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THE RIGHTS OF CHILDREN AND ADOLESCENTS IN ITALY: AN IMPACT ASSESSMENT OF CRC GROUP'S WORK FROM A REGIONAL PERSPECTIVE.

Supervisor: Prof. SARA PENNICINO

Candidate: MARIA TRABATTONI

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AKNOLEDGMENT

This graduation thesis is intended to be a practical tool which can offer support to the valuable work of the Italian NGO Group for the Convention on the Rights of the Child (Gruppo di Lavoro per la Convenzione sui diritti dell'infanzia e dell'adolescenza – Gruppo CRC) and to all the organizations and institutions working on multi-level governance and with a multi-disciplinary approach to ensure the full enjoyment of the rights of children and adolescents as set forth in the United Nation Convention on the Rights of the Child.

For this first achievement and for the passion and enthusiasm in working in the promotion and protection of the rights of children and adolescents, I am immensely grateful to:

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INTRODUCTION

This research aims to question whether the presence of regional inequalities concerning the right to health and the right to pursue the highest attainable standard of health towards children and adolescents living in Italy can be regarded as a case of systemic discrimination. This study has the ultimate goal of framing this failure within an international framework, verifying whether, in accordance with the principles of international law, it can be defined as a serious violation of human rights.

The inspiration for this work comes from the preliminary analysis of the monitoring Reports produced annually by the Italian NGO Group for the Convention on the Rights of the Child – Gruppo di Lavoro per la Convenzione sui diritti dell'infanzia e dell'adolescenza, which has been working for years on the concept of discrimination in Italy and which first analyzed the issue of discrimination rooted on a regional basis towards children and adolescents.

This research focuses mainly on the inequalities present on a regional basis regarding the right to health and the right to pursue the highest attainable standard of health. The right to health is fundamental to the full enjoyment of other human rights, and the presence of discrimination in this field results in a serious violation of human rights.

This study focuses mainly on inequalities toward children and adolescents living in Italy. This choice is driven by the awareness that the foundations for healthy living are laid mainly in the early years of life and the presence of regional disparities in access to health services will therefore result in some children and adolescents living in worse conditions than others, possibly condemning them to worse health conditions.

The first chapter of this research focuses on analyzing how the concept of structural discrimination is recognized and defined within international law. Since the right to health and to the highest possible standard of health is the basis for the full enjoyment of other human rights, the interdependent connection between these two principles will also be examined in this chapter. The aim is to delineate where the boundary beyond which a violation of human rights occurs within international law, with regard to the principle of non-discrimination in access to the fundamental right to health, specifically in relation to minors living in Italy. In addition, as the subject of this study is children and adolescents living in Italy, conventions that protect this group of people are also analyzed during this first chapter.

The second chapter aims to collect multiple national and international publications which quote inequalities rooted on a regional basis present in Italy in access to health services for children, to concretize the complaint of a situation of structural discrimination in Italy that has the serious effect of reserving different, and very often worse, treatment for children and adolescents living in the same country, depending on the region of origin.

The third chapter aims to demonstrate conclusively the presence of structural discrimination in access to certain health-related services against minors in Italy. To carry out this analysis, five health indicators were selected, and accurate data was collected region by region. The ultimate purpose is to provide a picture of the Italian situation, in relation to fundamental factors in the lives of minors in Italy, and to verify, through updated data, whether treatment appears to be homogeneous in all regions or the inequalities reported at the international level are supported and that therefore, the presence of structural discrimination can be confirmed.

CHAPTER 1. SYSTEMIC DISCRIMINATION IN THE FULL ENJOYMENT OF THE RIGHT TO HEALTH FOR MINORS

1.1 The concept of Systemic discrimination in International Law

1.1.1 Analysis of the general concept of discrimination as a serious violation of human rights

Discrimination, intended in all its possible forms, is one of the most widespread violations of human rights at the global level, affecting every year millions of people all around the world (Council of Europe, s.d.). In the complex delineation of this concept, it is important to recognize that intolerance is defined as "lack of respect for practices or beliefs other than one's own", while discrimination "occurs when people are treated less favourably than other people are in a comparable situation only because they belong, or are perceived to belong to a certain group or category of people" (Council of Europe, s.d.).

The United Nations affirms that the principle of equality and non-discrimination is "part of the foundations of the rule of Law" (Kostova, s.d.) and recognizes that "all persons, institutions and entities, public and private, including the State itself, are accountable to just, fair and equitable laws and are entitled without any discrimination to equal protection of the law" (United Nations General Assembly, 2012). In this Declaration, the United Nations is committed for the "respect for human rights and fundamental freedoms, respect for the equal rights of all without distinction as to race, sex, language or religion", and again emphasizes the responsibilities of all the States to respect human rights for all human beings without distinction of any kind.

Article 14 on the Prohibition of discrimination of the European Convention on Human Rights affirms that the fulfilment of the rights and freedoms enunciated in this Convention should be ensured without any kind of discrimination, and lists grounds of discrimination, such as "sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status" (Council of Europe, 1950).

Any kind of discrimination "with the 'purpose' or the 'effect' of nullifying or impairing the equal enjoyment or exercise of rights is prohibited under the non-discrimination provisions" (Icelandic Human Rights Centre, s.d.) and thus, the principle of equality and non-discrimination stands against any kind of inequality, whether direct or indirect. The Universal Declaration of Human Rights states that every person is entitled to enjoy the rights contained in the Declaration "without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (United Nations, 1948). Even the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (United Nations, 1966b) confirm in their respective conventions what was established in the Universal Declaration of Human Rights (United Nations, 1966a). The definition proposed by the International Convention on the Elimination of All Forms of Racial Discrimination affirms that should be considered racial discrimination any distinction or exclusion or restriction – based in the case of this Convention mostly on the ground of race and color – which has the effect or the purpose of "nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life" (United Nations, 1965). The statement "any other field of public life" extends the concept of the enjoyment of rights without discrimination to all areas of public life by stating that there is no full realization of the right of equality and non-discrimination if all the fields that composed the life of a person are not free from deprivation or inequalities. Even the Convention on the Elimination of All Forms of Discrimination against Women, in Article 1 defines discrimination against women as "any distinction, exclusion or restriction […], on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field" (United Nations, 1979) emphasizing the importance of extending the principle of non-discrimination to all the other areas which compose an individual's reality. Moreover, the Convention on the Rights of the Child in Article 2(1) defines that States parties of the Convention shall respect the rights set forth in the Covenant intended for every child "without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status" and adds, as reported in this definition, in the list of the grounds of discrimination, also the important issue of disability (United Nations, 1989). Analyzing regional systems, the African Charter on Human and

Peoples' Rights states that every human being should be entitled to the rights established by the convention "without distinction of any kind such as race, ethnic group, colour, sex, language, religion, political or any other opinion, national and social origin, fortune, birth or other status" (African Commission on Human and People's Rights, 1981). Article 19 of the same Charter affirms that all people "shall be equal; they shall enjoy the same respect and shall have the same rights" (African Commission on Human and People's Rights, 1981, art. 19). On the overview of the American conventions, while the definition provided by the American Convention on Human Rights considers among the grounds of discrimination "race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition" (Organization of American States, 1969a), the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights introduces the concept of discrimination which could also be based on "national or social origin, economic status, birth or any other social condition" (Organization of American States (OAS), 1999). Considering the European overview, article 14 on the Prohibition of discrimination of the European Convention on Human Rights (Council of Europe, 1950) lists "sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status" among the grounds of discrimination, and the European Social Charter (revised) confirms the list enunciated above.

By analyzing all the definitions contained in the major international conventions, it is evident how the concept of discrimination can be rooted in every field of an individual's life, and how crucial it is to eradicate inequalities to ensure the full enjoyment of human rights. In fact, the right to equality and non-discrimination "before the law and by law" is a general and fundamental right that "is essential to international peace and security; […] conditions the enjoyment of all human rights, be they civil, political, economic, social or cultural; […] States are obliged under international law to ensure and to respect" (Office of the High Commissioner for Human Rights in Cooperation with the International Bar Association, 2003, p. 648).

1.1.2 Definition of the concept of systemic discrimination

The first major distinction within the broad concept of discrimination is the one between direct and indirect discrimination. Direct discrimination "is characterised by the intent to discriminate against a person or a group” (Council of Europe, s.d.), in other words, it is realized when the treatment of one person or group of people is worse than treatment of others. Indirect discrimination occurs when “an apparently neutral provision, criterion or practice de facto puts representatives of a particular group at a disadvantage compared with others” (Council of Europe, s.d.). It is therefore important to highlight that indirect discrimination is “an effects-based concept” (Tobler, 2008, p. 29). In relation to this point, under the definitions of the most important human rights conventions, such as the Convention on the Elimination of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of Persons with Disabilities, it is explicitly addressed the concept of indirect discrimination as those “measures that are not discriminatory at face value but are discriminatory in fact and effect” (Tobler, 2008, p. 5). The European Court of Human Rights affirms that indirect discrimination “may take the form of disproportionately prejudicial effects of a general policy or measure which, though couched in neutral terms, has a particular discriminatory effect on a particular group” and underlines the concept that indirect discrimination “does not necessarily require a discriminatory intent” but “may arise both from a neutral rule or from a de facto situation” (European Court of Human Rights, 2022).

Specifically analyzing this concept, various international conventions and documents recognize under the broader definition of indirect discrimination another kind of discrimination which is defined as systemic. Systemic discrimination, which can also be defined as “structural discrimination”, “institutional discrimination” and “systematic discrimination”, “involves the procedures, routines and organisational culture of any organisation that, often without intent, contribute to less favourable outcomes for minority groups than for the majority of the population, from the organisation’s policies, programmes, employment, and services” (Council of Europe, 2020). Such discrimination is often not “rooted in an individual’s conviction regarding a person or a group of people, but in institutional structures, be they legal, organizational”. In other words, one of the main elements that characterized structural discrimination is not the will or intent, but rather the “effect of keeping minority groups in a subordinate position” (Altman, 2020).

1.1.3 Systemic discrimination in the sources of International Law

This paragraph analyzes how the concept of systemic discrimination is addressed in the sources and theories of international law, keeping in mind that this specific discrimination has not been specifically defined in international or European law (Council of Europe, 2020).

The Committee on Economic, Social and Cultural Rights raises the concept of discrimination as systematic and proposes a very accurate definition, affirming in article 12 that the Committee "has regularly found that discrimination against some groups is pervasive and persistent and deeply entrenched in social behaviour and organization" by affirming that "such systemic discrimination can be understood as legal rules, policies, practices or predominant cultural attitudes in either the public or private sector which create relative disadvantages for some groups, and privileges for other groups" (UN Committee on Economic, Social and Cultural Rights (CESCR), 2009, p. 5). In the following paragraph, inherent to the elimination of systemic discrimination, the Committee states that "States parties must adopt an active approach to eliminating systemic discrimination and segregation in practice", stressing on the point that "such discrimination will usually require a comprehensive approach with a range of laws, policies and programmes, including temporary special measures" highlighting the concept that States parties "should consider using incentives to encourage public and private actors to change their attitudes and behaviour in relation to individuals and groups of individuals facing systemic discrimination, or penalize them in case of non-compliance" (UN Committee on Economic, Social and Cultural Rights (CESCR), 2009, p. 12).

The Council of Europe affirms that "structural Discrimination is based on the very way in which our society is organised" (Council of Europe, s.d.), focusing on the idea that is the system itself that contributes to discriminate a group of people and very often there is no direct intention to discriminate.

In fact, this type of discrimination, since is rooted in the system, in a set of norms, in social mechanisms, it is not expressed as a belief of an individual who voluntarily discriminates a person or a group of people, but rather, it is "in institutional structures, be they legal, organisational". So, what is important for this kind of discrimination is to identify it, make it clear, separate it from the institutions in which it is rooted and make it recognizable and removable.

Even the European Commission against Racism and Intolerance (ECRI) states that structural discrimination "refers to rules, norms, routines, patterns of attitudes and behaviour in institutions and other societal structures that, consciously or unconsciously, present obstacles to groups or individuals in accessing the same rights and opportunities as others and that contribute to less favourable outcomes for them than for the majority of the population" (European Commission against Racism and Intolerance (ECRI), 2017). The European Commission against Racism and Intolerance – ECRI emphasizes the difficulty of addressing structural discrimination because, as it is rooted in a social system, it is not easily recognized. Indeed, "given that those involved are often not aware that their actions have a discriminatory effect; the issue of structural discrimination affects large numbers of people; and individuals find it difficult to challenge it due to the institutional power they must confront" (Crowley, 2020, p. 5). Moreover, once structural discrimination has been identified, equality bodies should "promote the use of positive action in particular in areas where deep-rooted, longlasting structural discrimination needs to be addressed" (European Commission against Racism and Intolerance (ECRI), 2017).

The European Commission has identified the concept of indirect discrimination, with special attention to impacts and effects. This strategy could be a way for making systemic discrimination visible in order to challenge it. Precisely because of this aspect of indirect discrimination, which tends not to manifest itself clearly but it must be identified within already existing structures, the prohibition of this discrimination "needs to be backed up with further legislative and non-legislative action to raise awareness of indirect discrimination and to tackle the structural problems that are exposed through any findings of indirect discrimination" (Council of Europe, 2020, p. 6). In addition, besides taking "measures aiming to raise awareness in relation to the problem of indirect discrimination as well as measures aiming to tackle the structural problems that are exposed through findings of indirect discrimination", Member States must be engaged "in social engineering in order to fight discrimination acquire a particular meaning in context" (Tobler, 2008, p. 68).

European Union analyzes the concept of indirect discrimination based on racial or ethnic origin, defining that this type of discrimination “shall be taken to occur where an apparently neutral provision, criterion or practice would put persons of a racial or ethnic origin at a particular disadvantage compared with other persons”. In this legislation, discrimination defined as “systemic” or “structural” is not mentioned.

European Court of Human Rights (ECHR) raises the idea of the existence of real discrimination, although there is no clear and direct intent in that direction, affirming that “when a general policy or measure has disproportionately prejudicial effects on a particular group, it is not excluded that this may be considered as discriminatory notwithstanding that it is not specifically aimed or directed at that group”.

In the Inter-American Commission on Human Rights, it is only addressed the concept of discrimination in general terms, stating that “The States Parties to this Convention undertake to respect the rights and freedoms recognized herein and to ensure to all persons subject to their jurisdiction the free and full exercise of those rights and freedoms, without any discrimination for reasons of race, color, sex, language, religion, political or other opinion, national or social origin, economic status, birth, or any other social condition” (Organization of American States, 1969b). It is interesting to note that in the Inter-American Convention against Racism, Racial Discrimination and Related Forms of Intolerance (A-68) emerges the idea of discrimination as a process rooted in social mechanisms, and therefore as structural, emerges where, in relation to racial discrimination, states parties of the Convention are “convinced that the principles of equality and nondiscrimination among human persons are dynamic democratic concepts that foster the promotion of effective legal equality” (OEA & OAS, 2009, p. 2) and that they are committed to combat any “racial discrimination in all its individual, structural, and institutional manifestations”.

