deaths were due to drug overdose (46%) or suicide (24%).[47] Another Australian study involving 7542 children followed for up to 14 years after criminal justice detention in the state of Queensland found that the rate of death was 6.4 times higher than among the age- and sex-matched general community. The leading causes of death in this cohort were suicide (36%), drug overdose (15%), and transport accidents (13%).[48]

Evidence that children released from criminal justice detention are at dramatically increased risk of preventable death is concerning and points to an unmet, ongoing need for support and treatment among these vulnerable young people. Death is likely the 'tip of the iceberg' for

Efforts to prevent children from being deprived of their liberty need not, and must not, come at the expense of investment in the best possible care for those who do experience deprivation of liberty.

these children, with a much larger number experiencing serious, non-fatal adverse health outcomes. Further investigation of long-term health outcomes for children deprived of liberty – in all settings – is urgently required. In particular, addressing the almost complete lack of high-quality, contemporary evidence on the health status of children deprived of liberty in much of the global south should be a top priority. Notwithstanding this, the available evidence underscores the reality that appropriate healthcare in detention is necessary but not sufficient to ensure good long-term health outcomes for these marginalized children.

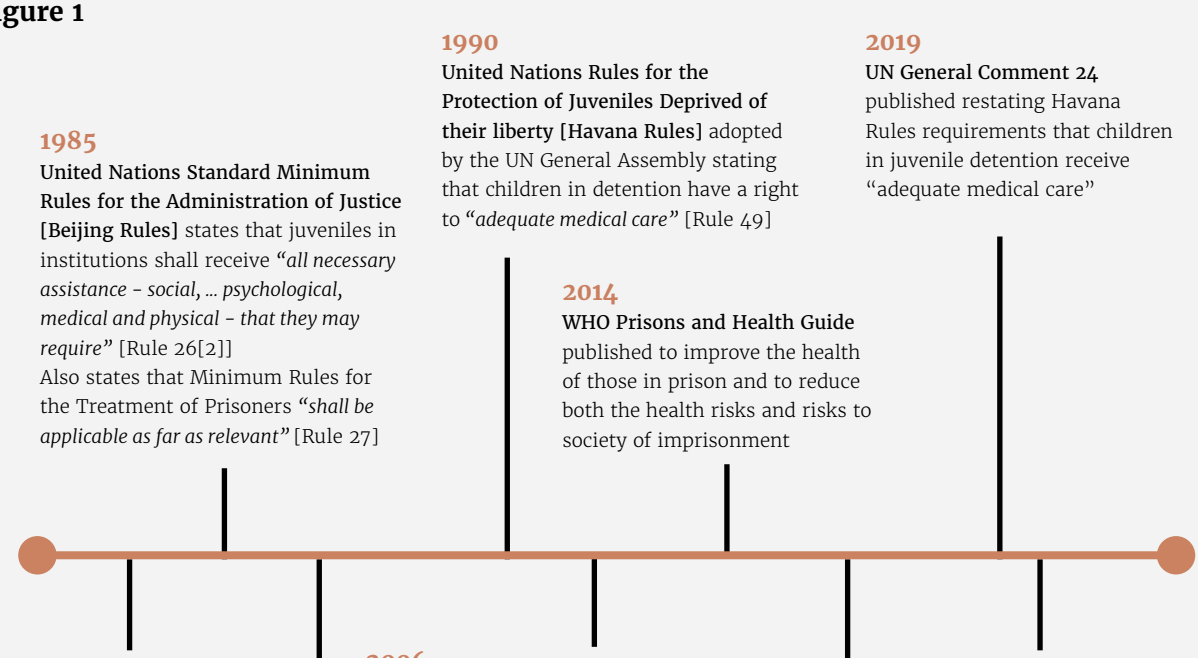
Objective of this report

This report identifies, critiques, and synthesises current standards for healthcare for children deprived of their liberty in all settings. We conclude that there is ambiguity in relation to the current international standards for healthcare for children deprived of their liberty. As such, there appears to be a need for an interpretation exercise to resolve any ambiguity and ultimately support efforts to achieve the highest attainable standard of health for all children, including those deprived of their liberty.

UN STANDARDS RELEVANT TO HEALTHCARE

The UNCRC recognises the right of all children to the highest attainable standard of health, and access to health services necessary to achieve this (Article 24.1).[3; pp7] The rights set forth in the CRC apply to all children everywhere without discrimination of any kind (Article 2).[3; pp2] This includes children deprived of their liberty in any setting. However, there is a lack of clarity regarding how this international standard applies to them. The evolution of these standards, as compared to the standards in relation to adults in prison, is depicted in **Figure 1** below. This figure demonstrates the diminution of the standard of healthcare required for children deprived of liberty in the administration of justice, and how a standard of "adequate medical care" seems to have now become accepted as the norm. This section discusses and critically analyses these standards for healthcare across diverse settings where children are deprived of their liberty.

