Module One: The Social Context of Children in Especially Difficult Circumstances (CEDC)

Background Document on

The Social Context of Children in Especially Difficult Circumstances (CEDC): Problems and Possible Actions

1. Introduction

Children are in especially difficult circumstances when their basic needs for food, shelter, education, medical care, or protection and security are not met.[1] Such children are at great risk of suffering malnutrition, disease and possibly death. Unless their own situation changes, their condition of gross disadvantage extends to their own children who may suffer even greater misery and suffering.

Disruptive social change is the principal cause of the growing numbers of children in difficult circumstances in developing countries and Eastern European countries. Rapid urbanization associated with socio-economic, cultural and political transformation has resulted in numerous negative changes, disrupting the family and its traditional support system and weakening community organizations. Many parents looking for non-existent jobs in the city end up poorer, with their children condemned to living in overcrowded slums and squalid environments. Likewise, children seeking work in cities of neighbouring or far away countries to support themselves and their families are exposed to abuse and exploitation by their employers and the majority remain poor. They are made to work hard and for long hours and generally lack access to educational and health care services. They are susceptible to malnutrition and disease and their lifespan is short.

The problem of CEDC is not confined to cities. In rural areas of many developing countries there are children who are victims of abject poverty, frequent drought and famine. These children remain largely invisible and need to be further studied and addressed. They include children of landless squatters and unemployed parents (especially poor single female heads of households) as well as children of nomadic parents in drought-stricken areas and those of ethnic minority groups. Their condition and environment prevents them from realizing normal growth and achieving their full potential. They too are perpetually vulnerable to malnutrition, disease and death.

Besides the categories identified above, other groups of children in especially difficult circumstances include children who live and work on the streets, abandoned and neglected children, orphans, battered children, children with disabilities, child workers, children in armed conflicts, child mothers (including child brides) and their children, displaced and refugee

[1]These groups of children are usually referred to as "children in especially difficult circumstances" (CEDC), "children in need of special protection" (CNSP), "children in distress", "children in crisis", "children in exceptionally difficult conditions", and so on. In this paper, CEDC is used since it is the most widely used term internationally. These children are, for shorter or longer periods in their lives, exposed to intense, multiple risks to their physical and mental health. A common characteristic of CEDC is that they lack proper adult care and protection, and that they lead their lives outside society.

children, children infected and affected by AIDS, children of imprisoned mothers, sexually abused children and sexually exploited children. All of these undergo various forms of deprivation, abuse or exploitation, and in most parts of the world, these categories of children are on the increase.

The Convention on the Rights of the Child, which is composed of 41 substantive articles, sets the standards for the rights of all children to survive, to develop, to be protected, and to participate fully in their family and society. These rights are all equally important and they must be seen in relation to each other in promoting a multi-disciplinary and cross-sectoral perspective.

The aim is to focus on the whole child, recognising the interrelationship between different rights and needs. In the case of children who live and work on the streets, sexually abused and sexually exploited children, for example, one must address many interrelated issues and not merely issues of separation from parents, adoption and family reunification (articles 9, 10, 18, 20, 21 and 27) and protection from sexual abuse and exploitation (articles 34, 35 and 36).

Other issues that must be addressed to successfully combat the problems facing these children include:

- Protection from discrimination (article 2);
- Allocation of resources (article 4);
- Right to life (article 6);
- Rights to name, nationality and identity (articles 7 and 8);
- Provision of health education and care (articles 17 and 24)
- Protection from physical and mental violence (article 19);
- Rights of disabled children to care and reintegration (article 23);
- Protection from economic exploitation (articles 28, 29, 31 and 32);
- Right to recreational activities (article 31);
- Protection from drugs (article 33);
- Right to liberty (articles 37 and 40); and
- Rehabilitation (article 39).

Almost all countries of the world have ratified the Convention on the Rights of the Child and by so doing have committed themselves to improve the welfare of their children. Indeed, many of the countries have made progress in reducing infant and child mortality as well as extending primary education to children. These developments however, do not apply to the rapidly growing numbers of children in especially difficult circumstances in the world. These children are on the fringe of social and health services available to help children.

2. Description of Selected Categories[2]

2.1. Sexually Abused Children

[2]Only three categories of CEDC, sexually abused children, sexually exploited children and 'street children', are dealt with in this section. It is important to note that these groupings of children are not exclusive from one another. A child that lives and works on the streets may also be sexually abused, a child engaged in prostitution, a child mother, a refugee, a child with disabilities, and so on.

Sexual abuse of children[3] can be defined as contacts or interactions between a child and an older or more knowledgeable child or adult (stranger, sibling, or person in positions of authority, such as parent or caretaker) when the child is being used as an object for the older child or adult's sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure. The two forms of sexual abuse that are considered in this report are rape, which is defined as any sexual behaviour imposed on a child by a stranger, and incest, defined as any sexual behaviour imposed on a child by a member of either the immediate or extended family. The extended family includes people whom the child or family has known for a significant length of time and whom they trust, such as fathers, stepfathers, uncles, siblings and other family members, as well as friends, neighbours, teachers, doctors and members of religious communities. Broadening the concept of incest beyond close blood relatives is very important. It helps underscore the special harm caused by any sexual activity between a person in a position of status, trust and authority, and a child in a position of dependency.

Sexual abuse can be physical, verbal or emotional, and includes:

- Physical sexual abuse: touching and fondling of the sexual portions of the child's body (genitals and anus) or touching the breasts of pubescent females, or the child's touching the sexual portions of a partner's body; sexual kissing and embraces; penetration, which includes penile, digital and object penetration of the vagina, mouth or anus; masturbating a child or forcing the child to masturbate the perpetrator.