1.2 Analysis of the connection between the principle of non-discrimination and the right to health

1.2.1 Analysis of prohibited grounds of discrimination: the concept of “other status”

As it was analyzed above, most of the International Covenants and Conventions define that human beings should be able to freely enjoy the rights set forth in the respective charters without any discrimination of any kind. In addition to this statement. A list of grounds for discrimination is always provided, with the purpose of being as broad and inclusive as possible. In most of the major International Covenants, the “express grounds” are usually related to the concepts of “race and colour”, “sex”, “language”, “religion”, “political or other opinion”, “national or social origin”, “property” and “birth”. The statement of “Other Status”, often presented as the conclusion of the list in question, is proposed as a flexible definition since “the nature of discrimination varies according to context and evolves over time” (UN Committee on Economic, Social and Cultural Rights (CESCR), 2009, p. 8) and includes all those motivations, more or less evident, that contribute to the creation of discrimination against certain individuals or groups of people. It is important to note that there is no fixed list of grounds of discrimination, but rather all attitudes that lead to the result of a condition of nonequality and discrimination are to be included under the label of “other status”. The definition “other status” has historically had a wide meaning (*Carson and Others v. The United Kingdom*, 2010) and its interpretation has not been limited to characteristics which are personal in the sense that they are innate or inherent (European Court of Human Rights, 2022). This list mostly refers to the concept of “disability”, “age”, “nationality”, “marital and family status”, “sexual orientation and gender identity”, “health status”, “place of residence” and “economic and social situation” (UN Committee on Economic, Social and Cultural Rights (CESCR), 2009) (European Court of Human Rights, 2022). As it is possible to note, the constant addition of grounds of discrimination has the purpose to be as inclusive as possible, since there are many factors that can lead to a condition of inequalities and discrimination. The full enjoyment of human rights can only be achieved by recognizing and combating all forms of discrimination that have the purpose or the effect of creating a condition of differential treatment and often some situations of inequality and discrimination arise in a condition where several factors coexist together at the same time. It is indeed important, when analyzing a specific situation in which discrimination is recognized, that all spheres related to this issue are analyzed, thereby a context can be identified as completely as possible.

1.2.2 Analysis of the connection between the right to health with the socioeconomic status and the place of residence

For the purpose of this research, three grounds of discrimination are specifically considered, which are health status, the place of residence and the economic and social conditions. As mentioned above, the basis that leads to a condition of discrimination results to be strictly linked and interdependent with each other and often the aggravation of one condition also leads to a worsening of the others. In this case study, health status depends on and is directly proportional to socioeconomic status. Both these factors are rooted in the place of residence. As one of the three bases of discrimination analyzed changes, the other parameters also change, confirming the close coexistence of these factors in the life of a person or group of individuals.

While the right to health will be analyzed more specifically in the following sections, this paragraph focuses on the socioeconomic status and place of residence, which are both considered as the grounds of discrimination and are deeply linked with the full enjoyment of the right to health.

Place of residence is considered, by international law, among the bases of discrimination. As it is possible to note, a condition of nonequality, very often, is given by the combination of various factors and conditions that contribute to worsening the living standards of one or more individuals.

In the list of the social determinants of health, most of these factors are strictly rooted in the place of residence, since the location could be crucial for a better or worse state of life depending on whether this place is more or less a recipient of funds and resources, is more or less connected to the rest of the area, is provided with the facilities for basic personal services, and so on. The Committee on Economic, Social and Cultural Rights states that there should be no discrimination on the basis of place of residence "whether an individual lives or is registered in an urban or a rural area, in a formal or an informal settlement, is internally displaced or leads a nomadic lifestyle" (UN Committee on Economic, Social and Cultural Rights (CESCR), 2009). In addition, the Committee places further emphasis on the concept that "Disparities between localities and regions should be eliminated in practice by ensuring, for example, that there is even distribution in the availability and quality of primary, secondary and palliative health-care facilities" (UN Committee on Economic, Social and Cultural Rights (CESCR), 2009), emphasizing how, equal access to health for everyone, could be strictly connected with the place of residence.

The economic and social status is considered as one of the bases of discrimination. The definition of economic and social condition includes many different factors and confirms the concept that the reasons that lead to a condition of nonequality and discrimination are very often interrelated and rooted in each other. People and individuals "must not be arbitrarily treated on account of belonging to a certain economic or social group or strata within society" (UN Committee on Economic, Social and Cultural Rights (CESCR), 2009).

Again, if we analyze the list of factors named as Social Determinants of Health, which will be precisely presented in the next section, it is clear how the sphere related to the economic and social status includes in its definition most of the points listed in the definition of Social Determinants of Health. In fact, poorer socioeconomic conditions correspond to fewer services, worse health status, fewer opportunities and thus, by reporting the words of the World Health Organization, "the lower the socioeconomic position, the worse the health" (World Health Organization, s.d.-a), affirming that the assurance to an equal and affordable access to primary health care could contribute to the elimination of barriers such as "poverty, social exclusion and housing, which are generally associated with mental health issues" (The Organisation for Economic Co-operation and Development (OECD), 2020).

1.2.3 The right to health and Social Determinants of Health (SDH) in International Law

The right to health is a "fundamental human right indispensable for the exercise of other human rights" (Office of the High Commissioner for Human Rights, 2000) and every person "is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity" (Office of the High Commissioner for Human Rights, 2000).

The right to health, in fact, is "closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement" (Office of the High Commissioner for Human Rights, 2000).

In addition, it is defined as an "inclusive right" as it includes "a wide range of factors that can help us lead a healthy life". These factors are defined, by the Committee on Economic, Social and Cultural Rights as the "underlying determinants of health" (Office of the High Commissioner for Human Rights, 2000) (World Health Organization, 2017), to show how much, the full implementation of this right depends on many other factors, especially on the socio-economic status of a person or group of people.

Even at the level of international law, the right to health is a fundamental human right, and for its full enjoyment there cannot coexist the concept of discrimination. The Universal Declaration of Human Rights, in article 25.1 states that "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services" (United Nations, 1948). In the International Covenant on Economic, Social and Cultural Rights arises the concept of the "highest attainable standard" both of physical and mental health and also pays special attention to the responsibility of states toward this right. Article 12.1 affirms that States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (United Nations, 1966b) and article 12.2 explains the steps to be taken by the States parties to achieve the full realization of this right. The International Convention on the Elimination of All Forms of Racial Discrimination, in article 5 (e) (iv), affirms that racial discrimination is necessary to be eliminated in order to enable human beings to fully enjoy fundamental rights, including "the right to public health, medical care, social security and social services" (United Nations, 1965). Even the Convention on the Elimination of All Forms of Discrimination against Women of 1979 affirms that "States Parties shall take all appropriate measures to eliminate discrimination […] in order to ensure, on a basis of equality of men and women, the same rights, in particular: […] (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction" (United Nations, 1979). The Convention on the Rights of the Child (United Nations, 1989) addressed the right to health with a special focus on the obligations of the States party since, under this convention, every action must be dealt with according to the best interests of the child. Article 11 of the European Social Charter of 1961 as revised focuses a special attention to the states' responsibilities towards issues that affect health.

In the African Charter on Human and Peoples' Rights of 1981, article 16 establishes that every person "shall have the right to enjoy the best attainable state of physical and mental health" (African Commission on Human and People's Rights, 1981) while article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 states that "everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being" (Organization of American States (OAS), 1999), establishing that States parties should follow specific measures, such as access to primary health care, extension of the benefits of health services to all the people under the jurisdiction of the state, ensure a universal immunization, prevent endemic disease, share education with the population on these issues and the satisfaction of the health needs of the poorest and vulnerable people. The right to health is addressed in many other conventions, such as in the Vienna Declaration and Programme of Action of 1993(World Health Organization, 1993), in the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (United Nations, 1991) and, finally in the Committee's general comment No. 5 on persons with disabilities apply to persons with mental illness (United Nations, Office of the High Commissioner for Human Rights, 1994).

The Commission on Human Rights affirms that the right to health is "an inclusive right" (Office of the High Commissioner for Human Rights, World Health Organization, 2008) because it includes "wide range of factors that can help us lead a healthy life". These factors, even defined as the Social determinants of health (SDH) are thus the non-medical factors that influence and determine health status and health outcomes. The World Health Organization considers them as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" and they are strictly connected with reality. In fact, "these forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems". These factors are interdependent and determine the living conditions of people living in a specific area. Indeed, the socio-economic level is proportionally related to health status, since: "the lower the socioeconomic position, the worse the health"(World Health Organization, s.d.-a).

Social Determinants of Health are the following: "Income and social protection; Education; Unemployment and job insecurity; Working life conditions; Food insecurity; Housing, basic amenities and the environment; Early childhood development; Social inclusion and non-discrimination; Structural conflict; Access to affordable health services of decent quality" (World Health Organization, s.d.-a). Analyzing the Social Determinants of Health (SDH) it is clear that there is an inextricable relationship of interdependence between the full implementation of the right to health and a context of poverty. For people who are living in poverty, health appears to be the basis on which other rights are built, in fact, “physical health and mental health enable adults to work and children to learn, whereas ill health is a liability to the individuals themselves and to those who must care for them”. The interdependence on the right to health with the other fundamental rights occurs when “individuals’ right to health cannot be realized without realizing their other rights, the violations of which are at the root of poverty, such as the rights to work, food, housing and education, and the principle of non-discrimination” (Office of the High Commissioner for Human Rights, World Health Organization, 2008). In addition, the right to health is strictly related to principles of equality and non-discrimination, since they are considered as “critical components of the right to health” (Office of the High Commissioner for Human Rights, World Health Organization, 2008). The right to health care is mentioned by the International Covenant on Economic, Social and Cultural Rights (art. 2 (2)) which define explicitly, within the concept of other status, the right to health, stressing on the concept that “many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information” (Office of the High Commissioner for Human Rights, 2000) and, by mentioning general comment No. 3, paragraph 12, affirms that “states that even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes” (Office of the High Commissioner for Human Rights, 1990).

Given the doctrine of international law and given the articles protecting the right to health, States Parties must take their responsibilities and “must make every possible effort, within available resources, to realize the right to health and to take steps in that direction without delay” adding that “inappropriate health resource allocation can lead to discrimination that may not be overt” (United Nations, Office of the High Commissioner for Human Rights, 1994). Also, States “have an obligation to prohibit and eliminate discrimination on all grounds and ensure equality to all in relation to access to health care and the underlying determinants of health” (Office of the High Commissioner for Human Rights, World Health Organization, 2008).

1.3 Deepening on the instruments of protection of children’s rights

Since the group of people considered in this research includes children and adolescents under the age of 18, it is useful to briefly present what conventions are adopted at the international level for the protection of the rights of children and adolescents, in order to provide the most comprehensive scenario possible for the purpose of this research.

1.3.1 The Convention on the Rights of the Child and its Three Optional Protocols

The doctrine of the promotion and protection of children’s rights is regulated by the United Nation Conventions on the Rights of the Child, which was adopted by the United Nations General Assembly on November 20, 1989 and entered into force on September 2, 1990.

This instrument, which to date is one of the most ratified in the history of the UN Conventions, lays the foundation for the respect, protection, and preservation of children's rights around the world. The Convention on the Rights of the Child is composed of 54 articles that cover all the fields inherent to the protection of children. This text stands as a flag of the belief that people of minor age need a very specific framework of protection, since, as stated in the preamble: “the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth” (United Nations, 1989).

To take a brief look at the Convention, the text is divided into three groups of articles. The first contains the enunciation of rights (Articles 1-41), the second part identifies the bodies in charge and how to improve and monitor the Convention (Articles 42-45), and the third describes the ratification procedure (Articles 46-54).

To provide an overview of this Convention, Articles 1, 2 and 3 are fundamental for setting the basis of this research. Article 1 stipulates the definition of the child, establishing that “Everyone under the age of 18 has all the rights in the Convention” (United Nations, 1989, art. 1). Immediately, Article 2 raises the issue of discrimination and quotes that States Parties shall respect and promote children’s rights “without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status” (United Nations, 1989, art. 2). Article 3 introduces the concept of the best interest of the child; it quotes that “in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration" (United Nations, 1989, art. 3). This article is important because it focuses on the concept that the child is "dependent" on the parents or guardians who take care of him or her, and since the child is a subject of law, any decision or action must always follow the principle of the best interest of the child. In addition to parents and guardians, the state in which the child resides must undertake every means and employ maximum efforts to ensure the full implementation of the rights contained in the Convention. In fact, Article 18 is about parental responsibilities and state assistance, contending that "States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child" (United Nations, 1989). Even Article 19 concerns the topic of the protection from violence, establishing that State Parties shall use all the available means to protect children from "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse […]" (United Nations, 1989, art. 19). Again, the Convention stresses on the responsibility of the state in Article 38, affirming that "[…] States Parties shall take all feasible measures to ensure protection and care of children who are affected by an armed conflict […]" (United Nations, 1989). Article 24 focuses its attention on the concept of health status, by introducing the notion of "the highest attainable standard of health", stating that "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 and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services" (United Nations, 1989, art. 24). The measures defined in the following article address important concepts for the full implementation of the right to health, and address infant mortality, to ensure adequate medical assistance, to combat disease and malnutrition, to secure adequate pre-natal and post-natal health care for mothers, to ensure that interested part are informed about the health rights to which children are entitled, and to pursue a preventive medicine. Article 25 is about the "review of treatment in care". Then the following articles cover: "social security" (Art. 26), the right to an "adequate standard of living" (Art. 27), the topic of "right to education" (Art. 28) and the "goals of education" in Article 29.

Articles from 43 to 54 describe the synergic work that adults or those who are responsible for children must undertake with governments in order to achieve the highest standards of rights for children.

In addition, the Convention has three Optional Protocols that have been adopted and ratified over the years. On the 25th of May 2000, two protocols were added to the Convention. The first one, the "Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography" (United Nations, 2000b), with its 17 Articles calls on states to prohibit child prostitution, child pornography and the sale of children into slavery (Save the Children UK, s.d.). It was adopted by resolution A/RES/54/263 at the fifty-fourth session of the General Assembly of the United Nations and entered into force on 18 January 2002. The second Optional Protocol, which was enacted during the same resolution, and which entered into force the 12 February 2022, is called "Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict" (United Nations, 2000a) and "asks governments to ensure children under the age of 18 are not forcibly recruited into their armed forces". There is also a third document, the "Optional Protocol to the Convention on the Rights of the Child on a communications procedure", which was added in 2011 and has the purpose to enable "children whose rights have been violated to complain directly to the UN Committee on the Rights of the Child" (Save the Children UK, s.d.). The ratification and implementation of these Optional Protocols have quoted and thus involved other important fields for the protection of children's rights and "lay the foundation for the safeguard of children's rights and their effective protection from violence, abuse and exploitation" (UN Special Representative of the Secretary-General on Violence Against Children, s.d.).

