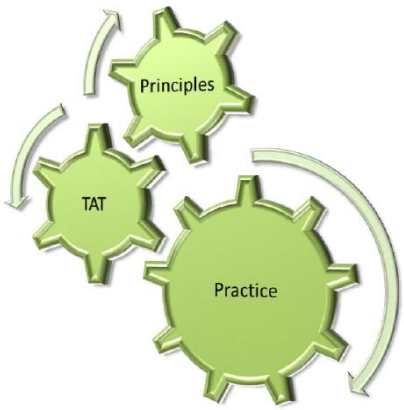
Think and Action Tank (TAT)
on Children's Right to Health



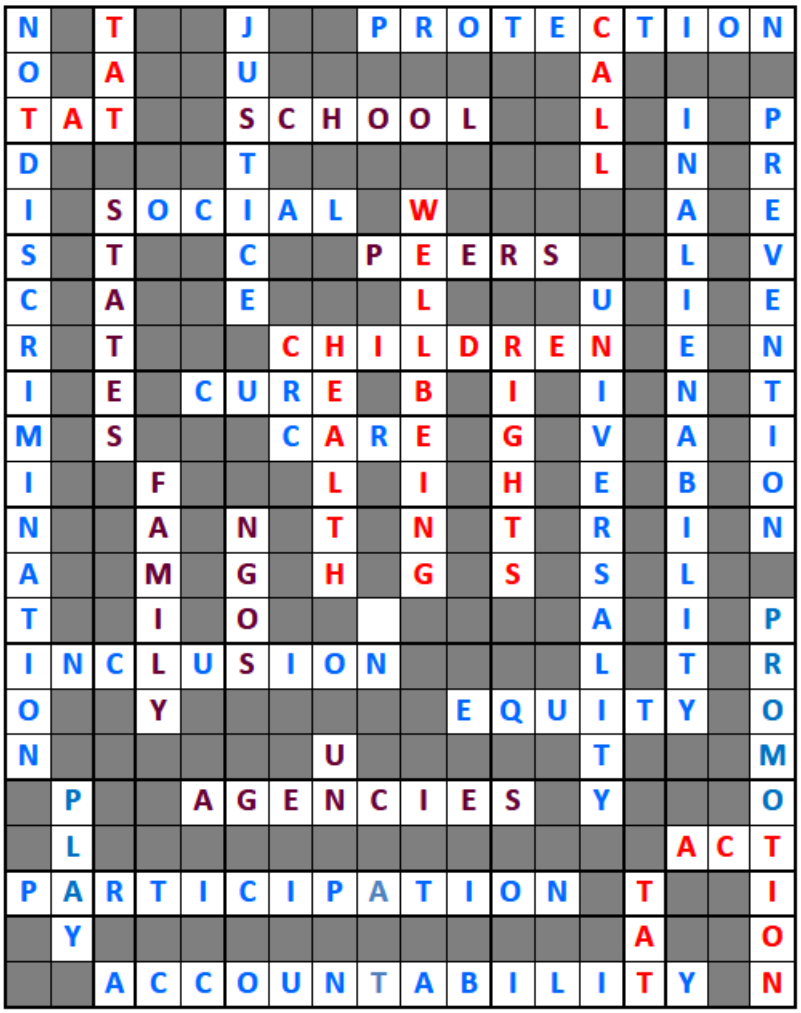
Translating the Principles of Child Rights into Practice

A RIGHTS- and EQUITY-BASED PLATFORM and ACTION CYCLE to Advance CHILD HEALTH and WELL-BEING

Bologna, Italy

January 1st, 2014

KEY WORDS



INFORMATION CONTACT:

ilariasimonelli79@gmail.com

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ACKNOWLEDGEMENT

The Think and Action Tank (TAT) on Children's Rights to Health is an open and inclusive global network of professionals, policy makers and others caring for children. The TAT convened in June 2013 to explore the relevant theory, knowledge, ideas and experience related to the challenge of translating the principles of child rights, social justice and equity into pediatric and child health practice. The TAT members have worked together over these past several months to establish a Rights- and Equity-based Platform and Action Cycle to advance Child Health and Well-being.

This document represents the fruits of this initial collaboration. The following members of the TAT have contributed their knowledge, expertise, insight and experience to the dialog, discussion and generation of this manuscript in an effort to continue the journey toward the universal realization of children's rights started more than 20 years ago with the ratification of the United Nations Convention on the Rights of the Child (CRC).

Klaus Arbeiter Medical University of Vienna (Austria)	**Raúl Mercer** Latin American School of Social Sciences (FLACSO), Buenos Aires (Argentina)
Ashley Bennett University of Florida, Jacksonville, (USA)	**Raquel J. Mullen** Santa Fe, New Mexico (USA)
Sue Bennett University of Ottawa (Canada)	**Rita Nathawad** University of Florida, Jacksonville (USA)
Andrew Clarke Lancashire Care NHS Foundation Trust, Preston (UK) Kidhasa, Pokhara (Nepal)	**Augusta M.Nicoli** Emilia-Romagna Agency for health and social care, Bologna (Italy)
José A. Diaz Huertas Hospital Universitario Niño Jesús, Madrid (Spain)	**Sverre O. Lie** Norwegian Directorate of Health, Oslo (Norway)
Ernesto J. Duran Strauch National University of Bogotà, (Colombia)	**James E. Robinson** University of Edinburgh, Scotland (UK)
Jochen Ehrich European Paediatric Association (Germany)	**Fabrizio Simonelli** (Italy)
Ana I. Fernandes Guerreiro (Portugal)	**Ilaria Simonelli** (Italy)
Giuliana Filippazzi European Association for Children in Hospital (EACH), Milano (Italy)	**Sarah Spronk** Policy Ministry of Foreign Affairs, Aja (Netherlands)
Kjersti Fløtten Akershus Universitetssykehus, Lørenskog (Norway)	**László Szabó** University of Semmelweis, (Hungary)
Jeffrey Goldhagen University of Florida, Jacksonville, (USA)	**Stella Tsitoura** Network of Children's Rights, Athens (Greece)
Jessica Kurtz Dickinson School of Law Pennsylvania State University (USA)	**Ziba Vaghri** University of British Columbia, Vancouver (Canada)
Matt Masiello Center for Health Promotion and disease prevention, Windber Research Centre, Windber (USA)	**Les White** New South Wales Health, Sidney (Australia)