Figure 1



1955
Standard Minimum Rules for the Treatment of Prisoners set low bar *"shall be available the services of at least one qualified medical officer [with] ...some knowledge of psychiatry" Rule 22*

1985
United Nations Standard Minimum Rules for the Administration of Justice [Beijing Rules] states that juveniles in institutions shall receive *"all necessary assistance - social, ... psychological, medical and physical - that they may require"* [Rule 26[2]]
Also states that Minimum Rules for the Treatment of Prisoners *"shall be applicable as far as relevant"* [Rule 27]

1989
UN Convention on the Rights of the Child clarifies that all children have a right to "the enjoyment of the highest attainable *standard of health*" [Article 24 [1]]

1990
United Nations Rules for the Protection of Juveniles Deprived of their liberty [Havana Rules] adopted by the UN General Assembly stating that children in detention have a right to *"adequate medical care"* [Rule 49]

2006
UN Convention on the Rights of the Person with Disablities clarifies that children with disabilities have a right to full enjoyment of *"all human rights and fundamental freedoms..."* [Article 7], and persons with disabilites deprived of their liberty are *'entitled to guarantees in accordance with international human rights laws including ... provision of reasonable accomodation."* [Article 4[2]]

2014
WHO Prisons and Health Guide published to improve the health of those in prison and to reduce both the health risks and risks to society of imprisonment

2015
Minimum Rules for Treatment of Prisoners [Mandela Rules] including specific guidance that prisoners should enjoy "the same standards of healthcare that are available in the community." [Rule 24]

2019
UN General Comment 24 published restating Havana Rules requirements that children in juvenile detention receive "adequate medical care"

2019
UN Global Study on Chidren presented to UN General Assembly, highlighting the poor health outcomes of children in detention and recommending that "health services in detention shall be of a standard equivalent to that available in the community at large"

Children's right to health

The UNCRC recognises the right of all children, without discrimination (Article 2), to the highest attainable standard of health, including the right to access the health services necessary to achieve this (Article 24.1). Article 24.2 of the UNCRC includes a non-exhaustive list of measures that State parties are required to take to implement the right to health, with a particular focus on primary and preventative care. The UN Committee on the Rights of the Child (**The Committee**) interprets children's right to health as a "right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health."[49; pp3] This holistic approach is consistent with the World Health Organization's (**WHO's**) broad definition of health as 'a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.'[50] It is also aligned with the broader focus on child development that the UNCRC promotes.[49]

The right to healthcare is also articulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights (**ICESCR**). The Committee on the Economic, Social and Cultural Rights (**CESCR**) has provided guidance that the 'highest attainable standard of health' takes into account 'both the individual's biological and socio-economic preconditions and a State's available resources,[52; pp3] and so must be understood as 'a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.'[52; pp3] Although it is acknowledged that the nature of these facilities, goods, services and conditions will vary 'depending on numerous factors, including the State party's development level,' the CESCR emphasises in General Comment 14 that these services must be 'accessible to everyone without discrimination', especially the most vulnerable or marginalized sections of the population.[52; pp4]

The right to health for adults in prison

In relation to people in prisons and other places of detention, CESCR General Comment 14 clarifies that States are under an obligation 'to respect the right to health by, ***inter alia***, refraining from denying or limiting equal access for all persons, including prisoners.' This standard is reiterated in the UN Standard Minimum Rules for the Treatment of Prisoners, which were updated 2015 and renamed ***the Mandela Rules***, requiring that ***'prisoners should enjoy the same standards of healthcare that are available in the community'*** (emphasis added). This is often referred to as the principle of equivalence. The Mandela Rules set the minimum standards in relation to access to comprehensive healthcare, continuity of care, record keeping, information sharing and confidentiality, transfers to hospital and specialist services, ethical considerations, and healthcare rights of women (and their children) in prisons.

These rules provide clear guidance for states about the minimum standards for the delivery of healthcare to people in prisons. However, they are less clear in their applicability to "institutions set aside for young people including juvenile detention facilities or correctional

schools."[53;pp7] In 1985 the UN General Assembly adopted the UN Standard Minimum Rules for the Administration of Justice ***(the Beijing Rules)***, which specifically stated that the Standard Minimum Rules for the Treatment of Prisoners "shall be applicable as far as relevant to the treatment of juvenile offenders" (Rule 27). However, in 2015 when the Standard Minimum Rules for Treatment of Prisoners were updated (and renamed the Mandela Rules), whilst the Preliminary Observations specifically noted that Part I (which includes the healthcare rights) would "in general" apply to juvenile institutions, the Rules themselves explicitly stated that they "do not seek to regulate juvenile detention centres". This had the unfortunate consequence of compounding the lack of clarity regarding healthcare rights for children deprived of liberty in the administration of justice, as demonstrated in Figure 1 above.

