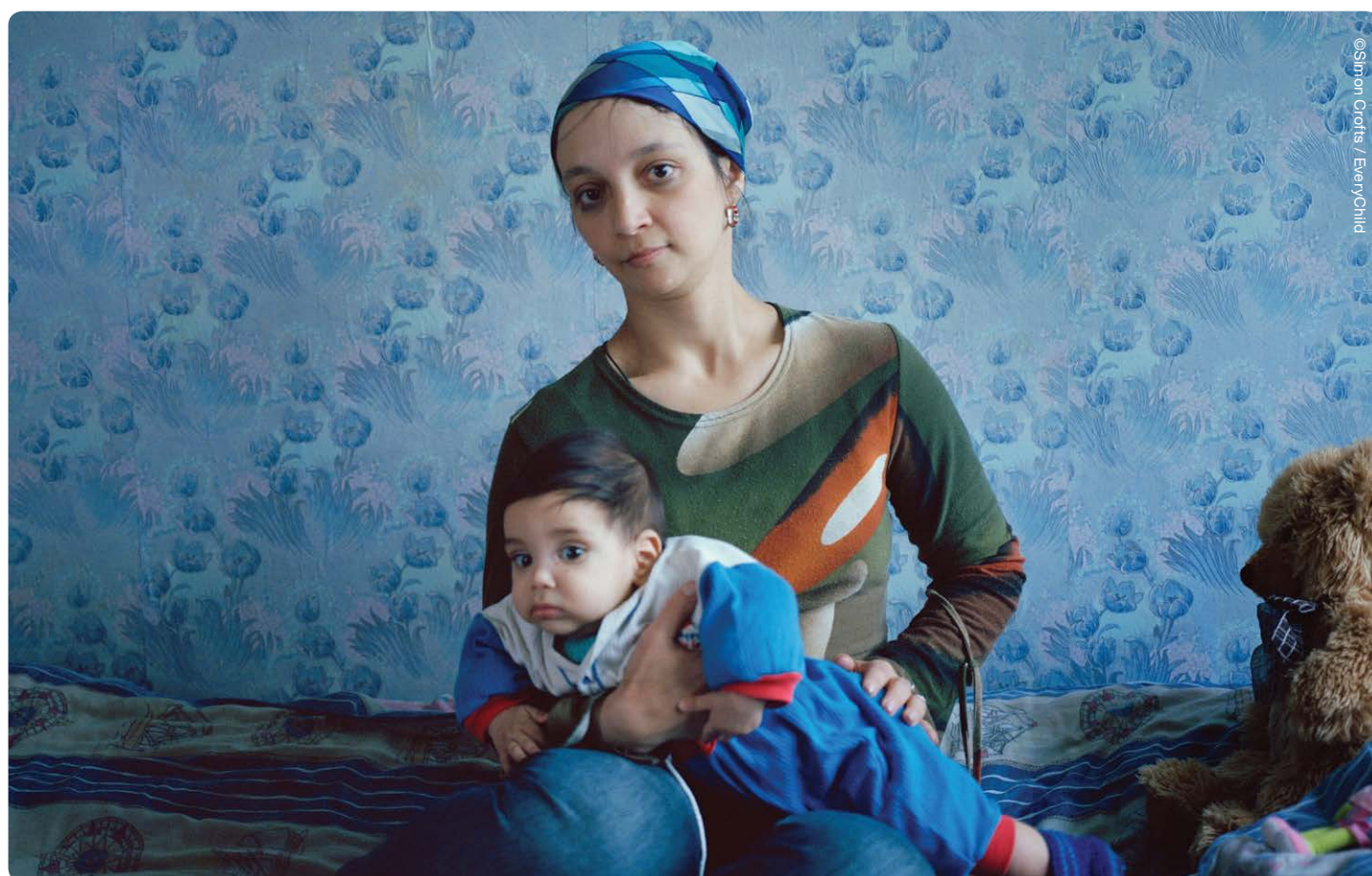


Protect my future

The links between child protection and **health and survival**



In the post-2015 development agenda

November 2012

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This inter-agency paper was written for submission to the United Nations consultation: 'Health in the Post-2015 Development Agenda.' By examining the links between child protection and health, this paper responds to the call for papers which address 'cross-sectoral action for health.' The paper specifically aims to provide answers to two of the questions posed for the consultation: What are the lessons learnt from the health related MDGs? How does health fit in the post-2015 development agenda?