- Verbal sexual abuse: sexual language that is inappropriate for the age of the child, used by the perpetrator to generate sexual excitement, including making lewd comments about the child's body and making obscene phone calls.

- Emotional sexual abuse: use of a child by a parent or adult to fill inappropriate emotional needs, thereby forcing the child to fulfil the role of a spouse.

- Exhibitionism and voyeurism: having a child pose, undress or perform in a sexual fashion on film or in person (exhibitionism); and "peeping" into bathrooms or bedrooms to spy on a child (voyeurism); exposing children to adult sexual activity or pornographic movies and photographs.

Though the incidence of sexual abuse is lower than of physical and emotional abuse and neglect, this does not diminish its importance. It is generally accepted that statistical data considering the reported cases of sexual abuse are significantly lower than the actual prevalence. Organizations that offer services to these children may have records of new cases that are reported to them. However, the data are largely documented in an unsystematic manner and reflect specific groups of victims. The police, for example, often only retain statistics on victims

[3] This definition is adapted by W. Kaime-Atterhog from: (a) W. Kaime-Atterhog, "Voices of sexually abused children who live on the streets of Nakuru, Kenya", unpublished report, Section for International Maternal and Child Health, Uppsala University, Sweden (1998); (b) D. Finkelhor, "Current information on the scope and nature of child sexual abuse, *The Future of Children,* vol. 4 (2): 31-53 (1994); and (c) National Centre on Child Abuse and Neglect, *Sexual Abuse of Children – Selected Readings,* Office of Human Development Services, US Department of Health and Human Services, DHHS Publication No. 78-30161 (1980), pp. 1-6.

who could not settle their case with the abuser. The figures recorded by hospitals reflect the numbers of victims who suffer from severe physical or emotional problems and require treatment. Lastly, social welfare officers may only have statistics of young victims who need social welfare assistance. In many cases, young victims and their families, out of shame or fear of banishment, do not disclose or report the abuse. In cases where sexual abuse is exposed, it is often not recorded as an agreement is made between the victim's parents and the offender, often with the involvement of officials. Many authorities on the subject report that the pressure on victims of sexual abuse to remain silent or to retract their stories is heavy, and threats of violence are not uncommon.

Figures of reported sexual abuse of children and youth in many countries show that the majority of the victims come from poor families, a finding that has led authorities to associate sexual abuse of children with social disadvantage. However, it is most likely that this is the result of the manner of disclosure, and the extent of sexual abuse among the more advantaged may be effectively concealed. In addition, children of all ages, including infants, are at risk. Rates of the reported cases of sexual abuse of children and youth are higher among girls; however, childcare professionals report that increasing numbers of boys are also sexually abused. In the majority of cases, the main form of abuse is genital intercourse.

The rape of a child by a stranger is the rarest form of sexual abuse. Young people are most at risk from those living with them, related to them or acquainted with them, such as fathers, stepfathers, uncles, older siblings, boyfriends, neighbours and caretakers.

Some of the common health problems affecting children who have been sexually abused that have been identified by health care professionals in some Asian countries include: depression, withdrawal, fear, anxiety, vaginal discharge, painful genitalia and pregnancy. Some children also experience psychiatric problems, including running away from home and post-traumatic stress disorder.

There are few programmes in developing countries that address the issue of child sexual abuse. In developed countries, there has been a major thrust of child maltreatment prevention efforts in the last two decades. At the primary level of prevention, programmes have aimed at educating children of all ages about sexual abuse and its effects, providing them with a sense of empowerment and teaching them how to recognise a situation of potential abuse, to protect themselves and what to do if they experience actual or potential abuse. Many of these programmes are school-based and, although they may differ in the way they are presented, they appear to have certain common areas, namely: 1) learning touch distinctions (i.e. good touch/bad touch; green light touches/red light touches); 2) learning rules about touching; 3) learning children's rights and body boundaries; 4) learning about private parts; 5) learning skills for avoiding abuse, including saying 'no', screaming for help, running away; 6) knowing the difference between 'good secrets' and 'bad secrets'; 7) realising the idea that sexual abuse is never the child's fault; and 8) knowing the need and ways to report abuse. The minimum requirements for a school-based prevention programme have been summarised as the 'four Rs', including training in remembering, recognising, resisting and reporting. These forms of preventive programmes have been criticised for placing much of the responsibility for avoiding sexual abuse on children. Since many have not been evaluated, it is difficult to determine their effectiveness.

Secondary prevention programmes target children at high risk and encourage them to disclose attempted or on-going sexual abuse and intervening early. In developed countries

school-based programmes have also served this objective. In addition, these programmes also focus on teachers and parents to inform them about appropriate ways of reacting to disclosures.

In the line of tertiary prevention, there are various therapeutic services for victims which help them break the pattern of abuse, diminish its consequences on the child and other family members, protect the victim from future abuse and prevent them from becoming abusers.

Little research has been conducted to date on the sexual abuse of children and youth in developing countries and the little data that is available is fraught with serious methodological problems. Sexual abuse is an extremely sensitive issue and one that is not easily solved owing to a traditional reluctance to intervene directly with other people's family life.

2.2. Sexually Exploited Children

Commercial sexual exploitation of children is defined by the United Nations as the use of a child for sexual purposes in exchange for cash or in-kind favours between the customer, intermediary or agent and others who profit from the trade in children for these purposes (parent, family member, procurer, teacher etc).

There are three forms of commercial sexual exploitation of children, which have already been defined by the United Nations: child prostitution, trafficking and sale of children across borders and within countries for sexual purposes and pornography.

