

GLOBAL CHILD HEALTH

Why children's rights are central to international child health

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The UN Convention on the Rights of the Child provides a framework for improving children's lives around the world. It covers both individual child health practice and public health and provides a unique and child-centred approach to paediatric problems. The Convention applies to most child health problems and the articles are grouped into protection, provision and participation. Examples of the first are the right to protection from abuse, from economic exploitation and from illicit drugs. We examine one particular problem in each of these categories, specifically child labour, services for children with a disability and violence against children. The role of the paediatrician in applying a children's rights approach is discussed. Children's rights are increasingly being accepted around the world but still there is much more rhetoric paid to their value than genuine enforcement. Paediatricians can make a difference to the status of children worldwide by adopting a rights-based approach.

justice into practice will require a fundamental shift in the education of child health professionals at all levels of training.^{3,4} Children's health needs are changing and paediatricians' priorities will have to change with them.⁵⁻⁷ Our paper provides a brief introduction and insight into how health professionals can apply the principles of children's rights and the articles of the CRC.

WHY IS IT IMPORTANT TO PAEDIATRICIANS?

Children's health is mediated by a complex and dynamic social, economic and physical environment that affects every aspect of a child's well-being. Ironically, the more we learn about the molecular and genetic basis of health, the more we have come to understand the influence of this environment on the expression of genes and the biochemistry of life. This is as true for children in the North (resource-rich countries) as it is for children in the South (resource-poor countries), and its relevance to paediatricians transcends the geography of their practice. In a globalised world, paediatricians will increasingly be confronted with child health issues rooted in a global society.

These and other societal transitions demand a new framework for conceptualising children's health and well-being, and a new set of principles to guide child health practice to ensure its relevance to children. The CRC provides this framework, these principles, and an architecture to support the application of children's rights to child health. In one holistic document, the CRC defines the prerequisites for the health and well-being of all children and the obligations of all elements of society to fulfil their rights. It is only through the fulfilment of children's rights that equity in child health can be achieved.

The CRC also redefines the role of children in society as participants (article 12) and, through their participation, as critical contributors to their own health and that of the community in which they live. As a result, the relationship between paediatricians and children will necessarily assume a new balance in which the predominant, non-biomedical determinants of health, particularly those that relate to behaviour, risk reduction, health promotion, mental health and chronic illness, could be more effectively dealt with.

The principles of the CRC can be applied at all levels of child health practice. The social and environmental roots of most current acute and chronic child health issues require the engagement

The state of children's health worldwide in 2006 is an indictment of the world community. Richard Horton, the editor of the *Lancet*, testified at the beginning of this year¹ that

children had fallen off the political agenda of international health. Over 10 million deaths had been ignored for far too long by governments and even international agencies. Children were invisible.

The *Lancet's* response has been to declare the next 10 years as a decade for the child.

The relevance and importance of a rights-based approach to this charge cannot be overstated. Such an approach implies the incorporation of the principles and practices of children's rights into all aspects of clinical and public health practice (table 1). The UN Convention on the Rights of the Child² (CRC) provides a framework to support this work in relation to the delivery of health services, child advocacy and the generation of public policy.

Table 1 illustrates the different interventions that result from a traditional medical approach to obesity and type 2 diabetes versus a rights-based approach.

The benefits for health professionals in learning to use the CRC will be significant as it allows us to see disease and ill-health in the context of environmental and social threats to children, and to relate to children as people in their own right. Integrating the principles of children's rights, equity and social

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Abbreviations: CRC, Convention on the Rights of the Child; Unicef, United Nations (International) Children's (Emergency) Fund

Table 1 Different interventions that result from a traditional medical approach to obesity and type 2 diabetes, versus a right-based approach

