

Abstract

The child population of the United States is undergoing a major transformation: one in five children in the United States is an immigrant or lives in an immigrant family, and three-quarters of all immigrant families have at least one child who is a U.S. citizen. Welfare reform's effect on children in immigrant families offers an illustrative case of how U.S. social policy could be examined and potentially altered through the lens of the Convention on the Rights of the Child. Use of the Convention to focus on children and reframe welfare legislation could help underscore the nature of children's social claims and help generate a national consensus as to how to address them more effectively. The Convention could provide specific guidance to the medical profession on how to address these challenges.

La population des enfants aux États-Unis est sur le point de subir des transformations majeures : un enfant sur cinq aux États-Unis est un immigrant ou vit dans une famille d'immigrants, et trois familles d'immigrants sur quatre ont au moins un enfant qui est citoyen américain. Les effets de la réforme de l'assistance sociale sur les enfants dans les familles d'immigrants pourrait se prêter à l'examen de la politique sociale américaine et à son éventuelle réforme et à travers l'objectif de la Convention des droits de l'enfant. L'usage de la Convention permettrait à la fois de placer l'enfant au centre des préoccupations et de recadrer la législation de l'assistance sociale, contribuant ainsi à la mise en évidence de la nature des revendications sociales des enfants et à la création d'une préoccupation nationale sur la manière de prendre celles-ci en compte plus efficacement. La Convention pourrait aussi guider la profession médicale de façon spécifique sur la façon de relever ces défis.

El perfil de la población infantil en los Estados Unidos está pasando por importantes transformaciones. Uno de cada cinco niños/as en los Estados Unidos es un inmigrante o vive con una familia de inmigrantes y tres cuartas partes de todas las familias inmigrantes tienen al menos un/a niño/a que es ciudadano estadounidense. El efecto que la Reforma a la Previsión Social tiene sobre los niños en familias de inmigrantes ofrece un ejemplo de cómo podrían examinarse, y posiblemente modificarse, las políticas sociales estadounidenses desde la perspectiva de la Convención sobre los Derechos del Niño. El uso de esta Convención en la examinación de los problemas de los niños y en la reestructuración de las leyes de previsión social podría ayudar a enfatizar la naturaleza de las reivindicaciones sociales a favor de los niños y generar una preocupación nacional respecto a cómo resolver estos problemas con mayor eficacia. La Convención puede proporcionar orientación concreta a los profesionales de la salud para resolver estos desafíos.

THE RELEVANCE OF THE UNITED
NATIONS CONVENTION ON THE
RIGHTS OF THE CHILD FOR UNITED
STATES DOMESTIC POLICY:
Welfare Reform and Children in Immigrant
Families

Jennifer Kasper and Paul H. Wise

The United States and Somalia remain the only nations in the world that have not ratified the United Nations Convention on the Rights of the Child (the Convention, or CRC), the most universally accepted, legally binding international human rights document in the world. Despite the fact that the Convention is widely viewed as the basic blueprint for describing, assessing, and promoting infant, child, and adolescent health and well-being, public discourse in the United States has largely ignored the Convention and its potential utility. Moreover, despite the Convention's many provisions related to child health and development, most health professionals in the United States are not familiar with the Convention or its successful use as a tool for informed advocacy throughout the world.

The basic premise of this article is that—while ratification of the Convention by the United States should proceed with urgency—the Convention's principles and mechanisms for implementation have direct relevance for the lives

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of children in the United States today. In order to ground this discussion in a practical policy context, this article will examine the impact of recent U.S. welfare policies on children in immigrant families. This case not only helps to identify the components of the Convention that are most relevant to policy development in the United States, but also provides guidance as to how the Convention may be used as a template for collective action on behalf of children.