1.3.2 The role of international rights monitoring regarding children's rights

Talking about the improvement of the Convention's monitoring and implementation methods, as mentioned above, the second group of Articles (i.e., Articles 42, 43, 44 and 45) are particularly important for the promotion of the respect of all the rights quoted in the Covenant and lay the foundation for a system that can effectively monitor and check the implementation of the Convention on the Rights of the Child. In particular, article 45 introduces and emphasizes the importance of a high level of cooperation between specialized agencies, the United Nations Children’s Fund and other United Nations organs, for the achievement of an effective and high implementation of the Convention. The following are the exact words of Article 45:

> In order to foster the effective implementation of the Convention and to encourage international co-operation in the field covered by the Convention:
> (a) The specialized agencies, the United Nations Children's Fund, and other United Nations organs shall be entitled to be represented at the consideration of the implementation of such provisions of the present Convention as fall within the scope of their mandate. The Committee may invite the specialized agencies, the United Nations Children's Fund and other competent bodies as it may consider appropriate to provide expert advice on the implementation of the Convention in areas falling within the scope of their respective mandates. The Committee may invite the specialized agencies, the United Nations Children's Fund, and other United Nations organs to submit reports on the implementation of the Convention in areas falling within the scope of their activities;
> (b) The Committee shall transmit, as it may consider appropriate, to the specialized agencies, the United Nations Children's Fund and other competent bodies, any reports from States Parties that contain a request, or indicate a need, for technical advice or assistance, along with the Committee's observations and suggestions, if any, on these requests or indications;
> (c) The Committee may recommend to the General Assembly to request the Secretary-General to undertake on its behalf studies on specific issues relating to the rights of the child;
> (d) The Committee may make suggestions and general recommendations based on information received pursuant to articles 44 and 45 of the present Convention. Such suggestions and general recommendations shall be transmitted to any State Party concerned and reported to the General Assembly, together with comments, if any, from States Parties. (United Nations, 1989, art. 45)

The Committee on the Rights of the Child is the body composed of 18 independent experts and it is aimed to closely monitor the implementation of the Convention on the Rights of the Child and its Optional Protocols in all its States parties (UN Office of the High Commissioner for Human Rights, s.d.-a). The monitoring system is based on a periodic review of the present situation inside each State which is party of the Convention. During monitoring, the Committee aims to make recommendations regarding the various situations within the states examined, in order to provide a guideline for future improvement and for the achievement of a higher level of implementation of the UN Convention on the Rights of the Child. As part of the process of reviewing, the Committee, in line with the provisions of Article 45, has the possibility to examine and analyze reports which are submitted by “UN agencies (e.g. UNICEF) and other competent bodies, including NGOs, National Human Rights Institutions (NHRIs), as well as children” (Child Rights Connect, s.d., p. 1), emphasizing the importance of collaboration of different actors and agencies in the drafting of reports at the national level, because “the preparation of an alternative report encourages and facilitates public scrutiny of government policies and provides NGOs and NHRIs with ways to influence the national agenda” (Child Rights Connect, s.d., p. 1). In addition, it aims to create an environment of comparison on the condition of children in a specific country, with the opportunity “to have a serious dialogue with all levels of government about the State’s efforts to comply with the CRC. Reporting can also empower those who take part in the process, by offering a legitimate external source to which children’s issues can be raised and addressed” (Child Rights Connect, s.d., p. 1). Since the purpose of the Committee is to achieve an ever-greater application in the States parties of the CRC, and thus ensure high standards of promotion and protection of children’s rights, the ongoing NGOs and NHRI’s work of advocacy and monitoring is a valuable tool and an important opportunity for the Committee. Indeed, the “effective engagement with the Committee’s reporting process provides an important opportunity to harness the power of the international human rights system to reinforce advocacy messages and affect change for the advancement of child rights at national level” (Laura Theytaz Bergman et al., s.d., p. 1).

In addition to this, in the General comment No. 2 (2002): The Role of Independent National Human Rights Institutions in the Promotion and Protection of the Rights of the Child (UN Committee on the Rights of the Child (CRC), 2002), Article 3 affirms that it’s fundamental for the Committee that the States parties "furnish information on any independent body established to promote and protect the rights of the child”(UN Committee on the Rights of the Child (CRC), 2002, p. 2).

Indeed, the General guidelines regarding the form and contents of periodic reports to be submitted by States parties under article 44, paragraph 1 (b), of the Convention (CRC/C/58), paragraph 18, highlights the importance of the involvement of Non-Governmental Organizations in the periodic reports, which is intended as an important synergic tool for achieving a level of monitoring which takes into account all the elements that compose the State in question. In fact, Article 19 requires the State to specify “any initiatives taken in cooperation with the civil society (for example, professional groups, non-governmental organizations) and any mechanisms developed to evaluate progress achieved” (UN Committee on the Rights of the Child (CRC), 1996, p. 5). States, in addition, are requested to report “The involvement of non-governmental organizations in awareness and advocacy campaigns on the Convention, as well as any support provided to them. The involvement of NGOs in the reporting process is important also for the pluralistic representation of the several elements of the society, in fact, Article 12 of the General comment No. 2 (2002): The Role of Independent National Human Rights Institutions in the Promotion and Protection of the Rights of the Child, emphasizes the fact that NHRIs should involve "human rights, anti-discrimination and children's rights non-governmental organizations (NGOs), including child- and youth-led organizations; trade unions; social and professional organizations (of doctors, lawyers, journalists, scientists, etc.); universities and experts, including children's rights experts […]" (UN Committee on the Rights of the Child (CRC), 2002, p. 3). In the "Guide for NGOs and NHRIs, The Reporting Cycle of the Committee on the Rights of the Child" published by the Organization Child Rights Connect (Child Rights Connect, s.d.), when presenting the CRC reporting process, emphasizes the fact that in order to comprehend the impact of the State's initiatives on children, who are the rights-holder in question, "it is essential for the Committee to have the perspective of NGOs, NHRIs and children themselves" highlighting that these national actors are "best placed to monitor the impact of the State's measures to fulfil their obligations under the CRC and to evaluate whether they are effective" emphasizing that "where gaps in implementation occur, they can suggest concrete recommendations to help a State to comply with its obligations under the CRC and its Ops" (Laura Theytaz Bergman et al., s.d., p. 1). The analysis of these mechanisms is useful for this research as many on the documents collected and analyzed in the next chapter are the result of precisely these monitoring systems.

1.4 Systemic discrimination in the full enjoyment of the right to health for minors: a serious violation of human rights

From this preliminary research, it is possible to understand various aspects useful for this study. First, the presence of discrimination constitutes a serious violation of human rights. Since the concept of systemic discrimination falls under the general concept of discrimination, the presence of systemic discrimination is also confirmed to be a serious violation of human rights. As seen, this kind of discrimination is entrenched in structures and mechanisms and then it is revealed as an effect and not as an intention to discriminate. To investigate the presence of structural discrimination it is fundamental to consider which are its main features in order to recognize and challenge it. First, systemic discrimination is very difficult to identify. This lack of identification also causes a delay in implementing policies to combat and eradicate it, since it produces the same effect as any other discrimination, namely that a particular group of people is subject to worse treatment than others. This is because one of the main features of structural discrimination is the fact of being an “effect-based concept”, that shows no appearance of objective discrimination but produces inequalities over time, with the persistence of policies that produce a discriminatory effect. Precisely for this reason, to investigate its presence, it is important to study the whole context in which, for years, there has been unequal treatment of certain people, as for example in this case that depends on their region of origin.

Moreover, since the right to health and the pursuit of the highest attainable standard of health are confirmed to be fundamental rights and cornerstone for the enjoyment of all other human rights, the presence of any kind of discrimination in health constitutes a serious violation of human rights. Finally, since children and adolescents represent the subject of this research, and since living a healthy childhood without discrimination but with full access to all health services is the basis for being able to lead a healthy life, the presence of discrimination in this area is even more serious and confirm the urgency of recognizing and identifying inequalities, in order to eradicate them. Thus, from this preliminary analysis it is possible to determine a clear border beyond which there always occurs a serious violation of human rights. If there is a systemic discrimination against children and adolescents living in Italy on a regional basis that affects health services, this must surely be considered a serious violation of human rights, because it violates the principle of equality and non-discrimination, the right to health and the pursuit of the highest attainable standard of health and all the conventions that protect children and adolescents at the international level.

CHAPTER 2. INEQUALITIES ON A REGIONAL BASIS IN ITALY: ANALYSIS OF INTERNATIONAL AND NATIONAL DOCUMENTS

As was clarified in the first chapter, the principle of equality and nondiscrimination is a cornerstone in human rights theory. Thus, the right to health and the right to the highest possible standard of health are basic and fundamental rights and milestones for the enjoyment of all the other human rights and so, as it was established, a framework of discrimination present in access to health services thus proves to be a serious violation of human rights.

This second chapter aims to gather and collect many of the most important reports and documents, published both at the international and national level, in which a complaint to the violation of the principle of non-discrimination in access to the right to health and well-being for children and adolescents in Italy is reported. First of all, this research analyses the documentation published by the United Nations in the course of various monitoring mechanisms, in particular the documents collected during the monitoring undertaken by the Treaty Monitoring Bodies and during the Universal Periodic Review. In addition, during this chapter even the UN General Comments and the Concluding Observations addressed to Italy by the Committee on the Rights of the Child are analyzed. As regards the Italian level, the reports that have been most consulted are those submitted by the Italian NGO Group for the Convention on the Rights of the Child – Gruppo di Lavoro per la Convenzione sui diritti dell'infanzia e dell'adolescenza – Gruppo CRC, which for more than twenty years has precisely analyzed the most important issues related to childhood in Italy, and which reports for the first time in several documents the problem of discrimination in accessing health services in Italy present on a regional basis.

2.1 Documents published during the United Nations monitoring

Within the broad framework of international monitoring mechanisms, the United Nations conducts two main types of human rights monitoring. These are divided into Treaty-Based monitoring and Charter-Based Monitoring bodies (UN Office of the High Commissioner for Human Rights, s.d.-b). The treaty-based monitoring bodies, which consist of ten committees made up of independent experts, are responsible for monitoring the level of implementation of the most important international treaties and covenants. On the other side, the mechanisms listed among the charter-based bodies include other instruments, such as the Human Rights Council, the Special Procedures, the Universal Periodic Review and the Independent Investigations.

Studying the documents submitted and published by these bodies, it is possible to clarify several issues. First, it is possible to note that, over the years, the problem related to the presence of inequalities on a regional basis in Italy in access to certain basic services, such as health-related ones, is increasingly recognized and defined. In fact, more precise and conscious denunciations are present in more recent documents.

Even the recommendations collected by the Universal Periodic Review highlight this issue especially in the third and final cycle of monitoring, where the problem of inequalities based on regional differences is clearly specified.

In addition, since children and adolescents are protected by the Convention on the Rights of the Child, this issue is both recognized in the documents produced by the Committee on the Rights of the Child and in several reports produced and submitted at the Italian level which are involved in the protection of the rights of children and adolescents. In addition, it is important to state that despite the growing awareness of the presence of regionally based inequalities related to fundamental issues such as health, this problem has remained hidden and underestimated for a long time since it is rooted in a system of policies, routines and social mechanisms and is therefore difficult to identify. For this aspect, and for many others, the inequalities analyzed reveal many typical characteristics of systematic discrimination.

This chapter aims to collect and study the main documents reporting on this issue over the past decade, to understand how much, the issue of regionally based discrimination is entrenched and systemic, and how much it actually constitutes an obstacle to the full enjoyment of basic human rights within the same country. Even, it aims to verify how much this issue is recognized and reported both internationally and nationally, and which recommendations are presented by monitoring bodies.

2.1.1 Treaty Monitoring Bodies

Regarding the Treaty Monitoring Bodies, the Committee on the Rights of the Child has on several occasions highlighted the issue of regional disparities in access to services, especially related to the right to health, for Italian minors. The Committee has emphasized that there is a difference in access to health care rooted on a regional basis, and that this differentiation in services can be framed under the broader concept of discrimination since at base, children and minors do not enjoy the same right equally throughout Italy.

In the document submitted by Italy, which Combined fifth and sixth reports (Committee on the Rights of the Child, 2017) are listed some interventions put in place for the care of the child to "mitigate regional disparities in accessing to children services" (Committee on the Rights of the Child, 2017, p. 10). The different programs launched in the Italian territory recognize the present inequalities, particularly in the territory of southern Italy. Point 108 of this document provides the example of the National Programme "Services for childcare and no selfsufficient elderly", which provides a time frame of 4 years (2013 to 2017) for implementation, and includes specific actions in regions where services are most in short supply, by providing funding "in Calabria, Campania, Apulia and Sicily to this scope: there are additional resources for public and nurseries under agreement, integrative and innovative services, territorial balancing" (Committee on the Rights of the Child, 2017, p. 19).

In the following document submitted by the Committee on the Rights of the Child with the title "List of issues in relation to the combined fifth and sixth periodic reports of Italy" (Committee on the Rights of the Child, 2019c) again many questions regarding inequalities present in different regions of Italy are raised. Indeed, point 8 focuses on the child poverty which results to be different region by region, and asks to the Italian state to "provide information on measures taken to address and eradicate child poverty across all regions, including on the adoption of the National Plan for Combating Poverty and Social Exclusion" (Committee on the Rights of the Child, 2019, p. 2). At point 9, the Committee focuses on the right to health for children and adolescents within the Italian territory, and calls for data and information to be provided asking Italy to ensure "that all children, including non-citizen children, have access to health services" (Committee on the Rights of the Child, 2019, p. 2).

In the Concluding observations on the combined fifth and sixth periodic reports submitted by Italy (Committee on the Rights of the Child, 2019a), the Committee, under the paragraph inherent to the principle of non-discrimination, reiterates the already expressed concerns about the regional disparities in access to health services and other services in particular for children and adolescents, such as “the disparities between regions in access to health-care services, the minimum standard of living and education for all children throughout the country” (Committee on the Rights of the Child, 2019a, p. 4). In addition, in the same document, the Committee, referring to the Sustainable Development Goals, recommends to Italy to ensure full protection against all forms of discrimination in particular by taking “urgent measures to address disparities between the regions in access to health-care services, the minimum standard of living, adequate housing, including the prevention of forced evictions, sustainable development, and education by all children throughout the entire country” (Committee on the Rights of the Child, 2019a, p. 4).

The Committee on Economic, Social and Cultural Rights focuses its attention on the issue of poverty in Italy, and in particular, in the List of issues prior to submission of the sixth periodic report of Italy (Committee on Economic, Social and Cultural Rights, 2020), submitted on the 16th of April 2020, the point 5 it stresses on the “regional disparities in terms of availability and coverage of certain social security benefits” (Committee on Economic, Social and Cultural Rights, 2020, p. 2) highlighting how territorial inequalities are reflected in the possibility of accessing certain services and being able to fully enjoy basic human rights. Focusing on this aspect, it is possible to collect data related to the level of poverty in Italy. The presence of disaggregated data region by region provides the possibility to be able to analyze an accurate scenario and to understand the gravity of the differences present at the regional level. In addition, the availability of data enables the Committee’s concerns and recommendations to be supported and reinforced, providing the chance to understand the seriousness of the situation. It is important to say that the fact that in some regions it is recorded a much higher level of poverty explains, in part, the difference in services and facilities related to all the fields of an individual’s life.

Considering the level of absolute poverty[1] in Italy, which occurs when families or individuals “cannot afford the minimum expenses to lead an acceptable life” («Che cos’è la povertà assoluta», 2022), families who are in absolute poverty in Italy recorded in the year 2021 are located for the 6,7% in the North (among the northern regions are included

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[1] According to ISTAT (Istituto Nazionale di Statistica) the absolute poverty represents “the monetary value, at current price, of the basket of goods and services considered essential for each household, defined according to the age of the members, geographical breakdown and type of municipality of residence”.