In 2014, at the same time the Mandela Rules were being updated, the WHO Health in Prisons Programme (**WHO HIPP**), within the WHO Regional Office for Europe, published a book entitled *Prisons and Health.* This book develops guidelines regarding standards for the provision of health services in prisons, emphasising that State parties have a 'special duty of care for those in places of detention,' and articulating strategies for meeting this duty of care. There is, however, currently no equivalent guidance or document for children deprived of liberty in the administration of justice.

Children deprived of liberty with a parent in prison

There are specific rules that apply to children detained with their mothers in prison in the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (***the Bangkok Rules***), which supplement the Mandela Rules. Rule 9 clarifies that "if a woman prisoner is accompanied by a child, that child shall also undergo health screening, preferably by a child health specialist, to determine any treatment and medical needs. *Suitable healthcare, at least equivalent to that in the community, shall be provided."* (emphasis added).

Children deprived of liberty in the administration of justice

As noted above and outlined in Figure 1, for children in detention, the current international standard is less clear. This section demonstrates the diminution of the standard of healthcare required for children deprived of liberty in the administration of justice, and how the lower standard "adequate medical care" seems to have now become accepted as the norm.

Beijing Rules (1985)

In 1985 the Beijing Rules were adopted by the UN General Assembly, stating that "juveniles in institutions shall receive *…all necessary individual assistance* – social, … psychological, medical and physical – that they may require because of their age, sex, and personality and in the interest of their wholesome development." (Rule 26.2). Building on the broad

articulation of the right to health established in the UNCRC, as described above, the Beijing Rules set a high standard of healthcare, including for children in the child justice system.

The Havana Rules (1990)

In 1990, the UN Rules for the Protection of Juveniles Deprived of their Liberty (***the Havana Rules***) were adopted by the General Assembly. Rather than adopting the wording of the Beijing rules or UNCRC, these rules require that States provide children in juvenile detention with *'adequate medical care.'* The Havana Rules clarify that this obligation extends to providing 'preventative and remedial care,' reiterating that care should be provided 'through the appropriate health facilities and services of the community … in order to prevent stigmatisation of the juvenile and promote self-respect and integration into the community.' Although, the term 'adequate' is not defined in the Havana Rules, CESCR General Comment 12, which discusses the term in relation to the right to 'adequate food,' essentially clarifies that "adequate" is 'to a large extent determined by prevailing social, economic, cultural, climatic, ecological and other conditions.'[57;pp3] Applying this to the concept of the right to health, 'adequacy' arguably invites and condones a lower standard than the broad and holistic right to positive health articulated in Article 24.1 of the UNCRC, and the higher bar set by the Beijing Rules and Mandela Rules as described above.

Committee on the Rights of the Child General Comment 24 (2019)

In General Comment 24 on 'children's rights in the child justice system', echoing the Havana Rules, the UN Committee on the Rights of the Child states that the minimum standard required for children deprived of their liberty in the administration of justice is the provision of '*adequate* physical and mental healthcare' (emphasis added).[58;pp20] Rather than referencing the more holistic approach to health articulated in the UNCRC, the further detail provided in the Havana Rules, or the detailed minimum standards set by the Mandela Rules, the General Comment states that children in juvenile detention have the 'right to be examined by a physician or a health practitioner upon admission' and to 'receive adequate medical care… which should be provided, where possible, by health facilities and services of the community.'[58]

As such, unlike the guidelines for adults in prison, the current framework seems to suggest that children in detention are not required to receive the same standard of health care as their peers in the community. This would be at odds with the fundamental principle of non-discrimination in the UNCRC (Article 2) and the right to healthcare (Article 24.1). It would also be contrary to guidance provided in General Comment 15, which reiterates that in implementing children's right to health, States should identify and address the 'factors … that create vulnerabilities for children or that disadvantage certain groups of children' in order to ensure health equity.[49;pp5]

Because these rules are not clarified or further specified, there is avoidable potential for discrepancies in the level of care provided to children deprived of their liberty in the administration of justice. Noting this, and in an attempt to clarify understanding of what is 'adequate,' the Global Study recommended that 'health services in detention shall be *of a standard equivalent to that available in the community at large.*' (emphasis added).