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It is our hope that this Platform and Action Cycle will help to ensure that the principles of the CRC, once described by Nelson Mandela as that, "luminous living document that enshrines the rights of every child without exception to a life of dignity and self-fulfillment," are translated into practice.

Fabrizio Simonelli
Bologna, January 1st, 2014

Preface

The United Nations Universal Declaration of Human Rights (UDHR) emerged in the aftermath of World War II. The "Right to Health," first expressed in this Declaration, is enshrined in the constitution of the World Health Organisation (WHO). The core principles of the Declaration and subsequent human rights documents, e.g., *universality, indivisibility, non-discrimination and participation*, are concordant with the underlying precepts of medicine, medical practice, public health and the principles of medical ethics—beneficence, non-maleficence, justice and autonomy. Yet, despite more than a half-century of enlightenment as to the relevance of human rights to the health and well-being of individuals and communities; and more recently rapid advances in knowledge of social epidemiology and the life course sciences, the principles of human rights, social justice and equity have not been well integrated into the foundation and framework of national, professional and societal standards for the development of health practice and systems, and the generation of relevant public policy. Furthermore, despite the availability of strategies and tools, including the United Nations Convention on the Rights of the Child (CRC) itself, the principles of human rights, social justice and equity have not been translated into health professional training and the delivery of health services.

While the ecology of health has changed dramatically since the 1970s, the approaches to health systems and programs have not. National and international health systems across the economic spectrum of countries remain focused primarily on the provision of health care and dependence on biomedical medicine. Global public and private sector health policies, systems and practices have not fully responded to the complexity of the social, economic, political-civil, environmental and cultural factors that generate health. This is in spite of the adoption of many human rights documents, e.g. UN Convention on the Rights of the Child (1979), Ottawa Charter for Health Promotion (1986), African Charter on the Rights and Welfare of the Child (1999), UN Convention on the Rights of People with Disabilities (2006), that provide a foundation and framework for the development and implementation of this proposed Rights- and Equity-based Platform and Action Cycle to advance Child Health and Well-being.

If child health professionals are to respond to the ever evolving needs of children, we must acknowledge our unique and profound obligation to uphold and implement the principles of children's rights to health and equity. To fulfill this obligation, all health professionals must be informed by a robust knowledge of human rights and health equity, and develop the competencies to translate these principles and norms into practice in the clinical setting, community and through the generation of public policy. This is essential to enable child-serving professionals to not only promote fairness and social justice in all aspects of clinical practice and systems development, but also to prevent health professional complicity in human rights abuses.

Toward these ends, this document is presented as the first in a series of manuscripts and tools to prepare all stakeholders, duty bearers and rights holders alike, in children's health and well-being to translate the principles and norms of child rights, social justice, equity and accountability into practice. We welcome and need the continuing input of professional and lay stakeholders from all sectors of society, and especially children, youth and families, if we are to succeed in this endeavor to achieve optimal health and well-being for all children, everywhere.

Section 1. Rationale and Purpose

Over the past several decades, multiple separate but potentially complementary global strategies have been employed to address child health across the spectrum of economically developed and developing countries. The Declaration of Alma Ata, and multiple subsequent documents reflecting new knowledge of social epidemiology, the life course sciences and the complex nature of child health, have established the necessity to embrace a broad definition of health, as defined by the World Health Organization (WHO). This necessity is rooted in an emerging understanding that all biomedical, social and environmental determinants of child health must be addressed if we are to optimize the health and well-being of children, eliminate disparities and achieve health equity. The emerging embrace by child health providers of their responsibility to address children's "*well-being*," in addition to their historical role in the prevention and treatment of disease and disability, is a simple yet profound reflection of the sea change in our understanding of child health—a change that will require new child rights-based tools and strategies to translate into practice. This document is the first in a series of manuscripts and tools to address how to implement a new and holistic rights and equity-based practice of child health and other child-oriented disciplines.

In order to understand this future orientation for the practice of a rights and equity-based approach to child health, it is necessary to briefly review past approaches to children's health and well-being.

***Needs-centered* approach.** This strategy is rooted in a "service-based" bio-medical paradigm for pediatrics and child health practice. Children's "needs" are framed primarily in the context of medical care that includes primary, secondary and tertiary health care services. Although purporting to address the prevention of disease and illness, disabilities and barriers to full growth and development, the vast majority of global health expenditures dictated by this approach to health has been for health care services, and in many countries, disproportionate expenditures for tertiary care. Through this approach, children have generally been framed and treated as *bearers of needs, objects of protection* and *customers of health and social services*. This approach has served to maintain the power differential in health systems.

