Downloaded from adc.bmj.com on 30 January 2007

From principle to practice: moving from human rights to legal rights to ensure child health

Barry Zuckerman, Ellen Lawton and Samantha Morton

Arch. Dis. Child. 2007;92;100-101
doi:10.1136/adc.2006.110361

Updated information and services can be found at:
http://adc.bmj.com/cgi/content/full/92/2/100

These include:

Rapid responses You can respond to this article at:
http://adc.bmj.com/cgi/eletter-submit/92/2/100

Email alerting service Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:
http://www.bmjjournals.com/cgi/reprintform

To subscribe to *Archives of Disease in Childhood* go to:
http://www.bmjjournals.com/subscriptions/

Downloaded from adc.bmj.com on 30 January 2007

REFERENCES

1. **Newman G**. *Infant mortality: a social problem.* London, UK: Methuen, 1906.
2. **Parliamentary Papers**. *Report of the Interdepartmental Committee on Physical Deterioration.* London: HMSO, 1904.
3. **Budin P**. Translated by WJ Maloney. The nursling. London, UK: Caxton, 1907.
4. **Lucas JP**, Arai L, Baird J, *et al.* A systematic review of lay views about infant size and growth. *Arch Dis Child* 2007;**92**:120–7.
5. **Wright C**, Callum J, Birks E. Health visitor management of failure to thrive: a randomised control trial. *J Epidemiol Community Health* 1997;**51**:606.
6. **Drewett R**, Corbett S, Wright C. Cognitive and educational attainments at school age of children failed to thrive in infancy: a population based study. *J Child Psychol Psychiatry* 1999;**40**:551–61.
7. **Wright CM**. The identification and management of failure to thrive: a community perspective. *Arch Dis Child* 2000;**82**:5–9.
8. **Frank D**, Zeisel S. Failure to thrive. *Pediatric Clin North Am* 1988;**35**:1187–206.
9. **Wright CM**, Parkinson KN, Drewett RF. The influence of maternal socioeconomic and emotional factors on infant weight gain and weight faltering (failure to thrive): data from a prospective birth cohort. *Arch Dis Child* 2006;**91**:312–17.
10. **Blair P**, Drewett R, Emmett P, ALSPAC Study Team, *et al.* Family, social and prenatal factors associated with failure to thrive in the Avon Longitudinal Study of Parents and Children (ALSPAC). *Int J Epidemiol* 2004;**33**:1–9.
11. **Batchelor J**, Kerslake A. *Failure to find failure to thrive.* London: Whiting and Bush, 1990.
12. **Wright CM**, Parkinson KN, Drewett RF. How does maternal and child feeding behaviour relate to weight gain and failure to thrive? Data from a prospective birth cohort. *Pediatrics* 2006;**117**:1262–9.

From human rights to legal rights

From principle to practice: moving from human rights to legal rights to ensure child health

Barry Zuckerman, Ellen Lawton, Samantha Morton

Perspective on the paper by Waterston and Goldenhagen (***see page 176***)

We applaud Waterston and Goldenhagen's[1] call to arms to healthcare professionals to consider the poor health of the world's children (the United Nation's Convention on the Rights of the Child providing the framework to direct such efforts). We also agree that it is essential to deal with the pervasive structural barriers that lead to inequality, poor health and suffering.[2] But, as we continue to push for rights-based laws around the world, we also encourage an active strategy of promoting the enforcement of existing laws that protect children—especially those laws that ensure access to children's basic needs, such as food, housing, safety, healthcare and education. Waterston and Goldenhagen themselves lay the groundwork by noting that one triumph of recent human rights campaigns has not only been to identify rights violations but also to establish rights-based laws in 50 countries. Indeed, a strategy focusing on the enforcement of existing laws would go a long way in dealing with a number of the injustices cited by the authors, such as non-compliance with Jordanian child labour laws and Kenyan laws regarding child well-being.

Over the past several decades, the confluence of human rights work, increased humanitarian infrastructure and new progressive governments has, in many countries, laid a foundation of legal rights accruing to children. Ensuring adherence to the laws delineating those rights is the next step. When evaluating and treating sick children, healthcare professionals frequently identify how inadequate food, housing, safety, access to basic medications such as vaccines or other unmet basic needs contribute solely or partly to preventable medical illness and poor child health. Although healthcare professionals are not lawyers, experience in the US suggests that a partnership between doctors and lawyers in the clinical setting can facilitate meeting families' basic needs—resources indisputably necessary for the health and development of children. We believe that this approach (or a variation thereof) will hold government systems accountable in enforcing laws that are intended to protect children's health. Moreover, providing legal services for basic needs constitutes a concrete action step that communities can take immediately, in addition to Waterston and Goldhagen's[1] excellent discussion of the tools available under the UN Convention on the Rights of the Child.

CHILD HEALTH SITE TO DEAL WITH SOCIAL DETERMINANTS CONTRIBUTING TO POOR CHILD HEALTH

Doctors and other healthcare providers are uniquely situated to intervene when children's basic needs are not being met. Not only are many children seen in child health settings for immunisation and treatment of illness but also a focus on prevention includes identifying non-medical determinants of child health. Nevertheless, although child health professionals are often aware of the social context of the patients they serve, they generally do not have the capacity (knowledge, training, time, resources, etc) to effectively intervene in non-clinical arenas. We view the clinical setting, where medical providers routinely screen families for a variety of barriers to child health, as providing a virtually unrivalled opportunity to identify violations of legal rights that impair children's health, and to connect affected families with legal services to challenge those violations. This opportunity can only be exploited if there is a partnership between health and legal professionals.

