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Interprofessional pediatric provider perspectives on children's rights: an exploratory study

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ABSTRACT

The United Nations Convention on the Rights of the Child (UNCRC, 1989) has drawn significant attention to children's rights on a global scale. While healthcare providers play a pivotal role in promoting children's rights, realizing these rights in practice remains a challenging endeavor. This study explored how pediatric healthcare providers perceive and implement children's rights in their practice. Using a mixed-methods, cross-sectional design, we distributed a12-item survey to an international sample of interprofessional pediatric healthcare providers. A total of 86 healthcare providers completed the survey, including pediatricians ($n = 38$), nurses ($n = 35$), and "other" interprofessional healthcare providers ($n = 13$). Almost all (99%) respondents associated children's rights with being heard, providing information, and participating in decision-making. Pediatricians were more likely to view family-centered care as supportive of children's rights and reported a stronger perceived integration of these rights within interprofessional teams. Qualitative findings highlighted caregivers' influence in shaping shared decision-making processes, and age-based views of children's decision-making capacities. Our findings suggest that the realization of children's rights in practice requires an interprofessional and collaborative approach. Future initiatives should focus on education, training, and policy developments to strengthen the integration of children's rights in pediatric care.

Introduction

The meaningful integration of children's rights in pediatric care can enhance health outcomes for children through an equity-oriented lens (Council on Community Pediatrics and Committee on Native American Child Health, 2010; Czyz & Gruskin, 2025; Goldhagen et al., 2020). Children's rights represent a "global agenda" for advancing justice and equity in child health by ensuring that all children are entitled to quality care (Goldhagen et al., 2020). The United Nations Convention on the Rights of the Child (UNCRC) (Assembly UNG and Directorate CHR, 1991) represents a comprehensive,

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ethical, and legal framework to support the realization of the rights of *all* children – regardless of race, class, ability, ethnicity, sexuality, age, locality, and gender (Czyz & Gruskin, 2025; Üstüner-Top & Cam, 2023). The 54 articles of the UNCRC can be categorized under the three "P's" framework of participation (in decision-making), provision (of information, education), and protection (from harm). More recently, two additional constructs have been added to this framework: power (genuine inclusion of children's voices) and preparation (by state officials to plan for children's health). Collectively, this "5 P's" framework promotes a view of children as rights-holding citizens and seeks to safeguard children's fundamental rights across all spaces that children inhabit (Jörgensen et al., 2023).

As duty-bearers of children's rights, healthcare providers (HCPs) should engage in clinical practices that promote children's rights (Alshammari et al., 2025; Georgousopoulou et al., 2023; Koller et al., 2024). These include listening to children, offering medical information, delineating misconceptions, ascertaining their need to know and be involved, providing choices where possible, and involving children in decision-making (Koller, 2021). In addition, partnering with children and families is important in realizing children's rights, as encapsulated by family-centered care (FCC) philosophies (Coyne et al., 2018). Equally, essential is the need for HCPs to engage in collaborative interprofessional practice to uphold children's rights (Foster et al., 2024).

Despite the moral integrity that children's rights bring to a pediatric clinical setting, significant challenges remain with implementing these rights in practice (Alshammari et al., 2025; Davies & Randall, 2015; Georgousopoulou et al., 2023; Moore & Kirk, 2010). Interprofessional HCPs have reported a lack of time to implement rights-based strategies (Alshammari et al., 2025). Challenges in managing the involvement of caregivers represent another barrier to upholding children's rights and FCC approaches (Davies & Randall, 2015; Üstüner-Top & Cam, 2023). While FCC is widely endorsed as a philosophical approach to care in pediatrics, its focus on family systems rather than children's individual needs can inadvertently diminish children's rights. Child-centered care (CCC) approaches inherently uphold children's rights by placing children at the center of thinking and practice (Coyne et al., 2018). Importantly, these care philosophies do not unfold uniformly across settings: acute, ambulatory, and community-based contexts each give rise to distinct interprofessional dynamics and care priorities, which shape how FCC and CCC are enacted in relation to children's rights (Kokorelias et al., 2019).