Child prostitution is the act of engaging or offering the services of a child to a person to perform sexual acts for money or other consideration with that person or any other person.

Trafficking and sale of children across borders and within countries for sexual purposes is the transfer of a child from one party to another for whatever purpose in exchange for financial consideration or other rewards. Sexual trafficking is the profitable business of transporting children for commercial sexual purposes. It can be across borders or within countries, across state lines, from city to city, or from rural to urban centres.

Child pornography is visual or audio material, which uses children in a sexual context. It consists of the visual depiction of a child engaged in explicit sexual conduct, real or stimulated, or the lewd exhibition of the genitals intended for the sexual gratification of the user, and involves production, distribution and/or use of such material.

There is no accurate data on the number of children that are sexually exploited but available information from various studies carried out in different countries indicate that the problem exists and that it is growing in magnitude. The actual number of sexually exploited children is also difficult to determine with accuracy because many of the sex establishments engaging them are concealed. Children working in the commercial sex sector in many developing countries are known to lie about their true age and often have fake identity cards. In many countries, the commercial sexual exploitation of children takes the form of prostitution and trafficking within and across borders for the purposes of prostitution. Pornography is not reported to be a serious problem.

While all children, especially girls, are at risk of sexual exploitation, those living in poverty, those who have been abandoned or abused, children who live and work on the streets, domestic

servants, the disabled, refugees and others affected by armed conflict are much more vulnerable. Sexually exploited children are often categorised on the basis of the structure within which they operate as this affects the degree of mobility and control over their lives, their earnings and their amenities. Children are often engaged in prostitution as street walkers, brothel prostitutes, bar and hotel waitresses or dancers, massage parlor attendants, theater or cinema ushers, temple prostitutes, school children and so on. While the majority of the children work independently, some work in establishments operated by adults. In many developing countries, the consumers of child sex are noted to be local men. While sex tourism does exist, observers note that it does not account for the vast majority of children brought into the sex trade because of local demand.

Commercial sexual exploitation endangers children's mental and physical health and impairs their development. The most common physical health problems are related to injury resulting from accidents and physical conditions in the working environment, long working hours, lack of sleep and substance use. The common symptoms of psychosocial disorders manifested by many of the children engaged in commercial sex are severe depression, guilt, powerlessness, deflated self-esteem and self love, escapism through dissociation, distorted perceptions of sex, inability to trust others, excessive emotional attachment, multiple phobias, loneliness, isolation, impaired ability to learn, poor memory and concentration span.

A number of actions have emerged at the national and local levels to prevent or combat the commercial sexual exploitation of children in developing countries. However, these activities remain limited and not well established at the community level. Primary prevention programmes focus on awareness creation regarding the causes, the exploiters and methods of recruitment, the effects on the children and appropriate ways of intervening. A handful of projects act as 'community watchdogs' and intervene in communities to prevent children at risk from being recruited. Yet, other programmes focus on health outreach, rescue and provision of treatment and care to those already trapped in the commercial sex industry. Health outreach programmes focus on HIV/AIDS education, counselling, first aid and provision of food to those engaged in prostitution on the streets. Mobile medical units are not yet developed and most children's medical needs are cared for at conventional health centres. Children at residential rehabilitation centres often have easy access to health care services. Treatment and rehabilitation programmes are provided largely by NGOs in most countries. However, due to their small size and limited budget, the numbers of children reached with services is often a fraction of those needing care. In some cases, full rehabilitation can be hindered by the severity of the effects of commercial sex work. The other factor is extremely negative attitudes towards children in prostitution in many countries of the world.

Few systematic studies have been undertaken with a view to understanding the phenomenon and evolving strategies to prevent and combat sexual exploitation of children based on that knowledge. Moreover, caregivers have not received adequate training to enable them to address the needs of the victims of sexual exploitation and their families. This means that care is often provided on a trial and error basis.

2.3 'Street Children'

The term 'street children' was introduced in the 1980s to refer to children who live or spend significant amount of time on the streets of urban areas to fend for themselves and/or their families through 'various occupations'. This also denotes children who are inadequately protected, supervised and cared for by responsible adults.

UNICEF makes a distinction between children *on* the streets and children *of* the streets. Children *of* the streets consists of boys and girls who see the street as their home. They may still have some family ties but seek shelter, food and a sense of family among their companions on the streets or they may have completely broken ties with their families and literally live on the streets. Often they have been abandoned by their parents, are orphans or runaways from neglectful or abusive families. Increasingly, this group includes children affected by war and AIDS orphans. The second group, children *on* the streets, includes those who still have family connections. They live at home, often in more than shacks, sometimes even attend school, but are sent to the streets by parents or go of their own accord to supplement the family income.

While concentrating on the children found on the streets, in his 1989 study in Rio de Janeiro, Brazil, Mark Lusk differentiated four main categories of the children:

- Family-based street workers;
- Independent street workers who have tenuous ties with their families and occasionally sleep on the streets;
- Children who live on the streets and have no contact with their families (children of the streets); and
- Children of street families (cited by Rizzini and others, 1994).

Apart from the abandoned or orphaned children who may become 'street children' immediately in their lives, the first two categories can also be gradual stages that one goes through to become a 'child of the streets'. Since they are already 'on the street', they should not be considered as potential 'street children'. The last category (d) seems to be where a second generation of 'street children' emerges from, as Onyango et al. (1991) concluded.

In the 1990s, some researchers have preferred to use the term 'working children' to refer to children who are generally found on the streets during the day, but who go home to sleep at night (children *on* the streets) and 'street children' to refer to those children to whom the street is their home (children *of* the streets). The term 'working children' is used since most of them have street jobs (Rizzini and others, 1994). In an attempt to avoid confusion, Rizzini and others (1994) clarified that this was not suggesting that 'street children' never work nor did all working children actually work.