Determinants	Morbidities	Indicators	Interventions
<i>Traditional biomedical approach</i>			
Genetics	Obesity	Rates of obesity	Diet Exercise
Calories	Type 2 diabetes	Rates of type 2 diabetes	Vending machine removal School meals
<i>Rights-based approach</i>			
Welfare reform Urban development	Obesity	Article 3. Best interests Advertising School meals Article 17. Access to information; Article 27. Adequate standard of Living Food security Geographical access to quality food Food costs	Restrict fast food advertising Nutritional school meals Tax incentives for supermarkets Price monitoring to ensure non-discriminatory pricing
Segregation Globalisation			
Media marketing policies Media deregulation Overuse of car	Type 2 diabetes	Article 24. Healthcare; Article 31. Leisure, recreation Access to recreational resources Time for recreation Article 32. Child labour	Access to healthcare Support for parks and recreational facilities Expanded use of schools, road traffic reduction Urban development policies re: the built environment Limiting child labour

of practitioners at all these levels to deal with the causes and symptoms of ill health which afflict most of the world's children. At the clinical level, the clinician can implement the core principles of the CRC by ensuring that children are not discriminated against in the healthcare system (article 2), considering the best interests of children whenever decisions are made that could have an effect on them (article 3), giving a voice and listening to children (articles 12–15) and by providing developmentally appropriate information to enable them to participate in decisions that will affect their lives (article 17). In addition, respecting the privacy and confidentiality of children will do much to facilitate their involvement in the healthcare system (article 16).

The CRC is also an effective tool to guide and support the expanded involvement of paediatricians and other healthcare providers in child advocacy and public policy development. There is an important part for professional organisations and individuals to play in advocating for the rights of children in their communities and globally. Globalisation and the intricate intersection of the lives of children throughout the world with societies in the North and South dictate the need for paediatricians and paediatricians to establish an international context for advocacy and public policy. The CRC provides a universally accepted framework to support these efforts. Examples of issues that paediatricians in the North and South will increasingly face in the context of their clinical work and advocacy include the following:

- The movement of children across borders through immigration, trafficking, adoption, etc, is a global child health issue. Articles 7, 8, 9, 10, 11, 20, 21, 22, 30 and 35 deal specifically with these concerns.
- In a global economy, the exploitation of children for and by adults within and outside a child's community is an international matter. Articles 32, 34 and 36 relate specifically to the protection of children from child labour and sexual and other forms of exploitation.
- International standards of conduct required to develop civil societies and peace benefit all countries. Societies cannot reach these standards unless children are extended the rights required to ensure that they are protected from abuse

and marginalisation. Articles 19, 37, 38 and 40 extend the rights of children to be protected from abuse and neglect, torture and deprivation of liberty, armed conflicts and aberrant juvenile justice systems.

- Finally, investment in the health and development of children (articles 23, 24 and 31), standards of living (articles 26 and 27) and education (articles 28 and 29) will pay significant dividends for all of us in the present and future.

INTERNATIONAL CHILD HEALTH PROBLEMS THAT WILL BENEFIT FROM A CHILDREN'S RIGHTS APPROACH

The articles of the CRC can be grouped into three broad classes of rights: protection, provision and participation. All three are

Table 2 Summary of key articles of the UN Convention on the Rights of the Child in health

Articles	Rights of protection
Article 6	Right to life
Article 9	Right not to be separated from parents (unless this harms the child)
Article 19	Right to be protected from all forms of abuse
Article 20	Right to special attention (eg, adoption and fostering if deprived of family)
Article 32	Right to be protected from economic exploitation
Article 33	Right to be protected from illicit drugs
Article 34	Right to be protected from all forms of sexual exploitation
Articles	Rights of Provision
Article 24	Right to the highest standard of healthcare
Article 27	Right to a standard of living adequate for the child's physical, mental, spiritual, moral and social development
Articles	Rights of Participation
Articles 7, 8	Right to an identity (name, family, nationality)
Articles 12, 13	Right to express views freely and to be listened to
Article 17	Right to access to information
Article 23	Right for disabled children to enjoy life and participate actively in society

applicable to health and healthcare, and are required to ensure optimal child health outcomes. The following sections provide an example of health issues faced by paediatricians that relate to each of these classes of children's rights. Table 2 provides a summary under each heading.

