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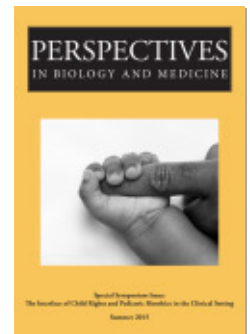
The U.N. Convention on the Rights of the Child: Relevance
and Application to Pediatric Clinical Bioethics

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THE U.N. CONVENTION ON THE RIGHTS OF THE CHILD

*relevance and application
to pediatric clinical bioethics*

GERISON LANSDOWN,* LAURA LUNDY,† AND JEFFREY GOLDHAGEN‡

ABSTRACT This article provides an overview of the relevance and import of the U.N. Convention on the Rights of the Child (CRC) to child health practice and pediatric bioethics. We discuss the four general principles of the CRC that apply to the implementation of all rights contained in the document, the right to health articulated in Article 24, and the important position ascribed to parents in fulfilling the rights of their children. We then examine how the CRC is implemented and monitored in law and practice. The CRC and associated principles of child rights provide strategies for rights-based approaches to clinical practice and health systems, as well as to policy design, professional training, and health services research. In light of the relevance of the CRC and principles of child rights to children's health and child health practice, it follows that there is an intersection between child rights and pediatric bioethics. Pediatric bioethicists and child rights advocates should work together to define this intersection in all domains of pediatric practice.

The U.N. Convention on the Rights of the Child (CRC) is among the most comprehensive of all international human rights covenants. It was adopted by the U.N. General Assembly in 1989, following a decade of discussion and debate

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relating to its content, and has now been ratified by every nation in the world except the United States. This level of endorsement and broad acceptance of its provisions establishes the articles of the CRC as global norms for the treatment of children and standards for the dignity and respect that is due them. The CRC provides a global agenda for children and childhood and has been described as “an authoritative, universal definition of the rights of children and young people” (Hammarberg 1990, 97–105), “unparalleled in its conceptual breadth” (Melton 2005, 646–57).

The transformative impact of the CRC lies primarily in two domains. First, it shifts the construct of children from individuals having needs to persons with entitlements to have their needs met. Whereas a need describes the conditions required for children to thrive, a right recognizes the child’s entitlement, by virtue of being human, to have that need fulfilled (Lundy 2014). Second, rather than constructing children as passive objects of adult protection, the CRC acknowledges that they are subjects of rights—active agents entitled to respect for their views and with the capacity to influence matters of concern to them (UNCRC 2009).

Unlike other human rights treaties, the rights articulated in the CRC address essentially all substantive realms of children’s lives. These include critical socio-economic rights (health, education, adequate standard of living), civil and political rights (identity, expression, association, and conscience), and obligations of states to protect children’s rights to be free from abuse, neglect, and all forms of exploitation. These obligations specify protections for particularly vulnerable groups of children, including children with disabilities, in detention, and conscripted as soldiers.

The broad scope of the CRC provisions and associated principles, including the requirement that all relevant rights be considered for all children in all matters that affect them, establishes the CRC’s capacity to address all aspects of children’s lives, even those that are not explicitly articulated in the text itself (Killkelly and Lundy 2006). With respect specifically to children’s right to optimal health, the 41 substantive articles of the CRC have direct application to the roles of health professionals. They provide a holistic and coherent approach to:

- Guide the community and hospital-based practice of child health professionals to ensure they are consistent with respect for human rights, advance the relevance of pediatrics and child health practice, and contribute to optimal health outcomes;
- Inform the design, provision and delivery of health systems to ensure compliance with the protection and fulfillment of children’s rights;
- Address the social and environmental determinants of health; and
- Generate public- and private-sector health policies that optimize children’s health and well-being by fulfilling their rights.

The following section discusses the core principles of the CRC and their relevance to children's health and pediatric bioethics. Subsequent sections address the child's right to health as defined in CRC Article 24, parents' rights in the CRC, and monitoring and evaluation.