The UN Convention on the Rights of the Child

The CRC has its origins in Article 25 of the Universal Declaration of Human Rights (UDHR), which states that every person has a right to “a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services...Motherhood and childhood are entitled to special care and assistance. All children...shall enjoy the same social protection.”¹ Article 12 of the International Covenant on Economic, Social, and Cultural Rights echoes this principle with an even stronger statement that focuses on the right to the enjoyment of the highest attainable standard of physical and mental health. It states that making “provisions for the healthy development of the child” is necessary for optimal child health and makes clear that access to health care is a critical prerequisite.²

The Convention has been widely praised for its integration of civil, political, economic, social, and cultural rights. Instead of a hierarchy of rights, it posits the interdependence of rights, acknowledging that they are of equal importance, each one reliant on the others for full expression. The Convention also recognizes children as human beings deserving respect, dignity, and rights. With 191 signatories, the Convention has received the most universal support of any UN convention to date. Notably, the U.S. joined the unanimous vote for the Convention by the General Assembly on November 20, 1989. It also made a commitment at the World Summit for Children in 1991 to “work to promote the earliest possible ratification and implementation of the Convention on the Rights of the Child.”³ Despite proclamations in support of this document and its

becoming a signatory, the U.S. has yet to ratify the Convention, and its provisions remain largely unknown to the U.S. child health community.

For practicing health care providers, five of the Convention's articles have particular relevance: the right to the highest attainable standard of health and access to health care; the right to a standard of living adequate for the child's physical, mental, spiritual, moral, and social development; the principle of non-discrimination; the importance of parenthood; and the responsibilities of government to realize the rights contained within the Convention and allocate appropriate resources.

The overriding theme of the Convention is that, in all actions concerning children, the best interests of the child shall be a primary consideration. It makes no distinction regarding race, ethnicity, or country of origin. It speaks of nondiscrimination and reinforces inherent human dignity regardless of socioeconomic status. It also states that governments should make additional provisions for the most vulnerable or marginalized children in a society. Children should be active participants in all deliberations and policies that affect them, and should be involved in the decision-making process. These themes provide a philosophical and practical basis from which to prioritize social policy in the U.S. and elsewhere.

The Relevance of the CRC to U.S. Social Policy

We believe that the ongoing failure of the United States to ratify the CRC does not eliminate the utility of the Convention to help shape public discourse and policy development in the United States. This belief is based on a series of both moral and practical considerations rooted in the history of the Convention and its growing importance as an international standard against which all national policies concerning children are ultimately judged.

The Moral Obligation to the Convention

The U.S. has been a contributor to a number of important human rights documents. It was instrumental in drafting and endorsing the UDHR, which contains articles on

nondiscrimination; the indispensability of economic, social, and cultural rights for a person's dignity; and an adequate standard of living for all. The U.S. ratified the International Convention on Civil and Political Rights (ICCPR), which also includes articles on nondiscrimination. Additionally, the ICCPR speaks of the family as the fundamental unit of society and entitled to protection by society and the state and stresses protections for children. Finally, the U.S. ratified the International Convention on the Elimination of All Forms of Racial Discrimination. Until recently, it was an active member of the UN Commission on Human Rights.

It is not widely recognized in the United States that U.S. representatives played a major role in drafting the CRC. From the beginning of the process in 1979, the U.S. delegation was a major contributor to nearly every article in the Convention.⁴ The articles pertaining to freedom of expression, thought, conscience, religion, association, and right to privacy in particular were written almost entirely by representatives of the U.S.⁵ The U.S. was a member of the UN General Assembly when it unanimously passed the treaty. Former President Clinton had then-Secretary of State Madeline Albright sign the treaty on February 5, 1995.

By signing the Convention, the U.S. government has indicated its general endorsement of the document. Even though it is not legally binding, this signature implies an obligation to eschew actions that would be in conflict with the CRC.⁶ A number of social policies in the U.S. have put the words of the Convention into practice: the Women, Infants and Children program is an exemplary nutrition program designed to provide healthy foods to low-income women and their young children; Medicaid is the national health insurance program available to many low-income individuals; and public education is free. However, as will be discussed, other policies appear to conflict with the Convention as well as with other human rights documents the U.S. has ratified. Given the central role the U.S. has played in designing human rights documents, participating in foundational committee work, and pursuing human rights worldwide, it seems contradictory that it does not fully recognize the most prominent human rights document

concerning children.

