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Establishing a Child Rights, Health Equity, and Social Justice-Based Practice of Pediatrics

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The United Nations' Convention on the Rights of the Child (CRC) came into force 25 years ago as the first human rights document focused solely on children.[1] The articles of the CRC are concordant with the underlying precepts of pediatrics and public health. Yet, despite ongoing changes in the social-ecology of health, more than a half-century of enlightenment as to the relevance of human rights to the health and well-being of children, and rapid advances in social epidemiology and the life course sciences, the principles of human rights, health equity, and social justice have not been integrated into health professional training. Neither have they been incorporated into standards for the delivery of health care, development of health systems, and generation of public policy.

To remain relevant, healthcare and health systems must function at the intersection of health and human rights. The availability of rights, equity, justice-based strategies and tools (**Table I**), and the principles and standards of numerous human rights documents—including the United Nations' CRC (1979),[1] Ottawa Charter for Health Promotion (1986),[2] African Charter on the Rights and Welfare of the Child (1999),[3] and United Nations' Convention on the Rights of People with Disabilities (2006)[1]—make this possible. However, global health systems remain focused primarily on selective strategies to promote child survival in low-income countries,[4] and access to health care and biomedical approaches to health in mid- and upper-income nations. Global public and private sector health policies, systems, and practices have arguably not responded to the complexity of the social, economic, political-civil, environmental, and cultural factors that generate health. They have not engaged rights, equity, and justice-based approaches to health policy, systems, and practice. This chasm between knowledge and experience and policy and practice must be acknowledged and addressed through medical education and research that is informed by the principles of human rights, health equity, and social justice.[5]

Toward these ends, the following general principles are presented to serve as the foundation and framework for the formulation of a rights-, equity-, and justice-based approach to pediatrics. They reflect the norms and standards of CRC Article 24 and related articles of the CRC addressing children's rights to health (**Table II**). As presented in the American Academy of Pediatrics Policy on Child Rights and Health Equity,[5] the integration of the principles and tools of human rights, social justice, human capital investment, and health equity ethics into all aspects of the education of child health professionals is necessary to prepare pediatricians to translate these principles and standards into practice, systems development, and the generation of public policies. We refer to this emerging rights-based practice of pediatrics as Community, Social, and Societal Pediatrics (*C-SSP*)—a practice that is as relevant to subspecialty care as it is to primary care pediatrics.

Principles for the Realization of Children's Right to Health

Appendix 1 (available at www.jpeds.com) presents a set of basic premises required for the realization of children's right to health. These principles define the parlance, definitions, documents, epidemiology, science, structure, and strategies that establish the foundation and framework for fulfilling children's rights to health. **Appendix 2** (available at www.jpeds.com) establishes normative standards and models for addressing a rights-based approach to health in the context of requirements for leadership, standards, models, competencies, systems, and youth participation.

Appendix 3 (available at www.jpeds.com) defines roles and responsibilities for states and professionals, as well as for including children's rights to mental health and early child development, in the realization of children's rights to health.

Appendix 4 (available at www.jpeds.com) addresses measures, monitoring, and evaluation, which are

CRC	Convention on the Rights of the Child

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Table I. Toolkit for translating the principles of rights, equity, and justice into pediatric practice

Foundational tools	Diagnostic-planning tools	Intervention tools
Human rights documents • United Nations' CRC • Covenant on Civil and Political Rights • Covenant on Social, Economic, and Cultural Rights • Convention on the Elimination of all Forms of Racial Discrimination • Convention on the Elimination of Discrimination against Women • Convention against Torture and Other Cruel, Inhuman, and Degrading Treatment • UN Convention on the Rights of Persons with Disabilities Other source documents • Social Justice Principles • Life-Course Science • Alma Ata Declaration • Ottawa Charter • Millennial Development Goals	• Health system framework • Root cause analysis • Budget analysis • Intergenerational justice analysis • Periods of risk analysis • Health impact assessment • Environmental impact assessment • Ethnography • Media/arts/photo voice • Environmental justice • GIS/mapping • Health related quality of life (HRQOL) • Equity indicators • Early childhood development indicators • Children's participation indicators • Logic models • Social capital scales	Health service/system level • Child-friendly hospitals • Gender tool • Cultural competence • Children's participation • Pain and palliative care • Evidence-based practice Household/community level • Ombudsperson • Child-friendly cities • Medical home • Children's participation Intersctoral/policy level • Medical-legal collaboration • Human capital investment • Built environment/urban planning • Intergenerational justice • Wealth transfer • Early childhood education • Community-based participatory and translational research • Children's allowances • Evidence-informed policy

fundamental to the development of new and innovative metrics that relate to the articles of the CRC, child advocacy, social mobilization, participation, etc.

