



Policy Statement—Health Equity and Children’s Rights

abstract

Many children in the United States fail to reach their full health and developmental potential. Disparities in their health and well-being result from the complex interplay of multiple social and environmental determinants that are not adequately addressed by current standards of pediatric practice or public policy. Integrating the principles and practice of child health equity—children’s rights, social justice, human capital investment, and health equity ethics—into pediatrics will address the root causes of child health disparities.

Promoting the principles and practice of equity-based clinical care, child advocacy, and child- and family-centered public policy will help to ensure that social and environmental determinants contribute positively to the health and well-being of children. The American Academy of Pediatrics and pediatricians can move the national focus from documenting child health disparities to advancing the principles and practice of child health equity and, in so doing, influence the worldwide practice of pediatrics and child health. All pediatricians, including primary care practitioners and medical and surgical subspecialists, can incorporate these principles into their practice of pediatrics and child health. Integration of these principles into competency-based training and board certification will secure their assimilation into all levels of pediatric practice. *Pediatrics* 2010;125:838–849

INTRODUCTION

The American Academy of Pediatrics (AAP) is dedicated to reducing health disparities and increasing health care equity for children and adolescents. Toward this end, health care equity was established as a universal principle of its agenda for children in 2005. In 2008, the AAP included health equity in its strategic plan and agenda that expanded this universal principle to focus on other factors that influence children’s health and well-being in addition to health care. The AAP continues to expand its programs and policies to address child health disparities through practice, advocacy, education, research, and policy formulation, primarily through initiatives related to ensuring access for all children to quality, patient-centered, and culturally effective medical care. These efforts are critical and must continue but are not sufficient to achieve health equity for all children. The fundamental determinants of children’s health and well-being, and subsequently the health and well-being of the adults they will become, are rooted in social, environmental, and behavioral factors that lie beyond the purview of the health care system.^{1,2}

COUNCIL ON COMMUNITY PEDIATRICS AND COMMITTEE ON
NATIVE AMERICAN CHILD HEALTH

KEY WORDS

disparities, equity, health equity, child health equity, children’s rights, UN Convention on the Rights of the Child, social justice, social capital, ethics

ABBREVIATIONS

AAP—American Academy of Pediatrics

UN—United Nations

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Health disparities in children, as summarized in an upcoming AAP technical report on racial and ethnic disparities,⁵ will remain all too prevalent until these determinants are addressed through a national agenda on child health equity—an agenda informed by the global children’s rights movement.^{4,5} The AAP and pediatricians have critical roles to play in designing, building, participating in, and sustaining this national agenda. To fulfill these roles, pediatrics and pediatricians must expand beyond a focus on health care and health disparities to engage the broader context of child health equity. This policy statement defines the principles and practice of child health equity as a foundation and framework to support and guide the work of pediatrics and pediatricians in the delivery of clinical services, child advocacy, and policy formulation.

BACKGROUND INFORMATION

Differences between groups in status and outcomes are referred to as disparities. Disparities are often described in relation to socioeconomic position, ethnicity, race, geography, gender, and age or in the context of a combination of these and other factors. This is particularly true with respect to child health disparities in the United States, which are routinely defined as a function of multifactorial determinants.^{6–8}

The distinction between the terms “disparity” and “inequity” is critically important. Whereas the term “disparity” only defines differences between groups, “inequity” describes the causes of disparities in the context of the social, economic, civil-political, cultural, and environmental conditions that are required to generate parity and equality. Inequities result in disparities in health status that are “unfair, unjust, avoidable and unnecessary.”⁹ By definition, these are amenable to change.⁹

Disparities in the well-being of children in the United States are growing.^{10–13} These racial, ethnic, gender, and class-based disparities have profound implications for the welfare of children in the United States and for the adults they will become.^{14–19} The sources of these disparities are deeply rooted in inequities in social and environmental determinants of health (eg, poverty, income inequality, maldistribution of educational and other resources, racism, and environmental injustice) and the failure of public policies to address them.^{20–26} The number of children being marginalized by our society is escalating, and child poverty and other indicators of children’s well-being rank the United States among the lowest of the industrialized nations in the world.^{27,28}

STATEMENT OF THE PROBLEM

If we are to succeed in our efforts to eliminate disparities in the health and well-being of children and ensure that all children reach their full potential, the root causes of health disparities must be addressed. The principles of child health equity—children’s rights, social justice, human capital investment, and health equity ethics—provide insight into these root causes and reveal the tools, skills, and strategies required to eliminate health disparities through equity-based clinical care, child advocacy, and policy formulation. Pediatricians and pediatrics have important roles to play in these endeavors, which will require substantive changes in our approach to training, clinical practice, child advocacy, policy formulation, and research.