Others such as Blanc et al. (1994) have argued that "real" 'street children' are those that live on their own on the streets and according to their definition, 'street children' are the roofless and rootless who live alone or with children like themselves.

From the available literature, it can be deduced that the definition of 'street children' is problematic and research has yet to unveil the various categories or sub-groups of children that fall under the general group of 'street children' in different cultural contexts. In this paper, the term 'street children' is not used as it is seen by the author as defining children by the circumstances that have negatively affected them instead of recognising that they are victims of socially deficient structures and social policies. Moreover, labelling is disliked by the children themselves because it reinforces negative social attitudes towards them. The author prefers the use of the term children who live and work on the streets as this puts children first, before the circumstances that affect them. Thus, in this paper, the term children who live and work on the

streets is used to describe children who work on the streets during the day and return home at night as well as those to whom the street is home.

Depending on the definition used, estimates of the numbers of children involved range from 10 to 100 million. The majority of these children are believed to be in developing countries, with 40 million in Latin America, 23-30 million in Asia and 10 million in Africa. Accurate data on the number of children involved in specific countries is largely lacking. However, Blanc and others (1994) argue that the *real* 'street children', namely, those children to whom the street is their home, are of relatively small numbers and represent a manageable problem. They estimated that in larger cities where the phenomenon of children who live and work on the streets is common, the numbers of children who literary live on the streets generally range from 1,000 to at most 3,000.

Street life has been taken as a domain of male children, who are believed to constitute 71 percent to 91 percent of all children who live and work on the streets, but the number of girls appears to be increasing.[4] In many countries, girls are reported to enter street life much later than boys. Girls are more likely to have worked as domestic servants and undergone various levels of abusive situations prior to turning to the streets. The street environment is particularly harsh for girls and many provide sexual favours to street boys for protection. The majority of the children who live and work on the streets fall in the 5-16 age-range and are expected to fend for themselves while others support their families as well.

Most children who live and work on the streets come from very poor parents who live in urban slum neighbourhoods, peri-urban areas, far away rural areas or they may also be living on the streets. Most of these parents are landless, unemployed or else engaged in unstable and unreliable income earning activities such as prostitution, unlicensed hawking, or brewing and selling of illegal alcohol. Not all studies, however, point to poverty as the main cause pushing children to the streets. In Uganda, for example, a survey carried out by a non-governmental organisation revealed that most children who live and work on the streets had been abused by their step-mothers (Redd Barna, 1996). In Kenya, Wainaina (1997) also found that most of the children are on the street due to family related problems. He further argues that most of them come from a family background of physical, emotional and/or sexual abuse. Although these findings point to family dysfunction and disintegration as the major reasons why children end up on the streets, it should be noted that most of these family problems are aggravated by poverty.

Day-to-day survival is the primary objective for most of the children who live and work on the streets and almost all their activities in the streets are in one way or another considered illegal particularly by law enforcers (Van Beers, 1996). From an analysis done on studies of children who live and work on the streets in Kenya, Nigeria and Zimbabwe, Ojwang (1996) identified the following specific activities of children in the streets: (a) spending long hours in the streets begging for money, food and other things; (b) selling small-scale merchandise in the streets to pedestrians and motorists; (c) directing motor vehicles into and out of parking in return for a tip; (d) watching over vehicles against interference or theft in return for a tip; (e) loitering along the streets for purposes of prostitution; (f) selling drugs and other illicit goods in the streets; and (g)

[4]It is important to mention from the very outset that most studies on children who live and work on the streets have focused on the 'visible' children on and of the streets, namely boys. Despite this clear gender imbalance in the data collected, the term children who live and work on the streets continues to be used in much of the available literature, and indeed in this report, as referring to both girls and boys.

engaging in petty crime such as picking pockets, snatching necklaces and handbags in the streets. The list is no way exhaustive since children who live and work on the streets will engage in any activity that would help them to earn a living. Other activities that children who live and work on the streets are known to undertake are touting, collecting papers or scavenging from garbage dumps or bins, shoe shining and acting as guides for blind beggars. The few studies that have been carried out on street girls show that their activities are limited to begging and prostitution.

Children who live and work on the streets are especially vulnerable to mental disorders and disease because life on the streets is unprotected and involves greater exposure to impairment of attachment, unsanitary living and working environments, drug abuse, prostitution (with high exposure to sexually transmitted diseases and HIV/AIDS), infectious diseases, malnutrition, accidents and, more recently, violence. They have limited access to health care services than other urban dwellers and their diseases go untended until they become severe. Consequently, mortality is high among them.

Much of the work in developing countries has focused primarily on preventing children from ending up on the streets and rehabilitation of those who leave the streets. Children who are still living with their families will often turn to community or neighbourhood health facilities when ill, while children who have left street life and are undergoing rehabilitation are provided with basic welfare services including food, shelter, health care, counseling, functional literacy and vocational training within or outside the rehabilitation centres. There are relatively few programmes that address the health problems of those children that literary live on the streets. In some countries, street educators provide first aid to these 'hard-to-reach' children and refer serious cases to hospitals and health centres. But in general, these children lack access to health education and professional care and when they get sick they remain that way or seek care when the conditions become serious. It is important that efforts to improve the lives of children who live and work on the streets also take into account their health needs while they are still on the streets.