Regardless of clinical context, a lack of clarity regarding what children's rights "really mean" in daily clinical practice continues to permeate pediatrics (Dorscheidt & Doek, 2018). As the language of rights remains somewhat obscured or undetectable in practice (Jörgensen et al., 2023; Koller, 2021; Koller et al., 2024). HCPs can benefit from practical guidance on *what* children's rights mean and *how* to integrate and promote

children's rights in care (Dorscheidt & Doek, 2018; Koller et al., 2024). Thus, the primary objective of this study was to report on the results of a preliminary survey developed to investigate how HCPs perceive and incorporate children's rights in their practice. Our secondary objectives were to:

(1) Describe the knowledge, perceptions, and beliefs of HCPs regarding children's rights.
(2) Assess how children's rights operate within healthcare teams and interprofessional communications.
(3) Explore how children's rights are reflected in philosophies of care (e.g. family centered, child centered or both).

The overall purpose of this study was to provide baseline data on interprofessional HCPs' knowledge, beliefs, and attitudes regarding children's rights in practice. We suggest that these data can be used to inform and guide future research and practice initiatives. To the best of our knowledge, this is the first survey study to explore HCPs' knowledge, beliefs, and attitudes regarding children's rights in the context of pediatrics.

Methods

This study employed a mixed-methods, cross-sectional survey design to explore and describe how HCPs perceive and incorporate children's rights in their clinical practices. In the context of this study, a "child" is defined as any human being below the age of 18 years (Assembly and Directorate UNG, 1991). Permission to conduct the study was granted by the Research Ethics Board at Toronto Metropolitan University (#2023–094). A brief survey was selected as an appropriate exploratory method because, to our knowledge, no validated tool currently exists to assess healthcare providers' perspectives on children's rights in practice. Our intent was to generate baseline descriptive data across an interprofessional sample, which could inform future, more in-depth studies on this topic.

Survey design

The survey consisted of 12 items which were developed to gather information on how interprofessional healthcare providers perceive and incorporate children's rights in their practice (see Appendix 1). All core team members (SE, DK, AM, AI) reviewed the survey items for clarity, length, and relevance.

The survey included qualitative and quantitative components to provide a comprehensive overview of the research topic, categorized under the headings: demographic questions (3 items) and survey questions (9 items)

(Appendix 2). The survey also included three closed-ended and two open-ended questions. Open-ended questions were intended to capture participants' perspectives on barriers to incorporating children's rights into care, the resources they rely on for understanding child rights, and any examples of best practices followed in promoting children's rights.

The survey was developed by members of the research team (SE, DK, AI) with expertise in psychosocial pediatric care, children's rights, and nursing. We acknowledge that this expertise, alongside first-hand clinical experiences, informed the study rationale, survey design, and interpretation of qualitative findings.

Survey distribution and study participants

The survey was distributed via e-mail to all members ($n = 500$) of the International Society for Social Pediatrics and Child Health (ISSOP). ISSOP represents a global network of health professionals, researchers, and advocates committed to advancing the health, wellbeing, and rights of children. The e-mail contained a link to an online version of the survey, hosted on Google Forms, a secure online survey platform. The survey was open for responses between November 2023 and July 2024. Two reminders to complete the survey were sent out at 2-week intervals.

Participants were eligible for inclusion if they: 1) were a HCP with current or past experience of having provided care to children, in any pediatric care setting (e.g., acute, community-based), 2) had stable internet access, 3) and had the ability to converse and respond in English. Participation was voluntary, and informed consent was obtained from all respondents before they began the survey. Participants were assured of the anonymity and confidentiality of their responses and received a small monetary compensation for completing the survey in the form of a gift card.

Analysis

Quantitative analysis

A statistician was consulted to assist with the analysis of quantitative data. Descriptive statistics were computed to summarize the general characteristics of the study population. Continuous variables were summarized using the minimum, maximum, mean, and standard deviation. Data were analyzed using one-way ANOVAs to determine whether healthcare providers' (HCPs) profession (i.e., nurse, pediatrician, other health professions) and years of pediatric experience (i.e., less than 5 years, 5–20 years, greater than 20 years) were associated with differences in HCPs' beliefs and perspectives on children's rights. In particular, we

explored potential group differences in HCPs' responses to the survey items related to; (a) beliefs about the degree to which family-centered care (FCC) inhibits children's rights, and (b) the extent to which HCPs believe children's are integrated in teamwork.

In our analyses, HCPs' profession or their years of experience represented the independent variable, while HCP beliefs and perspectives represented the dependent (i.e., outcome) variable. If the ANOVAs were statistically significant, the means for each group were examined to determine which two should be compared for the post-hoc analysis. The group numerically furthest from the others was chosen as the reference group, allowing for clearer interpretation of contrasts between groups. We acknowledge that this analytic decision may have influenced how the findings were interpreted, as alternative analytic groups may have yielded different results.

