

## Right to Health with Emphasis on Children, Women and Disabilities: A Literature Review

Amir Hossein Molkizadeh<sup>1</sup>, \*Mohammad Ali Kiani<sup>1,2</sup>, Rahim Baghban<sup>1</sup>, Somayeh Rahmanian<sup>3</sup>, Masumeh Saeidi<sup>4</sup>

<sup>1</sup>Department of Law, Mashhad Branch, Islamic Azad University, Mashhad, Iran.

<sup>2</sup>Department of Pediatrics, Faculty of Medicine, Mashhad University of Medical Sciences, Mashhad, Iran.

<sup>3</sup>Mashhad Branch, Islamic Azad University, Mashhad, Iran.

<sup>4</sup>Department of Medical Education, Faculty of Medicine, Tehran University of Medical Sciences, Tehran, Iran.

### Abstract

Human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination. The right to health is the economic, social, and cultural right to a universal minimum standard of health to which all individuals are entitled. The concept of a right to health has been enumerated in international agreements which include the Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights, and the Convention on the Rights of Persons with Disabilities. There is some debate on the interpretation and application of the right to health due to considerations such as how health is defined, what minimum entitlements are encompassed in a right to health, and which institutions are responsible for ensuring a right to health.

**Key Words:** Children, Disabilities, Health, Human Rights, Women.

\*Please cite this article as: Molkizadeh AH, Kiani MA, Baghban R, Rahmanian S, Saeidi M. Right to Health with Emphasis on Children, Women and Disabilities: A Literature Review. *Int J Pediatr* 2019; 7(6): 9611-22. DOI: **10.22038/ijp.2019.39345.3353**

---

### \*Corresponding Author:

Mohammad Ali Kiani (M.D), Faculty of Medicine, Mashhad University of Medical Sciences, Mashhad, Iran.

Email: [kianima@mums.ac.ir](mailto:kianima@mums.ac.ir)

Received date: Jan.25, 2019; Accepted date: Mar. 22, 2019

## 1- INTRODUCTION

### 1-1. Human right

Human rights are "the basic rights and freedoms to which all humans are entitled" (1, 2). Examples of rights and freedoms which are often thought of as human rights include civil and political rights, such as the right to life, liberty, and property, freedom of expression, pursuit of happiness and equality before the law; and social, cultural and economic rights, including the right to participate in science and culture, the right to work, and the right to education.

### 1-2. Human right to health care

An alternative way to conceptualize one facet of the right to health is a "human right to health care". Notably, this encompasses both patient and provider rights in the delivery of healthcare services, the latter being similarly open to frequent abuse by the states (3). Patient rights in health care delivery include: the right to privacy, information, life, and quality care, as well as freedom from discrimination, torture, and cruel, inhumane, or degrading treatment (3, 4). Marginalized groups, such as migrants and persons who have been displaced, racial and ethnic minorities, women, sexual minorities, and those living with HIV, are particularly vulnerable to violations of human rights in healthcare settings (5, 6).

The WHO Constitution was the first international instrument to enshrine the enjoyment of the highest attainable standard of health as a fundamental right of every human being ("the right to health"). The right to health in international human rights law is a claim to a set of social arrangements - norms, institutions, laws, and an enabling environment - that can best secure the enjoyment of this right. It is an inclusive right extending not only to timely and

appropriate health care but also to the underlying determinants of health, for example, access to health information, access to water and food, housing, etc.

The right to health is subject to progressive realization and acknowledges resource constraints. However, it also imposes on States various obligations which are of immediate effect, such as the guarantee that the right will be exercised without discrimination of any kind and the obligation to take deliberate, concrete and targeted steps towards its full realization.

The right to the highest attainable standard of "health" implies a clear set of legal obligations on states to ensure appropriate conditions for the enjoyment of health for all people without discrimination. The right to health is one of a set of internationally agreed human rights standards, and is inseparable or 'indivisible' from these other rights. This means achieving the right to health is both central to, and dependent upon, the realization of other human rights, to food, housing, work, education, information, and participation.

The right to health, as with other rights, includes both freedoms and entitlements:

- Freedoms include the right to control one's health and body (for example, sexual and reproductive rights), and to be free from interference (for example, free from torture and non-consensual medical treatment and experimentation).
- Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health (1, 7, 8).