U.N. CONVENTION ON THE RIGHTS OF THE CHILD: FOUR GENERAL PRINCIPLES

Translation of the principles of child rights into practice for health professionals can be best understood through an analysis of the relationship of the four core rights of the CRC—nondiscrimination (Article 2), best interests (Article 3), survival and development (Article 6), and participation (Article 12)—to clinical practice, health systems development, and the generation of child health policy. These four articles taken together are referred to as the “General Principles.” All rights must be realized for all children, and no right takes precedence over another. However, in order to enhance the decision-making processes through which children's rights are fulfilled, these four General Principles must be considered and applied across the implementation of all other rights in the CRC. The General Principles of child rights align to a large degree with those of bioethics: nondiscrimination with justice, best interests with beneficence, survival and development with non-maleficence, and participation with autonomy.

Article 2. Non-Discrimination

States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction 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.

Human rights are founded on two basic concepts: dignity and equality. Article 2 of the CRC recognizes and operationalizes the latter. As in other human rights treaties, the principle of nondiscrimination is not a standalone right, but one that applies to the implementation of all other substantive rights.

Article 2 insists that no child can be discriminated against on any of the prohibited grounds identified in the CRC. This means, for example, that it is not acceptable to allow differential levels of funding for services for groups of children without justification. Children who are stateless, refugees, or asylum seekers have exactly the same rights as any other child to food, shelter, education, protection, and optimal health and health care. This does not mean that all children must be treated the same: legitimate differences in treatment between children are acceptable if these are applied in order to advance health equity. An example would be providing school-based health services to children with disabilities that are not available to other children to enable them to attend school. However, any differentiation between children can only be justified if it is in the child's best interests.

Discrimination can be both direct and indirect and can take the form of individual, institutional, and structural discrimination. Both forms of discrimination have profound effects on the health and well-being of children in all countries. *Direct* discrimination takes place when an action, activity, law, or policy deliberately seeks to exclude a particular group of children. Examples of direct discrimination include: children with disabilities being denied the right to certain forms of treatment on the grounds of a perceived lower quality of life; access to health care being routinely limited by families' ability to pay for services; family planning and reproductive services for youth being limited by public policy; (barring girls from providing independent consent to human papilloma virus (HPV) vaccine; or lesbian, gay, bisexual, and transgender youth lacking access to services critical to their health. Legislation can also be enacted that discriminates specifically against all children as a group—for example, in the case of laws that permit children to be subjected to assault through physical punishment, when the same assault against an adult would constitute a criminal offense. By contrast, *indirect* discrimination arises when an action, law, or policy has the consequence of excluding or harming particular groups of children, even if that was not the intention. Examples of indirect discrimination include: laws that allow unregulated development and environmental decay, which can have fundamental effects on children's health and well-being; global trade policies that can impact children's health in myriad ways; hospitals that hold clinics in inaccessible buildings, which may discriminate against children with disabilities, or that fail to advertise or provide services in the languages used by immigrant or indigenous children.

Most health services are committed to nondiscrimination. However, ensuring that a service is not discriminatory requires a proactive analysis of what the service is providing, how it is functioning, and who it includes or excludes. The U.N. Committee on the Rights of the Child (Committee) has said that: "States should identify factors at national and subnational levels that create vulnerabilities for children or that disadvantage certain groups of children. These factors should be addressed when developing laws, regulations, policies, programmes and services for children's health, and work toward ensuring equity."