The Convention as an Authoritative Standard

The drafters of the Convention were drawn from a multitude of regions around the world and thereby ensured that a diversity of religious, cultural, and legal views, practices, and interpretations were represented. A number of provisions in the Convention can be considered to rise to the level of customary law, agreed to and respected by all sectors of the international community. A sense of legal obligation to the CRC and to international law leads to attempts at concordant, consistent practices and conscious refraining from certain practices by nations. Some states view the CRC as an extension of the UDHR. Therefore, since many of the rights contained within the UDHR are widely considered part of customary international law, it can be assumed that states have obligations with respect to these principles when they are contained within treaties such as the CRC, regardless of whether they have ratified them.⁷

The impact of the Convention can be appreciated in a variety of venues: resolutions on the rights of children have been incorporated into the annual agendas of UN bodies; the UN High Commissioner for Refugees and the International Labor Organization are altering the foci of their work to include child-specific concerns; UNICEF has reshaped its policies and programs based on the Convention; and the Convention's principles have been used as a basis for subsequent international legal documents such as the Hague Convention on Protection of Children and Cooperation in Respect of Intercountry Adoption.^{8, 9, 10, 11} In short, the CRC has created an international consensus on child interests that could provide a standard for assessing policies and practices of individual countries, including those of the U.S.

The Convention as Advocacy Tool

The carefully crafted articles of the Convention provide a template for advocacy efforts directed at improving the health and well-being of children. This use of the Convention as a framework for advocacy is based on two

related elements. First, the Convention provides legitimacy to causes that embrace its goals and components. The purposeful international process that generated the specific articles of the Convention not only provides legal guidance but also some political legitimacy. In Sweden, Brazil, Norway and Belgium, the CRC is viewed as an active policy document to be used in budgetary decision-making at all levels of government.¹² Other legislative/administrative endeavors include integration of the CRC into national legislation in the Democratic Republic of the Congo and Ethiopia; establishment of child parliaments and child courts in India; and formation of ombudsman offices in Zambia and Rwanda.¹³ From the perspective of advocacy, the Convention has been utilized to outlaw female genital mutilation in Burkina Faso, Senegal, Togo, and other African countries; protect the Roma people (more commonly known as Gypsies) in Romania, children with disabilities in Iran, and child laborers in Thailand; and combat sexual exploitation of children worldwide.^{14, 15} Numerous non-governmental organizations (NGOs) are collaborating with governments to address distinct child rights concerns.¹⁶ A New York City-based organization recently used the language of the Convention to address how New York and federal welfare reform policies violate the right to food and what steps need to be taken to strengthen the Food Stamp Program and make it accessible to those who need it.¹⁷ Another U.S.-based nonprofit organization has filed a brief with the Inter-American Commission on Human Rights, charging that U.S. policies, specifically welfare reform, violate the economic human rights of its poor.¹⁸ U.S. courts have notably referred to provisions of the Convention: in *Batista v. Batista*, the court cited Article 12 of the Convention in support of its decision that a 15-year-old girl's views and concerns should be heard.¹⁹ Additionally, many U.S. state constitutions contain language regarding care for the less affluent, and a small number of these states have used international law for interpreting their state statutes as pertains to education and minimum standard of living.²⁰

The second way the Convention supports practical

advocacy is in the way it inherently links different aspects of child rights that are too often addressed in an insulated fashion. The underlying logic and organization of the Convention suggests that it is not merely a list of child entitlements but rather a broad and unified vision of child rights. This comprehensiveness could prove invaluable to advocacy efforts by emphasizing the linkages between, and not the fragmentation of, children's claims to societal recognition and resources. For example, promoting the well-being of children from a holistic perspective can link access to health care, food, and education within school-based initiatives.

The Convention as Monitor

Rather than simply being a hortatory document, articles within the Convention require that every nation submit an initial report within two years after the Convention enters into force in that country and periodic reports every five years to document how they have implemented the CRC. These reports allow the Committee on the Rights of the Child to assess and critique the extent to which governments have realized their obligations.^{21, 22, 23} As of January 1999, the majority of countries had submitted initial reports and a number of them had submitted follow-up reports; the Committee has engaged in dialogue and given commentary on approximately half of them.²⁴ The CRC is privileged among UN human rights treaties in that it gives the Committee broad powers not only to comment on a country's progress in implementing the Convention, but also to obtain data from nongovernmental sources on the state of children within a particular nation; to provide technical assistance through UNICEF and other organizations to help countries meet their obligations; and to petition the UN secretariat to undertake studies on child rights issues.²⁵ This monitoring mechanism could prove useful in the U.S. for addressing child rights issues, keeping attention focused on these issues, and promoting long-term, sustainable solutions.