RATIONALE

Inequities in the social and environmental determinants of children’s health in the United States are pervasive and cumulative, affecting children from conception through adolescence. Children who experience inequities may fail to

reach their full potential,^{15–19} which is detrimental not only to them, their families, and the community but also to society in general. The gradient of inequities within societies is directly related to the degree of disparities.^{2,29,30} Socially divided societies pay a cost in community cohesion, drug and alcohol abuse, mental health problems, children’s physical development, crime, and other social problems.³¹

Why Do Health Disparities in Children Matter?

Eliminating health disparities would make a significant difference in the overall health of children. If health disparities in the United States were eliminated, such that all children had the same risks of adverse outcomes as those of the most economically privileged, the prevalence of poor outcomes (eg, low birth weight, cerebral palsy, intellectual disabilities, psychological problems, child abuse, disabilities attributable to intentional and unintentional injuries) would be reduced by 60% to 70%.^{32–37}

Inequities in children’s health also lead to disparities in adult health and well-being.^{15–19} These inequities contribute to chronic adult illnesses and to the intergenerational perpetuation of poverty and ill health found in many communities (eg, obesity, diabetes, cardiovascular disease, poor educational outcomes, unemployment, poverty, early death, etc).^{15–19,38,39} The burden of disease in low-income children and adults is costly, which puts huge pressures on health care systems.⁴⁰ Improving health equity for children should be among our highest priorities as a national strategy for improving the health and productivity of children and adults and decreasing health care costs.

Which Children Are Most at Risk?

Many children in the United States are marginalized by socioeconomic depri-

vation, social exclusion, racism, and discrimination. Populations of children at particular risk include those who are:

- living in severe and chronic poverty^{7,20–23};
- from racial and ethnic minority groups^{10–13};
- affected by drug and alcohol abuse^{41,42};
- in foster care and public institutions^{43,44};
- disabled and living with special health care needs that impair functions^{45,46};
- living with violence^{46–48};
- incarcerated in adult facilities or juvenile detention^{49,50};
- from homeless families and/or live as homeless teenagers^{51–53};
- from immigrant and refugee families^{54–56}; and
- uninsured and/or without access to health, mental health, and dental care.^{57,58}

The factors that lead to marginalization, social exclusion, and poverty are often coassociated.²⁵ For example, disability and racial and ethnic minority status are associated with poverty^{6–10}; disabled children are at higher risk of abuse⁵⁹; and family stress that arises from poverty and poor health is associated with family breakdown, violence, and homelessness.^{32,47,48,51,52} In the United States, the effects of racism beyond its association with poverty cannot be ignored.⁷

Children who experience multiple compounding risk factors are most likely to have their rights ignored and/or abused. Examples include violence against children in foster care,⁶⁰ discrimination against immigrant and refugee children,⁶¹ inadequate mental health services for children in detention,^{49,50} and the experience of children

in the judicial and juvenile justice systems.^{49,50,62,63}

Relevance of Child Health Equity

Life-course epidemiology and science have advanced our understanding of the mechanisms by which the complex ecology of social and environmental determinants generate and perpetuate child health disparities.^{14–19} They are thought to result from the cumulative exposure to risk counterbalanced by protective factors over the life course. There seem to be critical periods in the life course, most notably during pregnancy and early childhood, when risk and protective exposures have the greatest effect on health.^{14–19,25} Rapid changes in the demography of US children, transitions in the epidemiology of children's health and illness,⁶⁴ and advances in life-course epidemiology and science^{14–19} establish the imperative for a new paradigm for conceptualizing and addressing the health and well-being of children. Social and environmental degradation,^{20–23,31,32} discrimination and marginalization of children,^{7,8} and climate change and globalization^{65–68} are among the factors that contribute to this transformation of children and childhood and the millennial morbidities that affect them.⁶⁹

The relevance and importance of child health equity to the well-being of children, families, communities, and society in the United States and throughout the world cannot be overstated. These and other societal transitions will require new and expanded roles and functions of pediatricians if pediatrics is to remain viable and relevant to the health and well-being of children.

