

Thirtieth anniversary of the UN Convention on the Rights of the Child: advancing a child rights-based approach to child health and well-being

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SUMMARY

Global challenges to children's health are rooted in social and environmental determinants. The UN Convention on the Rights of the Child (CRC) articulates the rights required to address these civil-political, social, economic and cultural determinants of child well-being. The principles of child rights—universality, interdependence and accountability—define the tenets of social justice and health equity required to ensure all rights accrue to all children, and the accountability of individuals and organisations (duty-bearers) to ensure these rights are fulfilled. Together, the CRC and child rights principles establish the structure and function of a child rights-based approach (CRBA) to child health and well-being—that provides the strategies and tools to transform child health practice into a rights, justice and equity-based paradigm. The 30th anniversary of the CRC is an opportune time to translate a CRBA to health and well-being into a global practice of paediatrics and child health.

INTRODUCTION

Much has been accomplished with respect to child health since the adoption of the UN Convention on the Rights of the Child (CRC) 30 years ago¹ (table 1).

Nonetheless, optimal health and development remain aspirational goals for the majority of the world's children.²

Since the launch of the CRC, it has become clear that the root causes of child health and well-being are primarily defined by social and environmental determinants.^{3 4} Armed conflict, violence, migration, poverty, income inequity, disabilities, globalisation and climate change have become existential threats to children and childhood.^{5 6}

The 30th anniversary of the CRC provides an opportune time to review the principles of child rights and the contributions and challenges of a child rights-based approach (CRBA) to advancing global child health and well-being.

What is known about the subject?

- ▶ The most critical global challenges to children's health and well-being are rooted in social and environmental determinants of health.
- ▶ The UN Convention on the Rights of the Child (CRC) and related documents address these root civil-political, social, economic and cultural determinants of child health and well-being.
- ▶ The child rights principles—universality, interdependence and accountability—define the tenets of social justice and health equity required to ensure all rights accrue to all children, and that duty-bearers everywhere work to ensure these rights are fulfilled.
- ▶ Together, the CRC and human rights principles establish the structure and function of a child rights-based approach (CRBA) to child health and well-being.
- ▶ A CRBA provides the foundation and framework, strategies and tools, and methods and metrics to transform child health practice into a global rights, justice and equity-based paradigm for clinical and public health services, systems development and policy formulation.
- ▶ The challenge confronting us is to translate CRBAs to health and well-being into a global practice of paediatrics and child health.

What this study adds

- ▶ This study provides a foundation and framework for validating and implementing a Child Rights Based Approach to child health and wellbeing. It orients the reader to the historical context of child rights based approaches to child health that have defined the trajectory of current practices. It identifies past challenges to CRBAs to child health and examples of programs and initiatives that have responded to these challenges. It defines a new paradigm for the practice of paediatrics and child health that is grounded in the principles, standards and norms of child rights, social justice and equity.

**Table 1** The United Nations Convention on the Rights of the Child (CRC)**UN Convention on the Rights of the Child**

Economic rights	Adequate standard of living Social security Protection from economic exploitation
Cultural rights	Respect for language, culture and religion Abolition of traditional practices likely to be prejudicial to a child's health
Social rights	Life, survival and development Best possible health and access to healthcare Education Play Family life or alternative care Family reunification Fullest social inclusion for disabled children Support for parents to ensure protection of children's rights
Protective rights	Promotion of a child's best interests Protection from abuse and exploitation Protection from armed conflict Protection from harmful drugs Protection from trafficking Rehabilitative care postabuse or postneglect
Civil and political rights	Heard and taken seriously Freedom from discrimination in the exercise of rights Freedom of religion, association and expression Privacy and information Respect for physical and personal integrity Freedom from all forms of violence, torture, or other cruel, inhuman, or degrading treatment Due process of the law Recognition of the importance of treating the child with respect within the justice system Not to be detained arbitrarily

THE IMPACT OF A CRBA TO CHILD HEALTH

A CRBA to child health and well-being is mediated through the realisation of children's civil-political, social, economic and cultural rights, and only partly by fulfilling their right to healthcare.³⁻⁶ This approach translates the articles of the CRC into practice in clinical services and public health programmes, systems development and policy formulation.