Due to the exploratory nature of our study, we recognize that our decision to employ one-way ANOVAs did not allow for the inclusion of multivariable models of analysis (e.g., regression) to consider potential confounding between variables such as profession type and years of experience. Our primary aim was to generate foundational and baseline data regarding how provider roles and experiences may independently relate to beliefs about children's rights in pediatrics. Future research could build on this work by employing multivariable approaches to explore such relationships in more depth.

Qualitative analysis

Qualitative data gathered from two open-ended questions were imported into NVivo qualitative analysis software and analyzed using thematic analysis approach.[24] Using a deductive approach[15], data were coded for recurring themes on perceptions, barriers, and facilitators for integrating child rights in pediatrics. A codebook containing 25 codes was developed, in which codes were categorized under the headings: a) challenges experienced by HCPs, b) strategies used by HCPs, and c) outcomes for children and families associated with children's rights. This codebook was developed iteratively through collaborative discussions between authors and discrepancies were resolved by discussion. An overview of the development of codes is presented in Table 1. The qualitative findings were derived from solely two open-ended survey questions, which poses restrictions on the possible depth of analysis. Thus, while qualitative data valuable contextual insights to complement the quantitative findings, the qualitative results should be interpreted with this limitation in mind.

Table 1. Overview of coding development process.

Category	Code	Representative Quote
Challenges experienced by HCPs in realizing child rights	Caregivers as proxy decision-makers	"The legal system in the US heavily prioritizes parent wants and needs, and those sometimes conflict with children's needs and rights."
		"Parents sometimes inhibit the child's right to information about their treatment."
	Children's age dictating decision-making	"At times team members may think that the child is too young to have a voice."
		"It becomes challenging with younger patients, as it can be difficult to assess their level of understanding of the illness and treatment plans."
Strategies used by HCPs to promote child rights	Educating children and providing information	"We also educate the child directly about their diagnosis and treatment when appropriate."
		"Providing age-appropriate education"
	Engaging in shared decision-making	"Both parents were always included in the decision making for healthcare options for mother and child"
		"Promoting children's involvement in informed decision-making regarding their care."
Outcomes for children and families	Enhancing child comfort and coping skills	" . . . offering Child Life or distraction methods to support coping"
		" . . . we all worked hard at respecting children's right to play opportunities to help children cope"

Results

The primary objective of this study was to investigate how HCPs perceive and incorporate children's rights in their clinical practice

Sample characteristics

Overall, 89 healthcare providers (HCPs) from various disciplines responded to the survey with a 17% response rate. Three HCPs were excluded for not meeting eligibility criteria, resulting in 86 HCPs being included as participants in this study. To facilitate data management and analysis, respondents were categorized under the groups "pediatricians" ($n = 38$), "nurses" ($n = 35$), and "other" ($n = 13$), which included interprofessional providers such as child life professionals, a pharmacist, respiratory therapist, and a public health practitioner. An overview of professionals included in each category is displayed in Table 2.

The survey responses of all 86 HCPs were included in the quantitative analysis of the survey items. Out of 86 survey respondents, 77 (89.53% of

Table 2. Professions represented in respondent categories.

Category	Profession	Number
Pediatricians ($n = 38$)	Pediatricians	38
Nurses ($n = 35$)	Registered nurses	18
	Nurse practitioners	14
	Clinical nurse specialists	3
Other ($n = 13$)	Child life professionals	9
	Pharmacists	2
	Respiratory therapist	1
	Public health practitioner	1

total) provided answers to 2 open-ended survey questions and 77 cases were included for qualitative analysis.

Most respondents ($n = 48$, 55.81%) had between 5 and 20 years of experience working in pediatrics. Remaining respondents had either over 20 years' experience ($n = 30$, 34.88%) or less than 5 years of experience ($n = 8$, 9.30%). Table 3 provides an overview of the general characteristics of the respondents in terms of years of experience and geographical location, by discipline group.

Information on participants' country of residence was informally gathered. While most participants were based in Canada, others were located in Spain, the United States, France, Japan, Iceland, Australia, Hungary, Pakistan, Switzerland, Germany, India, and Nigeria.

Pediatric team compositions

Most respondents (94.19%) believed that HCPs represent key members of healthcare teams, followed by extended family, friends, and community members (83.72%), as well as caregivers and siblings (79.10%). Only half perceived children as forming part of teams; fewer cited school staff (30.24%) and "other" (6.97%) (e.g., social workers). Figure 1 depicts how respondents described the individuals who form part of healthcare teams.