### 1-3. Focus on Disadvantaged Populations

Disadvantage and marginalization serve to exclude certain populations in societies from enjoying good health. Three of the world's most fatal communicable diseases—malaria, HIV/AIDS, and tuberculosis—disproportionately affect the world's poorest populations, and in many cases are compounded and exacerbated by other inequalities and inequities including gender, age, sexual orientation or gender identity and migration status. Conversely the burden of non-communicable diseases – often perceived as affecting high-income countries – is increasing disproportionately among lower-income countries and populations, and is largely associated with lifestyle and behavior factors as well as environmental determinants, such as safe housing, water and sanitation that are inextricably linked to human rights (9).

#### **1-4. Violations of Human Rights in Health**

Violations or lack of attention to human rights can have serious health consequences. Overt or implicit discrimination in the delivery of health services – both within the health workforce and between health workers and service users – acts as a powerful barrier to health services, and contributes to poor quality care. Mental ill-health often leads to a denial of dignity and autonomy, including forced treatment or institutionalization, and disregard of individual legal capacity to make decisions. Paradoxically, mental health is still given inadequate attention in public health, in spite of the high levels of violence, poverty and social exclusion that contribute to worse mental and physical health outcomes for people with mental health disorders. Violations of human rights not only contribute to and exacerbate poor health, but for many, including people with disabilities, indigenous populations, women living with HIV, sex workers, people who use drugs, transgender and intersex people, the health care setting presents a risk of

heightened exposure to human rights abuses – including coercive or forced treatment and procedures (1, 2).

#### **1-5. Human Rights-based Approaches**

A human rights-based approach to health provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes. In pursuing a rights-based approach, health policy, strategies and programs should be designed explicitly to improve the enjoyment of all people to the right to health, with a focus on the furthest behind first. The core principles and standards of a rights-based approach are detailed below.

##### **1-5-1. Core Principles of Human Rights Accountability**

States and other duty-bearers are answerable for the observance of human rights. However, there is also a growing movement recognizing the importance of other non-state actors such as businesses in the respect and protection of human rights (10).

##### **Equality and Non-discrimination**

The principle of non-discrimination seeks ‘...to guarantee that human rights are exercised without discrimination of any kind based on race, color, sex, language, religion, political, or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation’.

Any discrimination, for example in access to health care, as well as in means and entitlements for achieving this access, is prohibited on the basis of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or

other status, which has the intention or effect of impairing the equal enjoyment or exercise of the right to health. The principle of non-discrimination and equality requires WHO to address discrimination in guidance, policies, and practices, such as relating to the distribution and provision of resources and health services. Non-discrimination and equality are key measures required to address the social determinants affecting the enjoyment of the right to health. Functioning national health information systems and availability of disaggregated data are essential to be able to identify the most vulnerable groups and diverse needs.

### **Participation**

Participation requires ensuring that all concerned stakeholders including non-state actors have ownership and control over development processes in all phases of the programming cycle: assessment, analysis, planning, implementation, monitoring, and evaluation. Participation goes well beyond consultation or a technical addition to project design; it should include explicit strategies to empower citizens, especially the most marginalized, so that their expectations are recognized by the State.

### **Universal, Indivisible and Interdependent**

Human rights are universal and inalienable. They apply equally, to all people, everywhere, without distinction. Human Rights standards – to food, health, education, to be free from torture, inhuman or degrading treatment – are also interrelated. The improvement of one right facilitates advancement of the others. Likewise, the deprivation of one right adversely affects the others.

### **1-5-2. Core Elements of a Right to Health**

#### **Progressive realization using maximum available resources**

No matter what level of resources they have at their disposal, progressive realization requires that governments take immediate steps within their means towards the fulfilment of these rights. Regardless of resource capacity, the elimination of discrimination and improvements in the legal and juridical systems must be acted upon with immediate effect.

### **Non-retrogression**

States should not allow the existing protection of economic, social, and cultural rights to deteriorate unless there are strong justifications for a retrogressive measure. For example, introducing school fees in secondary education which had formerly been free of charge would constitute a deliberate retrogressive measure. To justify it, a State would have to demonstrate that it adopted the measure only after carefully considering all the options, assessing the impact and fully using its maximum available resources.

### **1-5-3. Core Components of the Right to Health**

The right to health (Article 12) was defined in General Comment 14 of the Committee on Economic, Social and Cultural Rights – a committee of Independent Experts, responsible for overseeing adherence to the Covenant (11). The right includes the following core components:

#### **Availability**

Refers to the need for a sufficient quantity of functioning public health and health care facilities, goods and services, as well as programs for all. Availability can be measured through the analysis of disaggregated data to different and multiple strategies including by age, sex, location and socio-economic status and qualitative surveys to understand coverage gaps and health workforce coverage.