CHILD HEALTH EQUITY

Child health equity, as conceptualized in this policy statement, is composed of 4 elements: children's rights, social justice, human capital investment, and

health equity ethics. The principles encompassed within these components provide perspective and knowledge that can be integrated into the practice of primary care and subspecialty pediatrics and child health. They can be operationalized as tools, skills, and strategies for promoting children's health, address health disparities, and advance equity in child health.

Children's Rights and the United Nations Convention on the Rights of the Child

The United Nations (UN) Convention on the Rights of the Child (Convention) and the integration of its principles into the practice of pediatrics provide powerful tools and strategies to respond to the root causes of contemporary child health morbidities and disparities.⁷⁰ The articles of the Convention define the rights of children in the context of their social, economic, cultural, and civil-political status in society. In its entirety, the Convention redefines childhood, the status of children in society, and what constitutes children's health and well-being. The Convention establishes a template for child advocacy, a holistic approach to fulfilling children's needs, an inventory of optimal health outcomes, and a guide for health systems research. (See Table 1 for a list of rights contained in the Convention.) Consistent with the philosophy and policies of the AAP related to the medical home and family-centered care,^{71,72} the Convention references the family as the fundamental group of society, affirms the principle of respect for family autonomy, and obligates societies to fulfill the rights of children by providing families with access to the resources they require to meet the needs of their children.⁷³

The rights defined by the Convention establish the essential and holistic conditions required to ensure that children

TABLE 1 Relating the Taxonomy of Children's Rights to the Principles of Medical Ethics

Taxonomy of Rights	Inventory of Rights	Ethics Principles	Indicators
Economic	Adequate standard of living Social security Protection from economic exploitation	Justice: distributive and allocative	Is there a morally defensible system for allocating resources?
Cultural	Respect for language, culture, and religion Abolition of traditional practices likely to be prejudicial to a child's health	Autonomy	Do children feel that they are respected?
Social	Promotion of a child's best interests Life, survival, and development Best possible health and access to health care Education Play Family life or alternative care Family reunification Fullest social inclusion for disabled children Support for parents to ensure protection of children's rights	Beneficence	Do participants in the policy-making process act with charity and kindness?
Protective	Protection from abuse and exploitation Protection from armed conflict Protection from harmful drugs Protection from trafficking Rehabilitative care after abuse or neglect	Nonmaleficence	Is the dictate of "primum no nocere" adhered to in decisions made related to the child?
Civil and political	Heard and taken seriously Freedom from discrimination in the exercise of rights Freedom of religion, association, and expression Privacy and information Respect for physical and personal integrity Freedom from all forms of violence, torture, or other cruel, inhuman, or degrading treatment Due process in the law Recognition of the importance of treating the child with respect within the justice system Not to be detained arbitrarily	Autonomy	Do children consider themselves participants in their environment?

achieve an optimal state of well-being. Respect for all the rights embodied in the Convention is required to achieve this goal. No rights take priority over others.^{70,74} Although the United States is 1 of only 2 countries in the world that has not ratified the Convention (Somalia being the other), the Convention's articles are, nevertheless, as relevant to American children and society as they are to children elsewhere. As presented in following sections detailing the implications of an equity-based approach to practice, the promotion and protection of children's rights can be used to guide the work of pediatricians as clinicians and child advocates and the AAP in its public-policy endeavors to improve children's health and reduce health disparities.