Table 3. General characteristics of respondents (Total n = 86), by discipline group.

	Pediatricians n = 38 Mean (SD) Min-Max	Nurses n = 35 Mean (SD) Min-Max	"Other" HCPs n = 13 Mean (SD) Min – Max
Years of experience	23.11 (8.28) 6–50 **n (%)**	13.17 (8.74) 1–37 **n (%)**	17.46 (8.28) 3–28 **n (%)**

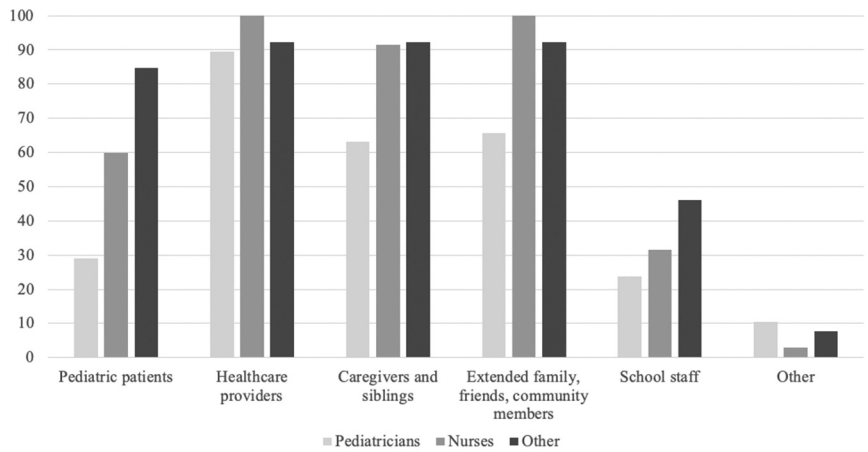

Figure 1. Individuals who form part of healthcare teams (total $n = 86$), by discipline group.

The meaning of children's rights

The following survey question assessed whether respondents endorsed a children's rights philosophy: "What is the degree to which you believe children should be engaged in their care?," in which a higher score indicated a more favorable perception of the importance of children's rights. The overall mean score was 4.70 (SD = 0.63). Nurses ($M = 4.77$, SD = 0.43) and "other" HCPs ($M = 4.77$, SD = 0.60) were more likely than pediatricians ($M = 4.61$, SD = 0.79) to endorse a rights-based philosophy.

Figure 2 depicts an overview of how respondents described the meaning of children's rights. Children's rights to be heard, to information, as well as providing care that optimizes growth were rated most favorably (98.84%), followed by providing psychosocial care that optimizes mental health (97.67%). The right to participate in decision-making was rated less favorably among pediatricians (97.37%), "other" HCPs (92.31%), and nurses (94.29%). Pediatricians also identified few (2.63%) "other" meanings, such as the rights to privacy, play, and to refuse or withdraw from care.

In response to the question "At what age do you believe pediatric patients have rights in their healthcare?," most respondents believed that middle-school age (7–12 years) represents the time at which children "receive" rights ($n = 24$, 27.91%), while many others reported that children's rights begin in infancy (0–1 year) ($n = 23$, 26.74%). Others believed children "receive" rights as preschoolers (4–6 years) ($n = 19$, 22.09%), as toddlers (2–3 years) ($n = 14$, 16.28%), and adolescents (13–18 years) ($n = 6$, 6.98%). While children's rights are fundamentally guaranteed to all children, this survey item was intended to capture participants' perceptions of when children are recognized as rights-holders in clinical practice, rather than to suggest that rights are granted at a particular age.