Valle d'Aosta, Liguria, Lombardy, Piedmont, Trentino-Alto Adige, Veneto, Friuli-Venezia Giulia, Emilia-Romagna) and for the 5,6% in the Centre (Tuscany, Umbria, Marche and Lazio). The macro region that includes the South and the Islands (more specifically composed of Abruzzo, Molise, Campania, Puglia, Basilicata, Calabria, Sicily and Sardinia) records an absolute poverty level of 10% (ISTAT - Istituto Nazionale di Statistica, 2022). Focusing on children and adolescents in Italy, 1 million and 382 thousand minors in Italy are registered in absolute poverty, the 14,2% compared with 9,4% of individuals at the national levels, revealing how absolute poverty is more concentrated among people under the age of 18. In addition, the CRC Report "I diritti dell'infanzia e dell'adolescenza in Italia – I dati regione per regione 2021 – The rights of children and adolescents in Italy – Data region by region 2021" (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2021a) collects data region by region on relative poverty for the year 2020. It is important to specify that people or families are considered to be in relative poverty when "whose disposable income (or consumption) is less than half (or in some cases 60 percent) of the average (or median) per capita income or consumption is conventionally considered poor in a relative sense" (Chiara Saraceno, s.d.).

Macro-zone	**Italian region**	**Data – Relative poverty**	**Italian average**
North	Valle d'Aosta	Not available	20,4
	Liguria	19,3[2]	20,4
	Lombardy	16,6	20,4
	Piedmont	16,1	20,4
	Trentino-Alto Adige (Bolzano, Trento)	Bolzano - Not available Trento - 11	20,4
	Veneto	13,1	20,4
	Friuli-Venezia Giulia	14,2	20,4

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[2] All numerical data are given in percentages.

	Emilia-Romagna	15,9	20,4
Center	Tuscany	15	20,4
	Umbria	13	20,4
	Marche	26,8	20,4
	Lazio	9,2	20,4
South	Abruzzo	26,5	20,4
	Molise	33,8	20,4
	Campania	34,4	20,4
	Puglia	29,2	20,4
	Basilicata	34	20,4
	Calabria	32,7	20,4
	Sicily	28,5	20,4
	Sardinia	22,8	20,4

(Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2021, pages 11, 22, 33, 44, 55, 66, 77, 88, 99, 110, 121, 132, 143, 154, 165, 176, 189, 200, 211, 222).

From the available data, it is clear that relative poverty is significantly higher in the southern regions, which is always recorded above the Italian average. Even, in three regions including Molise, Campania and Calabria, the registered percentage is more than 10 points over the Italian average.

These data are important because they shed light on the seriousness of the situation. In a macro area where there is a consistent increase in poverty (both absolute and relative) there are also many problems related to the lack of adequate facilities or services, first of all those related to the sphere of health. In fact, very often in the poorer context, one of the first areas to be affected is that related to access to health and health status. In fact, at this point it is important to consider the concept of the Social Determinants of Health (SDH). It is clear that as the quality-of-life declines, these factors that are interrelated and interdependent on each other will tend to be worse, and consequently, the standard of living of certain individuals registered in a specific place will be worse or better depending on the level of poverty or wealth present. In support of this concept, the "Sixth periodic report submitted by Italy under articles 16 and 17 of the Covenant" (Committee on Economic, Social and Cultural Rights, 2021), focuses on the issue of obesity status in minors in Italy. In the Report it is reported that “overweight is a more frequent with increasing age, mainly among: men, people with economic difficulties and/or low level of education, and people in the southern regions” (Committee on Economic, Social and Cultural Rights, 2021, p. 21). There are many factors on which the issue of obesity depends. A higher level of poverty often corresponds to a lower level of prevention and consequently, there is lower awareness of the problem and thus weak resolution of it. Focusing on minors, point 134 of the Report affirms that Italy is confirmed among the countries with the highest level of excess weight in minors among the World Health Organization Regional Office for Europe (according to the Childhood Obesity Surveillance Initiative – COSI (Committee on Economic, Social and Cultural Rights, 2021, p. 21) (World Health Organization, s.d.-b). Despite this, the Report highlights the fact that there are strong regional differences “with higher percentages in the Southern and Central Regions” (Committee on Economic, Social and Cultural Rights, 2021, p. 21). The problem of obesity not only affects the cultural and social aspects, but also fully influences the health status of individuals, both in pediatric and adult age. A condition of overweight or obesity increases the risk of going into cardiovascular disease, diabetes or other diseases. In addition, the risk for an obese child to become an obese adult varies between 2 and 6.5 times compared with non-obese children (Ministero della Salute, 2004) (Boggia, 2021a). This case reveals the close connection of interdependence between the sociocultural aspect and the health-related sphere.

2.1.2 Universal Periodic Review

By analyzing the monitoring mechanism of the Universal Periodic Review (UPR), which is a “State-driven process” (United Nations Human Rights Council, 2022), the country in question, driven by the Human Right Council of the United Nations, leads a monitoring which provides the opportunity to observe and track the level of implementation of human rights within its territory. Since it is a periodic analysis, each State undergoes monitoring every 4 years and a half. The Italian state, to date, has submitted to three cycles of monitoring, respectively in 2008, 2012 and 2017.

Studying the recommendations proposed by the states over the three monitoring cycles, it is interesting to note that the issue of inequalities on a regional basis is increasingly recognized and defined. During the first monitoring cycle, in the National Report, it is emphasized that the principle of non-discrimination is one of the foundations of the Italian

Constitution. It is also mentioned that the Italian government adopted in the Council Directive 2000/43/EC titled “implementing the principle of equal treatment between persons irrespective of racial or ethnic origin” (Council Directive 2000/43/EC of 29 June 2000 Implementing the Principle of Equal Treatment between Persons Irrespective of Racial or Ethnic Origin, 2000), which is a legislation based on the principle of equality and non-discrimination founded on “the principle of equal treatment in the public and private sectors, with respect to access to employment, occupation, guidance and vocational training, membership of workers’ or employers’ organisations, social protection, healthcare, social benefits, education, goods and services” (Human Rights Council Working Group on the Universal Periodic Review, 2010, p. 16). In addition, it is stated that Italian government must guarantee “the right to health and to the highest standards of physical and mental health” (Human Rights Council Working Group on the Universal Periodic Review, 2010, p. 20), by ensuring protection of the family, in particular mothers and children (as defined in articles 29-31) (Human Rights Council Working Group on the Universal Periodic Review, 2010, p. 20).

Recommendations related to the principle of equality and non-discrimination are always present in all monitoring cycles. During the first one, many countries recommend to Italy to implement the principle of non-discrimination in all areas of an individual’s life. In particular, the state of Uzbekistan focuses its recommendation on children, by requesting to “make efforts aimed at preventing and eliminating all forms of discrimination and abuse vis-Ã -vis children” (Universal Periodic Review - Uzbekistan, 2010), in order to ensure an equal and fair treatment in all spheres of life for all minors in Italy.

During the second cycle of monitoring, the recommendation of the Russian Federation focuses on the importance of ensuring continuous and complete protection towards the most vulnerable groups of the population such as children, but also “women, persons with disabilities, older persons, national minorities, especially Roma” (Universal Periodic Review - Russian Federation, 2014).

During the third cycle, for the first time, words such as inequalities and disparities were used to deepen the general concept of discrimination. Honduras requires the realization of “measures to combat discrimination, in particular discrimination against children with disabilities and children with migrant backgrounds, in order to reduce inequalities in access to education, health care and development” (Universal Periodic Review -

Honduras, 2019). This recommendation is important because it focuses on the concept of "inequalities in access", emphasizing the concept that discrimination can be present in access to certain essential services in the life of the child, such as education, health, or development. The fact that there is discrimination in access to fundamental services can be identified as an effect of procedures, policies or organizational culture that contribute to create a less favorable treatment for some people and thus to create an obstacle to the full enjoyment of basic human rights. In this case, of course, these conditions are not intentionally created by the state, but reside in structures and organization and produce a condition of inequality as a result. Again, this feature reveals the presence of discrimination intended as systemic.

The state of Luxembourg raises, for the first time at the level of the Universal Periodic Review monitoring, the issue of regional differences and inequalities rooted in the Italian territory in access to health care. The recommendation insists on the concept of implementing "necessary measures to limit regional disparities in accessing health care, including for migrants" (Universal Periodic Review - Luxembourg, 2019).

In another recommendation the state of Honduras stresses on the necessity to eradicate forms of discrimination and eliminate the structural causes of inequalities. This recommendation, which in its first part focuses on discrimination against women, states that it is necessary to "take measures to eradicate multiple forms of discrimination against women, and eliminate the structural causes of inequalities" (Universal Periodic Review - Honduras, 2019). This recommendation is important because defines the causes of inequalities as structural and requires the state to consider the concept of discrimination as rooted in certain structures and to work in to be able to eradicate the effect of inequality that occurs against those people – or groups of people – to enable them to enjoy their fundamental rights. As was mentioned in the study of systemic discrimination proposed in the first chapter of this research, what is important in dealing with this type of discrimination is first to recognize it, since it is rooted in structures and routines within broad mechanisms.

2.1.3 UN Concluding Observations to Italy and other relevant documents

At the end of the government reports assessment process, the United Nations publishes a document of Concluding Observations reserved for the examined state. These recommendations should be used as guidelines for the country to take more targeted actions to achieve an even greater level of implementation of human rights.

In the Concluding Observations published in 2011, United Nations, under point 8, expresses concerns regarding the presence of inequalities created by the way the system has been organized (involved bodies and resources), affirming that "the Committee is concerned that the devolution of powers from central to regional and other subnational levels of government has contributed to an inequitable implementation of the Convention at the local level" (Committee on the Rights of the Child, 2011, p. 3) stressing on the importance of developing "effective mechanisms to ensure a consistent application of the Convention in all regions by strengthening the coordination between the national and regional levels" (Committee on the Rights of the Child, 2011, p. 3).

Under point 17, the Committee urges the State party to "ensure that the national information system on the care and protection of children and their families becomes fully operational […]. In particular, the Committee recommends that the State party ensure a fully consistent approach across all regions to effectively measure and address regional disparities" (Committee on the Rights of the Child, 2011, p. 5). In the Concluding Observations published in 2019, the attention to the regional disparities is even more accurate. Point C focuses on General principles of the Convention, and under the principle of non-discrimination affirms that the Committee reiterates its previous concerns, especially the one related to "the disparities between regions in access to health-care services, the minimum standard of living and education for all children throughout the country" (Committee on the Rights of the Child, 2019b, p. 4) and recommends to Italy to undertake urgent measures "to address disparities between the regions in access to health-care services, the minimum standard of living, adequate housing, including the prevention of forced evictions, sustainable development, and education by all children throughout the entire country" (Committee on the Rights of the Child, 2019b, p. 4).

The Committee insists on the state's responsibility as regards the respect of the rights set forth in the Convention on the Rights of the Child. In the General Comment No. 5, under the paragraph related to "Decentralization, federalization and delegation", the Committee underlines the concept that "decentralization of power, through devolution and delegation of government, does not in any way reduce the direct responsibility of the State party's Government to fulfil its obligations to all children within its jurisdiction, regardless of the

State structure" and affirms that the state must ensure that the decentralization process does not "lead to discrimination in the enjoyment of rights by children in different regions" (Committee on the Rights of the Child, s.d.).

Even in General Comment No. 15, the Committee highlights the fact that the States parties, in this specific case Italy, in order to ensure the full enjoyment of the right to health and to the highest possible standard of health for all children and adolescents, has the obligation to secure that "children's health is not undermined as a result of discrimination, which is a significant factor contributing to vulnerability" (Committee on the Rights of the Child, 2013b, pages 4). Under this paragraph, the Committee focuses on the concept of discrimination, as also established by the definitions reported by most international conventions, which can be the result of different ground of discrimination such as, "the child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. These also include sexual orientation, gender identity and health status, for example HIV status and mental health" (Committee on the Rights of the Child, 2013b, pages 4-5). The Committee also emphasizes the point that attention should be paid also to those contexts in which more than one discrimination factor is present, since "the implications of multiple forms of discrimination should also be addressed" (Committee on the Rights of the Child, 2013b, pages 4-5). In fact, in this document it is specified that health and related services "must be accessible to all children, […] without discrimination of any kind" (Committee on the Rights of the Child, s.d.-b, p. 12).

2.2 Analysis of an Italian-level human rights monitoring: the Italian CRC Group

2.2.1 The Italian NGO Group for the Convention on the Rights of the Child –Gruppo CRC and its activity

Among the tools studied for this research, along with international monitoring, it is considered the valuable job of the Italian NGO Group for the Convention on the Rights of the Child – Gruppo di Lavoro per la Convenzione sui diritti dell'infanzia e dell'adolescenza – Gruppo CRC (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, s.d.-a). This network was created in December 2000, and its name comes from the translation of "NGO Group for the CRC" which was the previous name of the now called “Child Rights Connect”. Child Rights Connect, which is an organization based in Geneva, was founded in 1983 precisely during the drafting phase of the Convention on the Rights of the Child (which will be concluded in 1989). The Italian CRC Group has been part of the Child Rights Connect network, which aims to promote the full implementation and monitoring of the Convention on the Rights of the Child, in particular by facilitating the participation of National NGO Coalitions in UN Committee Sessions.

The Group is an Italian NGO, which is coordinated by Save the Children Italy, and, as Child Rights Connect, it is committed to the promotion and the full implementation of the Convention on the Rights of the Child. The Italian name is “Gruppo di Lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza – Gruppo CRC”, and represents a network “open to any association, NGO, cooperative, foundation and any other stakeholder from the third sector dealing with the promotion and protection of children’s rights in Italy” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, s.d.-a).

To date, the Italian CRC Group carries out the aim of drafting a supplementary Report on the full implementation of the Convention on the Rights of the Child in Italy, to be submitted to the United Nations Committee on the Rights of the Child under the High Commissioner for Human Rights. The mandate of the CRC Group is “to guarantee an independent, permanent and up-to-date monitoring system on CRC implementation, agreed upon by all members, and to implement relevant advocacy actions” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, s.d.-a). In addition to this task, the CRC Group is committed to draft a yearly follow-up on the level of implementation of the Convention on the Rights of the Child in Italy, to meet “public stakeholders in order to assess the implementation of the CRC Report’s recommendations and Concluding Observations” and to provide training for NGOs and other associations which are engaged in the implementation of the CRC. Talking about its activity, the CRC Group was formed in December 2000 and published its first Report in 2001. Since that moment, the CRC Group has been engaged in the production of different types of monitoring Reports at the Italian level. In fact, it is possible to classify their work in the following categories: Supplementary Reports, CRC Reports, Reports “The Rights of Childhood and Adolescence in Italy - Data Region by Region” and Report

"The Rights of Childhood and Adolescence in Italy. Resources dedicated to childhood and adolescence in Italy". At that time, the CRC group's priority was to prepare a Supplementary Report to the one that the State must submit every five years to the United Nations, since it has ratified the Convention on the Rights of the Child. This Report is important because it calls on the entire third sector engaged in the implementation of children's rights to express its viewopinion on the achievement of the goals set and the effective implementation of the Convention within the state. About 40 associations in Italy participated in the drafting of the first supplementary report. The working method involved each participant contributing based on their specific expertise. The document is the result of an important process of discussion and aggregation of the Italian third sector, which for the first time found itself united in defining a shared analysis of children's rights. The Report, which synthesizes the contributions and perspectives of many of the organizations and associations working with and for children in Italy, represents the first step toward the creation of a common observation platform on the rights of children and adolescents and a non-governmental monitoring system on the state of implementation of the Convention on the Rights of the Child. The supplementary report is intended to express the idea of a work that focuses more specifically on certain issues of the Convention considered most significant in relation to the current situation in Italy. The second Supplementary Report was published on the 18th of November 2009 and was subscribed by all the 86 associations part of the CRC Group at that time while the third one was published on the 6th of December 2017 on the occasion of Italy's review by the UN Committee. The document, which was signed by 96 associations, collects 157 recommendations from various entities such as government, local government, and parliamentary representatives (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, s.d.-b).