A CRBA to violence against children provides an excellent case study. The two optional protocols on the 'Involvement of Children in Armed Conflict' (2002) and 'Sale of Children, Child Prostitution, and Child Pornography' (2002) translated CRC protection rights into policy. General Comment 13 (2011), 'The right of the child to freedom from all forms of violence', then conceptualised violence as the outcome of complex political, social, economic and cultural determinants that require a holistic rights-based approach to address.

The Comment provided strategies to develop rights-based child protection systems.⁷ It subsequently catalysed global rights-based advocacy efforts to prohibit corporal punishment, female genital mutilation (FGM) and early marriage (the Sustainable Development Goals; SDG)^{7 8}(figure 1) and the "Know Violence in Childhood"⁹ are examples of recent rights-based approaches to ending violence against children.

CHALLENGES TO A CRBA TO HEALTH

Defining causality between CRBAs to child health and child health outcomes remains a challenge.¹⁰ In particular, requiring statistical significance to define cause and effect limits our capacity to capture 'the impact of rights-based transformations in health' and the 'lived experience' of human rights-based interventions.¹¹ With respect to ensuring children's rights to access quality healthcare, barriers can be attributed to the failure to integrate human rights into health law,¹² prioritise the right for disadvantaged communities to access health services¹³ and implement children's rights to participate in healthcare decisions.

Preparing child health professionals to translate the CRC and principles of child rights into practice remains a significant challenge.¹⁴⁻¹⁹ Despite the 'transformative potential of education for human rights in patient care',¹⁷ schools of medicine, nursing and public health have generally failed to include human rights training in curricula.¹⁶ This is reflected in a survey (2014) of European paediatric primary care providers that identified deep gaps in their knowledge and large variations in their practice of child rights.¹⁸

Underscoring the importance of professional education, nearly every recent country report of the Committee on the Rights of the Child (Committee) includes a statement on the need to expand the education of professionals on

SUSTAINABLE DEVELOPMENT GOALS



Figure 1 Sustainable Development Goals.

the principles and practice of child rights. This is particularly true for healthcare workers in low and middle-income countries who must frequently address violations of children's rights to the basic needs required for their optimal survival and development.¹⁴ The following sections discuss the principles of child rights, and their integration into healthcare and monitoring and evaluation.

THE UN CONVENTION ON THE RIGHTS OF THE CHILD

The CRC is a comprehensive human rights treaty recognising children as rights-holders possessing civil-political, social, economic and cultural rights (table 1). Its transformative impact is twofold. First, it changes the construct of children from individuals having needs, to persons with entitlements to have their needs met. Second, it replaces a view of children as passive objects of adult protection, with their recognition as subjects of rights—entitled to respect for their voice and the capacity to influence matters of concern to them, including healthcare decisions.

Four general principles establish a framework for operationalising children's rights.²⁰

- ▶ *Universal and inalienable.* Rights apply to all children—in their homes, schools, hospitals, detention and/or on the move across borders—they follow the child.
- ▶ *Interdependent and indivisible.* The realisation of one right depends on the realisation of all related rights.
- ▶ *Accountability.* Rights impose obligations on all individuals and organisations to fulfil them as 'duty-bearers'. Children and/or their advocates need the capacity to hold duty-bearers accountable for the realisation of their rights.
- ▶ *Role of the state.* It is the state's primary responsibility to implement and sustain the means by which children's rights are fulfilled. This includes ensuring all duty-bearers are informed about their responsibilities and acquire the capacities to fulfil them.

Though all rights are interdependent, four must be applied in the process of implementing all other rights.

Article 2 requires that all rights must be respected for every child without discrimination. With respect to health (Article 24), many countries fail to fulfil the rights of vulnerable children to optimal health and healthcare. Children on the move, for example, have severely restricted access to healthcare services.^{21 22}

Article 3 requires all actions concerning children consider their best interests. Accordingly, child health professionals must ensure children's best interests are considered in all decisions that affect them.²³ Examples include marketing of breast milk substitutes, access to quality child development services, vaccine policy, corporal punishment and FGM. Also, the views of children must be considered based on their evolving capacities in the determination of their best interests.