Children deprived of liberty for migration-related reasons

The healthcare rights of children deprived of their liberty for migration-related reasons are also not clearly and consistently articulated. This is a somewhat vexed issue because, as both the UN Committee on the Rights of the Child and the UN Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families have made abundantly clear – under no circumstances is the immigration detention of children allowed under international law as it is contrary to the child's best interests.

An overarching principle of the UNCRC is that all rights apply to every child within the jurisdiction of the State, without discrimination and irrespective of their nationality or migrant status (Art 2). Furthermore, Article 22 of the UNCRC requires that protection and humanitarian assistance be provided to achieve all the rights under the UNCRC for any child seeking refugee status or who is considered a refugee. Therefore, the right to the 'highest attainable standard of health' (Article 24) applies to all refugee, asylum seeker and migrant children, including those in immigration detention. This is reiterated in a joint General Comment, in which the UN Committee on the Rights of the Child and the UN Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families clarified that "every migrant child should have access to healthcare equal to that of nationals, regardless of their migration status."[59]

To provide further guidance regarding obligations relating to healthcare for refugee and migrant children, in 2018 the WHO Regional Office for Europe published the 'Health of Refugee and Migrant Children: Technical Guidance.' This document clarifies the principle of equivalence and notes apparent discrimination in provision of healthcare to refugee children. It notes that "…non-discrimination legislation implies that nations should provide care *on the same terms for*

Children with disabilities are also globally over-institutionalised and deprived of their liberty, including in the administration of justice. This is inconsistent with the guidance in General Comment 9 "on the Rights of Children with Disabilities" which clarifies that "children with disabilities in conflict with the law should not be placed in a regular juvenile detention centre by way of pre-trial detention nor by way of a punishment."[62]

both migrant and resident children."[60] This document sets out risk and protective factors for health and wellbeing among migrant children, and summarises evidence regarding health needs of newly arrived migrant children in Europe, including physical health (communicable and non-communicable diseases, and nutrition), and mental and psychological health.

Children deprived of liberty in institutions

For children deprived of their liberty in institutions, including alternative care or for notionally therapeutic reasons, Article 3 of the UNCRC makes it clear that these institutions, services and facilities 'shall conform with standards established by competent authorities, particularly with regard to health, safety, staffing and competent supervision.'[3] In relation to healthcare rights, in 2009 the UN General Assembly released 'Guidelines for the Alternative Care of Children'[61; pp16], which clarifies that carers should 'promote the health of the children for whom they are responsible and make arrangements to ensure that medical care, counselling and support *are made available as required'* (emphasis added). The guidelines also clarify that the designated entity should have responsibility for ensuring 'that the rights of the child are protected and, in particular, that the child has *appropriate care, accommodation, healthcare provision, developmental opportunities, psychosocial support, …*' (emphasis added).[61]

Children with disabilities are also globally over-institutionalised and deprived of their liberty, including in the administration of justice. This is inconsistent with the guidance in General Comment 9 "on the Rights of Children with Disabilities" which clarifies that "children with disabilities in conflict with the law should not be placed in a regular juvenile detention centre by way of pre-trial detention nor by way of a punishment. Deprivation of liberty should only be applied if necessary with a view to providing the child with *adequate treatment for addressing his or her problems which have resulted in the commission of a crime and the child should be placed in an institution that has the specially trained staff and other facilities to provide this specific treatment…"* (emphasis added).[62; pp20] This is also inconsistent with the standards adopted by the Convention on the Rights of Persons with Disabilities (**CRPD**) and the Committee, which, in its General Comment No. 5 (2017), on living independently and being included in the community, has highlighted the disproportionate levels of institutionalization of children with disabilities and the incompatibility of residential institutions with the right of children to live independently and be included in the community.[63]

In relation to healthcare standards for children who are deprived of their liberty, the CRPD clarifies that children with disabilities have a right to full enjoyment of "all human rights and fundamental freedoms on an equal basis with other children" (Article 7), and that those deprived of their liberty are "on an equal basis with others, entitled to guarantees in accordance with international human rights law … including by provision of ***reasonable accommodation"*** (Article 14(2)). The CRPD further reiterates that all persons with disabilities have the right to the enjoyment of the ***highest attainable standard of health without discrimination***

on the basis of disability, and that States parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation (Article 25).

Children deprived of liberty in the context of armed conflict

Whilst the International Covenant on Civil Political Rights (**ICCPR**) allows states to derogate from provisions during times of public emergency (Article 4), the UNCRC and CRPD do not contain derogation clauses. Indeed, Article 11 of the CRPD explicitly states that the rights of persons with disabilities must be upheld during armed conflict, humanitarian emergencies and natural disasters. Therefore, children detained in the context of armed conflict retain the right to the 'highest attainable standard of health.'