Conclusion

The relevance of pediatrics and pediatricians to the domestic and global well-being of children will depend increasingly on the extent to which the principles, norms, and practice of child rights, health equity, and social justice are integrated into the mainstream of global child and public health. The principles delineated in Appendices I-IV provide a foundation and framework for this integration. The extent to which child health professionals engage a rights, equity, and social justice-based approach to child health will determine the extent to which they lead change for the future of pediatrics. The challenges and opportunities related to children's right to health, including children's right to participation in the health system, communicating with children, and the Council of Europe's child friendly health care model, will be explored in depth in future articles on the European Paediatric Association pages. ■

References available at www.jpeds.com

Table II. Core CRC articles and those related to Article 24: Right to Health

Article	Description
Core articles	
Article 2. Non Discrimination	All rights are to be recognized for each child without discrimination on any grounds
Article 3. Best Interests	The best interests of the child should be considered in all decisions related to them
Article 6. Survival and Development	Optimal survival and development
Article 12. Participation	Respect for the child's views in all matters affecting them
Related articles	
Article 5. Evolving Capacities	Rights of parents to provide guidance to the child considering her/his evolving capacity
Article 17. Access to Information	Ensure accessibility of information from a diversity of sources
Article 18. Parental Capacities	State shall ensure parents have the capacity to fulfil the rights of their children
Article 19. Protection from Violence	Protection from maltreatment, and implemention of prevention and treatment programs
Article 23. Disabilities	Right to special care, education, and training to achieve dignity and greatest degree of self-reliance
Article 25. Review of Treatment	Entitlement to have placement of children in care evaluated regularly
Article 27. Standard of Living	Right to a standards of learning (SOL) adequate for physical, mental, spiritual, moral, and social development
Article 28. Education	Right to free primary education, accessible secondary education, and no corporal punishment
Article 29. Education	Right to optimal development of the child's personality, talents, and mental and physical abilities
Article 32. Protection from Exploitation	Protection from work that threatens his/her health, education, or development
Article 39. Recovery of Child Victims	Right to care and social reintegration for child victims of armed conflicts, torture, neglect, etc.

References

1. http://www.ohchr.org. Accessed October 12, 2014.
2. http://www.who. Accessed October 12, 2014.
3. http://acerwc.org/the-african-charter-on-the-rights-and-welfare-of-the-child-acrwc/. Accessed October 12, 2014.
4. http://www.unicef.org. Accessed October 12, 2014.
5. Goldhagen J, Etzel R, Melinkovich P, the Council on Community Pediatrics and Committee on Native American Child Health. Policy Statement. Health equity and children's rights. Pediatrics 2010;125(4):838-49.
6. Women's and children's rights: making the connection. UNICEF (UNFPA). http://www.unicef.org/gender/files/Women_Children_Rights_UNFPA_UNICEF_final.pdf. Accessed October 12, 2014.
7. Institute of Medicine. The Future of Public Health. Washington, DC: National Academy Press; 1988.
8. http://www.unicef.org/adolescence/files/ME_toolkit_booklet_4-2014.pdf. Accessed October 12, 2014.
9. http://www.unicef.org/publications/index_43110.html. Accessed October 12, 2014.
10. Southall DP, Smith S, Bull D, Radford A, Williams A, Nicholson S. The Child-Friendly Healthcare Initiative (CFHI): healthcare provision in accordance with the UN convention on the rights of the child. Pediatrics 2000;106:1054-64.

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Appendix 1. Principles for the realization of children's right to health: basic premises

BASIC PREMISES FOR THE REALIZATION OF CHILDREN'S RIGHT TO HEALTH

Principle 1. WHO definition of health. The practice of *Community, Social, and Societal Pediatrics* (*C-SSP*) is framed in the context of the World Health Organization's (WHO) definition of health.[2] This will ensure all prerequisites for health and health related quality of life are addressed and fulfilled. This will also expand the focus of pediatrics and pediatricians from "child health" to "children's health and well-being," and impact all aspects of the implementation and measurement of strategies related to the practice of *C-SSP*.