PROTECTION: CHILD LABOUR

Worldwide there are estimated to be 250 million children who contribute to the work force, 171 million of whom are considered to work in hazardous situations.⁸ As these children represent the most marginalised citizens in our societies, they also suffer from the effect of poverty and its associated health burdens. As they do not go to school, they experience opportunity costs in relation to their lost education and subsequent employment opportunities.

Health effect

The harm to the health of working children is marked. They often work in hazardous conditions for long hours. Their growth, development and mental health are harmed by this environment. They are deprived of adequate nutrition, an education and the benefits of parenting. A recent study in Jordan⁹ found that boys who work outside the home were stunted, anaemic, and 38% smoked more than five cigarettes a day. The study showed that 15% had started work before the age of 10 years and 86% were working >40 h a week. This is despite the strict laws in Jordan that prohibit child labour.

Solutions suggested

The United Nations (International) Children's (Emergency) Fund (Unicef) recognises¹⁰ that child labour might be an economic necessity for some families, and that rapidly ending all child labour is not possible. Raising awareness in the North of the harm being done through child labour is crucial, but outside pressure to end all labour may not be helpful. Working through governments and non-governmental organisations is more likely to be effective, and in particular to work for the ratification of International Labour Organisation Convention number 182 to end the worst forms of child labour, ensure that education, even if part time, is provided, and support other key areas of the child's development such as health, nutrition and sanitation.¹⁰

What child health professionals can do

Several CRC articles deal with the protection of working children by stating that children should not be exploited and that they have a right to education. Article 32 specifically refers to child labour. Recognition by society that children need protection and that their education is an economic necessity for the future will be assisted by greater publicity being given to the concepts of children's rights. Child health professionals can assist in identifying children in their practice who may be harmed by child labour, can collect data on the harmful effects of child labour, and can contribute to advocacy and public policy that limits child labour and its health consequences.

PROVISION: SUPPORT SERVICES FOR CHILDREN WITH DISABILITIES

According to Unicef,¹¹ there are 170 million children in the world with disabilities, and one in ten of them have a serious disability.

The vast majority have no access to rehabilitative or support services, and many are unable to acquire a formal education. In many cases, disabled children are simply withdrawn from community life; even if they are not actively

shunned or maltreated, they are often left without adequate care.

It is estimated that only 2% of disabled children in developing countries have any form of rehabilitation assistance or education.¹² Violence and abuse is three times more likely to happen to a disabled child. They are segregated and marginalised in special institutions, day centres and schools.

Health effect

The health effect of disability is lifelong. Lack of services may lead to early death and often to malnutrition, mental health problems and chronic pain owing to contractures and sores from unsupported ambulation. The compounding effect of poverty is often present, and carries with it its own burdens of ill health. Lack of education often leads to lack of achievement and to social isolation.

Solutions suggested

Legislation has been introduced in many countries (eg, the Disability Discrimination Act in the UK, 1995, and the Americans with Disabilities Act in the USA, 1990) to ensure that there is increased recognition of disability needs and improved awareness and training of professionals and others who come into contact with disabled people. This has come into effect as a result of lobbying and political activism by consumer groups and health professionals. If a high priority is to be given to providing services to children with disabilities, it will be increasingly necessary to engage, train and prepare non-government organisations, professionals, parents of disabled children and disabled children themselves to work together to effect change.

What child health professionals can do

In many countries, children with a disability are invisible. The CRC has a vital part to play to raise awareness that rights apply to all children in all circumstances, and that those who are vulnerable have a right to public services in relation to their degree of need. Paediatricians can do more than most members of the public as they are in a position to understand the health and social effect of disabilities. They have a critical role to play in advocating for the expansion of services and resources to serve the needs of these children and families in the generation of public policy to ensure that priorities are considered and integrated systems of care established.