***Assets-focused* approach.** This strategy is far more holistic than a "needs-centered" approach to health. It attempts to *generate* and *promote* optimal health, development and well-being by identifying and utilizing all of a community's and individual's social, educational, financial and personal capital (assets). Children are considered as *protagonists* of their health and wellbeing, and as *salutogenic agents*. This approach is the forbearer of the rights and equity-based approach that will advance the future of child health and well-being.

***Rights and equity-based* approach**. This emerging strategy addresses the holistic nature of child health by engaging the universal principles of human rights, social justice and equity in order to optimize child health, development and well-being. This approach recognizes children as *rights holders*; and families and public and private sector stakeholders in child health and well-being as *duty bearers.* As such, all *duty-bearers* are charged with the fulfillment of *all* rights identified in the human rights conventions, including most specifically, the CRC.

By definition, such an approach must integrate the critical element of child rights. A rights and equity-based approach to child health and well-being:

- Refers to a set of internationally recognised and legally guaranteed values and standards that provide strong arguments and mechanisms to address violations of rights.
- Requires the fulfilment of the rights of all children. This responsibility is mandatory and not voluntary, as is suggested in the case of needs-centred and *assets-focused* approaches to child health.
- Requires special protection measures for children because of their vulnerability and dependency with particular regard to children: with disabilities, abandoned or in residential institutions, homeless and living in low-income families, migrant and unaccompanied, victims of abuse, refugees and living in war zones, and others living in deprivation conditions;
- Requires consideration of the civil, political, social and economic systems, and the environment in which the child lives, in order to optimize health and social development at all organizational levels of society—family, community, region, national and global.
- Provides opportunities for change in governing policies using a framework of the principles of rights, equity and social justice, with particular regard to disadvantaged, abused and children with disabilities.
- Generates and establishes awareness, knowledge, experience and capacity in institutions, organizations, communities and among professionals and lay advocates; which can establish a cultural and scientific heritage for human development.
- Constitutes a key-resource to reduce inequalities and disparities in health, by addressing the social and environmental determinants, as well as access to services, goods and facilities.
- Provides rights- and equity-based indicators to monitor the fulfillment of the rights of rights holders (children), and, how duty bearers progressively fulfill their obligations under CRC and other human rights mandates.

Since the CRC came into force nearly a quarter century ago, child rights-based approaches to health have had an increasing impact on state and organizational policies for child health promotion. Looking toward the future, with advances in our knowledge of social epidemiology and the impact of social and environmental determinants on health and well-being throughout the life course, a child rights and equity-based approach to health will become increasingly relevant—particularly in the context of planning global policies and activities, such as the post 2015 Agenda related to Millennium Development Goals (MDGs).

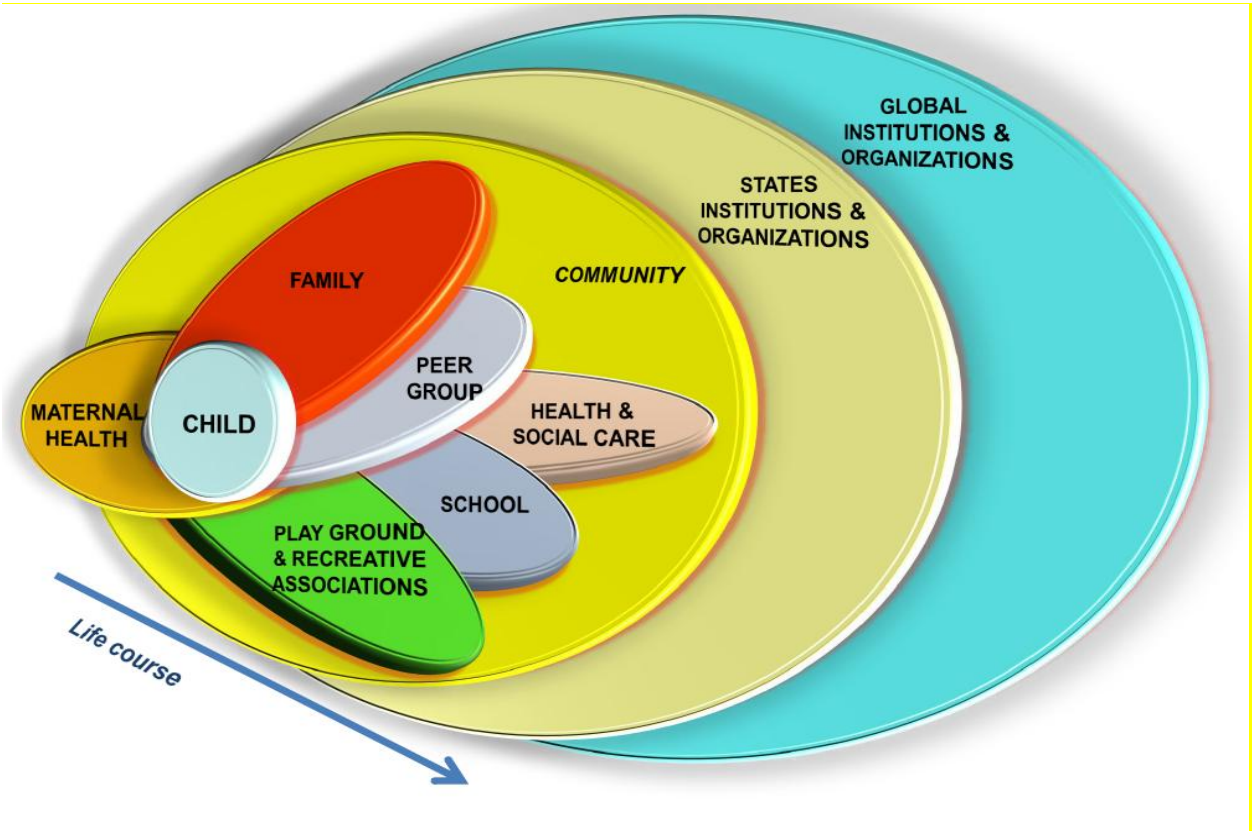
However, child rights-based approaches to child health derived from universal treaties and declarations, including the CRC, have not in general been systematically applied to practice.