For individual health professionals, a commitment to ensuring a nondiscriminatory approach to clinical care, health systems development, and the generation of health policies will necessitate not only adopting an explicit commitment to treat every child with equal respect, but also recognizing potential areas of prejudice or stereotypes and patterns of discrimination. Discriminatory health practices remain a global challenge. For example, in Europe, assumptions about cultural practices have led to a failure among doctors to respond appropriately to protect children from severe forms of physical punishment or from female genital mutilation. In the United States, the Institute of Medicine's *Unequal Treatment* has identified the unrecognized structural and institutional racism that pervades American health-care institutions (Coyne 2008). In the United Kingdom, a reluctance to intervene

in cases of extreme and widespread sexual exploitation when the perpetrators are from an ethnic minority community has resulted in ongoing sexual abuse of girls effectively sanctioned by localities. More generally, girls from low-income countries who are being sexually exploited or trafficked are less likely to be believed and experience hostility from health and justice systems more frequently than girls from more affluent backgrounds who report assaults.

Discrimination can also arise in health systems and public and private sector policies. A commitment to ensuring the right to health for every child (as rights holders) necessitates a parallel commitment to analyzing service utilization in order to identify exclusions, poor health service designs, and health policies that fail to guarantee equal access for every child to health care. Targeted investments and strategies to reach the most marginalized children are also required. Medical professionals have an obligation (as duty-bearers) to use their knowledge and experience to advocate for health practices, systems, and policies that challenge all exclusionary practices.

Article 3. Best Interests of the Child

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.

The concept of the best interests of the child is a core principle of the CRC. The Committee has determined that the concept of best interests entails a substantive right for children to have best interests taken into consideration when different interests are being assessed; an interpretive legal principle to guide decision-making; and a rule of procedure to ensure that best interests have been evaluated. The concept of best interests is a unique provision in human rights law, acknowledging that although children like adults are subjects of rights, they do not have autonomy and the automatic rights of decision-making associated with adulthood. Accordingly, adults are charged with ensuring that the best interests of children are considered in all decisions affecting them until the children are competent to independently exercise their rights on their own behalf.

With respect to child health professionals, the concept of best interests should guide how decisions are made on behalf of children, including decisions made in clinical practice and those related to health systems development and the generation of health policies. Article 3 of the CRC states that best interests must be “a primary consideration” in all actions concerning the child. However, the principle is referenced in many other articles of the CRC, including Article 9 (children should never be separated from parents unless this is in their best interests), Article 18 (the best interests of children should be parents’ basic concern), Article 21 (any placement for adoption must ensure that the best interests of the child are the paramount consideration), Article 37 (children should only be placed with adults in custody if it is in the child’s best interests to do so), and Article 40 (parents must be present in penal proceedings unless it is not in the best interests of the child).

It is important to note that these articles place varying levels of emphasis on the best interests principle. Article 3, for instance, requires that the best interests of the child be “a primary” consideration, but not the only consideration, in decisions that affect individual and groups of children. The scope of Article 3 covers “all actions concerning the child.” It recognizes that other rights/interests may need to be considered in decision-making, for example, isolating an infectious child in the interests of the wider community. In other CRC articles, which focus more narrowly on specific actions affecting children, the bar is raised. Article 18, for example, states that the child’s best interests will be parents’ “basic concern,” and in the context of adoption, the child’s best interests are the “paramount consideration.” Although each of the CRC articles is a statement of rights, they are not absolute and can thus be used as analytic tools to assess specific issues related to children.

The Committee has interpreted Article 3 as applying to children both as individuals and as a constituency. It applies when decisions are being made or actions taken in relation to a child’s personal health care, and also with regard to wider systems and policy decisions affecting the health of children at the community level. This broad-ranging interpretation is a radical new approach. Although the best interests principle is embedded in the child welfare legislation in many countries, its extension to all actions concerning children, including those taken by relevant private institutions, organizations, and individuals, is a major extension of obligations to children.

The term “best interests” also relates to the well-being of a child, the consideration of which is an important and emerging extension of the responsibilities of child health professionals. The well-being of children is determined by a wide range of circumstances, such as age, level of maturity, role of the family, and social and cultural norms and expectations, as well as the child’s individual history and experiences. Most parents and adults will defend their actions toward their children on the basis that they are in their best interests. However, within any group of parents and non-custodial adults, the understanding of what is in a child’s best interests will inevitably differ. Therefore, it cannot be assumed that a child’s best interests are objective facts. Furthermore, there may be tension between what is seen to be in the best interests of the child in the immediate term, as contrasted with his or her longer-term interests. And, sometimes the best interests of an individual child may conflict with that of a wider group of children. It is important to note that the concept of the best interests of the child requires a child to be considered directly as the bearer of rights and not indirectly through the auspices of parents or other adult duty-bearers.