From 2005 onwards the CRC Group published the Update Report on the Monitoring of the Convention on the Rights of the Child and Adolescent in Italy, with a total of 12 published reports.

In 2018 and 2021 the CRC Group published respectively two Reports entitled "The Rights of Children and Adolescents in Italy – Data region by region". The purpose of this publication is to provide a region-by-region overview of the condition of childhood and adolescence. This report presents data available from official sources disaggregated on a regional level. The publications are structured into regional fact sheets which offer accurate data which can be easily compared between different regions. Each sheet also presents a comparison between the regional figure and the Italian situation, so that regional trends can be more easily highlighted in comparison with the Italian average.

On May 27, 2011, on the occasion of the 30th anniversary of Italy's ratification of the UN CRC Convention – by law 176/1991 – the CRC Group proposed an additional publication focusing on the resources allocated by the Italian state to ensure effective implementation of the Convention.

2.2.2 The complaint of inequalities on a regional basis

The CRC Group, since the fourth CRC Report, focuses great attention on the issue of regionally based inequalities in access to services for minors in Italy, focusing a special attention to the right to health and access to health services.

The 4th CRC Report (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2008), was published on the 27th of May 2008 and refers to the years 2007 and 2008. This edition is fundamental because, for the first time an Italian report dedicates an entire paragraph to the inequalities on a regional basis, entitled "Adoption of effective measures to prevent and eliminate disparities on a regional basis"[3] (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2008, p. 35). In the introduction of the principle of non-discrimination, the CRC Group affirms that the principle on non-discrimination is fundamental, and it should be applied in all areas of children's lives. It focuses on the concept that "it is primarily the responsibility of the state, as the Constitution states, and of the relevant institutions, both at the central and local levels, to ensure the application of this principle and the removal of obstacles that prevent its full realization, while also providing victims of discrimination with the appropriate tools to assert their rights in court" (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2008, p. 34). The 4th Report shows some issues related to the topic of health and focuses its attention on the differences rooted on a regional basis. In fact, in chapter V related to "Health and Care", the CRC Group analyzes the situation related to birth rate, infant mortality, the use of psychotropic drugs for adolescent children, the chronic disease-

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[3] The CRC Group reports, except for the two Supplementary Reports, are available only in Italian language. The translations included in this research are translated by the author of the thesis.

related distress, and pediatric HIV/AIDS. During this analysis, the 4th Report confirms what was presented in the 3rd CRC report and raises the question of the presence of differences on a regional bases, in particular related to these health issues, affirming that a “greater incidence in the South than in the North of those that negatively influence the health status of the population, particularly the most vulnerable people”, adding that “at the territorial level, infant mortality in the South (5.3) is higher than in the North (3.3)” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2008, p. 70). Talking about caesarean sections, it is reported that the rate is still very high, as shown by data collected in some regions, such as “Campania (over 60% of deliveries), Sicily (52.3%) and Basilicata (50.4%)” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2008, p. 70). The CRC Group proposes many recommendations based on the concept of the elimination of the inequalities on a regional bases, such as this one addressed to the Ministry of Health, to the Ministry of Social Solidarity and to the Regions, which stresses on the necessity to “activate intervention programs (including educational, informational, and refresher courses) aimed at reducing the enormous inequality between and within regions in the care of the juvenile population” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2008, p. 71).

The 2nd Supplementary Report to the United Nations, in the monitoring of the Convention on the Rights of the Child and adolescents in Italy published on November 2009, reiterates an entire paragraph on the “Adoption of effective measures to prevent and eliminate disparities on a regional basis” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2009, p. 38). In addition, the CRC Group urges with many recommendations aimed at activating programs or setting up strategies to reduce the gap between Italian regions (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2009, p. 92). Regarding the issue of mental health, the CRC Group highlights that “in contrast to Regions in which an adequate system of NPIA[4] services has been created over the years and children and families are basically guaranteed care and therapy, there are many others in which facilities […] and departments for hospitalizations are lacking […]” (Gruppo CRC -

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[4] NPIA – Servizio di Neuropsichiatria Infanzia e Adolescenza – Child and Adolescent Neuropsychiatry Service.

Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2009, p. 100). Footnotes 94 and 95 (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2009, p. 100), specify that regions where the system works the most are Lombardy, Emilia Romagna and Piedmont, while those where services are lacking are Calabria, Campania and Puglia.

In May 2011, the CRC Group published the "Update Sheets – Schede di aggiornamento" related to the 2nd Supplementary Report, where there is an in-depth discussion on the issue of disparities on the regional basis, focusing on the increasing federalization on the Italian system of regions (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2011, p. 10).

In the 5th CRC Report many recommendations are reiterated, in particular the ones addressed to the Ministry of Labor and Social Policy, to the Ministry of Health and to the Regions, which focus on the necessity of activating action "designed to reduce the unacceptable inequality between geographic areas in the quality of pregnancy care, and to increase attention with respect to households with special needs, preconception counseling, support for parenting skills, and respect for the rights of women and children when hospitalized" (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2012, p. 66). Even in this document there is a great focus on mental health, which is addressed in different ways region by region, confirming a worse condition in southern regions (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2012, p. 72).

In the 6th CRC Report, many recommendations focus on several health-related issues, for which persist strong differences based on a regional basis (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2013, p. 78). Concerns about mental health and the related inequalities are also confirmed.

The 7th CRC Report, the paragraph entitled "Ensuring the right for all children to the opportunities of cognitive, emotional and social development in the early years of life" (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2014, p. 13), focuses a special attention on the inequalities present in health, as in other spheres of life, affirming that "WHO, UNICEF and the international scientific community are arguing with increasing strength that interventions to support parenting in the early years of life are the high road to promoting the right of all children to develop their potential and to reduce inequalities in health, as in education and social life”. Recommendations, as in the previous reports, stresses the necessity to activate special plans to decrease inequalities aimed to “reduce the unacceptable inequality between geographic areas and social groups in the quality of pre and perinatal care” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2014, p. 87). Even in this report some serious regional differences concerning health are reported, such as one that records a 30% higher infant mortality rate in southern regions than in northern regions (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2014, p. 86). Concerns related to the inequalities in the treatment of mental health are once again confirmed (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2014, p. 99).

In the following report, the 8th CRC Report, there are several insights into the importance of cultivating a high standard of health, without inequalities, starting from the earliest years of life, as this is the basis for a healthy life. The CRC Group affirms that preventive interventions and services “must increasingly adopt methodologies for overcoming inequalities in access” since “it is in childhood that the foundation for adults health is laid” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2015, p. 96). The most important international agencies, such as the World Health Organization and UNICEF insist on the necessity of actions to combat inequalities, affirming that it is fundamental to “implement a surveillance system capable of assessing health-related behaviors and effectively targeting interventions” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2015, p. 96). Even the 8th Report focuses its attention on important issues such as infant mortality (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2015, p. 105) and mental health in minors (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2015, p. 109), which record, even in this edition, a serious condition of inequality of services between northern and southern regions.

The 9th CRC Report presents many paragraphs focused on regional differences in access to health for minors in Italy. This Report affirms that in Italy remain unacceptable inequalities, especially in the “outcomes of care, in access to services, and in the types and quality of services provided” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2016). In addition, often for many indicators related to the sphere of health, the average recorded by the whole State conceals both serious weaknesses and excellences present in the different Italian regions. Even in this report, many regional differences are highlighted. For example, in 2014, the coverage of the second dose of the measles-mumps-rubella (MPR) vaccine was 65% in Calabria and Sicily while it is more than 85% in Veneto and Piedmont, where a better coverage has been ensured through actions taken at the regional level. Infant mortality rates (but also many other indicators such as, such as the proportion of children who receive a diagnosis that qualifies them for a support teacher; the number of children with disabilities who use support; the proportion of children who are not autonomous-in moving, eating, or going to the bathroom) in Calabria are two times worse as in many northern regions. The 9th Report, therefore, confirms the seriousness of a situation that persists and requires programs of action aimed at reducing regional differences, affirming that it is necessary an effort undertaken by all the bodies involved (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2016, pages 108-109-110).

In the 3rd Supplementary Report on the implementation of the Convention on the Rights of the Child, published in February 2018, again many recommendations addressed to the Regions, stress the necessity to “set up a working group to coordinate their different policies for children” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2017, p. 11) reiterating “the differences in the standard of living and opportunities that exist between different Regions” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2017, p. 14). In this edition, a special attention is focused on “the percentage of Caesarean births”, which is high and records serious differences, for example “Campania ranks first in Italy (60.5%), while Tuscany has the lowest number of Cesarean births” (21.7%) (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2017, p. 29). This Report records an “enormous regional differences in both access to and the quality of health care services in Italy”, since regional health migration is represented by a large movement from southern Italy, “above all Calabria and Campania, towards central and northern Italy” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2017, p. 31).

Even the 10th and 11th CRC Reports focus on the increasingly clear concept of regionally based inequalities in Italy. The 11th cycle reports the important fact that the United Nations, accepting the recommendation launched by the 3rd Supplementary Report, reiterated his concern about the "disparities that exist between regions with regard to access to health services, the essential standard of living and education for all minors in the country" (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2020, p. 11) by specifying that these disparities are to be considered as violations of the principle of non-discrimination, since "inequalities are synonymous with denied rights" (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2020, p. 121). The 12th and last CRC Report, in light also of the two CRC Reports which analyze data region by region, reiterated all the concerns presented, stating that "there are still major differences in both educational and socio-medial sphere" (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2022, p. 39).

2.3 Concluding analysis of documentation

The collection and the analysis of these documents and reports offers the valuable opportunity to elaborate on some important consideration.

First, thanks to the preliminary study on systemic discrimination introduced in the first chapter, it is possible to conduct the hardest task regarding this type of discrimination, which is to recognize it. In fact, as has been said, very often it is difficult to recognize and identify it because structural discrimination is rooted in structures, mechanisms, and policies, and does not reveal itself as a specific intention to discriminate, but rather as an effect of inequalities. Again, from the analysis of the documents, what is clear is the fact that this effect of different treatment is almost always present, and that therefore, in recent years, the treatment reserved to some minors compared to others is confirmed different and worse depending on the region of origin, thus confirming the presence of systemic discrimination against some children and adolescents.

CHAPTER 3. THE RIGHT TO HEALTH FOR MINORS IN ITALY: ANALYSIS OF FIVE INDICATORS

3.1 Case study presentation

This chapter aims to examine whether there is systemic or structural discrimination towards certain minors living on Italian territory, based on their region of origin. To carry out this task, a selection of specific and fundamental indicators related to the issue of health were chosen, and for each of them region-by-region disaggregated data were analyzed. The purpose is to verify, through numerical analysis of these indexes, whether some children and adolescents living in Italy face more disadvantaged conditions than others. Five indicators were selected and analyzed for this case study that relate both to access to specific primary health care services for children and adolescents and to health status in the early years of life. The indicators selected, a detailed overview of which will be provided in the following paragraphs, represent services that occur as the result of policies and mechanisms that have been in place for years, and which should ensure the same health services and thus the same rights for all children living in Italy.

The evidence of inequalities in access to these basic services thus confirms the presence of discrimination, which in this case is confirmed to be systemic as it is rooted in social mechanisms and structures, against certain children and adolescents based on their region of origin.

3.2 Presentation of the five indicators

As was previously mentioned, to conduct this research five indexes were selected, which are precisely analyzed during this chapter.

The five indicators are:

1. Caesarean section
2. Child mortality
3. Pediatric intensive care
4. Interregional mobility for pediatric care
5. Overweight and obesity status in adolescents.

These points are the result of a precise and accurate analysis of the main pediatric services and some of the most important monitoring of the level of health for this age group, which takes into consideration the various essential factors which are explained below.

- The five indicators refer to the main phases of a child and adolescent's life. In fact, the first point is about the beginning of a child's life precisely, the moment of birth. The type of delivery reveals a range of important issues, covering both the moment of pre-birth prevention and the level of postpartum care, thus revealing the deep connection of this moment with access to all other health services. Regarding the second indicator, infant mortality may depend on many causes, first of all, the complication of preterm delivery (EpiCentro, 2016), and confirms this as a critical issue in the early years of the life of a child. The emergence of a serious complication in the child's health necessarily requires the availability of pediatric intensive care, in order to provide assistance for the child in the most appropriate way possible, in a condition where both structures and materials are appropriate for the care of pediatric diseases. The interregional mobility for pediatric care is confirmed to be an issue to date that is more important than ever. Data presented by several studies confirms that there is an influx of people moving to other regions to seek the best care. The rates, as will be seen below, confirm a strong migration of patients moving from southern to northern regions. This massive displacement can be interpreted as a reaction to the lack of basic health care services and reveals the presence of inequalities in access to the right to health especially in certain regions. The analysis of overweight and obesity status in adolescents is one of the most representative indicators to reveal the level of well-being of children and adolescents. The differences recorded from region to region reveal many connected issues, such as the social, economic, and cultural contexts, the level of nutrition education in which a child grows up, but also the level of food poverty.
- The choice of these indicators is driven by the fact that all items are closely related to various factors which are defined as Social Determinants of Health (SDH). As was previously explained, these factors often do not relate strictly to health services, but they affect the level of health of an individual or group of people.

The choice of a specific type of birth, the level of hospitalization rate recorded in a region compared to another, or the level of obesity are factors that depend both on the social, cultural, and economic context in which people are born, grow up and live, but also on the level of prevention in place in relation to certain issues. In fact, to highlight this link between the right to health and social economic and cultural status, it is important to consider, for example, the fact that a poor prevention carried out in the early years leads to a higher level of sick children and thus a higher rate of hospitalization. Or, a high rate of severely obese children reflects a poor dietary culture, and often the absence of sports activity.

- The indicators chosen are supported by the presence of accurate and disaggregated data region by region to provide a comprehensive overview of the situation and to understand its severity. Having comprehensive data available in relation to a given issue is not a given factor; indeed, the problem of data collection is one of the most reported and discussed issues at the Italian level (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2022, p. 29). The CRC Group has for years insisted on the necessity to create effective methods for data collection. In fact, the presence of accurate data in reference to certain issues provides the opportunity to be able to fully understand the problem, both in its scale and seriousness, and the solutions or policies that are adopted as the solution can be created on a strong numerical basis. In addition, it is fundamental to collect data region by region because often the average calculated across regions hides details useful to understand where inequalities occur or where certain services are lacking. For example, in the case of child mortality, which will be more precisely analyzed in the next paragraphs, the Italian average does not reveal a serious general condition, but by analyzing the data region by region, it is clear that in some regions the record is far below the average, while in others it is far above.