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Introduction

The current global crisis in children's protection and care is both intrinsically harmful to children and threatens the achievement of other rights and broader development goals (EveryChild et al 2010; BCN et al 2012). In this paper, we focus on the inter-dependence between efforts to reduce the exploitation, abuse and neglect of children and global goals on health and survival as articulated by the current Millennium Development Goals (MDGs). We argue that for the mutual benefit of both these areas, the framework that will replace the MDGs in 2015 must both continue to include a focus on health and child survival, and encompass particular goals and indicators on children's protection.

Child protection may be defined as measures and structures to prevent and respond to abuse, neglect, exploitation and violence affecting children (Save the Children 2010). Child protection is integral to the better care of children, which involves ensuring that more children grow up in safe and caring families, or, when this is not possible, have a range of high-quality alternative care choices open to them (UN 2010). Ensuring the adequate care and protection of children requires co-ordinated, multi-sector policies, strategies and actions to address a range of rights violations during emergency and normal periods, including: harmful child labour, damaging institutional care and violence against children in the home and elsewhere.

This paper is part of an inter-agency series on the links between child protection and major development goals. Other papers in the series address subjects including education, population dynamics, climate change and conflict, and growth. This series is part of a global inter-agency campaign to raise the profile of child care and protection in development and humanitarian work, including the post-MDG framework.

The inter-dependence between health and child survival and child protection

In this section, we demonstrate the inter-dependence between global targets on health and survival with children's protection and care. We focus on the existing health and survival-related MDGs on infant mortality, maternal health, and combating HIV and other diseases. We also explore some linkages to child malnutrition and to other health issues where the relationship with child protection is especially strong.

How achieving current MDG health targets impacts on care and protection

Targets on maternal health

Despite significant progress in reducing maternal mortality, continuing high rates of maternal mortality in many settings leave many children growing up without a mother (WHO et al 2012). Whilst these boys and girls are often well cared for by fathers or extended family they can be both less likely to survive and more vulnerable to child protection risks. The lower rates of school attendance, and the higher risk of infant death amongst children who have lost a mother highlights the generally increased vulnerability of such children (Gertler et al 2004; UNICEF 2008). Lower school attendance is in turn associated with a number of child protection risks including early marriage and child labour (EveryChild et al 2010). The death of a mother often leads to the creation of step-families, and in some settings children are more vulnerable to abuse within such homes (EveryChild 2009).

Other elements of the MDGs' goals and targets on maternal health are also likely to impact on children's care and protection. For example, children's work may be increased when a mother is sick or incapacitated due to poor maternal health care. A lack of access to reproductive health care services can lead to unwanted pregnancies and parents relinquishing children into harmful institutional care.

Targets on HIV

Reducing the spread of HIV, including through crucial measures aimed at reducing mother-to-child transmission, is essential for ensuring both the health and broader well-being and protection of children. The HIV pandemic has greatly increased children's vulnerability to inadequate care and protection. For example, HIV increases household poverty and diminishes livelihood strategies, thereby exposing children to harmful child labour (ILO 2010; Mann et al 2012). Coming from an HIV-affected household makes girls more likely to engage in child domestic work and exploitative transactional sex (Save the Children 2012). In one study, girls whose caregivers are sick with AIDS related illnesses have a 19% chance of engaging in exploitative transactional sex, compared with a 2.8% chance amongst peers in other households (Cluver et al. cited in Save the Children 2012).

Millions of children around the world currently suffer the trauma of the death of parents as a result of AIDS related illnesses, and consequently enter alternative care, often of questionable quality. Evidence further suggests that discrimination against children living with HIV can restrict care options, pushing them into the more harmful forms of alternative care (Mann et al 2012). The loss of protection from a caregiver makes children more vulnerable to abuse and exploitation. In a study in Tanzania 30% of girls who had lost a parent reported sexual abuse, as compared to 20% of their non-orphaned peers (UNICEF et al. cited in Save the Children 2012).

Within families, the stresses and strains of living with HIV can make children in HIV-affected households more vulnerable to physical and verbal abuse. In one study, 12% of children being cared for by a caregiver suffering HIV-related health problems experienced physical abuse and 23% verbal abuse, compared with 5% and 8% for children with a healthy parent (Cluver et al cited in Save the Children 2012).

These combined consequences of HIV on child well-being can strain often already under-resourced child protection systems. The impacts of HIV on children's protection vary considerably depending on the age of the child. For example, for babies and young children, the loss of a loving and attentive parent or carer has been shown to have particularly devastating consequences for children's emotional, intellectual and cognitive development. For school-aged children growing older in an HIV-affected household may mean taking on adult responsibilities, including caring for younger siblings and providing for the family through child labour. For adolescents, as explored in more detail below, sexual abuse and early marriage can increase vulnerability to HIV-infection (UNICEF 2011).