PARTICIPATION: VIOLENCE AGAINST CHILDREN

Violence is among the greatest problems facing children worldwide and is prevalent in all North and South countries. Violence presents within the family and the community, is perpetrated by the state on children in custody and in public care, and through war. In 2001, the UN established a major international study on violence against children¹³ in collaboration with Unicef, the UN High Commissioner for Human Rights and the World Health Organization. The study will report in October 2006, but much has already emerged through the statements of the leader of the study, Paulo Sergio Pinheiro.¹⁴:

I have been struck by the fact that violence against children in all settings and contexts is very prevalent and knows no boundaries of geography, class, politics, race or culture.

In the UK, violence against children in custody has been publicised in the recent report of the Carlile Inquiry.¹⁵ Pain-compliant "distraction" techniques used on children under 17 years of age included bending the upper joint of the thumb forwards and downwards towards the palm of the hand,

pushing knuckles into the back to exert pressure on the lower ribs and exerting upward pressure on the septum of the nose. It is reported that in prisons pain is inflicted on children routinely rather than as an exception. Additionally, each time a child is taken to and from the courts they are strip searched.¹⁵

Health effect

The effects of violence on children's health hardly need restating. Death may be a merciful release from extreme forms of violence and the emotional effects may be lifelong and perpetuate a cycle of violence. Physical effects and disabilities are also common after severe episodes of violence.

Solutions suggested

Many solutions are recommended in the UN secretary general's report. Central to these is the participation of children and young people¹—for example, by ensuring that their opinions are heard in the media and by professionals, by enabling them to report violence to the relevant authorities and by providing opportunities for innovative approaches to prevention. Large groups of young people around the world have contributed to the findings and a few proposals are to

- establish an independent person who speaks on behalf of children (ombudsman);
- teach people about human rights and children's rights;
- stop people in the media from making violence a sensational issue by training them in the facts;
- inform children where they can report violence and where they can be safe if they report it.

What child health professionals can do

The UN report is entirely in line with the CRC and makes reference to it on many occasions. It was for this reason that the participation of children in the study was a central component. Violence against children is incompatible with the promotion of children's rights and the CRC is an important tool to combat it, by putting pressure on governments to implement child-protection measures. Child health professionals have a critical role to play in preventing violence against children by integrating the relevant articles of the CRC into their practice, by disseminating the findings of the secretary general's report to peers and the public and by ensuring the participation of children in the generation of local initiatives to prevent violence.

WORKING WITH THE UN CONVENTION ON THE RIGHTS OF THE CHILD

Implementation of a rights-based approach to child health through the use of the CRC will require public and professional advocacy. For example, health professionals can lobby for improving the statutory support for children and their place in society through the appointment of children's ombudsmen,¹⁶ appointing ministers for children, and by backing national and local legislation to ensure child protection and disability care. However, as children do not vote, governments are unlikely to promote these measures unless they are seen as being politically advantageous. Child health professionals have an important part to play in advocating for these changes, particularly in countries that do not place a high priority on the position of children.

Although the CRC has existed for only 15 years, great strides have already been achieved in its implementation. A recent

¹Act Now! Some highlights from children's participation in the regional consultations for the UN Secretary General's Study on Violence against Children. Save the Children 2005.

What is already known on this topic

- Worldwide, children suffer from severe health problems, lack of basic needs, and exploitation by the state and by their local communities.
- The UN Convention on the Rights of the Child was developed to ensure that children participate in society in a meaningful way, and that proper attention is paid to the protection of children and the provision of adequate services.
- There is currently little education of health professionals on the application of the principles of children's rights to clinical practice and child advocacy.