### Accessibility

Requires that health facilities, goods, and services must be accessible to everyone. Accessibility has four overlapping dimensions:

- Non-discrimination
- Physical accessibility
- Economical accessibility (affordability)
- Information accessibility.

Assessing accessibility may require analysis of barriers – physical financial or otherwise – that exist, and how they may affect the most vulnerable, and call for the establishment or application of clear norms and standards in both law and policy to address these barriers, as well as robust monitoring systems of health-related information and whether this information is reaching all populations.

### Acceptability

Relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmers are people-centered, and cater to the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.

### Quality

Facilities, goods, and services must be scientifically and medically approved. Quality is a key component of Universal Health Coverage, and includes the experience as well as the perception of health care. Quality health services should be:

- Safe: avoiding injuries to people for whom the care is intended;
- Effective: providing evidence-based healthcare services to those who need them;

- People-centered: providing care that responds to individual preferences, needs and values;
- Timely: reducing waiting times and sometimes harmful delays.
- Equitable: providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;
- Integrated: providing care that makes available the full range of health services throughout the life course;
- Efficient: maximizing the benefit of available resources and avoiding waste (1, 2, 7, 8).

## 2- MATERIALS AND METHODS

The current study is a review survey which was conducted to evaluate the Right to Health by studying Human Rights, Science texts, United Nations and WHO websites. To evaluate the texts, the singular or combination forms of the following keywords were used: "Human Right", "Rights", "Women", "Children", "Disabilities", "WHO", "World Health Organization", "United Nations", "UN", and "Right to Health". To evaluate the electronic Persian databases the following websites were searched: Scientific Information Database (SID), Ministry of Healthcare, Medical Articles Library of Iran (medlib.ir), Iranian Research Institute for Information (Iran Doc), Publication Database (Magiran), and also searches in other electronic databases such as Scopus, Medline, and Cochrane Library. In addition, a manual search was conducted in Google motor engine, Google Scholar, and bibliography of related articles and reviews. Two independent researchers screened articles and texts. In the next step, full texts of probably relevant articles and texts were summarized and categorized and based on the evaluated outcomes were presented.

### 3- RESULTS

The right to the highest attainable standard of "health" requires a set of social criteria that is conducive to the health of all people, including the availability of health services, safe working conditions, adequate housing and nutritious foods. Realization of the right to health is closely related to that of other human rights, including the right to food, housing, work, education and non-discrimination; equality; access to information; and participation. The right to health comprises both freedoms and entitlements. Freedoms include the right to control one's health and body (e.g. sexual and reproductive rights), and to be free from interference (e.g. free from torture and from non-consensual medical treatment and experimentation). Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health. Health policies and programmers have the ability to either promote or violate human rights, including the right to health, depending on the way they are designed or implemented. Taking steps to respect and protect human rights upholds the health sector's responsibility to address everyone's health.



#### 3-1. WHO Response

WHO has made a commitment to mainstream human rights into healthcare programs and policies on national and regional levels by looking at underlying

determinants of health as part of a comprehensive approach to health and human rights (12, 13).

#### 3-2. Standing up for the Right to Health

More people can access essential health services today than ever before, but at least half of the world's population still go without. Those living in the poorest countries, in the most marginalized communities, face the greatest challenges in access, the highest burden of disease, and the worst health outcomes. These are the ABCs of what it will take to deliver the right to health (1, 2).

# A

Is for access.

The right to health is about ensuring that everyone, everywhere can access affordable, quality healthcare. This is the defining principle of universal health coverage: no one should get sick and die just because they are poor, because of who they are or where they were born, or because they cannot access the health services they need.

# B

Is for Breaking Down Barriers.

Achieving universal health coverage requires deliberate and focused efforts to reach those most at risk of being left behind. Whether social, cultural, structural or financial, a rights-based approach means identifying disadvantage, and breaking down barriers related to access, affordability, the quality, or availability of healthcare services.

# C

Is for Civil Society.

Ensuring the participation of communities in health policies and programs is a fundamental principle of human rights, but is also good for health outcomes. It means engaging and empowering people in the decisions that affect their health, designing health systems around the needs of people instead of diseases and health institutions, so that everyone gets the right care, at the right time, in the right place.

**D**

Is for Determinants of Health.

Health is about more than health care. It also refers to the underlying determinants that impact our current and future health: factors like the food we eat, the water we drink, the air we breathe, the houses we live in, or the education we receive.

**E**

Is for Equality and Non-Discrimination.