Principle 2. Human rights documents. The full complement of human rights documents, including most specifically the UN CRC (1979),[1] Ottawa Charter for Health Promotion (1986),[2] African Charter on the Rights and Welfare of the Child (1999),[3] UN Convention on the Rights of Persons with Disabilities (2006),[1] and related General Comments inform and structure all elements of *C-SSP* practice.

Principle 3. Health equity and child rights. The practice of *C-SSP* engages the domains of pediatric practice presented in the AAP policy statement Health Equity and Child Rights[5]: (a) child rights, (b) social justice, (c) human capital investment, and (d) health equity ethics, as core elements of pediatric practice, systems development, and policy.

Principle 4. Social epidemiology and life course science. C-SSP uses the knowledge and experience of social epidemiology and the life course sciences to inform public and private sector organizations, agencies, institutions, professionals, and other stakeholders how to translate the principles of child rights, health equity, and social justice into the delivery of health services, the development of health systems, and the generation of relevant public policy. In particular, epigenetics provides critical insights into the complex interactions between social environments and gene expression.

Principle 5. CRC Article 24. The child's right to health, presented in CRC Article 24 and related articles (**Table II**), including the core CRC Articles 2 (non-discrimination), 3 (best interests), 6 (survival and development), 12 (participation), and 17 (access to information), serve as the primary principles for the practice of C-SSP. Article 24 is arguably among the most complex rights to fulfill, given our understanding of the impact of social and environmental determinants on the health and well-being of children. Advances in knowledge of the impact of child health on adult health trajectories greatly magnify the importance of fulfilling the child's right to health. Thus, in addition to the broad array of related articles within the CRC (**Table II**), strategies to fulfill children's right to health must also engage other human rights conventions and documents, in particular, those related to the health and well-being of women. Traditionally, women's rights agendas (sexual and reproductive rights) have been separated from children's rights agendas. More recently, we have come to understand the mutuality of respecting both women's and children's rights.[6]

Principle 6. Health system structure. Many state and institutional health policies remain grounded in selective primary care (low-income countries), and/or biomedical models focused on access to primary and subspecialty health care (mid- and upper-income countries). Global, national, and regional health policies must establish a rights, equity, and justice-based structure for the delivery of universal health services and related sector systems to address the social and environmental determinants of child health. These services and systems must conceptualize the CRC as a set of standards and norms, strategies, and tools that respond to root-cause determinants of child health and well-being.

Principle 7. Public health approach. C-SSP adopts a public health approach to fulfilling children's right to health. The US Institute of Medicine's report on the Future of Public Health[7] identifies three core functions of public health—Assurance, Assessment, and Policy—that can be used to frame the efforts of states, professionals, and stakeholders to implement CRC Article 24 and its related articles.

Appendix 2. Principles for the realization of children's right to health: normative standards and models

NORMATIVE STANDARDS AND MODELS FOR THE REALIZATION OF CHILDREN'S RIGHT TO HEALTH

Principle 8. Leadership. The knowledge and tools exist to transform the structure and function of health services and systems into rights, equity, and justice-based systems of care. C-SSP provides the leadership; establishes the goals, objectives and tasks; provides access to tools (**Table I**); and defines the metrics required to monitor the accomplishment of this transformation. The practice of C-SSP:

- Recognizes and addresses the complex interplay of social and environmental determinants of children's health and well-being.
- Establishes the CRC as a tool/matrix that can be used to frame responses to the complex interplay of child health determinants.
- Creates a common health systems framework to analyze and address child health services, systems, and policies.
- Requires states and institutions to identify the root-cause determinants of children's health prior to implementing prevention, promotion, and mitigation strategies.
- Develops and implements rights, equity, and justice-based tools that can be used to advance the health and well-being children.
- Catalyzes the development of curricula to prepare professionals to use/evaluate these tools.
- Ensures child and youth participation.

Principle 9. Normative standards. CRC Article 24 and its related articles establish the normative standards for the function of health systems and health outcomes. Public and private sector stakeholders in children's health and well-being must use the CRC articles related to health and, in particular, the core principles of child rights (Articles 2, 3, 6, 12, and 17), to frame, implement, and evaluate all policies, programs, and systems that impact child health. Given the right of all children to health, the impact of health on the realization of all other rights, the societal impact of child health on her/his well-being, and the effects of children's health on the adult life course, the child's right to health must be a priority for states' distribution of resources and other public policies.