  In conclusion, therefore, the selection of these indicators was also motivated by the reason that for each of the five selected indexes there are accurate data collected for each region.

Furthermore, for the purpose of this study, in addition to analyzing the data region by region, the indicators will be examined and divided into two macro-areas, created based on the geographic location of each region. These two macro-areas are respectively framed as the North Central regions and the Southern regions. Piedmont, Valle d'Aosta, Lombardy, Trentino-Alto Adige (with a specific focus on the autonomous provinces of Bolzano and Trento), Veneto, Friuli-Venezia Giulia, Liguria, Emilia-Romagna, Tuscany, Umbria, Marche, and Lazio belong to the first group, while Abruzzo, Molise, Basilicata, Calabria, Sicily, and Sardinia belong to the second one.

3.3 Analysis of the indicators

3.3.1 Caesarean section

The caesarean section is the first indicator presented in this study. To conduct this analysis, the index will first be briefly analyzed from a medical point of view, and then data collected region by region will be presented.

The cesarean delivery indicator is adopted at the international level among the indicators of Reproductive Health and at the Italian level among the markers which register the effectiveness and the appropriateness selected by the General Direction of Health Planning of the Italian Ministry of Health – Direzione Generale della Programmazione Sanitaria del Ministero della Salute (EpiCentro, Istituto Superiore di Sanità, s.d.). The World Health Organization repeatedly addresses this issue and states that caesarean sections are “effective in saving maternal and infant lives, but only when they are required for medically indicated reasons” (World Health Organization, 2015, p. 1). In addition, the WHO affirms that “caesarean sections can cause significant and sometimes permanent complications, disability or death particularly in settings that lack the facilities and/or capacity to properly conduct safe surgery and treat surgical complications” (World Health Organization, 2015, p. 1) insisting that this practice should be undertaken only when it is medically necessary. In addition to these complications, several studies claim that natural childbirth could protect the newborn from specific diseases (Fabio Di Todaro, 2019) (Ferretti et al., 2018) (Shao et al., 2019) (Dominguez-Bello et al., 2016).

Given these premises, the presence of a high percentage of caesarean sections in a specific region, or group of regions, is confirmed as a difference in access to a fundamental service of the child’s health, thus violating the principle of pursuing the highest attainable standard of health and the respect for the principle of the best interest of the child.

Regarding the data, the table illustrated below, shows the numbers related to three subsequent years, which are 2019 (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2021b, pages 16, 27, 38, 49, 60, 71, 82, 93, 104, 115, 126, 137, 148, 159, 170, 181, 194, 205, 216, 227), 2020 (Rosaria Boldrini et al., 2021, p. 56) and 2021 (Rosaria Boldrini et al., 2021, p. 56). The table highlights data as a percentage of total caesarean sections, both those registered in the public and in private clinics, respectively for the years 2019, 2020 and 2021. the Italian average by year is presented before each data list to facilitate comparison with each region.

Macro-zone	**Italian region**	**Caesarean section Data (2021) – Italian average 31,2**	**Caesarean section Data (2020) – Italian average 31,3**	**Caesarean section Data (2019) – Italian average 31,7**
North and center	Valle d'Aosta	20,8[5]	21,7	24,8
	Liguria	29,9	30,5	30,5
	Lombardy	23,1	23,2	23,7
	Piedmont	26,4	26,7	27,3
	Trentino-Alto Adige (Bolzano, Trento)	24,6 20,6	23,4 19,6	24,6 19,2
	Veneto	25,1	24,7	24,9
	Friuli-Venezia Giulia	21,0	20,5	20,9
	Emilia-Romagna	23,1	23,6	24,2
	Tuscany	19,1	20,5	21,2

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[5] All numerical data are given in percentages.

	Umbria	23,0	22,8	21,8
	Marche	25,6	26,4	26,6
	Lazio	36,7	35,9	36,6
South	Abruzzo	31,0	31,4	32,0
	Molise	35,6	37,1	37,0
	Campania	50,2	50,0	50,3
	Puglia	37,5	38,8	39,2
	Basilicata	33,3	35,3	34,9
	Calabria	38,5	36,8	38,0
	Sicily	39,9	39,9	39,9
	Sardinia	35,3	35,9	36,5

Source for the year 2019: Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, *I diritti dell'infanzia e dell'adolescenza in Italia – I dati regione per regione 2021*, pages 16, 27, 38, 49, 60, 71, 82, 93, 104, 115, 126, 137, 148, 159, 170, 181, 194, 205, 216, 227.

Source for the year 2020: Rosaria Boldrini, Miriam Di Cesare, Fulvio Basili, Campo Gaia, Moroni Rossana, Morgan Romanelli, Elvira Rizzuto, Vito Trevisani, *Certificato di assistenza al parto (CeDAP), Analisi dell'evento nascita - Anno 2020,* p. 56.

Source for the year 2021: Rosaria Boldrini, Miriam Di Cesare, Fulvio Basili, Campo Gaia, Moroni Rossana, Morgan Romanelli, Elvira Rizzuto, Vito Trevisani, *Certificato di assistenza al parto (CeDAP), Analisi dell'evento nascita - Anno 2021*, p. 56.

As can be seen from both the table, regarding the years analyzed, as for the northern and central regions, except for Lazio, none exceeds the Italian average, but rather some are confirmed to be below it by many points. On the other hand, by analyzing the situation present in the southern macro zone, all regions are confirmed to be above the Italian average, for the years 2019, 2020 and 2021. Some regions, even, such as Sicily and Puglia exceed the Italian average by almost 10 points, while Campania exceeds the average by almost 20 points. Observing the table, the two areas analyzed show markedly different characteristics, as numerical data, that should not be hidden from the Italian average. Thus, the data reveal that in some regions many more cesarean deliveries are performed, in percentage terms, than in others, going against international and Italian directives in this regard and increasing the risk of complications that can arise from this type of delivery if it is performed without a medical prescription.

3.3.2 Child mortality

Child mortality is defined as the probability, for a child, to die between the first and fifth years of life. Within this definition it is possible to talk about neonatal mortality and infant mortality, respectively intended as the probability to die within the first month of life and the probability to die before the first birthday, and about under-five mortality, which is "the probability of dying before the fifth birthday" (Demographic and Health Surveys - The DHS Program, s.d.). To date, it is estimated that globally, infant mortality is caused by a variety of factors, among which are listed "respiratory infections (19%), diarrhea (18% […], malaria (8%), pneumonia and neonatal sepsis (10%), pre-term birth (10%), and birth asphyxia (8%)" (EpiCentro, s.d.).

Italy has one of the lowest infant mortality rates in the world (ISTAT - Istituto Nazionale di Statistica, 2014) in fact, as highlighted by the CRC Report "The Rights of Children and Adolescents in Italy – Data by Region 2021" (I diritti dell'infanzia e dell'adolescenza in Italia – I dati regione per regione 2021) registered infant mortality in 2019 is confirmed to be 2,50[6], considering that the European average has a rate of 3,4 (Aogoi - Associazione Ostetrici Ginecologi Ospedalieri Italiani, s.d.).

As was previously stated, studying the average recorded data in a particular country can be reductive, as it hides the inequalities that can be rooted at the regional level.

This section shows infant mortality data for 2019, which are confirmed to be the most recent available data recorded by the National Institute of Statistics – Istituto Nazionale di Statistica (ISTAT) (ISTAT - Istituto Nazionale di Statistica, s.d.), and for 2018, studies the data already carefully collected and presented in the CRC group report The Rights of Children and Adolescents in Italy – Data by Region 2021 (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2021a).

Macro-zone	**Italian region**	**Infant mortality Data (2019)**	**Infant mortality Data (2018)**	**Italian average (2019)**	**Italian average (2018)**
North and center	Valle d'Aosta	2,38	2,21	2,50	2,88
	Liguria	2,63	2,54	2,50	2,88
	Lombardy	2,19	2,56	2,50	2,88

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[6] The present data means the number of deaths per 1,000 live births.

	Piedmont	2,43	1,96	2,50	2,88
	Trentino-Alto Adige (Bolzano, Trento)	1,53 2,12	3,22 3,45	2,50	2,88
	Veneto	2,56	2,12	2,50	2,88
	Friuli-Venezia Giulia	2,00	2,17	2,50	2,88
	Emilia-Romagna	2,78	2,31	2,50	2,88
	Tuscany	1,45	2,17	2,50	2,88
	Umbria	1,61	3,11	2,50	2,88
	Marche	2,17	1,67	2,50	2,88
	Lazio	2,39	3,04	2,50	2,88
South	Abruzzo	3,06	3,02	2,50	2,88
	Molise	1,56	2,11	2,50	2,88
	Campania	2,72	3,85	2,50	2,88
	Puglia	2,18	3,28	2,50	2,88
	Basilicata	3,54	4,04	2,50	2,88
	Calabria	4,42	3,95	2,50	2,88
	Sicily	3,34	4,03	2,50	2,88
	Sardinia	1,81	2,54	2,50	2,88

Source for the year 2018: Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, *I diritti dell'infanzia e dell'adolescenza in Italia – I dati regione per regione 2021*, pages 17, 28, 39, 50, 61, 72, 83, 94, 105, 116, 127, 138, 149, 160, 171, 182, 195, 206, 217, 228.

Source for the year 2019: ISTAT - Istituto Nazionale di Statistica, *Mortalità infantile per territorio di residenza: Quozienti di mortalità infantile, 2019*.

As it is clear from the analysis of the data, the southern regions of Italy record severely higher rates of infant mortality than those registered in the central and northern regions. In some cases, such as in Basilicata, Calabria and Sicily, the mortality rate is more than double compared to some regions in the center-north, which, however, the level remains mostly always below the Italian average. The Italian Society of Pediatrics – Società Italiana di Pediatria (SIP) has for years been concerned about the serious situation of inequality, stating that “a child born in the South is 47% more likely to die than one born in the Northeast”[7] (Boggia, 2020), remarking that “to birth in safety is a right enshrined in the State-Regions agreement of December 2010”. It is also clear that living the early years of life in a safe and comfortable condition is a necessary requirement for respecting basic human rights, the right to health and the right to the best interests of the child.

3.3.3 Pediatric intensive care

The first moments of a child's life, as was explained in the section on infant mortality, are certainly the most challenging and complicated. It is therefore a fundamental right of the child to have access to an adequate level of medical care in case their condition becomes complicated. Therefore, one of the essential and fundamental services to care in the early years of life is the intensive care unit, which is responsible for managing cases in which the patient requires a high intensity of care or results in a life-threatening condition. Intensive care units dedicated to the early years of life are divided into two main types, which are the Neonatal Intensive Care and the Pediatric Intensive Care. The first deals with the treatment of a child who is less than 30 days old or weighs less than 5 kilograms (Ospedale Pediatrico Bambino Gesù, s.d.). The pediatric intensive care unit accommodates patients aged 0-18 years with impaired vital functions (or at imminent risk of impaired essential functions) (Dipartimento di Salute della Donna e del Bambino, Università degli Studi di Padova, s.d.).

The purpose of this analysis is to understand how, at both the Italian and regional levels, the centers offering access to this fundamental and vital service are distributed, in order to understand whether all children have the same right of access to primary care and therefore are entitled to the full enjoyment of the right to health.

First of all, it is important to highlight that in Italy there is no defined and recognized method for the identification of Pediatric Intensive Care Units, and this lack makes it very complicated to accurately assess the number of beds and departments available (Boggia, 2021b). In the already difficult Italian condition often characterized by the absence of some specific data related to certain issues, the absence of a uniformly recognized

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[7] The text of this article is translated by the author of the thesis.

definition adds a further obstacle to understanding the magnitude of the problem and thus being able to address it with the right tools and energy.

Talking about numbers, the Italian Society of Pediatrics – Società Italiana di Pediatria (SIP), during the 76th Congress held in May 2021 confirms that "pediatric intensive care beds in Italy are about 202 with an average of 3 beds per 1 million population, well below the European average of 8"[8] (Boggia, 2021b), and emphasizes the evident importance of this specialized service for the child's care, since "pediatric intensive care is calibrated to children, there is a high specificity of not only the devices but also the skills of the pediatric intensivist" (Boggia, 2021b). The data presented in successive publications are intended to provide a comprehensive overview of the topic concerning intensive care in order to present at least in part the serious context of inequality rooted in Italy in relation to this issue.

First of all, almost 30% of children and adolescents aged 0-17 years, and more specifically 85 percent of patients in adolescent age (which is intended between 15 and 17 years) "are admitted to adult wards, in conditions of promiscuity with elderly patients and with medical and nursing staff inadequately trained for child and adolescent care"[9] (Ministero della Salute, 2017, p. 14). This condition results in children and adolescents who are hospitalized in a worse condition that is not calibrated to their medical and personal needs and requirements, increasing the risk of infant mortality (Lotti, s.d.) (*Report sulle terapie intensive pediatriche Italiane. Congresso SARNePI*, s.d.).

Since there is no one single and clearly defined definition on how to intend Pediatric Intensive Care units, for this research it is adopted the classification proposed by the Italian Society of Pediatric – Società Italiana di Pediatria (SIP), which considers as referral centers those units in which more than 100 patients under the age of 18 are admitted per year, and which therefore record considerable activity.

Regarding the hospitals equipped with pediatric intensive care, there are officially 26 centers (intended as intensive care wards with more than 100 patients per year under 18 years of age). The data reveals that there are also 36 units with between 100 and 20 patients per year, which record a gradually decreasing experience (Società Italiana di Pediatria SIP, 2022).

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[8] The text of this article is translated by the author of the thesis.

[9] The text of this document is translated by the author of the thesis.

The table below briefly presents the distribution of centers with pediatric intensive care at the regional level.

Macro-zone	**Italian region**	**Pediatric Intensive Care Data (2019)**
North and center	Valle d'Aosta	0
	Liguria	1
	Lombardy	7
	Piedmont	2
	Trentino-Alto Adige (Bolzano, Trento)	0 0
	Veneto	3
	Friuli-Venezia Giulia	1
	Emilia-Romagna	2
	Tuscany	2
	Umbria	0
	Marche	2
	Lazio	3
South	Abruzzo	0
	Molise	0
	Campania	1
	Puglia	1
	Basilicata	0
	Calabria	0
	Sicily	1
	Sardinia	0

Data reported in 2022: Società Italiana di Pediatria (SIP), *Terapie intensive: quando l'assistenza pediatrica fa la differenza*, Pediatria, Publication number 4-5, April-May 2022.

And thus, the distribution at the macro zone level results as follows:

Macro-zone	Pediatric Intensive Care Data (2019)
North and centre Italy	23
South Italy	3

Data reported in 2022: Società Italiana di Pediatria (SIP), *Terapie intensive: quando l'assistenza pediatrica fa la differenza*, Pediatria, Publication number 4-5, April-May 2022.