The lives of these children exemplifies the resilience, creativity, independence and survival drive of children living in difficult circumstances. This freedom and independence also means that children who live and work on the streets are difficult to be reached by traditional support programmes. They view health and social services as unfriendly, threatening and unhelpful. Many of the children aspire to obtain education, jobs, reunite with families and establish their own families and homes. The programmes that have had a great degree of success in working with children who live and work on the streets, are those that aim at strengthening their ability to cope and a sense of their own value as well as providing services in the areas of education, vocational training, housing and health care. These programmes first make contact with these children living and working on the streets through drop-in centers where children are provided with, for example, food, clothing, shower facilities and health care. A relationship of trust may be established during these contacts giving children the courage to talk about their problems. Children themselves decide when they are ready to leave the streets and begin a new life.

Research on children who live and work on the streets has focused on runaways and street life, victimization, legal considerations and attempts at rehabilitation. Research on health aspects, particularly of children who become pregnant through their street activities, and care of the newborn children is lacking. Similarly, data on the health seeking behavior of these children is not available. Programmes and research, so far, have primarily focused on urban areas, where the

problem is most visible, and children in small towns and rural areas remain unreached. Without data, it is impossible to formulate and plan realistic and well-targeted policies and interventions.

3. Strategies for Prevention

Child sexual abuse, sexual exploitation, problems of children who live and work on the streets, children with disabilities, refugees and displaced children, child mothers and so on are community health problems and, thus, prevention efforts must be initiated at the local level. Before presenting the strategies for prevention at the primary, secondary and tertiary levels it is necessary to first define the term 'health'.

3.1. Definition of the Term 'Health'

The World Health Organisation (WHO) defines health as "... *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*". This definition has received strong criticism for various reasons. It is believed to be a static definition that does not allow for development or change in an individual's state of health. Furthermore, Köhler and Jakobsson (1987) argue that the WHO definition of 1946 is inhuman and unfair in that it does not allow, for example, handicapped people to be considered healthy. They further note that the definition is also utopian, since hardly anyone can attain an absolute state of physical, mental and social well-being; and the definition says that social maladjustment is synonymous with ill-health and therefore should be treated medically, for example, with psychiatric care. Their final objection is that the definition makes the health services seem capable of solving every human problem, whether it is a sore throat, grief, loneliness or unemployment. According to Köhler and Jakobsson, this entails bringing medicine into every facet of life, and may lead to a 'health imperialism', which frightens many. Köhler and Jakobsson observe that many people prefer a dynamic health concept which is associated with the individual's own situation and implies that the person is able to cope with the demands which life makes. Despite this strong opposition, the WHO definition of health continues to be widely used, as its critics have not been able to find another all-encompassing definition. For lack of another comprehensive definition, the WHO definition of health is used in this report.

It is important to remember that although health is frequently equated in the minds of most people with physical well-being or the absence of physical disease, the WHO concept of health is far wider than that and includes two other dimensions that are often forgotten, mental and social well-being. Mental well-being, or stability within the mind, allows a person to be at ease within herself or himself and to cope with the changing world in which we live. Many people consider spirituality and emotional well-being including self-esteem, family attachment, feelings of love, and acceptance as important or even essential ingredients in this concept of mental well-being. The social dimension of health, on the other hand, includes knowledge and capacities that are needed to live successfully within a social context such as literacy, numeracy, vocational education, a sense of group identity and ability to cooperate with others. All these three dimensions of health are interlinked and influence each other.

The term 'health' also applies to the environment in which people live. Destruction and pollution of the environment results in contamination of food, water and air, which have a negative bearing on the health of the persons that inhabit that environment.

3.2 Prevention Strategies

NGOs and religious groups have spearheaded activities related to CEDC in most developing countries. They have been very successful in assisting the poor, supporting informal schools, assisting poor children in formal schools, improving shelter facilities, expanding child health and nutritional services (including feeding programmes), promoting skills development and credit facilities for income-generating activities, constructing and maintaining children's homes and educating disabled and other disadvantaged children. However, due to their limited capacity, they are unable to initiate such activities on a wide scale and include a comprehensive set of services. Competition for limited funds also makes it difficult for them to cooperate among themselves.[5]

The governments through the Children's Departments also manage a limited number of programmes, which include approved schools, feeding programmes, children's homes, borstal institutions, juvenile remand homes, bursary schemes, rehabilitation and vocational training and skills development programmes. In many countries, government programmes are seen to have had less success compared to those implemented by NGOs. Many poor people, particularly women and CEDC remain unaware of the existence of government schemes and programmes.[6] As a result some NGOs and women groups have taken the initiative to inform the public of government resources available under various programmes.

Despite a relative profusion of programmes, the number of children in especially difficult circumstances continues to increase at such an alarming rate that existing efforts provide merely a token response to the problem. Ultimately, the goals of children programmes should aim at promoting a safe and healthy environment in which all children can grow without fear of becoming a child in especially difficult circumstances (primary prevention); identifying vulnerable groups of children and preventing them from being forced into difficult circumstances (secondary prevention); and providing support and treatment to those who are already in difficult circumstances in order to reduce harm (tertiary prevention). In many developing countries, most programmes specifically addressing CEDC focus on tertiary prevention. Programmes for primary and secondary prevention must necessarily deal with larger underlying social, cultural and economic problems, which are usually viewed, in the context of general economic and social development programmes. The basic services approach is particularly effective for primary and secondary prevention, and should be an integral part of comprehensive CEDC programmes. Although the mix of programme objectives and strategies will vary from country to country, underneath are some general strategies for prevention and service improvement that are relevant for most developing countries.