Social Justice

Social justice refers to the fair distribution of resources. Resource dis-

tribution results from public- and private-sector policy decisions in venues and institutions at all levels of society. Pediatricians and the AAP can work to ensure that the best interests of children (Convention, article 3) are considered whenever and wherever policy decisions are made that relate to resource distribution (eg, in clinical practice, hospitals, schools, and communities), even if these decisions seem to have little relevance to children. They also can ensure that all such decisions do not discriminate against children on the basis of race, ethnicity, economic status, gender, disability, and/or immigration status (Convention, article 2).⁷⁰ Examples of social justice issues that relate directly and indirectly to the distribution of resources that affect the health and well-being of children are listed in Ta-

ble 2. Pediatricians and child health professionals, in collaboration with colleagues from other child-serving professions, community leaders, parents, children, youth, and young adults transitioning from pediatric to adult care, have critical roles to play in pol-

TABLE 2 Examples of Social Justice Issues That Affect Children's Health and Well-being

Access to healthy housing
Child-friendly neighborhood development
Land use that considers the best interest of children
Access to recreational facilities
Convenient and affordable transportation
Sufficient education resources
Freedom from gender discrimination
Required resources for disabled children
Adequate hospital budgets
Access to quality prekindergarten and early learning resources
Child- and infant-friendly hospitals
Appropriate physician reimbursement
Safe workplace conditions for adolescents

icity development if social justice related to children is to prevail.

Human Capital Investment

Capital investment in children reflects the moral and ethical commitment of society and communities to invest resources required to improve the health and well-being of all children and decrease disparities. The return on this capital investment can be measured in a traditional context of monetary value, but a new currency also must emerge as equity-based measures of health and well-being.^{75,76} Capital investment in children is conceptualized as being composed of 5 forms of capital: social, economic, environmental, educational, and personal capital.

Social Capital

Social capital establishes value for human relationships that affect children. In this regard, a working definition relevant to pediatricians is that social capital relates to social relationships in the family, institutions, and communities (eg, schools, clubs, and faith-based institutions) and among peers that positively influence the health and well-being of children.

Research has shown that a higher level of social capital in families and communities is associated with better health outcomes for children. Runyan et al^{77–79} have demonstrated the positive effects of social capital in moderating the impact of violence and unfavorable social environments on child health outcomes. Newly developed tools and approaches to care, including the medical home,^{71,80} family-centered care,⁷² psychosocial and environmental screening, Bright Futures,⁸¹ and social capital scales,⁷² can help pediatricians and others understand the concept of social capital and integrate its principles into practice.^{82,83}

Economic Capital

Economic investment of a country or community's wealth in children has a direct effect on the health and well-being of children.^{84–91} Children who live in poverty have poorer health and outcomes related to virtually every measure of well-being.^{7,20–23} Income inequality also seems to have a negative effect on child and adult health.^{84,85} Public policies that transfer wealth directly to families, and in particular to children, in the form of cash subsidies or services (eg, child care, medical care, food support, extended paid maternity leave, child allowances, housing subsidies) have a positive effect on children.^{86,88} Indirect investment in children through expansion of the Earned Income Tax Credit, for example, has the potential to lift families out of poverty and improve the well-being of children.⁸⁷ Comparisons between economically developed countries consistently show a direct relationship between wealth transfer and children's well-being.^{88,89} The timing of this investment is critically important, with the largest return resulting from investment in young children and families.^{90,91}

Environmental Capital

The environment in which children grow and develop has a profound influence on their health and well-being as children and into adulthood. Given our rapidly advancing knowledge of early brain development,^{14,19,92,93} the differential effects of the physical environment on the developing child,^{94–96} epigenetics,^{94,96} the prevalence of environmental injustice,⁹⁶ and the potential effects of climate change on children,^{65–67,97–100} it is incumbent on society to consider the environment and environmental justice in the context of child health equity.

Educational Capital

Education is a fundamental right of children.⁷⁰ Policies related to access to

quality education, particularly early learning,^{90,91,101,102} and those related to children with special needs⁹¹ reflect the transfer of educational capital (resources) to children. Such policies are important measures of equity.^{28,75} The return on the investment in early education has been well defined.^{90,91} The effects of education on health outcomes and measures of child and adult well-being have been similarly documented.^{90,91,103}

Personal Capital

Investment in the dignity of children and ensuring that all children, without discrimination, have a legitimate and realistic expectation to enjoy optimal health and fulfill their dreams and aspirations depends on equitable public policy. Investment in the personal capital of children and families is a fundamental issue of equity, a reflection of the values of a community and a measure of its humanity. It is also an investment in the health and well-being of an individual over his or her life course—from infancy through adulthood—and an essential component of the role of pediatricians as they care for and mentor the patients whom they serve.