This document aims to introduce an operational model to prepare institutions, organizations, policy makers, professionals and others caring for children to translate the principles of child rights and health equity into practice. To be effective, the proposed Platform and Action Cycle must be relevant to all children in all settings across their life course—including family, school, playground and recreational associations, websites and social networks, health and social care, neighborhood, peer groups, community, institutions and organizations—progressively and/or simultaneously, as schematically summarized in Figure 1.

When applied, the Platform and Action Cycle will be relevant to policy and decision makers' efforts to reduce health inequities, increase children's safety and well-being, improve access to quality health and social services, and improve the socio-economic conditions and environments required for optimal health and development. The proposed Platform and Action Cycle highlight the importance of the development of child rights-based indicators in order to translate child rights principles and norms into action.

The gap between official human rights declarations and daily practice has resulted from the lack of effective evidence-based operational models and tools required to translate the principles of child rights and equity into practice, and from inadequate education and preparation of professionals.

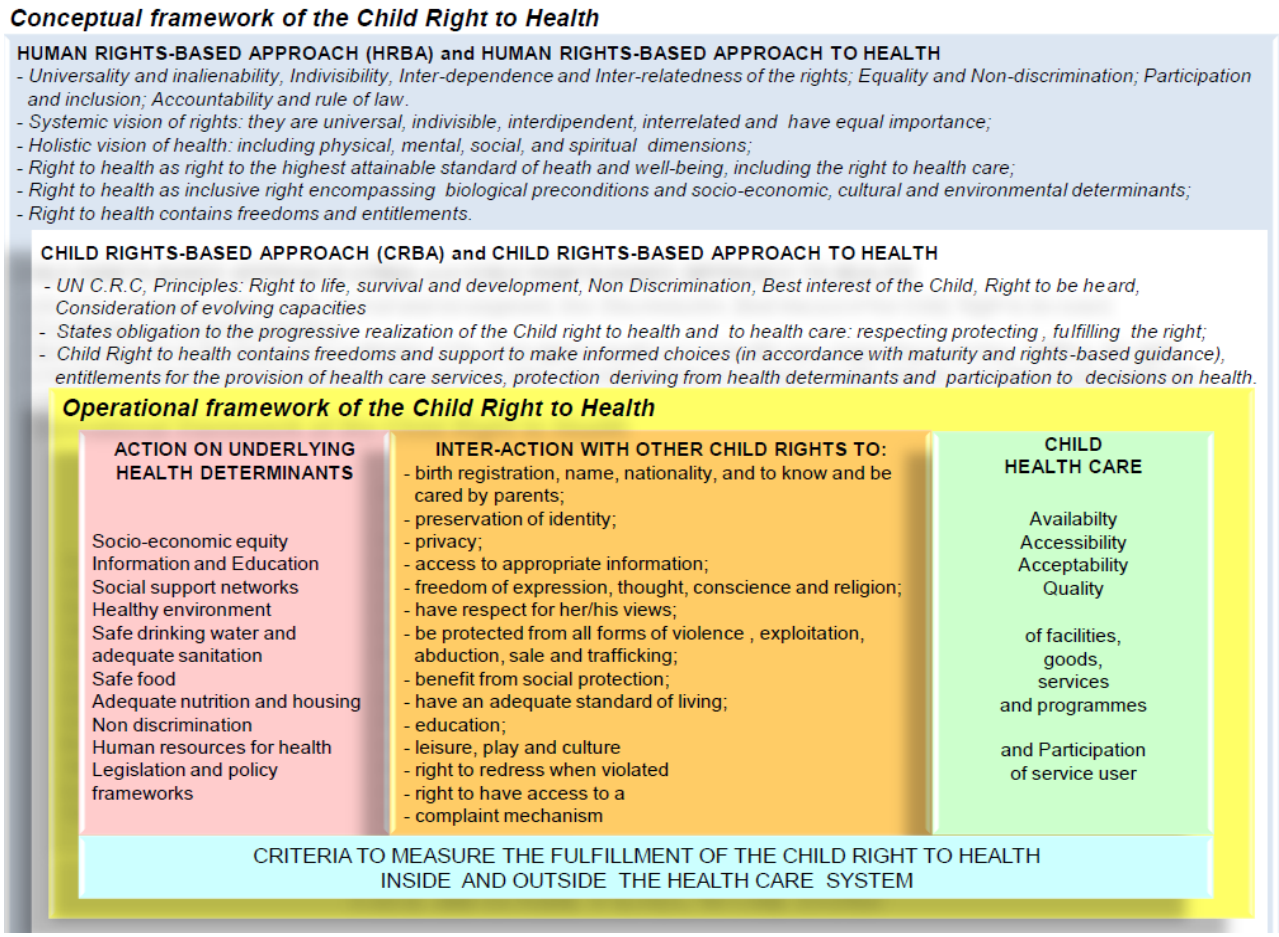
FIGURE 1: *Main Child life settings and range of the Platform for Translating Principles of Rights and Equity into Practice*



Section 2. The Conceptual Foundation and Framework

The proposed Platform establishes a solid foundation and holistic framework derived from the principles of human rights, equity, social justice and accountability to support and advance the translation of the principles and norms of rights into health practice. These principles are acknowledged globally, and through the CRC and other international conventions and documents, extended and applied to the unique being of children. Thus, this multi-scope framework integrates the principles of a Human Rights-based Approach (HRBA) to health with a Child Rights-based Approach (CRBA) to health and well-being. The conceptual framework informs the operational framework required for the translation of the principles and norms of child rights into practice. These conceptual and operational frameworks are schematically presented in Figure 2.