The logic and international appeal of the Convention as the "standard of care" for children makes it a useful instru-

ment for change on behalf of children in the U.S. As the Convention gains increasing currency in the international community, the failure of the United States to live up to standards of the Convention becomes even more glaring.

The CRC and Social Policy in the United States: The Case of Welfare Reform and Immigrant Families Children in Immigrant Families in the United States

The child population in the U.S. is undergoing a major transformation: one in five children in the United States is an immigrant or lives in an immigrant family, and three-quarters of all immigrant families have at least one child who is a U.S. citizen. This is the fastest growing segment of the child population. In fact, from 1990–1997, the number of these children grew at nearly seven times the rate of children in native families (i.e., those with U.S.-born parents).²⁶ In the past, the majority of immigrants were concentrated in California, Texas, and New York. Indeed, these three states combined contain more than two-thirds of the entire immigrant population. Recently, however, other states, such as Nevada, North Carolina, and Georgia, have witnessed unprecedented influxes of immigrants, which in turn have generated new challenges for state programs and policies.²⁷

Immigration poses unique stresses on children and families. They must adapt to a new social and often linguistic milieu. In many cases, they are separated from social supports. They must adjust to the disparity between their social, professional, and economic status in their country of origin and in the United States. And they experience elevated rates of ongoing depression, grief, and anxiety resulting from traumatic events that may have occurred in their country of origin or during their relocation to a new community and culture.²⁸

U.S. national data sets can be misleading because they provide primarily overall prevalence rates of socioeconomic status, health conditions, and access to health care in the entire child population. Many questionnaires lack sufficient, accurate information on immigration status. Additionally, even though a number of extensive data sets exist, there exist no linkages between them which would

help researchers gain a richer, more comprehensive understanding of the reality of life for children, especially marginalized immigrant children. The most recent report on child and youth well-being by the U.S. Department of Health and Human Services acknowledges that there are wide gaps in information, and the Federal Interagency Forum on Child and Family Statistics has adopted a mandate to improve the federal statistical system.²⁹ Based on current data sources, life for children in immigrant families is a challenge.

Children in immigrant families are far more likely to be poor than their native-born counterparts.³⁰ Foreign-born residents are almost twice as likely to have incomes below the federal poverty level and to be uninsured.³¹ However, studies have shown that with time, immigrants earn more than their native-born peers.³² This suggests that immigrant families' period of greatest need is during their first years after entering the country. The social circumstances of newer immigrants have also changed in response to changes in U.S. immigration policies.

The immigrant population of today is quite different from that of the early 1900s. The Immigration Act of 1924 limited the number of persons immigrating from outside the Western Hemisphere to 150,000 and based quotas on the country of origin's share of the U.S. population at that time. In this way, immigrants from European countries were favored. However, this pattern changed dramatically after the implementation of the Immigration and Nationality Act of 1965. This legislation restricted the number of people that could enter from any single nation to 20,000 and allowed parents, spouses, and minor children of U.S. citizens to enter the U.S. without counting toward the quota. As a result, Latino and Asian immigrants entered the country at greater rates. The 1986 Immigration Reform and Control Act allowed undocumented persons who had been in the country continuously since 1982 to receive amnesty.³³ These developments have made Latinos and Asians the largest group of new immigrants.³⁴ These two groups tend to be poorer, less educated, and less likely to speak English than other groups of immigrants.³⁵ They are