In order to ensure a holistic approach to children’s rights, it is possible and necessary to apply rigorous rights-based analyses to the implications and meaning of the best interests principle. With respect to health professionals, this means making a holistic assessment of all rights relevant to a child’s best interests while simultaneously ensuring that the views of parents are considered and that those of

the children themselves are given due weight based on their evolving capacities. In some circumstances, the best interests of the child cannot be reconciled with a community's interests—for example, where that community determines that it is being threatened by a challenge to a cultural practice deemed to be counter to an individual child's best interests. A comprehensive rights-based analysis of these situations, balancing all of the relevant rights articulated in the CRC, will facilitate deliberate resolutions to these challenging issues.

Consideration of the best interests of children also needs to inform decisions at the systems and policy levels. Holistic rights-based analyses can be used to determine what is in the best interests of the child in relation to the design of clinical services and priorities for research, and in the accommodation of children's different cultural and religious identities. At the policy level, for example, the best interests principle should inform decisions related to vaccine policies such that children can independently consent for immunizations and should facilitate access to sexual and reproductive health services. Decisions that impact social and environmental health determinants should also be guided by the best interests principle. This is particularly germane to children's rights to optimal survival and development (Article 6) and health (Article 24), in light of the substantive evidence base for poorer child health outcomes associated with poverty and income inequality, and inadequate allocation of expenditures for child health (WHO 2008). As child advocates, a clear role exists for health professionals to bear witness to the impact of clinical services and health systems and policies on children's best interests.

Article 6. Right to Life and Optimum Development

States Parties recognize that every child has the inherent right to life. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Article 6 of the CRC states that every child has an inherent right to life. Article 1, which defines the scope of the CRC, states that its provisions apply to every human being below the age of 18 years. It does not define when life commences, allowing individual states to determine whether conception or birth constitutes the point when a person becomes a human being and acquires human rights. Article 6 also imposes an obligation on states to ensure, to the maximum extent possible, the survival and development of the child. The concepts of survival and development are crucial to the implementation of the CRC as a whole, with many other articles specifically referencing their importance, and they are inextricably linked. During the drafting of the CRC, it was argued that these concepts had acquired a special meaning in the international arena, in that they recognized the need to “ensure the child's survival in order to realise the full development of his or her personality from the material and spiritual points of view” (HCHR 2007). For example, Article 29 emphasizes that the aim of education must be directed to achieve the overall development of the child to the child's fullest potential, and

Article 27 asserts the right of every child to a standard of living adequate for his or her overall development. Optimum development is an overall goal of the CRC.

Though the right to life and obligation to ensure optimum development are self-evidently central to the role of health professionals, controversial implications for practice can arise. For example, proactive efforts to protect a child's right to life might be perceived to conflict with the child's best interests in the context of sustaining the lives of extremely premature babies or intervening to prolong the life of a child with profound disabilities. In such cases, the overall best interests of the child would be the mediating principle that must be determined through a holistic consideration not only of the child's right to life but also of other rights related to the child's prognosis for development. In this situation, rigorous rights-based analyses would be required to ensure the child's right not to be discriminated against on any ground was being observed (Article 2)—for example, to guarantee that the child's life was not being devalued as a consequence of his or her disability (Article 23), ethnicity (Article 30), legal status (Article 22), or other grounds. Issues such as the child's right to freedom from inhuman or degrading treatment (Article 37) and to all forms of exploitation (Article 36)—for instance, as related to the pursuit of research that may not be in the best interests of the child—would also be taken into account. In all decisions made by health professionals, the child's wishes, when he or she is capable of expressing them, must be considered (Article 12).