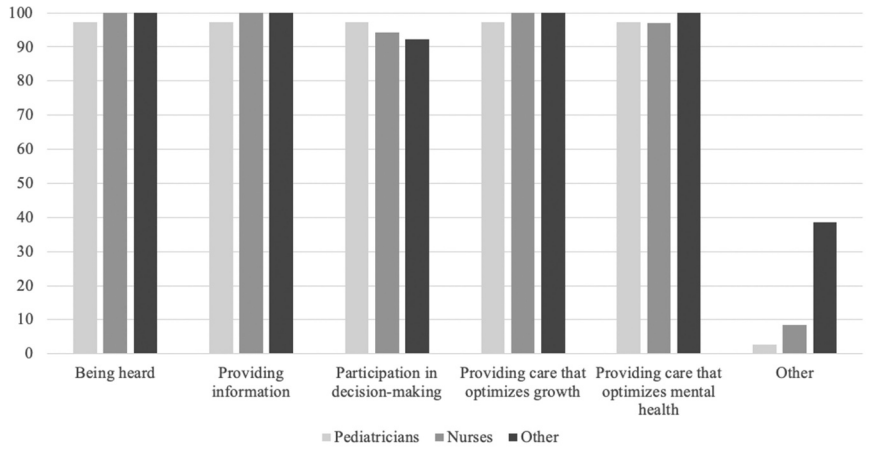

Figure 2. Overview of respondents' beliefs about the meaning of children's rights (total $n = 86$), by discipline group.

Beliefs about family-centered care

In response to the item: "To what degree does family-centered care inhibit the realization of children's rights in pediatrics?," participants reported that family-centered care inhibits children's rights, with a mean score of 3.16 (SD = 1.25). Between discipline groups, both nurses ($M = 4.77$, SD = 0.43) and "other" HCPs ($M = 4.77$, SD = 0.60) expressed greater concern about potential limitations of family-centered care for enacting children's rights, compared to pediatricians ($M = 4.61$, SD = 0.79).

Group comparisons

One-way ANOVAs were used to determine whether there were significant differences between groups according to profession and years of experience. If ANOVAs were statistically significant, the means for each group were examined to determine which two should be compared for the post-hoc analysis. Statistically significant differences are reported below. Comparisons between other variables (e.g., context of care – including acute, primary, post-acute care) did not reach significance and are not reported.

Profession and beliefs about children's rights

Results from a one-way ANOVA indicated that there was a significant difference in how participants from different professions believed family-centered care inhibited child rights ($F(2,83) = 7.263$, $p = .001$, ω2 = 0.13). Pediatricians were less likely to perceive family-centered care as limiting to children's rights, compared to nurses ($B = 1.03$, SE = 0.27, $p < .001$, 95% CI [0.48, 1.57]), and "other" HCPs ($B = 0.75$, SE = 0.38, $p = .049$, 95% CI [0.00, 1.50]). A one-way ANOVA revealed a significant difference between participants from different professions in the extent to which child rights showed up in their teams' care ($F(2, 83), = 3.242$, $p = .044$, $\omega^2 = 0.05$). Pediatricians were more likely to perceive that child rights showed up in how their team worked than nurses ($B = -0.44$, $SE = 0.17$, $p = .013$, 95% CI [−0.78, −0.09]).

Years of experience and beliefs about family-centered care

The degree to which participants believed that family-centered care can inhibit the realization of child rights was significantly associated with participant pediatric experience ($F(2,83) = 6.061$, $p = .003$, $\omega 2 = 0.11$). Namely, participants with over 20 years of experience were less likely to perceive family-centered care as limiting to children's rights compared to those with 5–20 years of experience ($B = 0.87$, SEE = 0.28, $p = .002$, 95% CI [0.32, 1.42]) and less than 5 years of experience ($B = 1.18$, SE = 0.47, $p = .014$, 95% CI [0.24, 2.12]).

Qualitative data

Among 86 HCPs, 77 (89.5% of total) responded to the two open-ended questions. Thematic analysis of this data supported the development of three main themes: (1) Perceptions of children's rights, (2), Barriers to integrating children's rights, and (3) Facilitators for promoting children's rights. Quotes that correspond to each theme are presented in Appendix 3.

Theme 1: perceptions of children's rights

The majority of HCPs equated children's rights to the interrelated acts of informing children "about their health/health choices," "informed decision-making," and "shared decision-making." Approaches to shared decision-making were predominantly guided by the role of caregivers and beliefs about children's age. For example, one clinical nurse specialist stated: "children's decisions regarding their health may be heavily influenced by their parents, rather than their own autonomous and informed decision making." As well, another HCP noted: "We are often focused on the rights of the parent(s) to have information and can forget to provide information to younger children."

In addition, children's rights were associated with providing children with choices to promote their sense of autonomy, as well as children's "right to be protected." However, despite describing several rights-based principles, HCPs' responses reflected limited awareness regarding the relevance and meaning of children's rights. For example, a nurse described: "inexperience/knowledge related to pediatric patients' needs and how to address/understand their rights."