more likely to work in lower-paying jobs, such as agriculture and retail, which generally do not have employer-based health insurance. The tenuous economic balance immigrant families try to maintain has an impact on their children as well. The poverty rate over the past 20 years has increased much more rapidly among Latino children (the majority of whom are immigrants or live in immigrant families) than among white or African American children.³⁶ Regardless of whether one focuses on health care, housing, or food, children in immigrant families experience greater hardships than other children.³⁷ A recent study of Latino and Asian legal immigrant families using the U.S. Department of Agriculture Food Security Instrument found that four out of five families experienced hunger or were on the brink of hunger. Additionally, the majority had incomes below the federal poverty level, yet they and their U.S.-citizen children had low participation rates in public assistance programs such as the Food Stamp Program.^{38, 39, 40} Thus, even though U.S.-born children are fully entitled to all public assistance benefits if their family's income is sufficiently low, this study and others suggest that those who live in immigrant families are less likely to be in families receiving public assistance than U.S.-born children with U.S.-born parents.⁴¹ Given the extensive literature demonstrating that uninsured children are less likely to have a regular source of care, less likely to receive appropriate preventive treatments, and more likely to have unmet health needs, it is not surprising that the triad of poverty, poor or no health insurance, and risks for poor health jeopardizes the lives of many children in immigrant families. Given their heightened socioeconomic vulnerability, low-income immigrants pose distinct concerns for clinicians and others concerned with health and well-being in the United States.^{42, 43, 45, 46, 47}

Inequities faced by immigrants are not peculiar to the U.S.; this is an ongoing reality for immigrants in European countries as well.^{48, 49, 50} The plight of refugees, asylum seekers, and documented and undocumented immigrants and their access to a country's social entitlements is an international problem. The Convention and other human rights documents can be utilized to address and shape policies affecting this population in all parts of the world, including Africa and Asia.

Welfare Reform: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

Welfare reform represents one of the most dramatic shifts in U.S. social policy in recent decades. Although its provisions have dramatically altered how societal resources are conveyed to all poor families, welfare reform has had a particularly profound impact on immigrant families. Historically, legal immigrants' eligibility for receipt of public assistance was the same as that of U.S. citizens: if they met the income requirement, they were eligible. This changed dramatically in 1996 when Congress enacted, and President Clinton signed into law, the Personal Responsibility and Work Opportunity Reconciliation Act, commonly known as welfare reform.⁵¹ As initially passed, this act denied federal Food Stamps, Medicaid, Temporary Assistance to Needy Families (TANF, also known as welfare), and Supplemental Security Income (SSI) to many formerly eligible legal immigrants, solely on the basis of their immigration status and date of entry. Immigrants who entered the U.S. legally after August 22, 1996, are denied these federal means-tested benefits during their first five years of residence. Despite restoration of SSI and Food Stamps to a small number of immigrants in later legislation, problems regarding access and financial stability persist. Essentially, the safety net of social programs that historically served to help immigrants in their initial years in the U.S. was removed. It is also of note that persons who enter and remain in the U.S. without appropriate documentation are not entitled to most public assistance.⁵²

At the state level, welfare reform gave states the discretion to permit or deny state-funded cash and health assistance and social services to legal immigrants. States choosing to provide public assistance had to do so only with state funds; no matching federal funds would be provided. As a result, public programs to assist immigrant families are a patchwork of federal and state initiatives—or no initiatives—depending on when the immigrant was first in the United States. As of May 1999, nearly half of all states did not provide state substitute programs for welfare, Medicaid, Food Stamps, or Supplemental Security Income for post-1996

immigrants.⁵³ For those states with state-funded programs, additional conditions are often placed on immigrants when determining eligibility for assistance for the immigrant, such as considering the income of a sponsor, residency requirements, and mandating that immigrants apply for citizenship in order to receive assistance.

Welfare reform has been associated with several troubling trends in immigrant participation in public programs. Approximately one million fewer children are enrolled in Medicaid, a development which disproportionately affects children in immigrant families because uninsured Medicaid-eligible children are more likely to be U.S.-born children of immigrant parents or immigrants themselves.^{54, 55} Use of public benefits fell more sharply among noncitizen households than citizen households.⁵⁶ Due to fears that accessing public assistance would jeopardize their immigration status, immigrants are avoiding public assistance even for their children who are U.S. citizens.⁵⁷ The number of participants in the federal Food Stamp Program has been declining in spite of concurrent documentation of increased need for emergency food assistance.^{58, 59, 60} The use of Food Stamps by U.S.-born children in immigrant families fell more sharply than use by U.S.-born children living with U.S.-born parents.⁶¹ The number of children participating in the Food Stamp Program has fallen more sharply than the number of children living in poverty, indicating a growing gap between need and assistance.⁶² The decline in welfare recipients is not related to a proportionate decline in poverty rates; in fact, the percentage of families living with incomes less than 50% of the federal poverty level is increasing.⁶³