FIGURE 2: *Conceptional and Operational Frameworks for Translating the Principles and Norms of Child Rights and Health Equity into Practice*



2.1. Key Principles of Human Rights-based Approach (HRBA)

The principles of human rights first established by the United Nations Universal Declaration of Human Rights (UDHR) include:

- *Universality and Inalienability*. Human rights are universal and inalienable. All people everywhere in the world are entitled to them. The human person in whom they inhere cannot voluntarily relinquish them. Nor can others usurp them from him or her. As stated in Article 1 of the UDHR, "All human beings are born free and equal in dignity and rights."
- *Indivisibility*. Human rights are indivisible. Whether of a civil, cultural, economic, political or social nature, they are all inherent to the dignity of every human person. Consequently, they all have equal status as rights and cannot be ranked *a priori* in a hierarchical order.
- *Inter-dependence* and *Inter-relatedness*. The realization of one right often depends, wholly or in part, upon the realization of others. For instance, realization of the right to health may depend on the realization of the right to education or of the right to information.
- *Equality and Non-discrimination.* All individuals are equal as human beings and by virtue of the inherent dignity of each human person. All human beings are entitled to their human rights without discrimination of any kind, including race, color, ethnicity, sex, gender, language, religion, age, socio-economic status, political affiliation, national or social origin, disability or other status as defined by human rights treaty bodies.
- *Participation and Inclusion.* Every person and all peoples are entitled to active, free and meaningful participation in, contribution to and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realized.
- *Accountability and Rule of Law.* States and other duty-bearers are answerable for the observance of human rights. In this regard, they have to comply with the legal norms and standards enshrined in human rights instruments.

Human rights are universal, indivisible, interdependent and interrelated. Rights have equal importance and do not follow a hierarchical ranking. Of consequence, commitments to rights for health imply action towards the realization of other rights.

2.2. Key Principles of Child Rights-based Approach (CRBA)

The CRBA extends the principles and norms of the HRBA to focus specifically on children and childhood. The CRC acknowledges children as *rights holders* and imposes obligations to States as *duty bearers* for the respect, protection and fulfilment of children's rights. Childhood is understood to be a period of continuous growth and development in multiple venues, e.g., family, community, institutions and social environments. The principles and practice of child rights emphasize children's rights to participation, including promotion of their health and decision making regarding their health and health care.

As noted in the previous section, all rights are interdependent, and consequently all have equal status as rights and cannot be ranked in a hierarchical order. There are nevertheless four fundamental principles of child rights specifically delineated in the CRC:

- Article 2. *Non-discrimination.* Rights are afforded to all children without exception.
- Article 3. *Best interest of the child*. Requires governments or other stakeholders to review policies and actions for their real or potential impact on children.
- Article 6. *Survival and development*. Requires state parties to ensure to, "the maximum extent possible the survival and development of the child." This principle is closely linked to the child's right to the enjoyment of the highest attainable standard of health and to health services (Article 24).
- Article 12. *Right to be heard*. Requires governments and other stakeholders to ensure that children's views are sought and considered in accordance with their age and maturity. This implies that the right to access information (Article 17) must be fulfilled, as children cannot adequately exercise their right to be heard unless they have an informed voice

The CRC establishes ethical and judicial principles, norms and standards valid for all children, in addition to methodological guidelines to integrate them into policies, programs and practices. The imperative of child development is contextualized in the CRC and practice of child rights and equity through the principles of *progressive realization of rights* and *evolving capacities* that recognize that autonomous decision-making should take into consideration the child's age and maturity. These principles, combined with: a) ongoing endeavors to create broad global coalitions focused on child rights, and b) the development of indicators and methods to evaluate the realization of children's rights, establish a convergence between child rights and public health. The UN Committee on the Rights of the Child is the monitoring committee for the CRC and ratifying governments are obligated to report on the state of the rights of their children every 5 years.

> ***The emphasis on the principles of child rights as delineated in the CRC in the domains of participation, protection and provision, including those most relevant to health, serves to differentiate the Child Rights-based Approach from the Human Rights-based Approach.***

2.3. The Human Rights-Based Approach to Health

With the above introduction to the principles of human and child rights, it is now possible to address the more specific intersection between human and child rights approaches to health. Health is a fundamental human right—every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. Moreover health is indispensable for the exercise of other human rights. According to WHO, the concept of health includes the physical, mental, social and spiritual aspects of life, and it is not the object of living, but a resource for everyday life and for the realization of the human potential. It is not restricted or based on health sector interventions only, but it should involve all the social and environmental sectors through multifaceted approaches that include policies and interventions.

There are a number of key aspects of the universal right to health that define the environment in which health is generated, and the processes through which health care and services are delivered. The right to health:

- Is an *inclusive right*, which in particular includes associated rights related to economic and social determinants of health.
- Contains freedoms, including the right to be free from non-consensual medical treatments, medical experiments and degrading treatments.
- Contains entitlements, including the right to: a) a policy of health promotion; b) a system of health protection, prevention, treatment and control disease; c) access to essential care for women and families, including maternal, child and reproductive health; d) equal and timely access to basic health services; e) the provision of health-related education and information; and f) participation in health-related decision-making at the national and community level.
- Involves access to health services, goods and facilities that must be provided to all without any discrimination. These goods and services must be *available, accessible, acceptable* and of the *highest attainable quality.*
    - *Available.* Public health programs, health-care facilities, goods and services must be available in sufficient quantity. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the resources committed by the State (public sector). They must address, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential medications, as well as social and environmental determinants.
    - *Accessible*. Health facilities, goods and services must be accessible to everyone without discrimination (financial, location, design, cost, child friendliness, etc.) within the jurisdiction of the State party. Accessibility has four overlapping dimensions: non-discrimination, physical, economic and information.