Article 6 articulates the child's right to life and optimum survival and development. 'Development' includes the physical, mental, spiritual, moral, psychological and social development of the child. Examples include enabling children in hospitals to pursue their right to play, education, and family life, and support for breast feeding policies.²⁴ The roles of health professionals in advancing children's rights to survival and development through their response to armed conflicts^{25–27} and climate change^{28–30} are rapidly evolving.

Article 12 introduces the right of every child capable of forming a view to have that view given due weight in accordance with their age and maturity. Article 12 requires children to be actively involved in their own healthcare. Child health professionals must provide adequate information to the child, privacy, opportunities for informed consent-assent and involvement in the design of health services and policy.^{31 32} It also includes the child's right to access formal complaint mechanisms and forms of redress.



A CRBA TO HEALTH AND DEVELOPMENT

Human rights-based approaches

Since the ratification of the CRC, the principles of a Human Rights Based Approach (HRBA) have been applied to children to establish a CRBA to health and well-being. Children are identified as ‘rights-holders’ with entitlements. Those responsible to fulfil these entitlements (rights) are considered ‘duty-bearers’ with obligations for which they are accountable. A CRBA requires using the CRC and principles of child rights to design, implement, monitor and evaluate health services, systems and policies.

Services and programmes

With respect to *services* and *programmes*, CRBAs apply all relevant rights in the CRC to improve healthcare delivery and health outcomes (Article 24) (table 2).

They require translation of child rights principles into practice, for example, adoption of charters on children’s rights in hospitals; commitment to hear children’s views; ensuring confidentiality; and adequate training for professionals.^{33 34}

Systems

Systems integrate the work of stakeholder organisations to address single or multiple rights.^{35 36} Examples include the European Association for Children in Hospital (EACH) Charter,³⁷ WHO health promotion in hospital protocols,^{38–40} Baby-Friendly Hospitals²⁴ and early childhood rights indicators.⁴¹ Systems must include the perspective and concerns of children themselves,⁴² and consideration of children’s best interests.

Policy

In the context of *policy*, CRBAs address the inequities, laws, services and budgetary issues that influence the realisation of children’s rights.

PRIORITIES FOR A CRBA TO CHILD HEALTH

Implementation of CRBAs to child health remains a work in progress. As it is difficult to attribute outcomes to specific CRBAs, new methodologies to assess the realisation of rights are required.⁴³ Children as subjects of rights—together with their parents/caregivers—must understand the rights to which they are entitled and how to exercise them.

The recent publication, *A Second Revolution: Thirty years of child rights, and the unfinished agenda*,⁴⁴ identifies 10 priorities for the realisation of child rights and implementation of a CRBA to child health and well-being. These priorities are opportunities to reframe the work of child health professionals.

1. Apply CRBAs to the SDGs.
2. Ensure every child’s right to be heard in all settings.
3. Demonstrate progress for all children.
4. Prioritise children in governance with increased public investments and accountability.

Table 2 Rights associated with Article 24: Children’s right to health and healthcare

Articles		Description
Article 2	Non-discrimination	All rights are to be recognised 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		Description
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 implementation of prevention and treatment programmes
Article 23	Disabilities	Right to 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 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-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 conflict, torture, neglect, and so on

SOL, Standard of Living.

5. Ensure multisectoral work and address the indivisibility of children’s rights.
6. Urgently address climate change and environmental harm.
7. Educate to achieve children’s rights.
8. Embed violence prevention at all levels.
9. Transform harmful social norms, and build on strengths of children, families and communities.
10. Prioritise windows of opportunity in early childhood and adolescence.