Theme 2: barriers to integrating children's rights in pediatrics

Data revealed several barriers to upholding children's rights in pediatrics which were associated with HCPs, children, caregivers, and wider institutional and government contexts. Challenges experienced by HCPs mainly related to managing caregivers' perceived dominance in shared decision-making processes. Several respondents alluded to how "parents sometimes inhibit the child's right to information about their treatment" and how "we often allow parents to make all the decisions regardless of children's wishes."

HCPs also described uncertainties regarding how to involve young children and children with developmental disabilities in decision-making. A nurse practitioner noted challenges associated with "developmental disabilities that affect the child's comprehension, cognition and/or ability to communicate." In terms of children's age, another nurse practitioner stated: " . . . team members may think that the child is too young to have a voice."

Funding and staffing issues represented institutional barriers toward implementing children's rights, as noted by a child life specialist: "I believe a huge challenge in providing equitable care that promotes children's rights is

resource allocation. There are physically not enough staff to meet the needs of all children in the hospital in a timely or fair manner." Another HCP stated: "In France, there are not enough pediatricians and not enough GPs. People don't have easy access to healthcare and there are huge social inequities. This puts us all under an enormous strain."

Theme 3: facilitators for promoting children's rights

Strategies to promote the integration of children's rights in practice included directly communicating with children, providing children with choices, as well as educating and listening to children. By involving children in decision-making through choice-making, HCPs aimed to promote the ethical principle of children's "best interests." In addition, HCPs emphasized the value of educating children on healthcare-related matters. One pediatrician described: "explaining to them what is happening through simple speaking or playing and showing books or videos to inform them in a pleasant way, so they can be aware and better participate." However, challenges were also associated with educating children, in that "It's not always easy to find ways to present information to children."

Discussion

We explored interprofessional pediatric healthcare providers' (HCPs) perspectives on children's rights and their implementation in practice. We found that most HCPs followed a rights-informed approach to care but there was variation in how they operationalized strategies to promote children's rights in practice. Despite an overarching "shared" approach to decision-making across HCPs, caregivers were described as holding a prominent role in these processes and often represented "proxy" decision-makers. While the tensions associated with children's wishes being taken over by adults is not new (Coyne et al., 2014; Moore & Kirk, 2010), this approach can diminish children's autonomy under the guise of "protection." Many HCPs also equated younger age with diminished decision-making capacity. Moreover, only half of participants believed that children form part of interprofessional teams. These findings suggest that developmental (i.e., age-based) outlooks on children's capacities and agency continue to permeate pediatric practices. Developmental frameworks may not consider other elements that can shape children's evolving decision-making capacities, such as their social maturity and previous healthcare experiences (Koller & Wheelwright, 2020; Lansdown, 2005). The continued presence of developmentalist assumptions is likely shaped by the interplay of individual beliefs, prevailing team norms, and institutional guidelines and policies (Alshammari et al., 2025; Koller et al., 2024). Moving beyond age-based conceptualizations of children's decision-making capacities is important to involve *all* children in decision-making and

align with the increasing complexities that characterize contemporary pediatrics (Koller & Wheelwright, 2020) – at both individual and systemic levels.

We also identified that HCPs with over 20 years' experience, particularly pediatricians, were less likely to perceive family-centered care (FCC) as potentially limiting to the realization of children's rights compared to those with fewer years of experience. HCPs' commitment to FCC aligns with existing research (Dall'oglio et al., 2018) and may reflect a promising starting point for upholding children's rights. However, variations in respondents' perceptions of FCC suggest that ambiguity remains regarding how FCC is defined, enacted, and measured in healthcare institutions (Kuo et al., 2012). Compared to nurses, pediatricians' views of FCC as less constraining may reflect their training and realities of their clinical role. Both pediatrics and nursing formally endorse FCC as a core philosophy that guides care (e.g., American Academy of Pediatrics, 2012). However, nurses may be more preoccupied with the practical realities of enacting FCC, including negotiating with families, balancing children's and parents' perspectives, and working under institutional and time constraints. These elements could make nurses more attuned to potential challenges associated with realizing FCC, and in turn, children's rights (Coyne, 2015; Shields, 2015).

In addition, our findings build on our previous research exploring the role of interprofessional teamwork for enacting children's rights (Koller et al., 2024). Compared to nurses, pediatricians in our survey were more likely to perceive children's rights as being integrated in how interprofessional healthcare teams work together. Variations in respondents' perceptions of children's rights accentuate the complex nature of interprofessional teamwork, and how it can be understood and enacted in practice (Jayasuriya-Illesinghe et al., 2016; Reeves et al., 2011). Such variation may inform how team members can best work together to promote children's rights.