Implementation of the right to adequate development also carries implications for health systems and policy priorities. For example, children in hospitals should be enabled to pursue their right to play (Article 31), education (Article 28), and family life (Article 9). Furthermore, decisions about whether early assessment and identification services are funded and available to all children and their parents, or whether breast-feeding is supported and promoted, also have implications for the right to optimal survival and development.

Article 12. The Right to Be Heard

States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 12 of the CRC recognizes that every child capable of forming a view is entitled to express that view and have it taken seriously in accordance with her or his age and maturity. The application of this right has been broadly conceptualized as "participation," although the term itself does not appear in the article. The Committee has acknowledged that the right to be heard is very broad-ranging. To begin with, the right to be heard applies to every child capable of forming his or her own views, regardless of age or disability. Children are often able to form views even when they are not able to communicate them verbally. It is the responsibility of adults as duty-bearers to understand and communicate in ways the

child understands—the capacity to communicate does not begin when children can converse in adult-centric language. The right to be heard also requires that children are able to express their views freely, and it applies to all matters that affect children. This includes issues affecting children as individuals, such as medical treatment, court orders, or the choice of a school, and those affecting children as a group, such as schooling, transport, budget expenditures, urban planning, poverty reduction, or social protection. Furthermore, the right to be heard requires that children's views be given due weight in accordance with their age and maturity. This does not mean that adults must do whatever children want, but it does mean more than just listening: it is necessary to give their views serious consideration. When considering children's views, it is also necessary to take account of their capacity to understand the implications and consequences of those views.

The significance of Article 12 is profound, and it represents the most transformational and challenging provision in the CRC. It demands a fundamental change in the traditional status of the child as a passive recipient of adult decisions and interventions, and accordingly in the nature of adult-child relations. It has major implications for professional practice and service delivery in the health field.

Article 12 also requires revised approaches in the way child health services are designed and delivered. Children should be consulted about their experience with health care, and their views should be used to inform the provision of services—for example, on the questions of how wards are designed, when and where clinics are held, and how to assure confidentiality (Cavet and Sloper 2004; DeWinter, Baerveldt, and Kooistra 1999). For health professionals at the clinical level, while Article 12 does not afford the young child autonomy in health decisions, it does require that children are provided information (Article 17), and are given time to ask questions, reflect on choices, and be involved in decisions (Article 13)—in the context of their evolving capacities (Article 5) (Coyne 2008). The Committee recognizes that there are often serious discrepancies regarding autonomous decision-making, “with children who are particularly vulnerable to discrimination often less able to exercise this autonomy” (Todres 1998). Thus, the Committee states emphatically: “It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality” (UNCRC 2013). Article 12 also requires that children be informed about how their views have been considered and the reason for any failure to act on them.

Article 24: The Child's Right to Health and Health Services

States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

The right to health and health services is expressed directly in the CRC and expanded significantly in comparison to previous human rights documents. Ar-

ticle 24 addresses: (1) the right to the “highest attainable standard of health” and access to health care services; (2) priorities for health care services; (3) “abolishing traditional practices prejudicial to the health of children”; and (4) the need for international collaboration, in particular in developing countries.

Of note is that Article 24 is proscriptive in its enumeration of outcomes that serve as metrics for the realization of this right. Among the issues and potential measures identified as priorities in paragraph 2 are infant and child mortality, access to primary health care, decrease in malnutrition, and access to pre- and postnatal care and chronic disease services. The article also requires education of parents and children, to ensure that families and children have access to the information required for decision-making and preventive health services.