In February 2007, UNICEF published Principles and Guidelines on Children Associated with Armed Forced or Armed Groups (***the Paris Principles***). The Paris Principles noted that children who have been associated with armed forces or armed groups 'are likely to have a variety of health-related needs that may be apparent immediately or may emerge over time.'[64] However, whilst the Paris Principles provide guidance regarding addressing the health needs of children being released from armed forces or groups, they do not provide any guidance regarding standards for provision of healthcare to children detained in the context of armed conflict. The Global Study noted that "in settings of civil unrest and armed conflict, disruption to healthcare and other services may have compromised the health of entire populations, including children."; *pp116* There is a clear need for more guidance regarding standards for healthcare in this context.

Children deprived of liberty on national security grounds

Finally, as noted above, although some conventions allow derogation in times of public emergency, the UNCRC does not contain an explicit derogation clause, and allows only very narrow exceptions to its provisions.[3] Children charged in military or security courts or in relation to being "recruited and used by non-State armed groups, terrorist or violent extremist groups"*58; pp21* come within the ambit of the State's child justice system and, therefore, the relevant international norms and standards apply to these children, including the standards related to healthcare as articulated above. Again, there is a need for clear and explicit guidance to ensure the attainment of this right.

CONCLUSION

Children who experience deprivation of liberty are distinguished by complex health problems that typically precede and contribute to their detention, and that may be further compounded by experiences of detention, particularly when the quality of healthcare in detention is suboptimal. With more than seven million children experiencing deprivation of liberty globally each year, the health of these children is important to global health and to efforts to reduce health inequalities. Despite this, remarkably little is known about either the health status of children deprived of liberty, or the health services available to them in these settings. The available evidence suggests that health services in places of detention are often inadequate, although the bulk of the evidence comes from a handful of high-income, mostly Western countries.

The Global Study recommended development of mechanisms to routinely monitor and report on health status and health services in places where children are deprived of liberty. Such monitoring would provide a platform for assessing health system performance against both identified health needs and relevant standards, and could drive necessary quality improvement and reform: What gets counted gets done. However, as our analysis has demonstrated, there is inconsistency and ambiguity in relation to standards for healthcare for children deprived of their liberty. This is contrary to the fundamental principle of non-discrimination of the UNCRC (Article 2) and Article 24.1 (right to healthcare).

The United Nations System Common Position on Incarceration identified healthcare standards in criminal justice detention as an important consideration. One of the Directions for Action identified in this report is to "enhance United Nations advocacy efforts in support of Member States", specifically including ensuring that (a) "…compliance with international norms and standards related to prison management and the treatment of prisoners, including the Nelson Mandela Rules and the Bangkok Rules, is monitored and enhanced", and (b) "…rehabilitation and health services in prisons are integrated, as much as possible, in the corresponding public systems, and are provided at a similar standard as in the community" (p. 17).[2]

Informed by the findings of the UN Global Study on Children Deprived of Liberty, the UN System Common Position on Incarceration, and our analysis of the evidence and relevant standards for children deprived of liberty, below we identify a number of areas where the UNTF, State parties and UN and civil society organizations may wish to focus attention and resources, in accordance with the UNTF mandate to support implementation of the recommendations of the Global Study.

RECOMMENDATIONS

The authors make the following recommendations:

1. The UN Committee on the Rights of the Child should clarify that all children, including those deprived of their liberty in all settings, have a right to the highest attainable standard of health.

2. Consistent with this, to resolve inconsistency, the UN Committee on the Rights of the Child should either revise General Comment 24 or provide clarifying guidance to support interpretation and confirm that:

    a. Children detained in the criminal justice system have a right to the 'highest attainable standard of health', and that consistent with this;

    b. Health services in detention shall be of a standard equivalent to that available in the community at large.

3. The Havana Rules, which were adopted by the UN General Assembly in 1990, should be updated to clarify that children in criminal justice detention should enjoy the same standards of healthcare that are available in the community, in line with other key UN instruments including the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, the Beijing Rules, and the Mandela Rules.

4. In line with the recommendations of the UN Global Study on Children Deprived of Liberty, and the commitments under the UN System Common Position on Incarceration, State parties, UNTF Members, UN and civil society organizations should jointly and individually partner with researchers in developed and developing countries to:

    a. assess the health needs of children deprived of liberty in all settings, importantly including mental health and both general and disability-specific health needs of children with disabilities;

    b. document and critically review healthcare governance and financing arrangements in all places where children are deprived of liberty;

    c. assess national legal and policy frameworks for compliance with international standards;

    d. document the nature and scope of healthcare available and delivered to children deprived of liberty in all settings, considering both compliance with relevant international norms and standards, and whether this healthcare is proportionate to identified health needs;

e. identify and rigorously evaluate mechanisms for improving health outcomes for children who are deprived of liberty, informed by the evidence and in consultation with children and young people;

f. systematically review and synthesise the evidence regarding health outcomes for children after deprivation of liberty, specifically including a review of the rates and causes of death in these young people.