Since most respondents in this study were based in Canada, it is useful to situate discussions of children's rights in healthcare within a broader global context. In Canada, rights-based approaches to pediatric healthcare education and policy are becoming increasingly recognized. However, other countries, particularly Scandinavian countries, have more systematically embedded children's rights into organizational and legislative frameworks. Compared to Denmark and Sweden (Rasmusson et al., 2010), for example, Canada has been critiqued as slower to adopt comprehensive rights-based implementation across healthcare institutions. Recent rights-based rankings (UNICEF, 2025) ranked Canada 19th out of 36 high-income countries on child well-being – significantly behind many Scandinavian countries that consistently perform at the top of these indices.

Implications for practice

Our findings highlight that healthcare providers (HCPs) value creating explicit opportunities for involving children in shared decision-making that align with children's preferences and needs (Koller et al., 2024; Moore & Kirk, 2010). By using child-oriented strategies (e.g., offering children choices), the actions of HCPs can help to (re)position children as autonomous rights-holders (Koller, 2017, 2021). Family-centered approaches to care can facilitate stronger shared decision-making and the inclusion of children's perspectives alongside family members (Coyne et al., 2018). However, ambiguity remains on what specific actions constitute family-centered care and how this approach can best be implemented and measured in healthcare institutions (Kuo et al., 2012).

From a policy perspective, effective interprofessional team functioning can be enhanced when HCPs are aligned on their conception of "centeredness" (e.g., family-, child-, person-, and/or patient-centered) that guides care (Coyne et al., 2018; Koller et al., 2024). Moving beyond family-centered approaches toward child-centered care (CCC) promotes the active engagement of all children in their care. Through a CCC lens, a child is viewed as an autonomous individual with their own perspectives, needs, and wishes, whilst still being shaped by their interrelations with others (e.g., HCPs, caregivers) (Ford et al., 2018). The realization of CCC policies also requires systemic investments and adequate resources, such as funding and, in turn, staffing. Moreover, attention must be paid to power dynamics and hierarchies within clinical teams and across professional roles. Clear role delineation regarding key tasks and priorities is needed to support HCPs' collective responsibility for upholding children's rights in practice (Coyne, 2015).

Particularly in their qualitative responses, participants described advocacy-related strategies such as raising awareness of children's rights by educating and informing children, as well as confronting systemic inequities (e.g., staffing shortages, resource allocation). In addition to resolving barriers such as staffing shortages, more target interprofessional education and training is needed for HCPs. Such training should address the foundational principles of children's rights and the (collaborative) strategies that HCPs can use to enact these rights (Chapman et al., 2023; Koller et al., 2024; Thestrup et al., 2024). Placing emphasis on communication as a core competence of HCPs can help to inform strategies for building trust, engagement, and understanding for children and families (Davison et al., 2023; Koller, 2017; Thestrup et al., 2024).

Limitations

Despite the novel, international, and interprofessional nature of this survey, our study has limitations. An overarching limitation of our

study pertains to the use of a non-standardized survey instrument, as: (a) our study was exploratory in nature, and (b) no standardized survey instrument currently exists pertaining to this topic. To strengthen construct validity of the survey, survey items were development in alignment with established frameworks and principles related to children's rights and child-centered care. To enhance content validity, all core team members reviewed the survey items for clarity, length, and relevance (Boateng et al., 2018).

An additional limitation of our study pertains to the self-reported nature of the data, through which HCPs may have provided responses that they perceived to be more socially desirable. This limitation may have contributed to an overestimation of the extent to which children's rights are integrated in practice. In addition, a subset of the participants was recruited from the International Society for Social Pediatrics and Child Health (ISSOP) and were thus more likely to have a strong orientation toward children's rights, social pediatrics, and child advocacy.

Considering the anonymous nature of the study, we did not collect data on participant gender, age, race, or ethnicity. In turn, we cannot assess whether such demographic elements shaped the survey responses. We recommend that future research incorporates a wider variety of demographic variables to better understand potential differences in perspectives across diverse groups of HCPs, cultures, and contexts.