The Committee has published a General Comment on the child’s right to health that describes Article 24 as an “inclusive right, extending not only to timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services, but also to a child’s right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants” (UNCRC 2013). This General Comment also stresses that the right to health is a holistic right connected to other rights in the CRC that relate to contemporary morbidities affecting the global health of children, including parental guidance and the child’s evolving capacities (Article 5); access to appropriate information and role of the media (Article 17); parental responsibilities and state assistance (Article 18); protection from all forms of violence (Article 19); rights of children with disabilities (Article 23); the right to periodic review of treatment (Article 25); the right to an adequate standard of living (Article 27); the right to education (Article 28); protection from various forms of exploitation (Articles 32 to 36); and recovery and reintegration for child victims (Article 39).

It should be noted that these articles associated with children’s right to health address the social and environmental determinants of health—determinants that have a profound impact on the health of children and the adults they will become. Accordingly, any root-cause analyses of children’s health, as well as any strategies to improve their well-being, must consider these rights in the domains of clinical care, systems development, and the generation of public policy. Not only does denial of the right to health have adverse consequences for the enjoyment of all other rights, but the enjoyment of Article 24 is dependent on the fulfillment of a range of other obligations under the CRC, most notably the rights denoted above and the four general principles.

PARENTS’ RIGHTS IN THE CRC

Parents are also rights-holders under the CRC. The Preamble affirms that the “family is the fundamental group of society and children should grow up in

a family environment in an atmosphere of happiness, love and understanding.” Multiple articles relate specifically to the role of parents as rights-holders and their responsibilities as duty-bearers to provide guidance to their children in the exercise of their rights under the CRC (Article 5). These articles include: Article 3.2, which identifies state obligations to provide protection and care taking into account the rights and duties of parents; Article 5, which covers respect for parental rights, duties, and responsibilities; Article 7, which covers the child’s right to know and be cared for by his or her parents; Article 8, which covers the right to family relations without unlawful interference; Article 9, which urges non-separation of children from parents unless in their best interests; Article 10, which explains obligations to address family reunification in a humane manner; Article 14, which expresses the rights and duties of parents to provide guidance in exercise of freedom of thought, religion, and conscience; Article 16, which urges non-interference with privacy or family; and Article 29, which explains that education must include development of respect for children’s parents. In addition, Article 18 reinforces the responsibility of parents in raising children, and the duty of the States Parties to support parents to do so as follows:

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. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.

For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.

States Parties shall take all appropriate measures to ensure that children of working parents have the right to benefit from child-care services and facilities for which they are eligible.

Parents’ rights and children’s rights are sometimes presented as being at odds with each other (Wardle 1995). This appears to be a particular concern in the United States, and it is considered to be one of the main reasons why it has failed to ratify the CRC (Kilbourne 1998). The criticism appears to rest on a misguided assumption that child rights-based approaches to the health and well-being of children inevitably mean that the views of children will be prioritized over the wishes of their parents. Although parents’ and children’s views most often align, there are undoubtedly times when the rights (and wishes) of children and parents may be in conflict and need to be resolved. In these rare instances, decisions will

be particular to the circumstances. However, there is a fundamental recognition within the CRC that parents' views are critical considerations in determining what is in a child's best interests, subject to the caveat that parents should not be allowed to act in ways that are considered to be harmful to the child (Archard and Skivenes 2009).

The Committee has said that: "Parents should fulfil their responsibilities while always acting in the best interests of the child, if necessary with the support of the State. Taking the child's evolving capacity into account, parents and caregivers should nurture, protect and support children to grow and develop in a healthy manner" (Archard and Skivenes 2009). A core concept of a child's rights-based approach to the health and well-being of children is that it is not only government's role to advance the rights of children, but also to provide parents with the capacity to do so.

MONITORING AND IMPLEMENTATION OF THE CRC

In recognition of the fact that resources are a crucial factor in the implementation of children's rights, states are expected to implement rights "to the maximum extent of their available resources and, where needed, within the framework of international cooperation" (Todres 1998). For skeptics, this is simply a pass that allows states to be human rights compliant, regardless of the levels of protection they offer. It has also been questioned whether the rights articulated in the CRC are so contingent upon resources that they are "deprived of any normative significance" (Alston and Quinn 1987). However, as the Special Rapporteur on the Right to Health has stressed: "progressive realization means that States have a specific and continuing obligation to move as expeditiously and effectively as possible toward the full realization of the right to health" (Hunt 2003, 9).