Inequalities can always impact on health-linked to where someone lives or where they were born, their gender, ethnicity, age, race, sexuality, asylum or migration, health or any other status. Inequality can also be reflected in discrimination and abuse that occurs in healthcare itself, affecting both health workers and service users. This undermines universal health coverage in multiple ways: by jeopardizing investment in health, deterring people from seeking healthcare, and disempowering or depriving people of their dignity.

### 3-3. WHO's Work on Gender, Equity and Human Rights

Tackling discrimination in healthcare requires a holistic and united response. It means working to strengthen service quality, raising awareness of the rights of health workers and service users - with mechanisms for redress - and tackling practices that are harmful to health (1, 2, 7).

Hunger in Yemen, REUTERS.





Hunger in Yemen, REUTERS.



### 3-4. History of Human Right to Health Care

#### Constitution of the World Health Organization (1946)

The preamble of the 1946 World Health Organization (WHO) Constitution defines health broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"(14). The Constitution defines the right to health as "the enjoyment of the highest attainable standard of health", and enumerates some

principles of this right as healthy child development; equitable dissemination of medical knowledge and its benefits; and government-provided social measures to ensure adequate health.

#### Universal Declaration of Human Rights (1948)

Article 25 of the United Nations' 1948 Universal Declaration of Human Rights states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing

and medical care and necessary social services". The Universal Declaration makes additional accommodations for security in case of physical debilitation or disability, and makes special mention of care given to those in motherhood or childhood (15).

### **International Convention on the Elimination of All Forms of Racial Discrimination (1965)**

Health is briefly addressed in the United Nations' International Convention on the Elimination of All Forms of Racial Discrimination, which was adopted in 1965 and entered into effect in 1969. The Convention calls upon States to "Prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law", and references under this provision "The right to public health, medical care, social security and social services" (16).

### **International Covenant on Economic, Social and Cultural Rights (1966)**

The United Nations further defines the right to health in Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights, which states:

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- The reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- The improvement of all aspects of environmental and industrial hygiene;

- The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- The creation of conditions which would ensure all medical services and medical attention in the event of sickness (17).

### **General Comment No. 14 (2000)**

In 2000, the United Nations' Committee on Economic, Social and Cultural Rights issued General Comment No. 14, which addresses "substantive issues arising in the implementation of the International Covenant on Economic, Social and Cultural Rights" with respect to Article 12 and "the right to the highest attainable standard of health" (18). The General Comment provides more explicit, operational language on the freedoms and entitlements included under a right to health.

### **3-5. Responsibilities of States and international organizations**

The obligations of nations are placed into three categories: obligations to respect, obligations to protect, and obligations to fulfill the right to health. Examples of these (in non-exhaustive fashion) include preventing discrimination in access or delivery of care; refraining from limitations to contraceptive access or family planning; restricting denial of access to health information; reducing environmental pollution; restricting coercive and/or harmful culturally-based medical practices; ensuring equitable access to social determinants of health; and providing proper guidelines for the accreditation of medical facilities, personnel, and equipment. International obligations include allowing for the enjoyment of health in other countries; preventing violations of health in other countries; cooperating in the provision of humanitarian aid for disasters and

emergencies; and refraining from use of embargoes on medical goods or personnel as an act of political or economic influence.

### **Convention on the Elimination of All Forms of Discrimination against Women**

Article 12 of the 1979 United Nations Convention on the Elimination of All Forms of Discrimination against Women outlines women's protection from gender discrimination when receiving health services and women's entitlement to specific gender-related healthcare provisions. The full text of Article 12 states (19):

Article 12:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

### **Convention on the Rights of the Child**

Health is mentioned in several instances in the Convention on the Rights of the Child (1989). Article 3 calls upon parties to ensure that institutions and facilities for the care of children adhere to health standards. Article 17 recognizes the child's right to access information that is pertinent to his/her physical and mental health and well-being. Article 23 makes specific reference to the rights of disabled children,

in which it includes health services, rehabilitation, and preventive care. Article 24 outlines child health in detail, and states, "Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States shall strive to ensure that no child is deprived of his or her right of access to such health care services". Towards implementation of this provision, the Convention enumerates the following measures (20-22):

- To diminish infant and child mortality;
- To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- To combat disease and malnutrition, including within the framework of primary health care, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- To ensure appropriate pre-natal and post-natal health care for mothers;
- To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- To develop preventive health care, guidance for parents and family planning education and services.

## Convention on the Rights of Persons with Disabilities

Article 25 of the Convention on the Rights of Persons with Disabilities (2006) specifies that "Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability". The sub-clauses of Article 25 state that States shall give the disabled the same "range, quality, and standard" of health care as it provides to other persons, as well as those services specifically required for prevention, identification, and management of disability. Further provisions specify that health care for the disabled should be made available in local communities and that care should be geographically equitable, with additional statements against the denial or unequal provision of health services (including "food and fluids" and "life insurance") on the basis of disability (23).