Use of the Convention to Critique Welfare Reform

Welfare reform's effect on children in immigrant families offers an illustrative case of how U.S. social policy could be examined and potentially altered through the lens of the CRC. Use of the Convention to reframe welfare legislation could help underscore the nature of immigrant families' social claims and help generate a national consensus as to how to address them more effectively. In particular, the

Convention highlights three key issues: nondiscrimination, adequate standard of living, and access to health care.

Discrimination

Article 2 of the Convention states that governments shall respect and ensure the rights set forth to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.⁶⁴ Nations must not only actively protect children from discrimination, but also must refrain from actions that may have a discriminatory effect. The Convention describes the overall responsibility that governments must have for all children: they are required to undertake all appropriate legislative, administrative, and other measures to implement the Convention, and they must use the maximum amount of available resources to ensure to the maximum extent possible the survival and development of the child.⁶⁵ The Convention charges governments to act on the principle of nondiscrimination as well as to identify vulnerable groups and take affirmative action to redress inequities.

In essence, the immigrant provisions of welfare reform legislation have proven inherently discriminatory in both their philosophical and practical impacts. The denial of benefits for immigrants cannot be said to have been based on a "welfare-to-work" concern because immigrants have generally been more active in the workforce than native-born citizens.⁶⁶ Rather, the legislation responded to anti-immigrant sentiment and attempts to reduce the costs of welfare. Even though noncitizens make up only 12% of the population with incomes below the poverty line and constitute approximately 5% of all people receiving public assistance, welfare reform's restrictions or denial of federal public benefits to them accounted for almost half of the federal "savings" that welfare reform was expected to generate.^{67, 68} The U.S. Department of Agriculture estimates that 1.6 million people, including 125,000 immigrant children and 700,000 citizen children living in immigrant households, were affected

by the federal Food Stamp cuts. Even though legal immigrants made up only 5.2% of all Food Stamp participants, denial of assistance to this group accounted for one-third of the "savings."⁷⁰ Welfare reform has also given states discretion in deciding if they want to include the income of immigrants *ineligible* for Food Stamps when calculating the amount of Food Stamp benefits for *eligible* U.S. citizens and legal immigrants in the household.⁷¹ This has the effect of further diminishing the amount of food available for everyone in the family. Given that recent studies have demonstrated high rates of hunger in low-income immigrant families, it would appear that some of these families would benefit from the receipt of Food Stamps. Also, studies completed in 1996 concluded that more people would be driven into poverty by the immigrant benefit reductions than by any other component of the welfare legislation.⁷² Given the financial contributions they make to U.S. society (approximately \$25 billion annually), immigrants have been denied many of the benefits that their tax dollars support.⁷³

Welfare reform has placed new stresses on immigrant parents. Current welfare policy is complex and sharply divides eligibility for public assistance based on citizenship. Bureaucracy has not kept pace with policy changes. Often employees of public assistance agencies are confused or misinformed about program rules as they pertain to immigrants. In some cases, they have been found to actively dissuade families from accessing benefits to which they are entitled.⁷⁴ In addition, families may not know they are eligible, or may avoid benefits due to fears of jeopardizing their immigration status.^{75, 76, 77} This environment serves to put children at risk for adverse outcomes and denies them an optimal environment for realizing their full potential.

The Necessities of Life

The U.S. has historically prioritized civil and political rights over economic, social, and cultural rights. This emphasis has enabled the U.S. to avoid discussion of poverty and economic inequalities as rights issues with health implications. Even though the U.S. Constitution discusses promoting general welfare as a governmental responsibility,

it has not regarded public assistance programs as legally required or as enforceable “rights,” but rather as discretionary services or programs that may be amended or rescinded on the basis of political or budgetary considerations.^{78, 79} The majority of children in the U.S. do not suffer from egregious neglect or violation of their civil and political rights (with some notable exceptions, such as confinement of juvenile offenders with adults and execution of juveniles for crimes committed).⁸⁰ However, large numbers of them, and children in immigrant families in particular, are greatly affected by inadequate attention to economic and social conditions. For poor children in America, the lack of access to health care, nutrition, decent and safe schools, and adequate housing raises serious concerns about the nature and scope of societal provisions of the necessities of life to all children.

