

Health and human rights

All our children: human rights and children of the street

Namar survives as a child of the street. For most of his life he has lacked nationality, family support, education, food, shelter, and safety (panel). Sadly, these are common conditions for more than 30 million children in developed and developing countries who meet the UN definition of a child of the street.

Children of the street are homeless youth without permanent shelter and guardianship. Since they are not provided with food, shelter, or safety, the acquisition of these basic requirements becomes their priority. Thus, they beg, steal, and engage in high-risk behaviours such as survival sex—trading sex for food, money, shelter, or drugs.^{1,2}

These behaviours put children of the street at risk of crime, violence, HIV infection, and other diseases. They also create social dynamics that separate these children from the rest of society.³ With separation comes isolation and stigmatisation. Street children are cognisant of this perception, especially when referred to as vermin,

druggies, presunto (ham), punks, hustlers, and piranhas.³⁻⁵ The result is the perception that these children are less than human or are to be feared and therefore not deserving of care.



Children living in a garbage dump, Ecuador

International human rights declarations such as the Convention on the Rights of the Child address children's right to food, shelter, nationality, education, health, and freedom from torture, sexual violence, and exploitation. The conditions of life of street children are a violation of these human rights.

In medicine, patients who present with life-threatening behaviours are treated with prevention counselling, pharmacotherapy, and environmental modification. The medical community accepts the obligation to treat. For the medical community to accept responsibility for caring for children of the street, these children's plight might have to fit a medical paradigm such as disease prevention, environmental health, or clinical treatment. The associated risk behaviours of the conditions of living of children of the street can be viewed as a collection of signs and symptoms, thus rendering being a child of the street a syndrome. Therefore, enforcement of human rights doctrines, resulting in the provision of food, shelter, health care, safety, and consequently in reduction of high-risk behaviours, morbidity, and mortality, can be viewed as therapeutic treatment.

The medical community can assist children of the street at three levels: with direct patient care, in conjunction with the local community, and at the national government level. Targeted advocacy is needed that focuses on interrupting the conditions of living that create morbidity and mortality in

this population. Since this action is consistent with the medical model, it is the responsibility and role of the medical community. Practically, providing direct patient care without regard to ability to pay and without intimidation enables the enforcement of the right to life and health.

Physicians are often natural leaders within their community. Working with community non-governmental organisations, they can provide leadership in establishing health-care systems, shelters, and programmes to improve children's conditions of living and provide a means to change their lives.

Physicians are often in key positions within national governments. As such, they can encourage protective legislation and establish national care networks for street children. Even more importantly, they are in a position to prevent, or at least report and speak out against, police brutality; make the killing of children of the street an enforceable crime; forbid the induction of these children into the armed forces; prohibit imprisonment of children with adults; and decriminalise the condition of living on the street. Children of the street are inherently devoid of guardianship and a means of advocating for themselves; thus, the responsibility for their care and protection is shared by us all. It is time for the medical community to embrace that responsibility.

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- 1 Kipke M, O'Connor S, Palmer R, MacKenzie R. Street youth in Los Angeles: profile of a group at high risk for human immunodeficiency virus infection. *Arch Pediatr Adolesc Med* 1995; **149**: 513-19.
- 2 Barker G, Knaul F. Exploited entrepreneurs: street and working children in developing countries. New York: Childhope USA, 1991.
- 3 Kipke M, Unger J, O'Connor S, Palmer R, LaFrance S. Street youth their peer group affiliation and differences according to residential status, substance use patterns, and use of services. *Adolescence* 1997; **32**: 655-59.
- 4 Summerfield D. If children's lives are precious, which children?. *Lancet* 1998; **351**: 1955.
- 5 European Network on Street Children Worldwide. Street children in north and south: a comparative summary. Amsterdam: Royal Tropical Institute, 1996.

Case study: Namar

13-year-old Namar was born in Djibouti, Eritrea, to an unmarried French father and Somali mother. His father left when Namar was very young. Namar was brought by his mother to Hargeisa, Somalia, and placed in an orphanage shortly before her death from AIDS. He left the orphanage because of abuse and has spent most of his life living alone on the streets. Occasionally Namar achieves something of a self-placement with a family, but all have ended in abuse. Because of his European looks, behaviours he has developed while on the street, and his illegitimate status his mother's clan has not welcomed him. In fact, their intolerance of him has resulted in occasional beatings. In order to survive, Namar acquires food, shelter, and safety through begging, selling a drug known as chat (qat), stealing, working the streets, and engaging in other activities that he is ashamed to relate.

Data from: Rose JS. Internal report for Save the Children USA, 2001.