What this paper adds

- Detailed examples of the relevance of the three core principles of children's rights—protection, provision and participation—to critical issues affecting children in the North and South.
- An analysis of the significance of a rights-based approach to child health practice at all levels of service (clinical, advocacy and policy).
- An introduction for the paediatrician as to how to implement a rights-based approach to child health, using the principles of UN Convention on the Rights of the Child, to benefit children internationally.

study undertaken by Unicef¹⁷ has shown that there has been comprehensive legal reform to incorporate the CRC into national laws in 50 of the countries studied. Sixty countries have ombudsmen or commissioners for children. The study also found that there is a considerable increase in civil society backing for the CRC and in the participation of children. In relation to the participation of children, the UN study on violence against children¹³ has fully integrated and considered the voices of children about their experiences of violence.

However, a report from Africa¹⁸ on the effects of the CRC on child protection services shows that although there is much rhetoric paid to the values expressed in the CRC, in reality these are still often ignored. For example, despite the enactment of many new laws in Kenya since 2000 related to the well-being of children, resources are inadequate. This report suggested that the government and communities have not as yet taken full ownership of the CRC, and that competing agendas, such as HIV/AIDS and the implementation of Education for All and Millennium Development goals, have taken priority over the pursuit of children's rights strategies. Governments should be enabled in the future to control the process of implementation.

There are few professionals with more respect and influence than paediatricians. If we are to succeed in ensuring equity in child health for all children in the North and South, and remain relevant to the needs of children, we will need to expand our roles and capacity to integrate a rights-based approach with the practice of paediatrics and child health, and train future generations of paediatricians in these principles and practice.

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REFERENCES

- Horton R. The coming decade for global action on child health. *Lancet* 2006;**367**:3–5.
- Convention on the Rights of the Child. <http://www.unicef.org/crc/> (accessed 19 Mar 2006).
- Blair MB. Training and education as a means of increasing equity in child health teaching of undergraduates. *Pediatrics* 2003;**112**(Suppl):747–8.
- DeWitt TG. The application of social and adult learning theory to training in community pediatrics, social justice and child advocacy. *Paediatrics* 2003;**112**(Suppl):S755–7.
- Royal College of Paediatricians and Child Health. *The next ten years: educating paediatricians for new roles in the 21st century*. London, RCPCH, 2002, <http://www.rcpch.ac.uk/publications> (accessed 22 Sept 2006).
- RCPCH. *Bridging the gaps: health care for adolescents*. London: RCPCH, 2003, <http://www.rcpch.ac.uk/publications> (accessed 22 Sept 2006).
- American Academy of Pediatrics. Community pediatrics: making child health at community level an integral part of pediatric training. *Pediatrics* 2005;(Suppl):ii.
- Unicef. *Fact sheet on child labour* (undated). Washington, DC: Unicef.
- Hawamdeh H, Spencer N. Work, family socioeconomic status, and growth among working boys in Jordan. *Arch Dis Child* 2001;**84**:311–14.
- Unicef. *State of the world's children, 2004*. Oxford: Oxford University Press, 2004.
- Unicef. *State of the world's children, 2006*. Oxford: Oxford University Press, 2006.
- Rehabilitation International. http://www.rehab-international.org/Anon-publications/10_22.htm (accessed 20 Mar 2006).
- Anon. The United Nations Secretary General's Study on Violence against Children. <http://www.violencestudy.org> (accessed 19 Mar 2006).
- Pinheiro PS. Statement at the 60th session of the General Assembly, 14th Oct 2005. <http://www.violencestudy.org> (accessed 22 Sept 2006).
- Lord Carlile of Berriew. *An independent inquiry into the use of physical restraint, solitary confinement and forcible strip searching of children in prisons*. London: The Howard League for Penal Reform, 2006, www.HowardLeague.org (accessed 22 Sept 2006).
- United Nations Special Session on Children. First global meeting of independent human rights institutions for children. <http://www.unicef.org/specialsession/activities/ihri-stmnt.htm> (accessed 22 Sept 2006).
- Pais MS, Bissell S. Overview on implementation of the UN convention on the rights of the child. *Lancet* 2006;**367**:689–90.
- Onyango P, Lynch MA. Implementing the right to child protection: a challenge for developing countries. *Lancet* 2006;**367**:693–4.

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