5. In line with the recommendations of the UN Global Study on Children Deprived of Liberty, and the commitments under the UN System Common Position on Incarceration, State parties, UNTF Members, UN and civil society organizations should collaborate on the development of practical technical guidance documents. These should be underpinned by the best evidence and based on good practices drawn from different country contexts, to support implementation of healthcare standards in all places where children are deprived of their liberty.

6. The WHO should, in cooperation with relevant State parties, UNTF Members, UN and civil society organizations, seek to adapt its existing system for routinely monitoring and reporting on health status in European prisons, for implementation globally in all settings where children are deprived of liberty, so that regional and global progress towards these standards can be measured.

REFERENCES

1. Nowak M. The United Nations Global Study on Children Deprived of Liberty. Geneva, 2019.
2. United Nations. United Nations System Common Position on Incarceration. New York: United Nations, 2021.
3. United Nations Commission on Human Rights. Convention on the Rights of the Child, adopted 7 March 1990, E/CN.4/RES/1990/74.1990. https://www.refworld.org/docid/3b00f03d30.html
4. Borschmann R, Janca E, Carter A, et al. The health of adolescents in detention: a global scoping review. ***Lancet Public Health*** 2020; 5(2): e114–e26.
5. Kinner SA, Snow K, Wirtz AL, Altice FL, Beyrer C, Dolan K. Age-specific global prevalence of hepatitis B, hepatitis C, HIV and tuberculosis among incarcerated people: A systematic review. ***Journal of Adolescent Health*** 2018; 62(3): S18–S26.
6. Borschmann R, Janca E, Willoughby M, et al. The health of adolescents in detention: a global scoping review. ***The Lancet Public Health*** 2020; 5(2): 114–26.
7. Kinner SA, Borschmann R, Willoughby M, et al. Impacts on Health of Children Deprived of Liberty. In: Nowak M, ed. The United Nations Global Study on Children Deprived of Liberty. Geneva: United Nations; 2019.
8. Hughes N, Ungar M, Fagan A, et al. The health determinants of adolescent criminalisation. ***Lancet Child Adolescent Health*** 2020; 4(2): 151–62.
9. Golzari M, Hunt SJ, Anoshiravani A. The health status of youth in juvenile detention facilities. ***Journal of Adolescent Health*** 2006; 38(6): 776–82.
10. Kinner SA, Degenhardt L, Coffey C, Sawyer S, Hearps S, Patton G. Complex health needs in the youth justice system: A survey of community-based and custodial offenders. ***Journal of Adolescent Health*** 2014; 54(5): 521–6.
11. Office of the Special Representative of the Secretary-General on Violence against Children (UN SRSG). Hidden Scars: How Violence Harms the Mental Health of Children. 2020. https://violenceagainstchildren.un.org/news/hidden-scars-how-violence-harms-mental-health-children
12. Kinner SA, Hughes N, Borschmann R, et al. The health of children deprived of liberty: A neglected human rights issue. ***The Lancet Child & Adolescent Health*** 2020; 4(1): 6–7.
13. Golzari M, Kuo A. Healthcare utilization and barriers for youth post-detention. ***Int J Adolesc Med Health*** 2013; 25(1): 65–7.