IMPLEMENTING CRBAS IN HEALTH SETTINGS

Status of CRBAS to Child Health

A global pattern of neglect and violation of children's rights to health exists within healthcare services, systems and policies.³⁹ At the policy and systems levels, these include inadequate financing, training, accountability and child protection. Inappropriate clinical practices include lack of pain control, excessive use of intramuscular injections and indiscriminate use of antibiotics. Failures also include lack of respect and sensitivity for the child, avoidable separation from parents, disrespect for privacy and dignity and failure to include children and families in decision-making.⁴⁵

Training and performance gaps among healthcare professionals with respect to child rights persist. For example, in a recent Portuguese study (2015) of youth engagement in the process of obtaining informed consent—95% of responding paediatricians stated their training had gaps concerning the realisation of this right.⁴⁶ Similar findings unfolded in studies in Kyrgyzstan and Tajikistan.⁴⁷

Thus, it is crucial that child and public health practitioners and decision-makers are aware of the importance and rationale for fulfilling children's rights to optimal health and development. Providing professionals education and the capacity for translating knowledge into practice will be necessary to achieve optimal health outcomes for children.

ADVANCING CHILDREN'S RIGHTS IN HEALTHCARE SETTINGS

Multiple initiatives have emerged over recent decades to advance the integration of child rights into child health services. The EACH Charter,³⁷ for example, establishes 10 rights of children and their families related to hospitalisation. Other rights-based charters and advocacy movements have been subsequently adopted, including the Charter of the International Children's Palliative Care Network.^{48,49} Milestones in the implementation of child rights in healthcare settings are summarised in [table 3](#).

The evolution of the Child Friendly Healthcare Initiative (CFHI)⁵⁰ is particularly instructive. CFHI was launched in 2000 as a model for implementing children's rights in hospitals and healthcare settings. The 12 Standards and accompanying metrics translate relevant articles of the CRC into health practices in multiple venues—home, community, outpatient facilities and hospitals.

The Task Force on Health Promotion for Children and Adolescents in Hospitals was then established in 2004,⁵¹ and subsequently published a *Self-evaluation Model and Tool on the Respect of Children's Rights in Hospital* (SEMT) in 2009.⁵² The SEMT has been translated into 10 languages and has undergone rigorous evaluations in Europe and Australia.⁴³

Informed by these evaluations—assessment tools specific to administrators, health professionals, children, adolescents and parents were developed.^{53,54} Strategies and tools for implementing CRBAs to child health in primary healthcare facilities are now being established and assessed.^{54,55}

Table 3 Efforts to advance CRBAs to health and development

Year	Effort
1988	Voluntary associations in 12 European countries coalesce producing the Leiden Charter in 1988.
1993	The EACH Charter results from their subsequent collaboration as the European Association of Children in Hospital. The Charter describes 10 articles, closely related to the CRC, on the rights of sick children and their families. ³⁷
2000	The Child-Friendly Healthcare Initiative uses the mandate of the CRC to define child-friendly healthcare by developing and promoting 12 child rights-based Standards applicable in any setting, each with supporting criteria that encompass all aspects of healthcare provision for children. These Standards are accompanied by systematic assessment and quality improvement tools piloted in Uganda, Pakistan, Kosovo, Moldova and the UK. A manual is made available online for health workers and health planners.
2004	The Task Force on Health Promotion for Children and Adolescents in Hospitals (HPH-CA) was established in 2004 within the international Health Promoting Hospitals network. HPH-CA publishes the <i>Standards on Health Promotion for Children and Adolescents A Task Force HPH-CA Tool</i> . ⁵¹
2008	Hospital Amigable Initiative developed in Chile, promoting and assessing care against a framework of 12 Child Rights-based Standards in hospitals in Chile and Argentina.
2010	The final report on the implementation process of the Self-evaluation Model and Tool on the Respect of Children's Rights in Hospital is released.
2012	Pilots of the model are completed in 17 hospitals in Europe and Australia resulting in the publication of further assessment tools on children's rights in hospital. ⁵³
2015	Pilots implemented by WHO lead to the development of a Manual and Tools for the Assessment of Children's Rights in Primary Health care. ⁵⁴
2017	WHO Global Strategy for Women's, Children's and Adolescents' Health and the Nurturing Care Framework demonstrate the relevance of a CRBA to child health and well-being.
2018	WHO Standards for improving the quality of care for children and young adolescents in health facilities include specific Standards relating to the respect, protection and fulfilment of child rights at all times during care.