Moreover, progressive realization of rights requires a number of basic and immediate commitments. The principle of minimum core content requires that children cannot be deprived of the basic assistance they need to live in dignity. And the principle of non-regression specifies that states cannot act in ways that make prevailing conditions worse. In addition, there are immediate obligations to ensure that there is no discrimination in terms of access to services and assistance, however limited that may be (Article 2). Enforcement mechanisms that ensure there is a process for identifying breaches, independent monitoring of compliance, and sustained international pressure to advance the realization of children's rights are crucial factors to the success of progressive realization.

As with all other human rights treaties, the CRC establishes a mechanism for international monitoring of progress in its implementation. An 18-member Committee of experts reviews the progress of states' implementation of the CRC, according to reporting guidelines that specify the information that the state is required to submit (Article 44), and issues a report every five years. The Com-

mittee also welcomes submissions from other interested parties, including NGOs, many of whom work collaboratively to produce an alternative report often involving children meaningfully in the process of compiling it. At the conclusion of the process, the Committee publishes their *Concluding Observations*. These reports describe and analyze individual states' progress in implementation of the CRC. While the scope and depth of the reports is limited by the time and space available, the observations, along with the States Parties' self-evaluations, provide rich insights into the condition of children's rights and health in each signatory state.

Each state is required to take all administrative and legal measures to implement the CRC (Article 4). Many countries have incorporated the CRC in law through provisions in national constitutions and domestic legislation. This ensures that the standards and norms articulated in the CRC can be called upon and enforced in courts. The provisions in the CRC, and a "child health in all policies" strategy, as recommended by the Committee, should be used to develop and inform policy (public and private sector) and to highlight the links between children's health and its underlying determinants: "Every effort should be made to remove bottlenecks that obstruct transparency, coordination, partnership and accountability in the provision of services affecting children's health" (UNCRC 2013).

The CRC has been used to provide guidance to both those involved in clinical practice and to those conducting research relating to children's health. In terms of the latter,

the Committee underscores the responsibility of entities, including academics, private companies and others, undertaking research involving children to respect the principles and provisions of the Convention and the International Ethical Guidelines for Biomedical Research Involving Human Subjects. The Committee reminds researchers that the best interests of the child shall always prevail over the interest of general society or scientific advancement. (UNCRC 2013)

Moreover, in all cases the Committee has emphasized the importance of education and training, encouraging states "to adopt and implement a comprehensive strategy to educate children, their caregivers, policymakers, politicians and professionals working with children about children's right to health, and the contributions they can make to its realization" (UNCRC 2013).

CONCLUSION

In one comprehensive document, the U.N. Convention on the Rights of the Child defines prerequisites for the optimal survival and development of children and the obligations of individuals, parents, communities, and states to fulfill this right by realizing all relevant rights articulated in the document. With respect to child health, the CRC and associated principles of child rights provide strategies for rights-based approaches to clinical practice and health systems, as well as

to policy design, professional training, and health services research (Goldhagen 2003). The metrics of these rights-based approaches to child health can be measured as: holistic and coherent approaches to child health practice articulated in terms of the realization of children's rights; respect for the dignity of children consistent with their position in society as rights-holders; the design, provision, and delivery of rights-based health systems and policies that integrate the core principles of child rights and provisions of Article 24; and the use of the principles, standards, and norms of child rights to address social and environmental determinants of child health.

In light of the relevance of the CRC and principles of child rights to children's health and child health practice, it follows that there is a clear intersection between child rights and pediatric bioethics. The opportunity exists for pediatric bioethicists and child rights advocates to work together to define this intersection in terms of clinical practice, health systems development, and the generation of health policy (UNCRC 2013).

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