3.3.1. Strategies for Primary and Secondary Prevention

Primary and secondary preventive measures must address underlying problems such as basic needs, family instability, socio-economic inequity, communal conflicts, environmental degradation, and poverty.[7] However, within the broad framework of overall socio-economic

[5]The fight against AIDS has changed this to some extent and many NGOs have realized the need to cooperate if they are to meet the various needs of those seeking care.

[6] Many CEDC may be aware of these programmes and may even have enrolled in a number of them at one time. However, they may view them as threatening and staff members insensitive and unhelpful.

[7]It has been argued that since poverty is a structural problem, the major responsibility for its resolution lies with government agencies. However, many people view NGOs as having had considerable success in improving the

development that is needed, there are specific strategies and actions that most directly affect the situation of children. Education and child services are important, as are measures that enhance the welfare and stability of families with children. Strengthening legal measures and raising public awareness of children's rights creates an environment for protection of the most vulnerable children.

Supportive legal framework and policies

Only the government has the mandate and capacity to create and alter laws and policies and provide overall coordination of national programmes. It is crucial that the government establishes a supportive legal framework and policies to facilitate the work for children at all levels.

Promotion of Universal Basic Education

Children who continue in school until completion of a basic education at age 14 or 15 are much less likely to be lured into exploitative work or situations where they are abused, at least while regularly attending school. They also have the school social network to fall back on if difficulties do arise. Therefore expanding education facilities and extending free and compulsory education to all children between 6 and 15 years of age is an extremely effective strategy for prevention of the most exploitative types of child labor and much of the problem of children who live and work on the streets. Advocacy for universal basic education is needed, both to expand resources and personnel in the education sector, and to get the support of parents in this effort.

Other aspects of education that need attention are: excessively uniform curricula, inflexible schedules, location of schools mainly in better off areas, and the high cost of education. All of these discourage participation by less privileged groups, and lead to a high drop-out rate, It is particularly important for less developed countries to recognize the inevitability of some work for most children. Therefore, schooling should be available which allows children to continue working, but still have an opportunity to study and a curriculum that is interesting and practical in relation to life and work. The underprivileged children's educational programme in Bangladesh is an example of such a programme.

Community-based child and youth services

Proper nutrition, mother and child health care and early childhood mental stimulation are also fundamental primary and secondary preventive measures. Programmes addressing these problems prevent or reduce disability, enable children in otherwise deprived conditions to overcome their situation, to compete effectively in school, work or sports, and, most importantly, develop a higher self esteem. Programmes of this type help to break the inter-generational transmission of poverty and ignorance, which underlies much of the exploitation and abuse of children.

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living standards of the poor. The experience of organizations working with the poor reveals that once the poor understand their conditions, they no longer consider mere economic improvement sufficient. NGOs, therefore, may not help people to escape from poverty but they do remove some of the worst forms, enabling people to focus better on the next stage of the struggle to improve their lives.

A good system of primary health care, home-based day care in poor areas, and preschools, can go far in preventing problems for disadvantaged children later on. Community-based study halls, sports facilities and youth centers keep young people off the streets and are also effective long-term preventive measures. Urban and area basic services programmes in many developing countries have already demonstrated that such services can be provided within the combined means of the government, NGOs and poor communities, if a basic services strategy is used.

Increasing family stability

Family stability cannot be tackled directly, but it can be indirectly influenced, through education, raising public awareness, and counseling and support of families at risk. Interventions in this area require a thorough and sensitive qualitative analysis of all aspects of the family in local cultural contexts. Even within the same country there may be many variations that need to be taken into consideration in trying to promote family stability. Here again, community-based strategies are most likely to be effective. Nearly every community has traditional advisers or counselors on cultural and family matters. It would be wise to begin by supporting such traditional systems, unless they are clearly detrimental to the children. Even in such cases, the training and reorientation of traditional elders and cultural leaders at the community level is likely to be more effective, and less expensive, than attempting to develop corps of professional family counselors. Several countries have incorporated family life education in both the formal and informal education curriculum. While considerable progress has been made, much remains to be done. Most developed countries also have been negligent in promoting and protecting family stability, and only recently several have begun to give this more attention. This is clearly an area where countries at all levels of development have much to learn from each other.

In some respects, the strength of family traditions in most Asian and African cultures has cushioned the shock of rapid industrialization and urbanization and declining economic growth respectively. On the other hand, the extended family in Africa, which serves as the social security system, is on the decline. In Asia, the near total autonomy of families in rearing of children has suppressed exposure of intra family child abuse and prevented public intervention.

Children as a "Zone of Peace"

Every effort must be made to prevent children from becoming victims and combatants in armed conflicts. In the 1980s, the idea was advanced that children should be considered as a "Zone of Peace".[8] This means that armed conflicts should not use children as combatants, target children for attacks or terrorism, or intentionally interrupt or destroy facilities and services for children. This concept has been effectively used to temporarily suspend hostilities to permit immunization campaigns, and to bring international pressure to bear on all sides in armed conflicts. However, it has done little to reduce the numbers of abandoned and refugee children and the psychological trauma that are the inevitable result of armed conflict. Only the prevention of armed conflict itself can eliminate these problems.

3.3.2. Strategies for Tertiary Prevention

[8]This concept was first formulated in 1983 by Nils Thedin of Sweden in a proposal to UNICEF. It has since then been used in El Salvador in 1985 to vaccinate 250,000 children during three days of intensive work, in Uganda in 1986, in Lebanon in 1987, in Afghanistan from 1988 to 1989 and in Sudan from 1989 to 1995.

A key element in tertiary prevention is the availability and accessibility of counselling, treatment and rehabilitation services for physical, mental and social problems. Treatment and rehabilitation can focus on the individual, family or community and can be carried out in an institutional setting or on an outreach basis. Services that treat children are largely in the health and social sectors and have a great variation.