Translation of Principles of Human-Capital Investment Into Practice

Contextualizing child advocacy as the expansion of capital investment in children through clinical care, community development, and policy generation provides new strategies for pediatricians and the AAP to improve the health and well-being of all children. Using social capital as an example, at the clinical interface, pediatricians can include questions about the child's network of social relationships as part of routine anticipatory guidance and counsel parents about the importance of these relationships to their children. Referrals to mentoring, athletics, quality child care, and other resources

in the community can be made. At the community and policy levels, pediatricians can work with all sectors of the community to advocate for and generate public policies that ensure equitable access and quality improvements in early learning and after-school programs, scouting and Boys and Girls Clubs, community centers and recreational programs, and other resources that will increase children's social capital.

Other examples of the translation of the principles of human capital investment into practice include identifying and responding to clinical issues resulting from (1) a family's lack of access to basic needs (financial capital), (2) detrimental environmental exposures (environmental capital), (3) inadequate educational services for children with special needs (educational capital), and (4) a child's poor sense of self-efficacy and lack of a vision for the future (personal capital). Pediatricians and the AAP are in a unique position to advocate for expanded capital investments in children at the individual and community levels. At the public-policy level, the AAP can work individually and with other child advocacy organizations to ensure that all forms of capital are invested in children as a matter of public- and private-sector policy.

Health Equity Ethics

Health equity ethics adapts and applies the traditional principles of medical ethics, (eg, justice, beneficence, nonmaleficence, and autonomy) to a child rights framework.¹⁰⁴ It defines an expanded set of rights-based ethical principles that can be used as a tool for the consideration and analysis of issues related to the components of child health equity.

The principles of medical ethics relate directly to the 4 primary principles of children's rights, as defined by the UN

TABLE 3 Relating the Core Principles of the UN Convention on the Rights of the Child to the Principles of Medical Ethics

Children's Rights Principles	Medical Ethics Principles
Article 2: Nondiscrimination	Justice
Article 3: Best interests	Beneficence
Article 6: Survival and development	Nonmaleficence
Article 12: Providing children a voice and listening to them	Autonomy

Convention on the Rights of the Child: nondiscrimination (article 2), best interests (article 3), survival and development (article 6), and providing a voice and listening to children (article 12).⁷⁰ Table 3 relates the 4 core principles of children's rights to the 4 principles of medical ethics. Table 1 presents an inventory of the rights defined by the articles in the UN Convention, cross-referenced with the 4 principles of medical ethics. Table 1 also lists examples of indicators that could be used to measure policies that affect these rights. With this matrix, a rights-based perspective can be integrated into ethical decision-making, including the work of hospital ethics committees, to address issues that go beyond primarily biomedical concerns, enrich dialogue and discussion, and provide new tools for clinical practice, child advocacy, and policy formulation.¹⁰⁵

IMPLICATIONS FOR PRACTICE

The principles and practice of child health equity provide tangible knowledge, tools, skills, and strategies that can be applied by pediatricians to clinical care, child advocacy, and the formulation of public policies. The principles provide a foundation and framework to better prepare clinicians and child-serving institutions to ensure the fulfillment of children's rights to:

- child- and family-centered pediatric practices and institutions that consider the best interests of all chil-

dren without discrimination when decisions are made^{70–72,106–109};