## 4- CONCLUSION

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. Article 1 of the United Nations Universal Declaration of Human Rights (UDHR) (24).

- The WHO Constitution (1946) envisages "...the highest attainable standard of health as a fundamental right of every human being".
- Understanding health as a human right creates a legal obligation on States to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to provide for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.

- A States' obligation to support the right to health – including through the allocation of "maximum available resources" to progressively realize this goal - is reviewed through various international human rights mechanisms, such as the Universal Periodic Review, or the Committee on Economic, Social and Cultural Rights. In many cases, the right to health has been adopted into domestic law or Constitutional law.
- A rights-based approach to health requires that health policy and programs must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the recently adopted 2030 Agenda for Sustainable Development and Universal Health Coverage (20, 25).
- The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status. Non-discrimination and equality requires States to take steps to redress any discriminatory law, practice or policy.
- Another feature of rights-based approaches is meaningful participation. Participation means ensuring that national stakeholders – including non-state actors such as non-governmental organizations – are meaningfully involved in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation.

## 5- CONFLICT OF INTEREST: None.

## 6- REFERENCES

1. UNITED NATIONS. Available at: <https://www.un.org/en/sections/issues-depth/human-rights/>.
2. WHO. Human Rights. Available at: [https://www.who.int/topics/human\\_rights/en/](https://www.who.int/topics/human_rights/en/).
3. Beletsky L, Ezer T, Overall J, Byrne I, Cohen J.

"Advancing human rights in patient care: the law in seven transitional countries". Open Society Foundations, 2013.

4. Open Society Institute. "Health and human rights: a resource guide". Open Society Foundations, 2013.

5. Ezer T. "Making laws work for patients". Open Society Foundations, 2013.

6. J Amon. "Abusing patients: health providers' complicity in torture and cruel, inhuman or degrading treatment". World Report 2010, Human Rights Watch, 2010.

7. Pillai, Navanethem. "Right to Health and the Universal Declaration of Human Rights". *The Lancet*. 2008; 372 (9655): 2005–6. doi:10.1016/S0140-6736(08)61783-3.

8. Gruskin, Sofia; Edward J. Mills; Daniel Tarantola. "History, Principles, and Practice of Health and Human Rights". *The Lancet*. 2007; 370 (9585): 449–55. doi:10.1016/S0140-6736(07)61200-8.

9. Hendriks A. "UN Convention on the Rights of Persons with Disabilities". *European Journal of Health Law*. 2007; 14 (3): 273–298. doi:10.1163/092902707X240620.

10. General comment No. 20: Non-discrimination in economic, social and cultural rights Committee on Economic, Social and Cultural Rights. 2009.

11. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) CESCR (Committee on Economic, Social, and Cultural Rights). 2000). 11 August. Doc. E/C.12/2000/4.

12. Transforming our World: The 2030 Agenda for Sustainable Development. UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1.

13. Guiding principles for business and human rights, Implementing the United Nations

"Protect, Respect and Remedy" Framework Office of the high Commissioner for Human Rights, Geneva, 2011.

14. Constitution of the World Health Organization (PDF). Geneva: World Health Organization. 1948.

15. Universal Declaration of Human Rights, United Nations, 1948.

16. International Convention on the Elimination of All Forms of Racial Discrimination, United Nations, 1965.

17. International Covenant on Economic, Social and Cultural Rights, United Nations, 1966.

18. General Comment No. 14. Geneva: UN Committee on Economic, Social and Cultural Rights. 2000.

19. Convention on the Elimination of All Forms of Discrimination against Women. New York: United Nations; 1979.

20. Convention on the Rights of the Child. New York: United Nations; 1989.

21. "Child Rights". World Health Organization. Retrieved 5 November 2013.

22. Goldhagen, Jeffrey. "Children's Rights and the United Nations Convention on the Rights of the Child". *Pediatrics*. 2003; 112 (Supp. 3): 742–45. PMID 12949339. Retrieved 5 November 2013.

23. "Article 25 - Health | United Nations Enable". Available at: [www.un.org](http://www.un.org). Retrieved 20 October 2017.

24. "Universal Declaration of Human Rights adopted by General Assembly resolution 217 A (III) of 10 December 1948".

25. Saeidi M, Ajilian M, Farhangi H, Khodaei Gh. Rights of Children and Parents in Holy Quran. *Int J Pediatr* 2014; 2(Supplement 4): 103-13.