14. Furlow B. Inconsistent and inadequate health care for incarcerated youth in the USA. ***The Lancet Child & Adolescent Health*** 2020; 4(2): 104-5.
15. von Werthern M, Robjant K, Chui Z, et al. The impact of immigration detention on mental health: a systematic review. ***BMC Psychiatry*** 2018; 18(1): 382.
16. Wood LC. Impact of punitive immigration policies, parent-child separation and child detention on the mental health and development of children. ***BMJ Paediatrics*** Open 2018; 2(1).
17. Organization WH. Health concerns among children deprived of liberty: policy brief: World Health Organization. Regional Office for Europe, 2021.
18. UN General Assembly. UN Global Study on Children Deprived of Liberty. 2019. https://documents-dds-ny.un.org/doc/UNDOC/GEN/N19/213/15/PDF/N1921315.pdf?OpenElement
19. Hughes N, Ungar M, Fagan A, et al. The health determinants of adolescent criminalisation. ***Lancet Child & Adolescent Health*** 2020; 4(2): 151-62.
20. Corona Maioli S, Bhabha J, Wickramage K, et al. International migration of unaccompanied minors: trends, health risks, and legal protection. ***The Lancet Child & Adolescent Health*** 2021; 5(12): 882-95.
21. Berens AE, Nelson CA. The science of early adversity: is there a role for large institutions in the care of vulnerable children? The Lancet 2015; 386(9991): 388-98.
22. Borschmann R, Coffey C, Moran P, et al. Self-harm in young offenders. ***Suicide and Life-Threatening Behavior*** 2014; 44: 641-52.
23. Fazel S, Doll H, Langstrom N. Mental disorders among adolescents in juvenile detention and correctional facilities: a systematic review and metaregression analysis of 25 surveys. ***J Am Acad Child Adolesc Psychiatry*** 2008; 47(9): 1010-19.
24. G B, R Y, N L, S F. Mental disorders among adolescents in juvenile detention and correctional facilities: an updated systematic review and metaregression analysis. ***Journal of the American Academy of Child and Adolescent Psychiatry*** 2020; 60(1): 46-60.
25. L W, P E. Improving the juvenile justice system for girls: Lessons from the states. Washington DC: Georgetown Center on Poverty, Inequality and Public Policy, 2012.
26. P P, R O. Understanding the social and emotional wellbeing of Aboriginal LGBTIQ(SB)+ youth in Victoria's youth detention. ***Social Inclusion*** 2021; 9(2): 18-29.
27. Hail-Jares K, Cumming C, Young JT, Borschmann R, Lennox N, Kinner SA. Self-Harm

and Suicide Attempts among Incarcerated Lesbian, Gay, and Bisexual People in Australia. ***Australian & New Zealand Journal of Psychiatry*** 2023: volume 57(4), pages 562–571.

28. Furler JS, Harris E, Chondros P, Powell Davies PG, Harris MF, Young DY. The inverse care law revisited: impact of disadvantaged location on accessing longer GP consultation times. ***The Medical Journal of Australia*** 2002; 177(2): 80–3.
29. Cookson R, Doran T, Asaria M, Gupta I, Mujica FP. The inverse care law re-examined: a global perspective. ***The Lancet*** 2021; 397(10276): 828–38.
30. The Lancet. 50 years of the inverse care law. ***The Lancet*** 2021; 397(10276): 767.
31. Cesaroni C, Grol C, Fredericks K. Overrepresentation of Indigenous youth in Canada's Criminal Justice System: Perspectives of Indigenous young people. ***Australian & New Zealand Journal of Criminology*** 2018; 52(1): 111–28.
32. AIHW. Youth justice in Australia 2020–21. Canberra: Australian Institute of Health and Welfare, 2022.
33. Johnston I, Williams M, Butler T, Kinner SA. Justice targets in Closing the Gap: let's get them right. ***Australian and New Zealand Journal of Public Health*** 2019; 43(3): 201–3.
34. UNICEF. Detention of Children in the Time of COVID-19. New York, 2021.
35. You D, Lindt N, Allen R, Hansen C, Beise J, Blume S. Migrant and displaced children in the age of COVID-19: How the pandemic is impacting them and what can we do to help. ***Migration Policy Practice*** 2020; 10(2).
36. Gautier L, Nguengang Wakap S, Verrier F, et al. Responding to Increasing Health and Social Needs of Unprotected Unaccompanied Minors in Paris in the Context of COVID-19: A Mixed Methods Case Study. ***Journal of Immigrant & Refugee Studies*** 2022: 1–20.
37. R M, J F, N K, et al. Comprehensive Clinical Paediatric Assessment of Children and Adolescents Sentenced to Detention in Western Australia. ***J Fetal Alc Spect Disorder*** 2022; 4(1): 16–31.
38. Cumming C, Kinner SA, Preen D. Closing the gap in Indigenous health: Why section 19(2) of the Health Insurance Act 1973 matters [Letter to the Editor]. ***Medical Journal of Australia*** 2016; 205(6): 283.
39. Kinner SA, Young JT. Understanding and improving the health of people who experience incarceration: An overview and synthesis. ***Epidemiologic Reviews*** 2018; 40(1): 4–11.
40. Abram KM, Choe JY, Washburn JJ, Romero EG, Teplin LA. Functional Impairment in

Youth Three Years after Detention. ***Journal of Adolescent Health*** 2009; 44(6): 528-35.