- *Acceptable.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life course requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

- *Highest attainable quality.* Health facilities, goods and services must be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved drugs and hospital equipment, safe and potable water, and adequate sanitation.

The concept of "the highest attainable standard of health" takes into account the individual's biological preconditions, the socio-economic, cultural and environmental determinants of health and the State's available resources, with particular regard to developing countries. The right to health encompasses a response to the underlying root-cause determinants of health, fulfilment of all rights of provision, protection and participation, access to facilities, goods, services and protective social policy.

Ultimately, the HRBA to health aims to integrate these principles, standards and norms into health policies and practices. Of consequence, the HRBA addresses the inequities, discriminatory practices '*de jure et de facto,'* and unjust power relations that are often at the heart of health disparities and inequities.

The Human Rights-based Approach to health encompasses: a) an etiological (causal) explanation of health status, derived from a wide spectrum of determinants (genetic, biological, socio-economic, cultural, environmental); b) a holistic (comprehensive) vision of health, including physical, mental, social and spiritual aspects; and c) a teleological (consequential) perspective of health as a prerequisite for the full attainment of human potential; and ultimately, d) the principle that optimal health and well-being and health equity is derived from the realization and fulfillment of all rights delineated in the Universal Declaration of Human Rights.

2.4. The Child Rights-based Approach to Health

The CRBA to health expands the focus of previous human rights conventions to address the unique needs and status of children. With respect to the right to health, Article 24 requires that, "State parties recognise 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. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services." With respect to the child's right to health, it is also important to refer to the CRC Article 6 that states, "States Parties shall ensure to the maximum extent possible the survival and development of the child."

Another key principle of a CRBA to health is the requirement that States are deemed, "subject to progressive realization of the right to health." State obligations fall into three categories, namely obligations to: a) *respect*, which requires States to refrain from interfering directly or indirectly with the right to health; b) *protect*, which requires States to prevent third parties from interfering with the right to health; and c) *fulfill*, which requires States to adopt appropriate legislative administrative, budgetary, judicial, informational, educational, promotional and other measures to fully realize the right to health.

The child's right to the highest attainable standard of health depends on the realization of nearly all other rights outlined in the CRC, but in particular:

- Article 5. Parental guidance;
- Article 17. Access to appropriate information;
- Article 18. Parental responsibilities and state assistance;
- Article 19. Protection from all forms of violence;
- Article 23. Rights of children with disabilities;
- Article 25. Right to periodic review of treatment;
- Article 27. Right to adequate standard of living;
- Article 28. Right to education;
- Articles 32-36. Protection from all forms of exploitation;
- Article 39. Recovery and reintegration for child victims.

The Child Rights-based Approach to health includes the binding obligation and responsibility of States and their institutions to realize the child's right to health. Children often suffer adverse impositions from adults—wars, socio-economic inequities, cultural deprivation, abandonment, abuse, trafficking, maltreatment, neglect, and cultural practices that threaten children's rights to life, health and development. States must overcome indifference and choose children's health, safety and well-being as values to be protected, provided and promoted in practice.

Section 3. The Foundational Elements

In order to develop an organic operational model for the translation of the principles and norms of human and child rights into practice, the proposed Platform must be grounded in a solid rights and equity-based foundation. This foundation is composed of the following elements, which are informed by the principles of human and child rights discussed in the previous sections. A common understanding of these elements and parlance is necessary to ensure successful communication among and between *rights holders* and *duty bearers*, effective child advocacy, rigorous evaluation of child rights-based initiatives and research at the intersection of child rights and health.

- ***Child.*** A holder of the right to enjoyment of the highest attainable standard of health and well-being, and owner of evolving capacities emerging during growth and development across the life course until age 18.
- ***Rights.*** Universal, indivisible, interdependent and interrelated values: acting for a child's right to health implies commitment toward the realization of other rights.
- ***Health.*** A process toward physical, mental, social and spiritual well-being influenced by a wide spectrum of determinants (genetic, biological, social, economic, cultural, environmental); and as a resource for the full realization of the human potential. In its complexity, health is defined in the multiple dimensions of well-being, development, safety, equity, social justice, freedom and peace.
- ***States.*** Institutional bodies obliged and responsible for the protection, provision and promotion of children's rights to health together with other children's rights. The role of States and their Institutions is to provide the capacity for families to fulfill the rights of children and to act directly when families are unable to do so;
- ***Children's participation.*** According with their age and maturity, decisions concerning their health require their participation and empowerment.
- ***Equity.*** Policies that advance the conditions required to assure the fulfillment of every child's right to the highest attainable standard of health and well-being and to realize their full human potential.
- ***Social justice.*** The requirement for assuring impartiality, fairness and equity in the distribution of resources.
- ***Accountability.*** Obligations brought upon States Parties and other duty bearers following ratification of CRC. Compliance with these obligations is germane to the concept of human rights.