- confidentiality, privacy, and dignity^{70,107–109};
- have a voice and be listened to, particularly in clinical decision making and informed consent^{70,107–109};
- information that is available in a language and at a developmental level they will understand^{70,107–109};
- access to a full continuum of health care without discrimination on the basis of (1) insurance, refugee, and/or immigration status,^{51–58} (2) disabilities,^{33,36,46} and/or (3) placement in foster care, the juvenile justice system, or other public venues^{43,44,49,50};
- optimal pain control and symptom management, sedation for invasive procedures, and palliative and end-of-life care that conform with international rights-based standards of care for child health practices^{108,109};
- optimal nutrition, including breastfeeding, through compliance with international standards for infant nutrition^{106,110} and by providing mothers with the information and resources required to ensure that they have the capacity and option to make and implement decisions that are in the best interests of their infants and children¹⁰⁶;
- evidence-based health care;
- access to psychosocial and mental health services, including education and recreation in the hospital setting^{107–109}; and
- protection from all forms of violence and exploitation.^{70,107–108}

For child-serving institutions, admission and discharge, quality improvement, and other practice and organizational policies and protocols should reflect this equity- and rights-based approach to care. All staff, including physicians, nurses, paraprofessionals, and support personnel, should be

oriented and trained to implement them. Ethics committees should integrate the principles of health equity and children's rights into their deliberations, and a children's charter, modeled after the charter adopted by the European Association for Children in Hospital (EACH),¹⁰⁸ should be developed and displayed by all practices and institutions that care for children.^{107–109} The EACH charter enumerates the rights-based standards of care that are required to be fulfilled by health care institutions that serve children in Europe.

With respect to clinical care, pediatricians can implement the principles of health equity to address the root social and environmental causes of childhood morbidity, as well as the prevention and treatment of the illnesses they cause. An equity-based pediatric practice would approach:

- well-child care by promoting Bright Futures' emphasis on nurturing environments for all children and adolescents⁸¹;
- asthma and lead poisoning in the context of a child's right to adequate housing and protection from environmental exposures^{70,94–96};
- obesity and diabetes as a function of a child's right to breastfeed and access quality food and recreation^{70,106,110};
- injury as a right to protection from environmental exposures and the consideration and promotion of the best interests of children when decisions are being made about the built environment^{70,94–96,111};
- school failure as a child's right to access quality early learning environments that foster optimal development through childhood, child care, and school-based services^{70,90,91};
- developmental, behavioral, and mental health problems as a child's right to nurturing home and family environments that protect them

from chronic traumatic stress, and access to early prevention, diagnostic, and therapeutic services⁷⁰; and

- dental disease as a child's right to adequate nutrition and access to dental care.⁷⁰

The role of all pediatricians thus expands from the provision of clinical care to include child advocacy at the clinical and community levels to address root causes of childhood illnesses and morbidities. Multiple tools are available to support clinicians in this regard,^{70,75,80–82,106–120} although additional training will be required to prepare them to implement this new practice paradigm. Practice standards must evolve to support this equity-based practice paradigm, and reimbursement strategies must be pursued to ensure that the economics of practice support this approach to care. Pediatricians and organized medicine must work to make this a reality, as they have succeeded in the past to advance universal health insurance systems for children, expand specialized insurance coverage and services for vulnerable populations of children, ensure reimbursement for well-child care, and, most recently, advance enhanced payment for patient-centered care.

The extent to which pediatricians become directly involved with the formulation of public policy will vary, but all must be prepared to support their peers, the AAP, and other child-serving institutions, organizations, and professional societies in their public policy endeavors in respect of children and families. Pediatricians have many available partners in these endeavors in the fields of law, social work, economics, business, and public health, as well as parents, children, youth, and transitioning adults.

RECOMMENDATIONS

The AAP and pediatricians have synergistic roles to play to ensure that social and environmental determinants of health are addressed through clinical practice, child advocacy, and policy formulation to promote health and eliminate inequities that result in child health disparities. This is an explicit goal of the US Department of Health and Human Services *Healthy People 2010* initiative.¹¹⁶

American Academy of Pediatrics

Health equity contributes to optimal child health and reduction of health disparities through the generation of appropriate public policies, health-enhancing public programs, and a clinical focus on issues of children's rights, social justice, the environment, and human capital investment. Through education and training in the relevance of the components of child health equity to clinical care, child advocacy, medical education, research, and policy formulation; and the integration of the principles and practice of child health equity into its endeavors to advance health outcomes for children, the AAP can influence all aspects of child health practice, improve children's health, and decrease health disparities.