41. Teplin LA, Elkington KS, McClelland GM, Abram KM, Mericle AA, Washburn JJ. Major Mental Disorders, Substance Use Disorders, Comorbidity, and HIV-AIDS Risk Behaviors in Juvenile Detainees. ***Psychiatric Services*** 2005; 56(7): 823-8.
42. Teplin LA, Jakubowski JA, Abram KM, Olson ND, Stokes ML, Welty LJ. Firearm Homicide and Other Causes of Death in Delinquents: A 16-Year Prospective Study. ***Pediatrics*** 2014; 134(1): 63-73.
43. Teplin LA, Welty LJ, Abram KM, Dulcan MK, Washburn JJ. Prevalence and persistence of psychiatric disorders in youth after detention: A prospective longitudinal study. ***Archives of General Psychiatry*** 2012; 69(10): 1031-43.
44. Welty LJ, Harrison AJ, Abram KM, et al. Health Disparities in Drug- and Alcohol-Use Disorders: A 12-Year Longitudinal Study of Youths After Detention. ***American Journal of Public Health*** 2016; 106(5): 872-80.
45. Kinner SA, Degenhardt L, Coffey C, et al. Substance use and risk of death in young offenders: A prospective data linkage study. ***Drug and Alcohol Review*** 2015; 34: 46-50.
46. Ruch DA, Steelesmith DL, Brock G, et al. Mortality and Cause of Death Among Youths Previously Incarcerated in the Juvenile Legal System. ***JAMA Netw Open*** 2021; 4(12): e2140352.
47. Coffey C, Veit F, Wolfe R, Cini E, Patton GC. Mortality in young offenders: retrospective cohort study. ***BMJ*** 2003; 326(7398): 1064-6.
48. Kinner SA, Young J, Patton G, et al. High risk of preventable death in justice-involved young people: A retrospective data linkage study. in prep.
49. UN Committee on the Rights of the Child. General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), adopted 17 April 2013, CRC/C/GC/15. 2013. https://documents-dds-ny.un.org/doc/UNDOC/GEN/G13/428/14/PDF/G1342814.pdf?OpenElement
50. World Health Organization. Constitution1946. https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1
51. UNICEF. Prepared for UNICEF by Rachel Hodgkin and Peter Newell. Implementation Handbook for the Convention on the Rights of the Child. 2007. https://www.unicef.org/reports/implementation-handbook-convention-rights-child
52. UN Committee on Economic Social and Cultural Rights (CESCR). General Comment

No. 14 (2000): The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4.2000. https://digitallibrary.un.org/record/425041?ln=en

53. UN General Assembly. United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). (Resolution 70/175), adopted 17 December 2015. https://undocs.org/A/RES/70/175
54. WHO Regional Office for Europe. Good governance for prison health in the 21st century: a policy brief on the organization of prison health. viii, 32 p., 2013. https://apps.who.int/iris/handle/10665/326388
55. UN General Assembly. United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bankgkok Rules), adopted 21 December 2010 (Resolution 65/229). 2010. https://www.unodc.org/documents/justice-and-prison-reform/crimeprevention/UN_Rules_Treatment_Women_Prisoners_Bangkok_Rules.pdf
56. UN General Assembly. United Nations Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules), adopted 14 December 1990 (Resolution 45/113).1990. https://www.un.org/ruleoflaw/files/TH007.PDF
57. UN Economic and Social Council. Committee on Economic Social and Cultural Rights (CESCR) General Comment No. 12: The Right to Adequate Food, adopted 12 May 1999, E/C.12/1999/5. 1999. https://documents-dds-ny.un.org/doc/UNDOC/GEN/G99/420/12/PDF/G9942012.pdf?OpenElement
58. UN Committee on the Rights of the Child (CRC). General Comment No. 24 (2019) on children's rights in the child justice system (CRC/C/GC/24), replacing General Comment No. 10 (2007). 2019. https://digitallibrary.un.org/record/3899429?ln=en
59. UN Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW). Joint general comment No. 4 (2017) of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families and No. 23 (2017) of the Committee on the Rights of the Child on State obligations regarding the human rights of children in the context of international migration in countries of origin, transit, destination and return, 16 November 2017, CMW/C/GC/4-CRC/C/GC/23, 2017.
60. WHO Regional Office for Europe. Health of refugee and migrant children: technical

guidance. vii + 32 p, 2018. https://apps.who.int/iris/handle/10665/342285

61. UN General Assembly. Guidelines for the Alternative Care of Children, adopted 18 December 2009 (Resolution 64/142). 2009. https://digitallibrary.un.org/record/673583?ln=en
62. UN Committee on the Rights of the Child. General comment No. 9 (2006): The rights of children with disabilities CRC/C/GC/9, 2006.
63. UN Committee on the Rights of Persons with Disabilities. General Comment No. 15 (2017) on living independently and being included in the community (art. 19), adopted 27 October 2017, CRPD/C/GC/5.
64. UNICEF. The Paris Principles. Principles and Guidelines on Children Associated With Armed Forces or Armed Groups. February 2007. https://www.unicef.org/mali/media/1561/file/ParisPrinciples.pdf