These strong linkages between HIV and maternal mortality and child protection and care suggest that those working in child protection must take adequate steps to support the achievement of health goals through their work. Examples of how health targets can be better incorporated into child protection systems are included in Annex 1. Here, it is especially important to highlight birth registration, an issue which spans both access to health care and child protection services.

How improving children's care and protection can benefit health and survival goals

Reducing neglect and improving the quality of alternative care will make MDG targets on infant mortality and nutrition more achievable

As noted by the World Health Organisation (WHO) poor quality care has a substantial effect on infant survival:

"In all human groups, babies depend on warm, responsive, linguistically rich and protective relationships in which to grow and develop. They cannot survive in environments that do not meet thresholds of these characteristics" (WHO 2004 p.3)

Neglect is a common problem throughout the world with girls likely to suffer more than boys in some settings. In some states in India evidence suggests that girls are often breastfed less often and weaned earlier than boys (CRIN 2011; Pinherio 2006). Neglect may also expose children to harmful behaviours or practices that cause health problems or even death, and may prevent children from being able to access appropriate health care. In some cases the preference for boys can extend to even more harmful practices, with 41% of neo-natal female deaths in some states in India attributed to infanticide (Pinherio 2006).

In addition to the neglect and violence experienced within homes, many children who are placed in alternative care also often experience care of such poor quality that it threatens their survival. In particular, there are growing numbers of children living in institutions where large numbers of children often co-exist in over-crowded unhealthy conditions, and neglect and physical abuse is common (EveryChild 2011; Williamson and Greenberg 2010). Evidence from Russia suggests that the mortality rate for children under four years old in institutional care is ten times higher than the general population (Ministry of Health and Social Development 2007). In many settings, children with disabilities in institutional care are especially likely to experience neglect and abuse,

Protect my future: The links between child protection and health and survival

exacerbating their disabilities and health problems (EveryChild and BCN 2012; UN 2011).

In addition to these problems with institutional care, the inadequate care of other children outside of parental care threatens the survival and nutrition of many girls and boys. The vast majority of children outside of parental care in the developing world are looked after by extended families, most commonly grandparents. Despite their best efforts, a lack of external support means that these vulnerable older carers are not always able to offer children the care they need to survive and thrive (EveryChild and HelpAge International 2012). Children who are outside of any care, living alone on the streets or with employers, commonly struggle to get enough to eat. Child domestic workers may be denied food as form of punishment, and girls and boys living on the streets commonly have to scavenge for meals (Blagbrough 2008; Consortium for Street Children 2009).

Neglect and abuse have long term negative health consequences

As noted by the WHO, childhood neglect and abuse has numerous health implications into adulthood, threatening children's capacities to contribute to societies in the future. Children who are neglected or abused may become physically or psychologically ill, with many long term implications, including sexual and reproductive health problems and psychological and behavioural problems such as alcohol and drug abuse, risk-taking behaviours, post-traumatic stress disorder, suicidal behaviour and self-harm (WHO 2002; WHO 2006). Children who experience sexual violence at a young age have been shown to be more likely to engage in risky sexual behaviour as adults, increasing exposure to HIV and unwanted pregnancy (Save the Children 2012). Other longer-term health consequences of neglect and abuse include heightened risk of cancer, chronic lung disease, heart disease and liver disease (WHO 2002; WHO 2006).

Child labour has a major impact on the survival and health of older children

There are 115 million children globally engaged in hazardous child labour, at risks of injury, long-term health problems and death (ILO 2010). In the United States, 374 15-17 year olds died at work over a 10 year period, and in the Philippines around 24% of all economically active children suffered injuries at work over a year-long period. In general, children are far more vulnerable to health problems and injury than adults doing the same jobs, and adolescents and boys may be especially vulnerable (ILO 2011a).

"I have one elder sister, three elder brothers and two younger brothers. Only the youngest went to school. I was working on the quarry and earned Rs 30/- a day. I worked all day from morning to evening, chiselling stones, making them into rubble, carrying head loads and all other very painful tasks. I had blisters on my hands and feet all the time. There was no day when I did not get hurt and cry in pain."
(14-year old boy from India cited in ILO 2011a p. 33)

Children's vulnerability in work is greatly enhanced if their labour is forced, and recent estimates suggest that there are currently 5.5 million children engaged in forced labour globally (ILO 2012).