The Convention explicitly recognizes that children do not live in isolation; they are uniquely dependent upon the adults in their lives for their health and well-being. Child claims to justice are therefore innately tied to familial claims of justice. The Preamble to the CRC and Articles 5 and 18 reinforce that a child’s parents are indispensable for the child’s upbringing. Article 27 states that the family should be afforded the necessary protection and material assistance (e.g., nutritional and housing assistance) so that it can fully assume its responsibilities within the community.⁸¹ The language used in this article of the Convention implies active engagement on the part of local, state, and federal governments. The Convention’s use of the word “recognize” implies that a government cannot prevent the realization of a right. When the Convention says a government “shall take measures” and “shall provide material assistance,” this indicates that governments should take a proactive stance to prevent resource-poor environments that jeopardize child health and well-being.

Welfare reform was premised on the notion that regulations designed to remove parents from the welfare system could operate simultaneously with a humane safety net of programs directed at children. Yet welfare reform policies directed at adult members of an immigrant household have

repercussions for the children of that household. It is short-sighted to think that children will somehow be spared when legislation is implemented that directly harms their parents. An attempt to promote the rights and health of children necessitates a preoccupation with the rights and health of their families.

The provisions of welfare reform that pertain to immigrants clearly do not meet these basic standards. Denial of Food Stamps deprives immigrants of “the most important nutritional assistance program for the prevention of hunger,” even though human rights standards preclude the U.S. from interfering with people’s access to food.^{82, 83} Since enacting welfare reform legislation, the U.S. has seen declines in participation rates in Medicaid and Food Stamps and increases in the uninsured population and the demand for emergency food assistance, facts which demonstrate a regression in the implementation of economic and social rights.⁸⁴ These findings represent an incongruity between relatively liberal immigration policies and interest in supporting and integrating immigrants into society during their initial years in the United States.⁸⁵

Access to Health Care

Article 24 of the Convention declares that every child has a right to the enjoyment of the highest attainable standard of health and access to health care facilities. It unequivocally states that governments should endeavor to make health care universally available for children.⁸⁶ With nearly 12 million uninsured children, a disproportionate number of whom are children in immigrant families, the U.S. has fallen far short of the goal of universal access to health care for children. Immigrants face a multitude of obstacles when seeking health care.^{87, 88, 89} The citizenship status of the child and parents affects insurance rates, especially in “mixed-status” households (a household where some members are citizens and others are noncitizens) in which low participation rates in health insurance programs are due to ineligibility or fears that accessing government programs such as Medicaid will negatively affect a household member’s immigration status.⁹⁰ Welfare reform exacerbated this

situation by denying health insurance to immigrant children who entered the country after August 22, 1996. These children are not entitled to Medicaid or the State Children's Health Insurance Program (two federal programs for low-income people) unless individual states decide to use state funds to provide coverage.^{91, 92}

The Convention states that governments "shall strive to ensure no child is denied the right of access to health care."⁹³ This requires that governments take positive measures to make sure this right can be effectively exercised. The Convention's use of the word "recognize" in relation to the right to health also means that governments are obligated to refrain from obstructing the exercise of the protected right. Based on this interpretation, denying health insurance to immigrant children, allowing states to decide if they want to use state funds for provision of health insurance to immigrant children, and delaying clarification of public charge determinations for immigrants are obstacles to the practice of this right. Overall, implementation of 1996 welfare reform legislation failed to meet the standards set out in the CRC and has proven to be unjust in its treatment of immigrants. The legislation is discriminatory, denies basic life necessities, and impedes access to health care for immigrants. Rather than recognize immigrants as a group with human rights and in need of services, it actively discriminates against them in public discourse and programs.