AN EXAMPLE FROM THE US

In the US, medical–legal partnerships (www.mlpforchildren.org) have begun to redraw the boundaries of potential solutions.[3] Close to 50 clinics and hospitals now rely on lawyers to assist paediatric teams in dealing with the health concerns of low-income populations. We think that this innovative model has global implications, especially as young democracies take hold and tackle implementation of the rule of law, a ''system in which the laws are public knowledge, are clear in meaning, and apply equally to everyone.''[4] The fundamental objective of a medical–legal partnership is to radically

Downloaded from adc.bmj.com on 30 January 2007

change healthcare delivery for vulnerable children by having lawyers help medical teams deal with the non-biological factors that exacerbate health problems. Through early identification of legal problems and effective intervention, lawyers and healthcare professionals working together can often prevent illness or offer sick children an improved chance of recovery by ensuring that, at a minimum, the children's basic needs for food, housing, safety, healthcare and education are met.

Based on a model of healthcare delivery developed at Boston Medical Center (Boston, Massachusetts, USA), medical–legal partnership involves three core activities:

- *Training and education of healthcare workers*: Training for healthcare professionals in (1) understanding children's basic needs; (2) how those needs are dealt with in the local legal system; and (3) how the local legal system can be successfully navigated to enforce those rights.
- *Direct legal assistance to patients*: Providing direct legal assistance to children and families in the clinical setting, with an emphasis on screening and identifying legal issues as well as effectively responding to them.
- *Systemic advocacy*: Working in partnership with healthcare professionals to influence systems that provide resources crucial to child health and development, with a focus on eliminating any practices inconsistent with laws and thus protecting children's access to those resources.

Medical professionals are certainly aware of the multitude of non-biological factors that contribute to common childhood diseases, but on their own those clinicians are powerless to effect change, especially when legal issues are involved. Lawyers, on the other hand, have the precise tools necessary for effective intervention—knowledge of how to navigate decision-making systems, expertise in the assertion of different types of legal authority, and training in the art of advocacy and persuasion. Having a lawyer available to consult with a paediatric team, when non-medical barriers to child health arise, is an advantage for both the medical provider and the patient, and, we would argue, society at large.

This unusual model, partnering law with medicine, results from a recognition that child health for low-income children cannot be meaningfully improved by relying on medical interventions alone. Moreover, as laws and policies nominally protecting children are only useful if they are respected and enforced, infrastructure must be developed to both identify and remedy legal violations. In our view, the infrastructure that will best accomplish these goals is the medical–legal partnership model. Indeed, particularly in resource-poor settings, families will often forgo either medical or legal assistance if they must travel to two different places for such services.

Of course, integrating a medical–legal partnership model in the developing world presents different challenges than doing so in the US. It can be challenging to find competent, transparent (non-corrupt), altruistic medical and legal professionals in certain countries. Moreover, these professions are often inefficient and/or ineffective. To effectively introduce medical–legal collaboration in resource-poor settings, the local legal and medical professions must have matured to the point where human rights principles and legal advocacy are not just accepted but embraced. Such maturation may require targeted training or informational sessions for key lawyers, doctors, institutions and governmental entities. In addition, the medical–legal partnership team must be connected to change agents and non-formal legal structures such as councils of elders or alternative dispute resolution mechanisms. Internal pressure may be required to shift the paradigm of justice. But ultimately, we contend that access to legal services for needy families will strengthen and test the very institutions that new democracies seek to develop.

This medical–legal model is taking hold in resource-poor settings or resource-poor countries, including support from a new initiative through the Soros-funded Open Society Institute (http://www.soros.org/initiatives/health/focus/law). Its benefits should have ripple effects well beyond the health and well-being of individual families and children. Firstly, collaboration among lawyers and healthcare providers will create an important constituency for related efforts ranging from human rights campaigns to legislative advocacy. Secondly, identifying and dealing with violations of laws that emanate from a human rights framework will add teeth to those laws and that framework. This in turn will ultimately promote a wider embracing of the rule of law as a universal standard.

ACKNOWLEDGEMENTS

This work was supported in part by the WK Kellogg Foundation, Robert Wood Johnson Foundation, the Jessie B Cox Charitable Trust and The Atlantic Philanthropies. We thank Chi-Cheng Huang, MD, and Jonathan Cohen for their helpful comments.

Arch Dis Child 2007;**92**:100–101.
doi: 10.1136/adc.2006.110361

Authors' affiliations

B Zuckerman, E Lawton, S Morton, Department of Pediatrics, Boston Medical Center, Boston, Massachusetts, USA

Correspondence to: Dr B Zuckerman, Boston Medical Center, 771 Albany Street, Dowling 3509 South, Boston, MA 02118, USA; barry.zuckerman@bmc.org

Competing interests: None.

REFERENCES

1. **Waterston T**, Goldenhagen J. Why children's rights are central to international child health. *Arch Dis Child* 2007;**92**:176–80.
2. **Farmer P**. *Pathologies of power: health, human rights, and the new war on the poor*. Los Angeles, CA: University of California Press, 2005.
3. **Zuckerman B**, Sandel M, Smith L, *et al*. Why pediatricians need lawyers to keep children healthy. *Pediatrics* 2004;**114**:224–8.
4. **Carothers T**. *Promoting the rule of law abroad: in search of knowledge*. Washington, DC: Carnegie Endowment for International Peace, 2006:4.