Non-institutionalized care as a first step

Traditionally, governments and religious organizations have established welfare homes providing complete residential care and schooling for various categories of CEDC. Critics have argued that this strategy is costly and the resources available limited. As a result of lack of resources, such institutions seldom have adequate professional staff, and are often poorly equipped, furnished and maintained. Residential care institutions have also been accused of seeking to perpetuate themselves and expand their operations as much as possible. Therefore, they may not be diligent in trying to reunite children with their families, especially if it is difficult to find parents or they need counseling and support in order to properly care for the child. Such institutions are also seen to tend to regiment children and not allow them to leave the institution, and, in the worst cases, they can become a kind of prison for children. Even the better public institutions, it is believed, do not have enough personnel or flexibility to provide individualized guidance and care for children.

Services for children in difficult circumstances need not be provided in a fully controlled residential institution. Examples of non-institutional services exist in many Asian and Latin American countries, but they are usually small NGO projects or local community initiatives. Drop-in centers for children who live and work on the streets in the Philippines, mobile crèches for children of women construction workers in India, mobile health clinics in Brazil, the underprivileged children's education programme in Bangladesh and Nepal, youth centers providing hot meals, a place for bathing and temporary accommodation in Thailand, feeding programmes for refugee families in Angola are a few examples of non-institutionalized services that can be provided.

The advantage of such non-institutionalized services are that they are cheaper and permit children freedom to continue with work and maintain contact with families, friends and other support networks in their own community. This also permits children to make their own decisions and choose their own way of life, seeking guidance and help when they feel they need it. Because such limited services are cheaper, they can be extended to a much larger group of children, or this can free resources for other CEDC programmes.

The main objective of the non-institutionalised programmes mentioned above is to reach many children with services, including employment alternatives, but give them the opportunity to decide when they are ready to leave their current lifestyle. It should be borne in mind, however, that there are children for whom institutional care is necessary, at least for an initial period to prepare them physically, socially, emotionally and psychologically to be (re)integrated into society. The approach that is selected depends on the careful examination of the child and his or her family and community.

Health outreach as an example of non-institutionalised care

Ill health is the natural product of life on the streets, in refugee camps or in prostitution.

Unfortunately, the pressures imposed by street, work, and brothel or bar life make health a very low priority. By and large, many CEDC do not use mainstream services or come later when help is more difficult. The discriminatory treatment of health care providers, who do not see these as being entitled to use their services, serves to further alienate the children from the health care system. Their experience is often a negative one, and word of mouth keeps them and other children away. As a result, health care for these children ends up being poor and fragmented. Furthermore, the provision of information, education and communication to CEDC in general is rarely linked with the health services locally available. Health services, therefore, need to be accessible to these children who may be living outside of mainstream society to promote health, and especially to intercept problems at an early stage for human, health and economic reasons.

Outreach work - locating services where the hidden population can be found - is necessary in order to engage the children and link them to health services while providing them with education and raising their expectations. In much of the world today, many CEDC lack specific information about how to make use of existing services. They often do not know what is available, where it is, how to use it, what will happen when they get there, what it will cost, whether it is confidential, private or painful, what will follow and, perhaps most important, whether they will be welcome. Underneath are some of the few areas where health promotional activities may benefit these children.

Health surveillance: Opportunistic screening for conditions such as chronic bronchitis, dental caries, poor hearing, poor visual acuity, indigestion, feet and skin problems as well as vaginal tract infections are likely to reveal problems that can be prevented or treated at an early stage. This is likely to improve the quality of life of these children.

Immunisation: It is important to ensure that CEDC (and their offsprings) are up to date with their immunisations, in particular tetanus.

Enhancing knowledge: CEDC in many countries are not provided with adequate knowledge about their own development, especially in regard to sexuality. They need appropriate knowledge about growth and changes in puberty. Children living on the streets, children with disabilities, refugee and displaced children and others need to know how to protect themselves from sexual abuse and sexual exploitation and how to prevent pregnancy, STDs and HIV/AIDS. They should be counselled about safer sexual practices and condoms made available to those that are sexually active. Information on how to protect themselves against illness and injury including the consequences of tobacco, drugs and alcohol should also be communicated to them. It is also important for the educators and counsellors to discuss issues such as rest, nutrition (in particular food hygiene and safety), personal hygiene and personal safety with the children. It is well recognised that information, education and communication (IEC) and counselling can lead to a change in behaviour, transforming both the beneficiaries of such services as well as the service providers.

Enhancing life skills: CEDC need to develop their capacity to communicate and make plans and decisions. This will entail teaching children ways of communicating, expressing their feelings and working with others. It is equally important for educators to also teach children practical skills like first aid as well as thinking of ways of how to solve problems. Good attitudes are very closely linked to life skills and thus educators should teach the children the skill of listening to other people as a sign of showing respect. Good attitudes, however, are not only required of CEDC. Educators too must learn how to listen to the children as a sign of showing respect. Giving

children an opportunity to talk about their emotions without fear of being censured gives them the self-esteem to know their feelings do matter.

For CEDC to be able to protect their health, a friendly environment in which information, counselling and other services are provided in a confidential manner by people whom they trust and who are empathetic to their needs is necessary. Peer education and counselling are two ways of assisting these children to participate, contribute and assume responsibility while obtaining the information they need. In some countries, peers are used as effective outreach as they are more likely not to reprimand the children for their questions. To do this well, however, requires a partnership with adult care providers, initially, to help obtain and provide sound information from reliable sources, and for support to the children providing such help, since they may be faced with situations, which require more than straightforward information. Peer counselling is harder to achieve, since it requires special training in counselling and psychological skills, adequate knowledge of the needs of specific groups of CEDC, ways to meet these needs and how to know when to refer to others. This requires training, supervision and above all, continuing support, since it can be a stressful and very demanding task. Health care providers would also benefit from training on how to reach CEDC and how to meet their special needs.