The Current Opportunity

The United States has never been more prosperous than it is today. Even so, poverty has never been more deeply concentrated in childhood.⁹⁴ This implies both that there is an urgent need to improve the lot of children and that there have never been greater material resources to do so. There have been heated debates about the merits and errors of welfare reform. However, this battle has largely ignored a practical consideration of children's interests. The CRC provides an opportunity to shift the paradigm to focus on children.

The Convention could provide specific guidance to the medical profession to address these challenges. The

Convention should have a special resonance for pediatricians and others who have both the capacity and responsibility to care for children. A basic tenet of pediatric practice is to advocate for "the best interests of the child." According to the Convention, the best interests of the child does not mean that a child's interests will always prevail; rather, it allows for child interests to be considered and given equal weight to competing interests.⁹⁵ The pediatric community could benefit in this regard by using a human rights perspective to inform the public debate on children's issues. Pediatricians use growth charts in their daily practice to compare a child's growth to norms for his/her particular age and sex. One can think of the Convention as the growth chart for children's interests, a template by which child advocates can measure progress in promoting the health and well-being of children.

The American Academy of Pediatrics (AAP) has endorsed the CRC and supports full access to all social, educational, and health services for all children regardless of immigration status.^{96,97} Thus, it has a special opportunity to use the Convention to reframe the traditional analysis of the underlying social determinants of child health status and guide policy and practice changes. The AAP could be at the vanguard of creating a coherent, comprehensive child advocacy agenda that incorporates the principles of nondiscrimination, government responsibilities, importance of parenthood, and the need for a sufficient standard of living and access to health care to ensure the optimum health and development of children.⁹⁸

The Convention relies on universal principles that can be utilized to highlight themes of equality and disparity on a national and international basis. It is also a means of strengthening the professional commitment to address these social forces through public advocacy and daily practice. As Jonathan Mann wrote, "A society in which human rights are promoted and protected, and in which human dignity is respected, is a healthy society; that is, a society in which people can best achieve physical, mental, and social well-being."⁹⁹ Now is the time for the child health community to focus its professional capacities and embrace human

rights as a central means of addressing child needs. The CRC can serve as a framework for thoughtful, disciplined discussion from a child-and family-sensitive lens.

The UN High Commissioner for Human Rights has devised a list of activities to help promote children's rights.¹⁰⁰ The first step is to organize a multidisciplinary group that includes children to examine child rights without any thoughts of financial constraints. From this follows a discussion of budgetary realities and, finally, prioritizing which problems a country will address first. It is also important to keep in mind what outcomes are being sought, in what order, and how these will be measured. In the context of the U.S., this group could then scrutinize federal legislation to guarantee that laws are in keeping with the principles of the Convention. For example, advocates could insist that eligibility for the State Children's Health Insurance Program and Medicaid include all immigrant children. In 2002, when welfare reform is up for reauthorization, they could address restoration of needed nutritional and health assistance to immigrants.

Another step advised by the UN High Commissioner involves a comprehensive review of the health and well-being of children, especially the most vulnerable. The federal government should reevaluate its mechanisms for collecting data on child health and wherever possible link data sets to look beyond "broad demographic or epidemiologic trends and examine consequences for specific subgroups."¹⁰¹ In each one of these steps, health professionals and child advocates can be instrumental in contributing their knowledge and experience. For example, they could recommend that more information on immigration status be collected for national data sets and that further research on welfare reform's impact on children be conducted. They could be instrumental in devising new data sets that investigate and elucidate the relationship between human rights and health.

The Convention can offer a means by which disciplined, thoughtful discussion of child interests can occur prior to enactment of legislation. The CRC provides a blueprint for public policies, for public action, that would attend

to the requirements of families with children, for linking societal resources with societal need. All those who work with children would benefit from exploring the principles of the Convention and linking its provisions to the challenges of their daily practices. However, the public at large must also be informed of the Convention and its constructive impact throughout the world. For, as the last decade has taught us, it will take more than enormous societal wealth to improve the well-being of children in the United States. It will require a more informed and directed public discourse regarding the translation of high principles into the material reality of everyday life. Health professionals and others who care for children can be at the vanguard of this effort. In many ways, seeking guidance from the Convention could help reframe traditional obstacles to meaningful reform and provide the kind of framework and collective discipline to ensure that a society grounded in justice will ultimately make the promotion of child rights a central priority.

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