Principle 10. New medical models. Advances in knowledge and understanding of the impact of social and environmental factors on health, and the biology and physiology underpinning this impact, require parallel changes in strategies to optimize the health and well-being of children and the adults they will become. These strategies must be rights, equity, and justice-based in order to succeed. Fulfilling the elements of Article 24 and its related articles will require new medical models to embrace rights, equity, and justice-based models of health services, systems, and policies.

Principles 11. Systems-of-care principles. States should embrace systems-of-care principles with respect to developing, implementing, and evaluating the systems and practices required to fulfill the health rights of children. These principles include the necessity of systems and practices, at a minimum, to be family centered, youth guided, culturally and linguistically competent, and evidence-based.

Principle 12. **Child and youth participation.** Children and youth and, in particular, those marginalized by social and environmental determinants, disabilities, and medical conditions, must be fully engaged in defining, developing, implementing, and evaluating policies, systems, and practices related to the broad spectrum of initiatives required to fulfill their rights to optimal health and well-being. Metrics to measure child and youth participation must be established and used for assessment and quality improvement.[8]

Appendix 3. Principles for the realization of children's right to health: roles and responsibilities

ROLES AND RESPONSIBILITIES FOR THE REALIZATION OF CHILDREN'S RIGHT TO HEALTH

Principle 13. States' responsibilities. States cannot devolve or relinquish their responsibility to ensure children's right to health through privatization, outsourcing, or other strategies, nor as a result of externally imposed restrictions on their public health responsibilities for assurance, assessment, and policy development.[7] This relates to states' own internally generated policies for privatization of public health programs and health services, as well as internationally imposed policies related to structural adjustment and economic policies.

Principle 14. Professional education. The neglect and indifference toward the principles of child rights, equity, and justice in relation to health, and the general disregard of the social and environmental determinants of health and life course sciences in the education of health professionals, have contributed and continue to contribute to the failure to optimize children's health and well-being and reach Millennial Developmental Goals.[2] The continued marginalization of children by race, sexual orientation, age, gender, disability, social status, etc. also contributes to these failures. Child health professionals must be educated in the practice of health and human rights.

Premise 15. Mental health and early child development. Mental health has been neglected in the discourse of child health. With advances in knowledge related to brain and early child development, it has become increasingly clear that both child and adult physical and mental health and well-being are determined early in childhood. Implementation of Article 24 must include a focus on children's mental health, including the need to address early brain development, as critical elements of a child's right to health, education, survival, development, and other related rights (Table II). CRC Article 6 and General Comment 7 address the priority of ensuring children's rights to optimal early child development.

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Appendix 4. Principles for the realization of children's right to health: measures, monitoring, and evaluation

MEASURES, MONITORING, AND EVALUATION FOR THE REALIZATION OF CHILDREN'S RIGHT TO HEALTH

Principle 16. Metrics. The metrics used to measure the success of rights, equity, and justice-based approaches to the practice of C-SSP include its capacity to both prepare states, professionals, professional organizations, and other stakeholders to respond to the root causes of contemporary child health determinants; as well as prevent and mitigate future health issues (eg, the impact of globalization and climate change on children.

Principle 17. Levels of indicators. The practice of C-SSP establishes two levels of rights, equity, and justice-based indicators: (a) outcome indicators that can be used as metrics across and within countries, and (b) proximal determinant indicators that can be used to address root cause determinants unique to individual communities.

Principle 18. Rights, equity, and justice indicators. Metrics used to evaluate the design and implementation, and formative, summative, and transformative outcomes of policies, systems, programs, and practices related to CRC Article 24 and related articles should be structured as rights, equity, and justice indicators.[2,8-10]

- Rights indicators use the principles of human rights and articles of the CRC to describe the status of structure, process, and outcome variables related to the status of children.[2,8]
- Equity indicators explicitly move the science of measurement from quantifying disparities to assessing the root causes of disparities and suboptimal child health and well-being, and the capacity of systems to ensure all children can reach optimal outcomes.
- Justice indicators measure the allocation and distribution of finite resources required to advance rights and ensure equity in systems.

Principle 19. Disaggregation of data. Rights and equity indicators cannot be based/measured by aggregate data. Data related to practice, systems, policies, and outcomes must be disaggregated to reflect disparities based on geographic, gender, socio-economic, political, cultural, and environmental determinants.

Principle 20. Metrics of root-cause determinants. Given the impact of social, economic, political, cultural, and environmental determinants on child health and well-being, health equity indicators must measure these root-cause determinants in the context of formative and summative assessments of all aspects of state, professional, and stakeholder efforts to fulfill the health rights of children.