Addressing early marriage is important for achieving MDG targets on maternal deaths, infant mortality and HIV

Both the spread of HIV and maternal deaths are greatly affected by the high rates of early marriage in many regions, with one in seven girls in developing countries marrying before adulthood (Population Council 2008). Many girls are forced into marriage by families. Girls are

expected to get pregnant shortly after marriage and each year two million girls under the age of 15 give birth (ODI and Save the Children 2012). Such early pregnancies are extremely risky for both mother and baby. Pregnancy-related deaths are the leading cause of mortality for girls aged 15-19 worldwide with girls under 15 are five times as likely to die as a result of childbirth than women in their twenties (World Vision 2008). Babies born to teenaged mothers are 50% more likely to die in the first month of life than those born to women in their twenties (ODI and Save the Children 2012).

In addition to early motherhood, early marriage also leaves girls at risk of HIV infection. Frequent sexual activity with often older husbands means that married girls are even more vulnerable to HIV infection than their sexually active but unmarried peers (IWHC 2008).

"...before marriage I had no information or knowledge on marriage and sex. ... The first day after the wedding I refused my husband, I told him I was still young. ...he forced himself on me and beat me when I tried to push him away." (Married girl in Tanzania, cited in CDF and Forward 2010 p.20)

Addressing sexual abuse and exploitation is also important for achieving MDG targets on maternal deaths, infant mortality and HIV

Sexual abuse and exploitation can also leave children vulnerable to HIV and dangerous early pregnancies. Sexual abuse and exploitation are sadly common experiences for children worldwide. It is estimated that two million children, mainly girls are sexually exploited in the commercial sex trade each year.¹ In Mexico one study showed that 18.7% of children reported having experienced sexual abuse (Pinea-Lucaterro et al 2009), and in Namibia, 21% of women studied reported sexual abuse as a child (Pinherio 2006). Children who have been trafficked, who are working as domestic workers or who are street connected are at great risk of sexual abuse (Consortium for Street Children 2009; ILO 2011a/b).

"One boy in my gang knew a way of making fast moneyhe encouraged me to go with him and his friends. They met a German tourist ..and he paid them \$2-5 to sexually abuse them. I would not join in; I just kind of hung out with them...After a few months, I saw more kids getting paid to do this. I needed the money and I wanted to be like my older mates." (A 13-year old boy living on the streets in Cambodia cited in Thomas de Benitez 2007 p.13).

Ensuring the adequate care and protection of children is crucial for their survival and health during emergencies

Children's vulnerability is heightened during emergencies. Children commonly become separated from parents; disjointed communities may be unable to protect children from violence and/or exploitation, and children may be recruited into armed forces or groups, and at extreme risk of death and injury. This has numerous implications for children's health and survival. For example, sexual violence against girls is a common feature of conflict, with implications for the spread of HIV and early pregnancies that threaten the lives of young mothers. A general lack of safety and security can also stop conflict-affected children from accessing life-saving health care services (CPWG 2012; see also Annex 1).

¹ Cited in: http://www.unicef.org.uk/campaigns/campaign_sub_pages.asp?page=5

Equity in health care systems and child protection

Equitable health care systems aim to meet the needs of all sections of the population, young and old; rich and poor, rural and urban. This should include health care for girls and boys without adequate care and protection who often have an even greater need than children in the general population, due to factors such as exposure to hazardous work, early sexual activity and substance abuse, and the trauma associated with parental separation. Poverty and economic inequality have been shown to be closely linked to inadequate care and protection, and this poverty is also associated with inadequate access to health care, creating spirals of disadvantage (The Better Care Network et al 2012). Unfortunately, there is much evidence to suggest that highly vulnerable children without adequate care and protection are not receiving sufficient or appropriate health care and support. For example:

- Married adolescent girls face numerous barriers to family planning, including cost, distance and attitudes of service providers (ODI and Save the Children 2012).
- Children living or working on the streets are often discriminated against by health care service providers and unable to access family planning services.²
- Children living with employers are often denied access to health care. Research shows how child domestic workers commonly have to work long hours with sharp knives, hot stoves and heavy loads, but are often not allowed to visit doctors when accidents occur (ILO 2011a/b).
- A recent review of the literature suggests that children in residential care who are living with HIV do not always get adequate health care and psychosocial support, and information regarding prevention is also lacking (Mann et al 2012).

Not only do health care providers often fail to meet the needs of children without adequate care and protection; misguided actions may actually increase separations. For example, in some settings, health care professionals encourage new parents from disadvantaged backgrounds or with children with disabilities to place their babies in the care of the state in the belief that they will be better looked after. This often leads to the unnecessary institutionalisation of children (UNICEF 2010). The failure of health care systems to meet the needs of vulnerable children in some settings is unfortunate, as, if well designed, health care systems can be effective entry points to child protection systems by identifying at risk groups. Annex 1 provides details of how health care systems can better support the protection of children.