These two tables show the distribution of centers at the regional level. Considering the two macro areas into which the regions are divided by their geographical location, it can be noted that most of the centers which admit more than 100 patients under the age of 18 are located in the northern and central regions. As for the southern regions, only 3 centers with considerable activity are recorded, confirming that this service is scarcely present. In fact, this data shows a serious lack of services, since more than half of the southern regions, including Abruzzo, Molise, Basilicata, Calabria, and Sardinia do not record any center on their territory. This fact is established as a serious inequality towards some children and adolescents, who do not have access to the same right to health as others, based on their region of origin. The intensive care unit, as was mentioned before, is an essential ward for safely carrying out several other medical services, as it is the unit that intervenes if a complication occurs. Not having the opportunity to care for a child with the appropriate medical services not only violates the principle of the best interest of the child but also endangers the child's life.

Regarding neonatal intensive care, the data appears to be more uniformly defined at the Italian level. In fact, the Italian Society of Neonatology – Società Italiana di Neonatologia (SIN) annually publishes an accurate analysis of the numbers recorded in Italy regarding the most important issues concerning neonatology. The most recent study reports data for the year 2019. This analysis aims to realize how many birth centers in Italy are equipped with neonatal intensive care. The survey identified that 411 birth centers were active in 2019, respectively 172 in northern regions, 79 in central regions, and 160 in southern regions (Fabio Mosca et al., 2019, p. 7). A total of 203 departments responded to the survey, accounting for 49 percent of the total. Of these, 101 out of 172 wards (58%) are located in the North, 48 out of 79 (61%) are located in the Center, and 54 out of 160

(34%) are in the South and Islands (Fabio Mosca et al., 2019, p. 7). Data published in this study are presented in the table below.

Macro-zone	**Italian Region**	**Centers without neonatal intensive care Data (2019)**	**Centers with neonatal intensive care Data (2019)**	**Total centers**
North and center	Valle d'Aosta	1	0	1
	Liguria	0	1	1
	Lombardy	19	17	36
	Piedmont	16	9	25
	Trentino-Alto Adige (Bolzano, Trento)	3 0	1 1	4 1
	Veneto	11	6	17
	Friuli-Venezia Giulia	4	2	6
	Emilia-Romagna	3	7	10
	Tuscany	11	8	19
	Umbria	2	2	4
	Marche	7	0	7
	Lazio	8	10	18
South	Abruzzo	6	2	8
	Molise	0	0	0
	Campania	0	9	9
	Puglia	0	6	6
	Basilicata	1	0	1
	Calabria	1	3	4
	Sicily	7	10	17
	Sardinia	7	2	9

Source for the year 2019: Società Italiana di Neonatologia, *Libro bianco della neonatologia anno 2019 – SIN Società Italiana di Neonatologia. Indagine sull'organizzazione delle unità operative di neonatologia e terapia intensiva neonatale italiane*, pages 7-8.

Macro-zone	**Centers without neonatal intensive care**	**Centers with neonatal intensive care**	**Total centers**	**% Survey coverage**
North	57	44	101	58
Center	28	20	48	61
South	22	32	54	34
Total	107	96	203	49

Source for the year 2019: Società Italiana di Neonatologia, *Libro bianco della neonatologia anno 2019 – SIN Società Italiana di Neonatologia. Indagine sull'organizzazione delle unità operative di neonatologia e terapia intensiva neonatale italiane*, pages 7-8.

As can be immediately seen from the data collected in these tables, centers with neonatal intensive care, in Italy, are much more numerous and more evenly distributed than centers with pediatric intensive care in general. Again, however, most of the wards with neonatal intensive care are located in the north-central regions, recording 64 units compared to the 32 in the south. Analyzing the data, it is possible to note that there are 4 regions in Italy without any neonatal intensive care unit, and these are Valle d'Aosta among those in the north, Marche in the center, and Molise and Basilicata in the south.

From the analysis of the numbers on the presence of wards with pediatric intensive care and neonatal intensive care units, it can be seen that in some regions there is less availability of services, there are fewer dedicated wards and fewer places, and in some cases, they are completely absent. Finally, in reconstructing this picture, the area that suffers most from this shortage is the south, where especially the lack of pediatric intensive care emerges as a serious violation of some fundamental human rights, such as the right to equality and non-discrimination, the right to health, and the right to pursue the best interests of the child. The lack of important health services triggers other issues such as, for example, the fact that the management of some diseases is handled by other departments, often not specific to the care of the minors, and the phenomenon of health migration, which will be addressed in the next section.

3.3.4 Interregional mobility for pediatric care

Interregional health mobility refers to the phenomenon "which involves many patients who benefit from health services provided by institutions outside their region of residence" (Epicentro, Istituto Superiore di Sanità, s.d.). Within this definition, two types of mobility can be identified, which are respectively the active and the passive mobility. Specifically, active mobility indicates "the attraction index of a region and identifies the healthcare services offered to non-resident citizens" (De Curtis et al., 2021), while passive mobility identifies "the healthcare services provided to citizens outside the region of residence" which is also defined as the "escape index". The attraction index means the ability of a region to attract patients from other regions, while the escape index means the propensity of patients to travel from their regions for health care services. These two indicators, therefore, could be taken as a measurement index to assess the quality of certain services within a given regional context, keeping in mind that many other factors may also result in a worsening or improvement of the services in question, such as the "effectiveness and efficiency of each Regional Healthcare Service, presence of Reference Centers for specific diseases, waiting lists, diagnostic services and availability of treatments, and perceived or real quality of assistance" (De Curtis et al., 2021).

Before analyzing the data, carefully collected by both the CRC Group (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2018) (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell'Infanzia e dell'Adolescenza, 2021a) and by a valuable study entitled "Pediatric interregional healthcare mobility in Italy" (De Curtis et al., 2021) it is important to understand, at the economic level what are the differences implied by these two types of mobility. Active mobility constitutes a credit item, while passive mobility is a dept item. In fact, regions that provide health care services and thus receive patients from other regions are refunded by the regions of origin from which people migrate. As can be better observed from the tables below, there are some regions that have a positive balance, while others have a negative one, and this aspect is confirmed as one of the "main performance indicators of Regional Healthcare Systems, both for its economic relevance and for the adequacy/satisfaction of the services provided" (De Curtis et al., 2021).

The population examined in the research "Pediatric interregional healthcare mobility in Italy" focuses on children between the ages of 0 and 14 and analyzes all the Diagnosis Related Group (DRG), by also studying the high complexity DRG. In addition, the report published by the CRC Group "The rights of children and adolescents in Italy – Data region by region 2021, I diritti dell'infanzia e dell'adolescenza in Italia – I dati regione per regione 2021" provides data on interregional mobility for all children and adolescents aged 0-18, so these numbers will also be considered in order to present a scenario that is as complete as possible.

The first table presented shows the data recorded both at the level of the two macro zones identified for the study and at the Italian level. These numbers offer the valuable possibility of calculating two other indexes, which are essential for this research, and these are the Hospitalization rate as a percentage and the Escape Index.

Macro-zone	**Population 0-14**	**Total hospitalization**	**In-region hospitalization**	**Out-region hospitalization**
North and center	5,146,568	632,027	588,586	43,441
South	2,725,319	377,877	332,905	44,972
Italy	7,871,887	1,009,904	921,491	88,413

Source for the year 2019: Mario De Curtis, Francesco Bortolan, Davide Diliberto & Leonardo Villani, *Pediatric interregional healthcare mobility in Italy*, 2021, table 1 Hospitalizations and escape index in Italy in the 0–14 population (2019).

Three main features are immediately evident from this first table. The first reveals that the population of minors aged 0 to 14 years present in the north-central regions is more than double the population in the southern regions. Looking at the hospitalization rate, however, it shows that the number of minors aged 0 to 14 who were hospitalized in the south is proportionally greater than those hospitalized in the north. In addition, looking at the last column, the number of children and adolescents who were hospitalized outside their home region is higher for southern regions than the one recorded by northern regions.

Thus, looking at the indexes calculated from the analyzed data, it can be seen that the hospitalization rate of children and adolescents aged 0-14 years recorded in the north-central regions is more than one percentage point lower than the rate recorded in the southern regions. Even the escape index is higher in southern regions, registering almost double the value recorded in the northern and central regions, as it is shown in the table below.

Macro-zone	**Hospitalization rate (%)**	**Escape index (%)**
North and center	12.3	6.9
South	13.9	11.6
Italy	12.8	8.8

Source for the year 2019: Mario De Curtis, Francesco Bortolan, Davide Diliberto & Leonardo Villani, *Pediatric interregional healthcare mobility in Italy*, 2021, table 1 Hospitalizations and escape index in Italy in the 0–14 population (2019).

The table below further shows the data disaggregated region by region. Regarding the hospitalization rate, most of the regions that exceed the average recorded at the Italian level are in the southern macro area. In fact, while in the north-central area only Liguria and Lazio regions are above the 12.8 % threshold, among the southern regions it is exceeded by Abruzzo, Molise, Campania, Basilicata, Puglia, Calabria, and Sicily.

Macro-zone	**Italian region**	**Hospitalization rate (%)**	**Escape index (%)**
North and center	Valle d’Aosta	10.9	24.8
	Liguria	14.7	9.2
	Lombardy	11.9	4.8
	Piedmont	11.3	8.5
	Trentino-Alto Adige (Bolzano, Trento)	11.6 12.3	15.7 5.5
	Veneto	10.8	7.2
	Friuli-Venezia Giulia	11.0	7.7

	Emilia-Romagna	11.5	7.4
	Tuscany	12.5	4.8
	Umbria	12.4	25.5
	Marche	12.6	14.9
	Lazio	15.1	4.2
South	Abruzzo	14.3	22.1
	Molise	13.4	40.1
	Campania	14.7	9.5
	Basilicata	13.4	28.9
	Puglia	13.7	10.9
	Calabria	14.2	20.9
	Sicily	13.3	7.3
	Sardinia	12.4	9.3

Source for the year 2019: Mario De Curtis, Francesco Bortolan, Davide Diliberto & Leonardo Villani, *Pediatric interregional healthcare mobility in Italy*, 2021, table 1 Hospitalizations and escape index in Italy in the 0–14 population (2019).

On the other hand, as can be seen from the following table, which shows the overall expenditure on hospitalizations, the total spending is around 1.7 billion euros, of which 193.6 million euros refers to passive mobility. Looking at the division of passive expenditure, it can be observed that more than 50% of the overall expenditure is sustained by the southern regions, registering an amount of 103.6 million euros. It is important to mention that, in the distinction adopted by this study, the macro group of north-central regions includes 12 regions, while in the southern one only 8. In addition, it is significant to note that the average cost of escape index in southern regions is asserted to be 15.1 percent, which is almost double that recorded in the north-central region.

Macro-zone	**Population 0-14**	**Total cost of hospitalizations (millions of €)**	**In-region hospitalizations' costs (millions of €)**	**Out-region hospitalizations' costs (millions of €)**
North and center	5,146,568	1070.6	980.9	89.7
South	2,725,319	688.5	584.5	103.9
Italy	7,871,887	1759.2	1565.5	193.6

Source for the year 2019: Mario De Curtis, Francesco Bortolan, Davide Diliberto & Leonardo Villani, *Pediatric interregional healthcare mobility in Italy*, 2021, table 2 Overall costs of hospitalizations and passive mobility costs in Italy (2019).

To clarify the data collected regarding the escape index, the table below explains in which direction flows of people move to other regions to seek the care they need.

Macro-zone	**Total hospitalizations (% on the total population)**	**Out-region hospitalizations (%)**	**Passive mobility to regions of Center-North (%)**	**Passive mobility to regions of South (%)**
North-Center	12.3%	6.9%	87.2%	12.8%
South	13.9%	11.9%	85.5%	14.5%

Source for the year 2019: Mario De Curtis, Francesco Bortolan, Davide Diliberto & Leonardo Villani, *Pediatric interregional healthcare mobility in Italy*, 2021, table 2 Overall costs of hospitalizations and passive mobility costs in Italy (2019).

Several statements can be deduced from the analysis of these numbers. First, the percentage of hospitalizations is higher among southern regions than in northern ones. In addition, for southern regions, the percentage of minors who are hospitalized outside their region of origin is confirmed to be nearly twice as high as those residing in the center and north. The percentages of minors who move from their region of origin to regions in the center-north are confirmed to be 87.2 percent for regions in the center-north and 85.5 percent for regions in the south, compared with a significantly lower percentage for passive mobility recorded by those in the south. This difference is also confirmed with regard to passive mobility for high-complexity hospitalizations (De Curtis et al., 2021, table 4).

Even the report “The rights of children and adolescents in Italy - Data region by region 2021, I diritti dell’infanzia e dell’adolescenza in Italia – I dati regione per regione 2021” (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2021a) (Gruppo CRC - Gruppo di lavoro per la Convenzione sui diritti dell’Infanzia e dell’Adolescenza, 2021a) published by the CRC reports data on interregional hospital mobility for children and adolescents aged 0-17 years, regarding the year 2019, confirming the trend presented by the study.

From the analysis of these valuable publications, it is possible to recreate an accurate picture of what is the issue of pediatric interregional mobility and its seriousness. The hospitalization rate is the first index to be analyzed. in fact, these numbers hide several problems and lack in both preventive and primary health services. Escape index data confirm that there is pediatric interregional mobility in all regions but reveal that the north central regions are the destination of the flows of minors coming from both macro areas analyzed (in both cases for more than 80% of whole mobility). As was previously highlighted by the paragraphs related to the other indicators, it is important to focus deep attention on children and adolescents living in southern regions, since their childhood and adolescence are at greater risk than those living in north central regions “as they have a higher poverty index and a higher infant mortality rate” (De Curtis et al., 2021), explaining that the healthcare mobility of these minors “determines profound suffering due to the detachment from their place of origin, economic problems for families due to the overall cost of the transfer and work difficulties for parents” (De Curtis et al., 2021). The problem thus becomes more and more rooted considering that southern regions, due to the mechanism of inter-regional compensation, must refund for health care services provided to their citizens in other regions. As for 2019, this amount is confirmed to be more than 90 million euros, which could have been invested locally to improve the health services already existing. This radicalization of service difference thus creates inequality and confirms the presence of discrimination rooted in facilities and in the system, which is difficult to be recognized and addressed.

3.3.5 Overweight and obesity in adolescents

The issues of pediatric overweight and obesity are confirmed to be two fundamental aspects of the well-being of children and adolescents, both during childhood and adulthood. In fact, the condition of obesity forms the basis for the development of pathological conditions that also affect adult life (Redazione SISMED - Società Italiana Scienze Mediche, 2022). These two aspects are classified as social determinants of health, as they gather in their analysis a series of factors that then determine the level of health. Prevention in this context plays a key role, along with several social, cultural, and economic aspects that often determine the living conditions of the minor. These factors are closely linked; in fact, it is important to focus on issues such as nutritional habits and thus the culture of food and a healthy diet, but also the economic availability in order to supply healthy and quality food. During this section, the condition of 8- and 9-years old children during the year 2019 was analyzed, recording the level of overweight and obesity present in each region.

For the purpose of this research, to recreate a complete and accurate picture, it is meaningful to present both data reported by CRC Group reports and data published by the national surveillance system "OKkio alla SALUTE" established at the Istituto Superiore di Sanità (Epicentro, Istituto Superiore di Sanità, 2019h).