Conclusion

This exploratory study examined interprofessional pediatric healthcare providers' perspectives on children's rights, and their integration in clinical practice. Our findings suggest that the meaningful fulfillment of children's rights in healthcare remains challenging and complicated by provider- and institutional-level barriers. HCPs' professional background and years of experience influence how providers engage with children's rights. While many HCPs support a rights-based philosophy, barriers such as time constraints, caregiver influence, and policy-level challenges persist. Developmental issues involving the child's age continue to serve as an obstacle in recognizing the child as an autonomous being. Our social representation of what a child is capable of, appears to hinge on how old they are, which leaves younger children at a disadvantage. Targeted education, policy development, and interprofessional collaboration could attenuate gaps and strengthen the integration of children's rights in pediatrics. Promoting children's rights in pediatric settings can lead to the promise of equitable and ethical care for each and every child.

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Appendices

Appendix 1: Survey Questionnaire

Demographic Questions

1. What is your profession?
2. What pediatric care setting do you work in? (e.g., specialty, child age range)
3. How long have you worked in pediatrics?

Survey Questions

4. Who is part of your pediatric care team?
   □ Healthcare providers
   □ Caregivers, siblings, and guardians
   □ Extended family, friends, and community members
   □ Pediatric patients
   □ School staff
   Other:_____
5. In your view, to what degree do you believe that pediatric patients should be engaged in their care?
   (Not at all) □ 1 □ 2 □ 3 □ 4 □ 5 (Always)
6. In your practice, to what degree does family-centered care inhibit the realization of children's rights in pediatrics?
   (Not at all) □ 1 □ 2 □ 3 □ 4 □ 5 (Frequently)
7. To what degree do you believe that pediatric patients have rights in their healthcare?
   (Not at all) □ 1 □ 2 □ 3 □ 4 □ 5 (Always)
8. At what age do you believe pediatric patients have rights in their healthcare? (e.g., participation in decision making, sharing of healthcare information, etc.). Check all that apply:
Infants (0–1 year)
   □ Toddlers (2–3 years)
   □ Preschoolers (4–6 years)
   □ Middle school age (7–12 years)
   □ Adolescents (13–18 years)
9. In your opinion, children's rights in the context of their healthcare includes:
   □ The right to be heard
   □ The right to information
   □ The right to participate in healthcare decision-making
   □ The right to developmentally appropriate care that optimizes growth
   □ The right to psychosocial care that optimizes mental health
   Other:_____
10. To what degree do children's rights show up in how your team listens to and engages children in their own care?
   (Not at all) □ 1 □ 2 □ 3 □ 4 □ 5 (Always)
11. Could you provide an example of how your team promotes children's rights?
12. Could you describe any challenges related to how your team understands or makes decisions related to children's rights?

Appendix 2: Overview of survey categories and questions

Category	Question	Response Format
Demographic questions	1. What is your profession?	Open-ended
	2. What pediatric care setting do you work in?	Open-ended
	3. How long have you worked in pediatrics?	Open-ended
Survey questions	4. Who is part of your pediatric care team?	Categorical
	5. To what degree do you believe that pediatric patients should be engaged in their care?	5-point Likert scale
	6. In your practice, to what degree does family-centered care inhibit the realization of children's rights in pediatrics?	5-point Likert scale
	7. To what degree do you believe that pediatric patients have rights in their healthcare?	5-point Likert scale
	8. At what age do you believe pediatric patients have rights in their healthcare?	Categorical
	9. Children's rights in the context of their healthcare includes:	Categorical
	10. To what degree do children's rights show up in how your team listens to and engages children in their own care?	5-point Likert scale
	11. Could you provide an example of how your team promotes children's rights?	Open-ended
	12. Could you describe any challenges related to how your team understands or makes decisions related to children's rights?	Open-ended

Appendix 3: Examples of representative quotes within each theme

Theme	Representative Quote
Theme 1: Perceptions of Children's Rights	"In end-of-life care discussions, at the request of parents, only some information is shared to protect their child"
	"We provide privacy and confidentiality when it is appropriate to allow them to make choices about their care"
	"We generally discourage withholding information from children who are old enough to understand it."
Theme 2: Barriers to Upholding Children's Rights	"We do have a culture that strongly promotes parental rights, and whose perspective is that children are subservient to the parents. That larger culture would be our greatest barrier"
	"At times, we may perceive that a child's decisions regarding their health may be heavily influenced by their parents, rather than their own autonomous and informed decision making"
	"Challenging with developmental delay and lack of clarity on children's understanding/ability"
Theme 3: Facilitators for Promoting Children's Rights	"Promoting age-appropriate care that optimizes positive growth and development"
	"a very simple example is engaging the child in the conversation when developmentally able"
	"Providing age-appropriate education"