Direct services through NGOs and Governments

CEDC require individualized attention to determine the exact nature of their problems, and what family or other ties they may still have which should be taken into consideration. They frequently have psychological problems and each child needs to be dealt with on a case-by-case basis. Government agencies are, by their very nature, bureaucratic structures for providing standardized and routine services. Therefore, it is not surprising that NGOs are often more effective in providing the individualized services that these children need. NGOs do however have a number of problems and weaknesses. Usually they have limited and very unstable funding since they depend on voluntary contributions. They naturally try to select those types of children and situations with high visibility and high appeal for fund raising. This may often cause excessive concentrations of services in urban areas and for some types of children and leave other children and small towns and rural areas with little support. Because of the large number, small size and varying methods and quality of NGOs, the governments are often reluctant to channel resources through them without excessive controls.

Considering these factors, the optimum system would be to rely more on NGOs for direct services to children, but within a framework of governmental regulation and sustained financial support. Several countries have evolved systems of this nature, which seem to work relatively well with social welfare councils for children or children's committees being the link between the government and NGOs. The government can also play a strong role in direct service provision channeling funds for services to NGOs, by regulating and registering NGOs, and by facilitating coordination among government service agencies and NGOs. In Zimbabwe, where the government and NGOs work closely in addressing CEDC issues, NGOs are encouraged and supported to develop and initiate programmes but they are required to hand over these projects to the government once they are well established and stable (personal communication, 1999 CEDC Course participant). There is likely to be a continuous source of tension between governments and NGOs, but it is a healthy tension, if the government remains primarily a facilitator.

Linking CEDC and Community Services

Linkages between CEDC services and existing community organizations and service systems helps to mobilize community resources, helps coordinate implementation and assures that they are well adapted to local conditions. In many countries CEDC and basic services programmes, focusing mainly on primary health care, education, housing, justice, and income-generating skills, have been linked from the outset. Indeed, CEDC programmes have largely grown out of efforts to serve the most deprived working and children who live and work on the streets in urban basic service programmes. In some countries the reverse has happened. Tracing the families of children who live and work on the streets has led to the identification of particular communities where basic service programmes were introduced as preventive measures.

Using community volunteers and non-professionals

Although professional social workers, psychologists and administrators are needed in CEDC programmes, there is not enough professionals nor money to pay them. Indeed, the most effective workers with CEDC are those people who have faced such difficulties themselves and overcome them. Former children who live and work on the streets are the best street educators; former refugees are more sensitive to the psychological trauma suffered by refugee children; and respected neighbors and community leaders may be the most effective and accepted counselors for a family with abused or neglected children. Many volunteers and non-professionals can be supported at the same cost as one professional. Professionals should be used strategically in training, supervision, and handling referrals of the most difficult cases. In this way, the quality of programmes can be maintained, while a much larger number of children can be served by dedicated volunteers and non-professional staff.

4. Conclusions

The year 1990 witnessed some extraordinary events at the global level concerning the rights of the child. The United Nations Convention on the Rights of the Child came into force in 1990. In September of the same year, a record number of Heads of State met at the World Summit for Children to pledge their commitment to children by adopting the World Declaration on the Survival, Protection and Development of Children and a Plan of Action for its implementation. Presently, almost all countries of the world have ratified the Convention, and three have signed it. Moreover, many countries now have national programmes of action to implement the Summit goals.

Some countries have made progress in reducing the mortality rate of children aged below five years, but social problems facing the surviving children have increased tremendously. Poverty is mentioned consistently as a cause, with the socio-economic needs, particularly in developing countries, compelling children to engage in exploitative work to support themselves and their families. In addition to these socio-economic needs is an increasing pattern of family breakdown, as a result of migration from rural to urban areas and from one country to another. As parents are pressured to meet the demands of modern life, children may find themselves neglected or abused. They may become “runaways, throwaways or walkaways”, because the safety net traditionally accorded by the family unit no longer offers them security (Muntarbhorn, 1992).

Inadequate housing arrangements in slum neighborhoods, where families have only one room and thus children and parents share sleeping quarters, may also contribute to driving children "of age" to the streets. Poverty is also closely related to disability, as many conditions affecting children in developing countries are easily prevented by proper health care and nutrition. Civil war has taken its toll on the world's children and leaves the surviving children, disabled, malnourished, orphaned and scarred for life.

If major changes are to be effected in the lives of the world's children living in the conditions described in this report, then, words must be matched by deeds at the local levels. This calls for realistic laws and policies, but these are of no consequence if they are not enforced. For example, most countries have laws on child labor, child abuse and protection of children in difficulties already in place, which are sufficient to permit substantial improvements in the situation, but enforcement is lacking. Therefore, ratifying the Convention will do little, unless these rights are publicly known and laws are enforced to provide protection and services to these children. These children, their families and communities deserve special attention, protection and assistance as part of national efforts and international cooperation. Muntarbhorn (1992) sums this well: *"It is not only the law that counts, but the whole development process. It is not only policies that count but also implementation, evaluation and concomitant budgets. It is not only education that counts but also earnings. It is not only the governmental sector that counts but also the non-governmental sector, particularly in the call for popular participation. It is not only federal programmes that count but also municipal and local action. It is not only national initiatives that count but also international commitment, with the child and the family as the center of human development."*