Section 4. The Action Cycle

In order to realize rights, they must be operationalized. The Action Cycle herein presented to operationalize the Child Rights and Equity-based Platform for Child Health and Well-being involves three action steps: *Contextualizing, Assessing* and *Improving*. It is critically important to note that most societies do not have a culture of child participation. It should be a priority to involve children in every stage of the Action Cycle, including assessment and improvement. They should be consulted and their opinions must serve as catalysts for change.

This Action Cycle integrates the principles and foundational elements of human and child rights as previously presented. An overview of the steps in the Action Cycle follows. Guidelines and tools for how each step can be implemented in the process of fulfilling specific rights of children are currently in development and will be presented later on.

Step 1. *Contextualization*

In order to remain relevant across the life course of a child—from birth through adolescence—rights must be contextualized in relation to the developmental states of childhood, and then applied to all children in the multiple settings in which children live, grow and develop. These rights can be formulated as objectives that are: a) *consistent,* with the principles of the CRC; b) *coherent,* with the guidelines and resources of the agencies tasked with implementing these rights; and c) *clear, measurable* and *accountable*, using performance standards and tools that are generally available in the community in which children live.

Key-questions in this step include:

- *"Does the contextualized statement meaningfully represent the application of the selected right?"*
- *"Is the statement clear and understandable; and are the objectives measurable?"*

At its conclusion, this step will deliver a list of statements related to specific child life settings framed in the context of goals, objectives, standards and performance criteria required to define the status of the realization of a child(ren)'s right to health.

Step 2. *Assessment*

The second step of the Action Cycle is meant to assess the status of the realization of rights in a particular setting, gaps in this realization and improvements required to progressively realize these rights by applying the criteria defined in the first step of the Action Cycle. This situational assessment and gap analysis requires a thorough assessment using root cause analysis and other available tools to as completely as possible define the underlying social and environmental factors responsible for the generation of a rights-respecting settings in which the child lives and develops. Root cause analyses must include an assessment of the social, civil-political, economic and cultural milieu in which the child lives. It can also be framed in the context of the realization of the rights of provision, protection and participation defined by the CRC. The assessment step must routinely and actively involve children and their families.

Key questions in this step of the Action Cycle are:

- *"What are the best indicators to measure the fulfillment of the child's right to health in a specific setting?"*
- *"Who would undertake the assessment? Can it be managed internally within the child's life setting, or does it require external facilitation?"*
- *"Are the monitoring indicators specific, measurable, available, relevant and time-bound?"*
- *"If present, what are the deficits and problems emerging from the assessment?"*
- *"What are the causes of deficits and gaps in fulfilling the child's rights?"*

This step will use and/or develop indicators that are in alignment with the recommendations made by the Office of Higher Commissioner on Human Rights (OHCHR, 2012) with respect to the components of programs to advance human rights. These elements include:

- *Structure*, including the existing policies, financial provisions, organizational environment in support of the right;
- *Process*, including programs, interventions, initiatives; and
- *Outcome*, including the impact on young children's health, development and well-being.

At its conclusion, this step will collect data comprehensive enough to deliver an Intermediate report on the existing situation and a set of indicators that can be used to measure the realization of rights in the following step.

Step 3. *Improvement*

The third step in the Action cycle involves ongoing planning and implementation of interventions and quality improvement strategies required to realize the rights reflected in the statements and objectives, and situational and gaps analyses accomplished in the first two steps. Indicators developed in Step 1 and utilized in Step 2 of the Action cycle should be used as the framework for improvement and reporting in Step 3.

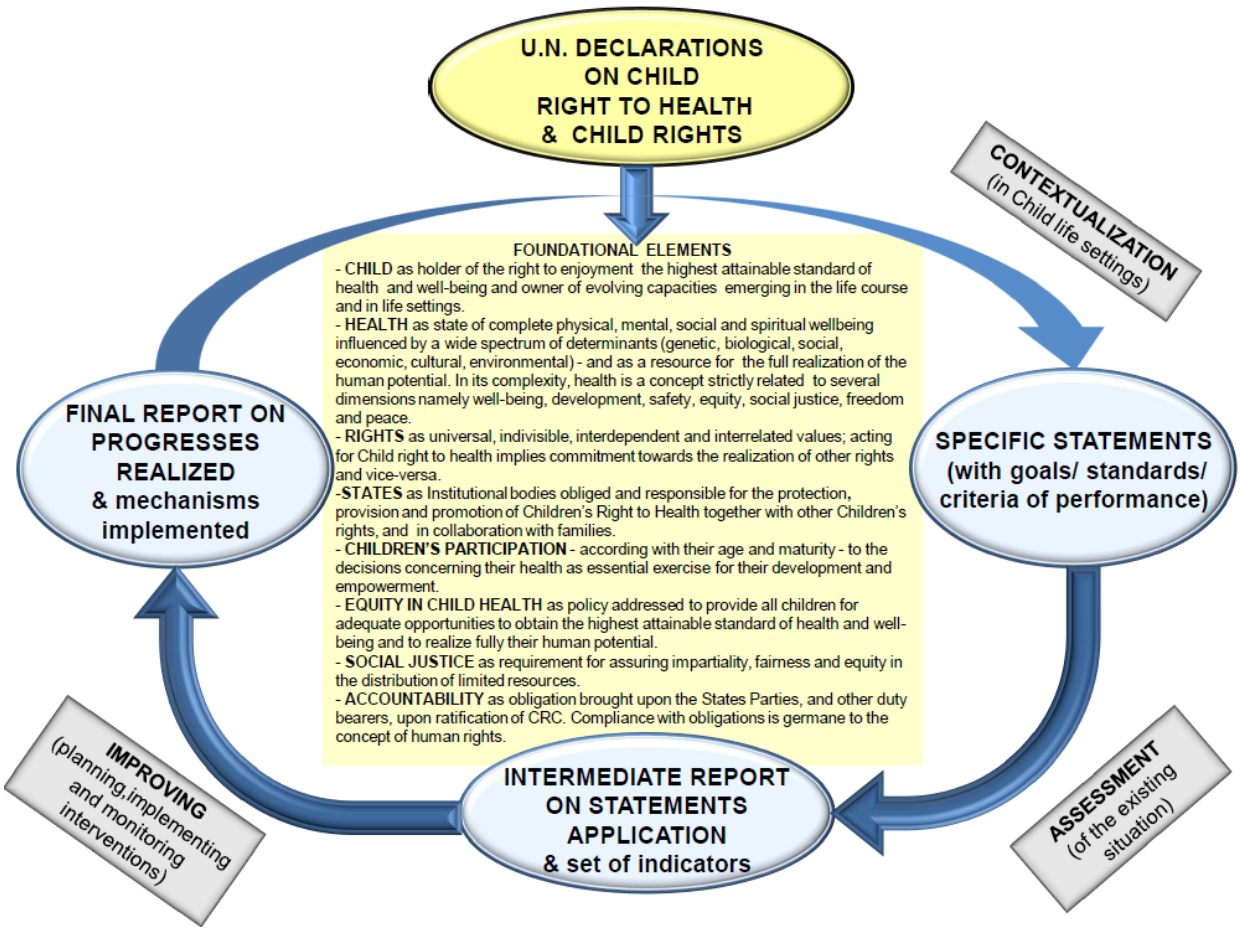
Key-questions in this step include:

- *"What are the most important gaps that we should try to address? How should we prioritize them?"*
- *"How is it possible to overcome the existing gaps?"*
- *"What are the best strategies required for improving the application of the statements?"*
- *"What support for children (according with their age and maturity), families, tutors and caregivers, professionals, etc. is required to facilitate each of the steps in the Action Cycle."*
- *"What actions shall be taken; who will do these; and by when?"*
- *"How is it possible to ensure the monitoring of the improvement process. Who should lead it and who should be involved?"*

- *"What are the results and the limits of the interventions carried out in the settings in which children live and develop?"*
- *"Are the results evidence based and/or are they consistent with the essential values reflected by the standards of human rights, social justice and equity?"*
- *"What other statements have to be considered for further improvement?"*

At the conclusion of this step, it will be possible to report on the process and the progress made toward the realization of the rights of children and remedies to more fully realize these rights in the context of the environments and developmental stages of the child. However, as the name of the Platform suggests, this is an *Action Cycle* that will require ongoing and sustainable efforts to continuously improve the health and well-being of children.

FIGURE 3: *A Rights- and Equity-based Platform for Child Health and Well Being: Foundational Elements and Action Cycle*



Section 5. A Call for Action

This proposed Platform and Action Cycle is the work of an international collaborative endeavoring to identify, develop, implement and evaluate evidence-based approaches, methodologies and tools to translate the principles and norms of children rights, health equity, social justice and accountability into practice.

We encourage professionals committed to and engaged in a rights-based approach to health to use this Platform and Action Cycle sharing their experiences.

We invite:

- *Health professionals, social and justice workers, educators,* to implement this Platform and Action Cycle in their workplaces, involving children in the process;
- *Families, tutors and volunteers,* to find in this Platform and Action Cycle support for their commitment to the health and well-being of children;
- *Children and adolescents,* to find in this Platform and Action Cycle an opportunity to affirm their right to participation in decisions concerning their health and well-being;
- *Policy makers and health managers,* to include this Platform and Action Cycle among their strategies for promoting child health and well-being;
- *Public health systems,* to plan and use this Platform and Action Cycle in the generation of policies to fulfill the rights of children to optimal health and well-being, health equity and the availability, accessibility, acceptability and quality of their health care services;
- *Private health institutions and agencies,* to adopt this Platform and Action Cycle as tools for contributing to children's right to health, and for improving the quality of services;
- *NGOs and associations* defending and promoting the child's right to the highest attainable standard of health, to participate and contribute in the implementation process of this Platform and Action Cycle ;
- *Universities and schools* managing courses for health professionals to add this Platform and Action Cycle to their curricula and training modules;
- *Social networks and organizations* working on the child's right to health to disseminate this Platform and to contribute to its adaptation and implementation;

- *National and regional governments and offices,* to use this Platform and Action Cycle to translate the child's right to health into practice;

- *International agencies and organizations,* to use this Platform and Action Cycle in their efforts to fulfill children's rights to health and to realize the MDGs Post-Agenda 2015 process;

- *Mass media,* to disseminate experiences and results of application of Children's rights, also including the present Platform and Action cycle;

- *All the actors above mentioned,* to apply this Platform and Action Cycle with special consideration for children living in difficult and depriving social, economic, cultural, conditions; growing in unhealthy environment; living in disadvantaged or violent settings, where the enjoyment of their rights is denied or neglected.

A goal of this collaborative effort is to bridge the many gaps that characterize the deficits and fragmentation of a child rights approach to health. These include existing gaps between: a) rights holders and duty bearers; b) generations of duty bearers, c) needs and rights-based approaches to child health, and d) patients and caregivers; as well as those that define countries along the spectrum of economic development and that characterize conditions experienced by children in peace and war. If we are to succeed in our efforts to fulfill the rights of all children to optimal survival and development, we must begin by using rights- and equity-based tools and approaches to health. This proposed Platform and Action Cycle provides such tool and approach with which to continue this journey.

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