Toward this end, the AAP, in collaboration with the public and private sector and community, state, and national organizations and institutions, will advocate at all levels of society for:

1. Integration of the principles and practice of child health equity into AAP policies and endeavors.
2. Consideration of the best interests of children by policy makers when legislation and decisions are being made that could potentially affect children.^{70,106–111}
3. Access to linguistic and developmentally appropriate information

required by children and families for them to be informed decision makers concerning issues that affect them and their communities.^{70,107–109}

4. Children's participation and involvement in decision making regarding issues that affect them.^{70,107–109}
5. Equitable access to relevant health services for all children.⁷⁰
6. Exploration of the use of the principles of child health equity and the articles of the UN Convention on the Rights of the Child to frame and measure private- and public-sector clinical care, advocacy, and policy formulation.⁷⁰
7. Routine use of child health impact assessments to determine the potential effects of legislation and policy decisions on children's health and well-being.¹¹⁵
8. Examination of administrative models for protecting children's rights, such as the appointment of independent children's rights commissioners (ombudspersons) who are accessible to all children and families to ensure that children (*a*) are not discriminated against, (*b*) have their best interests considered by decision makers, (*c*) have access to information and a voice in their communities, and (*d*) have all their rights, as delineated in the UN Convention, fulfilled.¹¹⁷
9. Development of child-friendly cities. The Child Friendly Cities movement is a global effort, similar in some respects to "America's Promise," to establish communities in which the voices, needs, priorities, and rights of children are an integral part of public policies, programs, and decisions.^{111,121}
10. The reduction of child poverty; racism; individual, structural, and institutional discrimination; gender inequities; and environmental injustice

through legislative advocacy and policy development.^{51,90,91,93,96,118}

11. Legislation to support parents and parenting at home, in the workplace, and in the community.^{70,73,90,91}
12. Development of national health equity indicators that are linked to the social and environmental determinants of children's health.^{75,76,113,119,120}
13. Implementation of a national child health equity research initiative to develop evidence-based interventions that target the social and environmental determinants of children's health.¹²²
14. Development of competencies and curricula for training professionals in child health equity.¹¹⁴
15. Ratification of the UN Convention on the Rights of the Child.^{70,123} The AAP, in collaboration with other national and international organizations, should work with the UN Committee on the Rights of the Child to ensure that the implementation of the articles of the Convention reflect new scientific knowledge and respond to the evolving needs of children.

Clinical Practice

Pediatricians have an important role to play at all levels of clinical practice and child advocacy to improve the health of children and reduce health disparities. Pediatricians can identify and intervene to shape the social and environmental determinants that affect the health of their patients. They can work with communities to provide support to families and ensure the equitable delivery of health services. As influential members of communities, pediatricians can access the media and decision makers to advocate for changes in the environments in which children live. They also can use their close links with local authorities and community services to ensure that

policies are implemented and work to the benefit of all children.

Toward these ends, pediatricians can support efforts to:

1. Integrate the principles of child health equity (eg, children's rights, social justice, human-capital investment, and health-equity ethics) into their practices.
2. Use individual clinical encounters as opportunities to screen and address the social, economic, educational, environmental, and personal-capital needs of the children and families they serve.
3. Use the principles of child health equity as the foundation for child advocacy and policy development.
4. Raise awareness of the relevance of social and environmental determinants to children's health and well-being in their communities and among legislators and other policy makers.
5. Decrease child health disparities through the implementation of the principles and practice of child health equity.

SUMMARY

To eliminate discrimination and improve the health of all children, reduce child health disparities, and advance child health equity, the root social and environmental determinants of children's health must be identified and mitigated. There is an extensive evidence base that links the social epidemiology of these determinants to children's well-being. Advances in life-course sciences have expanded our knowledge of how these determinants affect the biology of children's health and the trajectory of adult health outcomes. The principles and practice of child health equity—children's rights, social justice, human capital investment, and health equity ethics—provide perspective and knowledge to

reorient pediatricians and pediatrics to the importance of social and environmental determinants to the well-being of children. They provide the tools, skills, and strategies to eliminate health disparities and ensure that every child reaches his or her full potential for health and development.

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