² See for example research by Street Action in Durban, South Africa: <http://streetaction.org/research-advocacy/projects>

Conclusion and recommendations

This paper demonstrates the strong inter-dependence between goals on health and child survival and the protection and care of children. Child survival is essential for the achievement of all child rights, including rights to protection and care, and maternal health and HIV have a major impact on child protection outcomes. Neglect, the quality of children's care, early marriage and sexual abuse have all been demonstrated to impact on the achievement of current MDG health targets. In addition, eliminating hazardous child labour and childhood neglect has benefits for the survival and well-being of older children, with impacts lasting long into adulthood. To ensure maximum synergies between efforts to address health and child protection, it is imperative for a future health and survival goal to include the a target reflecting the following:

- An increase in equity in access to health care, including access for the poorest and most vulnerable groups and children without adequate care and protection.

Both for the well-being and safety of children, and for ensuring that child survival and health targets can be met, it is also essential that the post-MDG framework includes a goal and indicators on child protection and care. For example:

By 2030 we will ensure all children live a life free from all forms of violence, exploitation, abuse and neglect, and thrive in a safe family environment.

It is our hope that the addition of such a goal will help ensure well-resourced national child protection systems, with mutual benefits for those striving to improve children's protection and care, and those working to enhance rights to health and survival.

Annex 1: Additional evidence

Examples of what child protection systems can do to better support global goals on health and child survival³

- Include assessments on health in discussions with vulnerable children and families, provide information of services, and make referrals as appropriate. This should include services around the prevention, treatment and testing of HIV and reproductive health care services.
- Recognise the trauma often caused by child protection abuses, and ensure appropriate screening and referral mechanisms to psychological or clinical mental health support. This may be especially important for children also affected by HIV.
- Include relevant health messages in community-based child protection activities.
- Promote birth registration as a key means of ensuring access to all services.
- Ensure that children in alternative care have access to health services, including appropriate interventions for the prevention, testing and treatment of HIV.
- In addition to linkages with health, ensure co-ordination with other sectors. For example:
 - Social protection systems, as poverty and livelihood strategies have a major impact on both health and child survival and child protection and care.
 - Nutrition education and support to ensure that all children, including children living with HIV, are receiving the right nutritional support.

Examples of how health care systems can better support child protection⁴

- Recognise the particular health care needs of the most vulnerable children, including those that are in extended family care, have married young, are engaged in hazardous child labour, migrant children, stateless/unregistered children, children with disabilities, and children who are living or working on the streets and are in residential care. Actively reach out to these groups. Consult with diverse groups of children in the development of health care facilities and ensure that those services are gender and age appropriate.
- Recognise and respond to the particular health care and psychosocial support needs of older carers to enable them to better look after children.
- Ensure that the training of all health workers encompasses basic training on child protection and the importance of family-based care/the dangers of institutional care.
- Enable and empower health care professionals to disseminate child protection messages through their work.
- Put in place codes of conduct regarding child-safe guarding in health care systems.
- Establish systems to enable referrals to child protection services if necessary.
- Ensure that health workers consider the specific needs for counselling, antenatal and postnatal care of children and adolescents who have experienced sexual abuse and exploitation, including within marriage.
- Promote birth registration as a key means of ensuring access to all services.
- Monitor health care system to ensure equitable access for all, including through the participation of children (in-line with their evolving capacities) and their families in monitoring and review.
- Recognise that strengthening child protection systems and health systems are mutually supporting strategies and increase synergies particularly across referral mechanism.

³ Adapted from Kean (2012) and CPWG (2012)

⁴ Adapted from CPWG (2012) and EveryChild et al (2010)

Protect my future: The links between child protection and health and survival

- Recognise the diversity of families and support fathers as caregivers and provide information on child development, health and protection to all care givers.
- Promote sexual and reproductive health information and services to men, women, girls and boys.

An example of the synergies between child protection and health: Improving access to cooking fuel in humanitarian settings

Around the world, the use of wood stoves to cook presents major health and child protection risks. Women and girls are usually responsible for both collecting firewood and cooking family meals. Collection can mean travelling long distances, especially in emergency settings when firewood may be particularly scarce, and women and girls are commonly raped or abused whilst they travel. Once they return home, the use of the firewood in often confined conditions increases the risk of respiratory illness. In response to these concerns, an inter-agency task force has been established to ensure that humanitarian workers engaged in health, shelter, child protection and other sectors work together to develop alternatives to the risky collection and use of firewood (Women's Refugee Commission 2011).

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