CRBA, child rights-based approach; CRC, UN Convention on the Rights of the Child; EACH, European Association for Children in Hospital.



With the success of these initiatives, WHO is beginning to mainstream CRBAs into planning and delivery of health services. In 2017, WHO issued the *Regional Framework on Improving the Quality of Care for Reproductive, Maternal, Neonatal, Child and Adolescent Health* in the WHO European Region.⁵⁶ In 2018, the global *Standards for improving the quality of care for children and young adolescents in health facilities* was released. The Framework and Standards explicitly require institutions and systems to provide and report on care that respects child rights.⁵⁷

Ultimately, advancing the rights of children to optimal health and development will require systematic efforts across all sectors of the healthcare system. These include the capacity for rights-based transdisciplinary practice, new tools and metrics grounded in the principles of child rights and systems of accountability and redress for children.

MONITORING AND EVALUATION

Weak systems for monitoring States' obligations to fulfil the rights of children continue to challenge the realisation of children's rights.^{58–60} In response, the UN Office of the High Commissioner for Human Rights has called for more attention to the use of indicators as tools to collect data and monitor compliance.^{61–69}

Most child rights indicators address each right in isolation without linking it to other rights. The human rights principle of interdependence necessitates a coordinated approach to monitoring that includes all related rights. To comprehensively monitor the right to health, for example, data must also be collected on other relevant rights (table 2).

Fully integrated structure, process and outcome (SPO) indicators that address civil-political, economic, social and cultural rights will be required in the future to advance and monitor the realisation of child rights (box 1).

Integrating the assessment of a State's policies, processes and outcomes over time can expose gaps in capacity and facilitate evidence-informed responses and decision-making.

GlobalChild⁴³ is an example of a comprehensive SPO monitoring initiative that has generated comprehensive and interconnected SPO indicator sets to assess all substantive rights in the CRC.⁷⁰ This CRBA to monitoring child health addresses all determinants of health—civil-political, social, economic, cultural and environmental—that influence health and development and respect for children's dignity and evolving capacities. It also embraces a participatory and transparent approach to disaggregated data collection in order to reveal systemic discrimination against groups of children.

CONCLUSION

Much has been achieved to advance the realisation of children's rights since the CRC launch—yet new challenges to child health and well-being are presenting with an intensity rarely before confronted. While it is difficult

Box 1 Structural, process and outcome indicators

Structural indicators demonstrate State and non-State commitments to undertake measures in keeping with human rights obligations.

Potential indicators include:

- ▶ Legislation, policies and strategies to ensure the highest standards of health and well-being, for example, constitutional guarantees to assure every child the right to health.
- ▶ Legislation providing minimum guarantees in terms of access to quality healthcare, including refugee, immigrant, ethnic minority children, and so on.
- ▶ Legislative and policy commitments to guarantee an adequate standard of living, and protection from all forms of violence.
- ▶ Implementation of an accessible and effective complaint mechanism, through the establishment of children's ombudspersons or commissioners.

Process indicators assess progress in transforming State and non-State actors' commitments to child rights-based approaches (CRBA) to programmes, systems and policy. Potential indicators include:

- ▶ Budgetary allocations for health, marginalised children's access to services and proportion of children covered by health insurance.
- ▶ Access to affordable housing and social security, and effective enforcement of child protection legislation.

Outcome indicators capture the individual and collective results of the measures put into place by the State. Potential indicators include:

- ▶ Rates of mortality, obesity, youth suicide and violence against children.
- ▶ Perceptions from children about how they experience the realisation of their rights.

to parse the direct effects of a CRBA to specific child health outcomes, it has become clear that civil-political, social, economic, cultural and environmental factors are the primary determinants of child health and well-being. It is only through the implementation of a CRBA that we will be able to effectively address these determinants.

The knowledge and experience accrued since the adoption of the CRC is ushering in a new era, a 'Second Revolution',⁴³ framed by the CRC and SDGs.⁷¹ Child health professionals have important roles to play in response to the global challenges to child health and well-being. Knowledge of the principles of child rights and experience with applying a CRBA to clinical practice, systems development and policy formulation will provide them the tools required to fulfil the rights of all children to optimal survival and development.

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