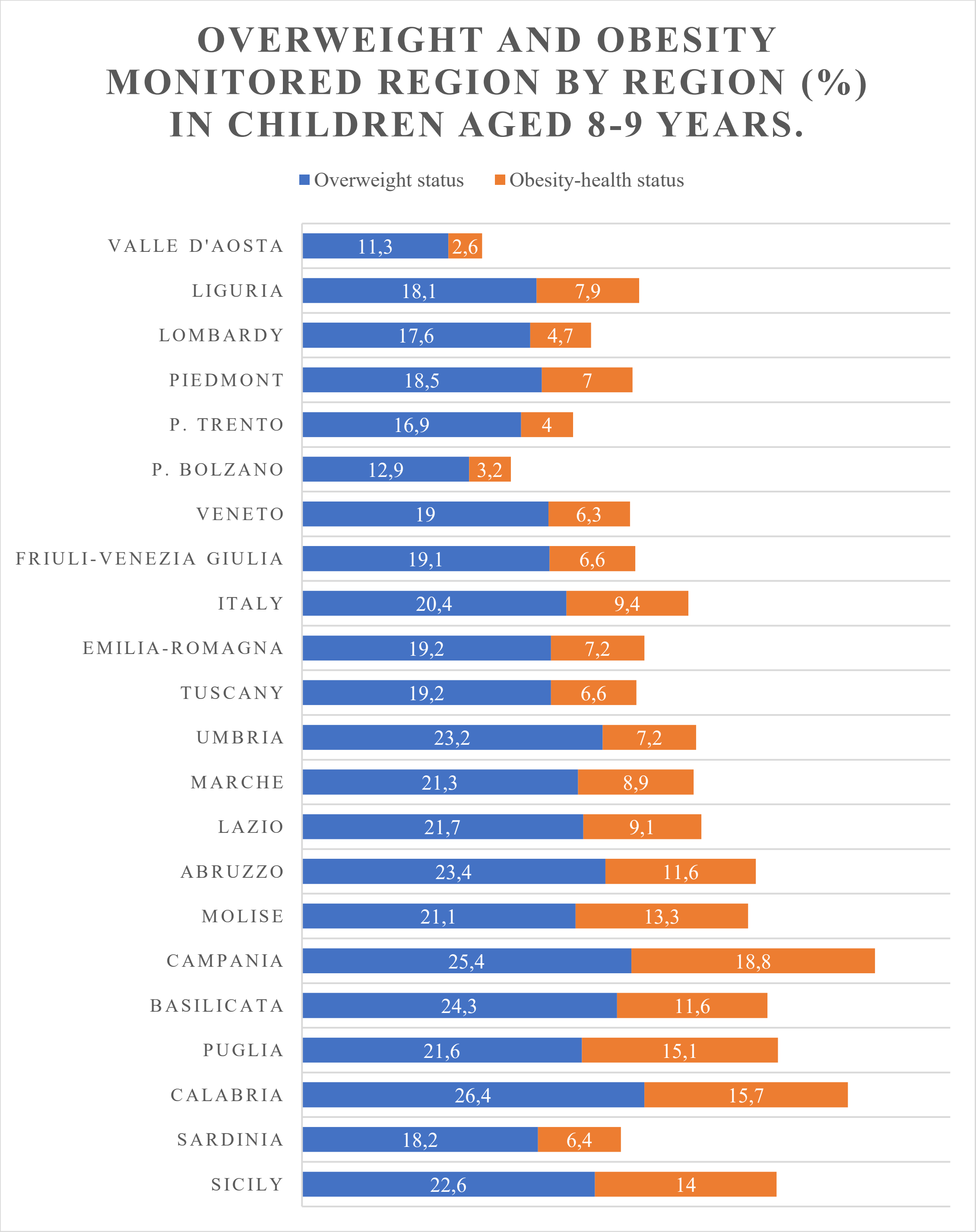
The table shows the Italian regions divided into the two macro areas already analyzed, which are the central north and the south. The reported data for both the level of overweight children and those with severe obesity is recorded as a percentage of the total sample population. To fully understand the data reported and the severity of the situation recorded in some regions, it is useful to recall the Italian average, which is confirmed to be 20.4% for the level of overweight, and 9.4% for the level of obesity.

Macro-zone	Italian region	Overweight status	Obesity status
North and center	Valle d'Aosta	11.3	2.6
	Liguria	18.1	7.9
	Lombardy	17.6	4.7
	Piedmont	18.5	7.0
	Trentino-Alto Adige (Bolzano, Trento)	12.9 16.9	3.2 4.0

	Veneto	19.0	6.3
	Friuli-Venezia Giulia	19.1	6.6
	Emilia-Romagna	19.2	7.2
	Tuscany	19.2	6.6
	Umbria	23,2	7.2
	Marche	21,3	8.9
	Lazio	21,7	9.1
South	Abruzzo	23,4	11.6
	Molise	21.1	13.3
	Campania	25.4	18.8
	Basilicata	24.3	11.6
	Puglia	21.6	15.1
	Calabria	26.4	15.7
	Sicily	22.6	14.0
	Sardinia	18.2	6.4

Source for the year 2019: EpiCentro – L'epidemiologia per la sanità pubblica, Istituto Superiore di Sanità, *OKkio alla SALUTE, Indagine nazionale 2019: i dati,* data are collected from the sheets published in the study for each region.

To visualize the difference present in the various Italian regions, the graph below again depicts the data just analyzed, with a different model that sums the level of the two issues in the same row of analysis. As can be seen, southern regions confirm significantly higher levels than those in the central north.



Source for the year 2019: EpiCentro – L'epidemiologia per la sanità pubblica, Istituto Superiore di Sanità, *OKkio alla SALUTE, Indagine nazionale 2019: i dati,* data are collected from the sheets published in the study for each region.

Regarding the level of obesity, the Italian average recorded for 8-9 years old children during the year 2019 by the Italian "OKkio alla salute" survey is confirmed to be 20.4%. Among northern regions, no one exceeds the Italian average and, for example, Valle d'Aosta (Epicentro, Istituto Superiore di Sanità, 2019b), Trentino-Alto Adige (Epicentro, Istituto Superiore di Sanità, 2019a) (Epicentro, Istituto Superiore di Sanità, 2019i), but also Liguria (Epicentro, Istituto Superiore di Sanità, 2019e), Lombardy (Epicentro, Istituto Superiore di Sanità, 2019h) and Piedmont, are confirmed to be below the average by some percentage points. As for the center, the regions of Umbria (Epicentro, Istituto Superiore di Sanità, 2019g), Marche (Epicentro, Istituto Superiore di Sanità, 2019f) and Lazio (Epicentro, Istituto Superiore di Sanità, 10 November2019) record a percentage of 23.2, 21.3 and 21.7, respectively, thus slightly above the Italian average. Looking at the situation among the southern regions, it can be observed that all regions, except for Sardinia, remain above the Italian average. The situation is particularly serious in Calabria (Epicentro, Istituto Superiore di Sanità, 2019c), which records a value of 26.4%, 6 percentage points higher than the average, but also in Campania (25.4%) (Epicentro, Istituto Superiore di Sanità, 2019d) and Basilicata (24.3%).

The situation in southern Italy is even more critical and serious when analyzing the data recorded for obesity. The data refer to 2019, and the sample of the analysis is again 8-and 9-year-old children. For all north-central regions, the percentage remains below the Italian average of 9.4 percent, ranging from 2.6% in Valle d'Aosta to 9.1% in Lazio. Regarding the southern regions, however, all are confirmed to be significantly above the national average. Analyzing the data, the Abruzzo and Basilicata regions record the lowest value among southern regions, of 11.6%, however, 2.2 percentage points higher than the Italian average. In increasing order then are Molise with 13.3%, Sicily with 14%, Puglia with 15.1%, Calabria with 15.7%, and finally Campania with the highest value of 18.8%, which is confirmed by almost double the national average.

The most serious aspect that emerges from this picture is the fact that the level of both overweight and obesity is higher than the Italian average throughout the southern macro area, presenting a worse and more widespread health status than in the north-central regions. Considering this overview, it is interesting to understand which factors, also intended as social determinants of health, contribute to the level of the health status of minors related to this issue.

The CRC Group in the report “The rights of children and adolescents in Italy - Data region by region 2021, I diritti dell’infanzia e dell’adolescenza in Italia – I dati regione per regione 2021” also presents an important focus on the issue of food poverty, which connects deeply with the issues of overweight and obesity. Food poverty is defined as the inability of individuals to access safe, nutritious food in sufficient quantities to ensure a healthy and active life relative to their social context (Franca Maino, s.d.) (Food and Agricolture Organization of the United Nations, 1996). Thus, regarding food poverty, the report published by the CRC group studies the percentage of children and adolescents who do not consume a protein meal per day during 2019. The analysis shows that regions such as Basilicata, Campania and Sicily significantly exceed the Italian average (recording 4.9%, 5.4% and 8.4%, respectively, against a national average of 2.8%).

It is clear from this analysis that levels of childhood overweight and obesity are markedly higher among southern regions than those in the central north.

This data reveals its full gravity when considering that children and adolescents who are obese in childhood are more likely to lead not only a less healthy childhood, but especially adulthood, since "Overweight and obese children are likely to stay obese into adulthood and more likely to develop non-communicable diseases like diabetes and cardiovascular diseases at a younger age" (Sahoo et al., 2015), and thus the greater presence of overweight or obese children represents a worse health status. This aspect confirms the presence of deep-rooted inequalities in health status as well, with southern regions at a disadvantage compared to others.

4. CONCLUSION

4.1 Concluding analysis

In light of what has been presented throughout this research, this concluding chapter aims to propose a final analysis that presents the deep connections existent between the study of the concept of systemic discrimination and the Italian condition analyzed as a case study.

As it has been presented during this study, systemic or structural discrimination has specific characteristics which are rooted within a given context, and it is necessary to set up a framework of actions and practices to tackle and combat the resulting inequalities.

4.1.1 Definition and identification of systemic discrimination

To address a condition of discrimination, the essential starting point is to recognize precisely what kind of discrimination it is. As was mentioned throughout the first chapters, systemic discrimination is a type of discrimination that is very difficult to identify, and even for this trait, seeking a precise definition is a key point to be able to address it. This fact occurs because systemic discrimination is not the result of measures that are intentionally designed to be discriminatory against a group of people, but on the contrary, it is the outcome of measures that appear to be neutral but produce a discriminatory effect once they are applied. Moreover, these measures are often rooted within legal rules, policies, practices, routines, or attitudes that lead to the creation of a disadvantageous condition for a part of society. Identifying in a routine a practice that leads to a condition of inequality is a complicated and complex process, which involves a thorough and deep examination of all the contexts and sectors which make up the reality. This process can be aided by the analysis of the current condition present in the country, which suggests the outcome of the application of norms or measures that are generally accepted. Studying data and numbers is an essential tool, which very often can reveal differences in treatment and thus the presence of inequalities.

4.1.2 Recognition of systemic discrimination within the context analyzed

Once a condition of inequality is recognized, which is not easily evident but is the result and the effect of generally accepted practices and routines, it is important to lay the groundwork for tackling present inequalities, to eradicate them. This is not a simple task; on the contrary, it is the result of practices that are created ad hoc and put into practice with the aim of challenging present conditions of inequality. As was stated in the study, in fact, this type of discrimination requires a comprehensive and inclusive approach, including the creation of a range of laws, policies and programs, including temporary special measures that are designed to address the situation in a concrete way.

In the case study presented, the research of systemic discrimination therefore starts from an accurate and profound analysis of the current, tangible, and present situation in Italy today. In fact, the research focuses on the analysis of some indicators related to the sphere of health, for children and adolescents living on the Italian territory. As has been explained, the indicators analyzed are the result of a solid research base and aim to return as accurate but at the same time comprehensive a picture as possible of the health rights and health status of children and adolescents in Italy.

From the numbers available, it can be confirmed that in Italy conditions of inequality in access to health and full enjoyment of the right to health for children and adolescents based on their region of origin exist.

In the southern macro-region, the data confirm the presence of a widespread and disadvantaged condition in which children and adolescents have less access to basic health services and thus experience their childhood in a more fragile and difficult condition. It is important to emphasize that this condition is not the result of intentionally discriminatory measures, but on the contrary, is the result of practices that are entrenched in behaviors and structures, and thus are generally accepted and hardly addressed. It is precisely for this reason that at this point, it is important to work on numbers and data, and therefore it is important to analyze the present condition so that we can clearly recognize which situations of inequality need to be addressed.

This work stands as a report on current inequalities in access to certain health services for children and adolescents in Italy. The road to combating this type of discrimination is complicated, but it begins with its identification, with the study of definitions and data, so as to identify a starting point for the creation of measures that can tackle these inequalities and that can restore fundamental rights to children and adolescents pursuing their best interests, as declared by the United Nations on the Rights of the Child.

4.1.3 Addressing and challenging systemic discrimination

As reported by the Council of Europe Portal on Intercultural cities (Council of Europe, 2020), systemic discrimination “cannot be tackled on a once-off basis, it requires sustained attention from and initiative by organisations” including four practices specifically, to properly address a condition of structural inequalities. The first strand invites the community to gear up (Council of Europe, Intercultural cities, 2020, p. 2), with the purpose of creating the conditions within society to address systemic discrimination. The second practice, which also gathers the work done in this research, is to identify the presence of systemic discrimination and includes the action of diagnosing systemic discrimination problems and the creation of a dialogue with those affected by the issue and the monitoring of patterns of discrimination (Council of Europe, Intercultural cities, 2020, p. 4). The practice of preventing represents the third strand, which is about “developing systemic remedies to what is a systemic problem” by “redesigning the systems that create disadvantage and implementing new systems required to advance equality” (Council of Europe, 2020). The final action concerns the implementation of practices which involve all the fields, including the city, public and private sectors, organizations, and institutions in order to achieve a coherent response.

4.1.4 Recommendations

This final paragraph aims to report a short list of recommendations created

on the basis of the definitions collected in the course of this study and on the accurate analysis of the condition of the right to health for children and adolescents living in Italy. The suggested recommendations are identified within the definition proposed by the Council of Europe for addressing conditions of systemic discrimination, which are divided into four strands of intervention that provide a first phase of gearing up to deal with systemic discrimination, a second one aimed at identifying situation of structural discrimination, a third involving the preparation of actions designed to prevent the occurrence of this type of discrimination, and finally the phase of action and spread of good practices to address and eradicate systemic discrimination.

Recommendation 1:

Acting on culture and awareness at the Italian level regarding both the new and general concept of systemic discrimination and the situations already in place in Italy that report situations of structural discrimination.

Recommendation 2:

Intensify and refine data collection actions at all levels of governance on the Italian territory, so that all entities are covered by a single, capillary network and data can be analyzed in a homogeneous manner and with a single, nationwide scale of reference.

Recommendation 3:

In the context of preventing situations of systematic discrimination, there are suggested actions aimed at creating an environment sensitive to the issue, in which both institutions and citizens are aware of the phenomenon of structural discrimination and are able to recognize it in advance.

Recommendation 4:

As part of the action to address systemic discrimination, since this condition is difficult to identify and affects all spheres that make up social, cultural and economic reality, it is suggested that representatives of the public and private sectors, citizens, institutions and organizations be involved around a single working table in order to create a single observatory that can create and monitor in a multidisciplinary manner and on the basis of precisely collected data the actions to be taken at all levels of governance to address situations of systemic discrimination.

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