STREET CHILDREN, DRUGS AND HIV/AIDS:
The response of preventive education
STREET CHILDREN, DRUGS AND HIV/AIDS

THE RESPONSE OF PREVENTIVE EDUCATION
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INTRODUCTION

Children in difficult circumstances find that even the most basic of their rights are flouted. These children include street children, who have fled the indifference, negligence, ill-treatment and sexual abuse of their homes to end up, for want of an alternative, in the street. The street becomes their refuge and their gang their new family. Yet they do not find safety for all that. Their living conditions are rough, and the threats hanging over them endanger their survival all the time. Being a street child means not eating one’s fill, sleeping in unsanitary places, confronting violence and sometimes becoming a sacrificial victim, as well as growing up without support, love or protection, having no access to education or health services, losing all dignity, and becoming an adult before knowing what it is to be a child.

In such circumstances, neither drugs nor HIV/AIDS represent a danger. Drugs “help” to cope with everyday life, while HIV/AIDS imperils a future so uncertain that there seems no need for protection. Consequently street children are potential victims of both, often without realizing it and always at the cost of their lives.

Are there any alternatives to such a fate? Is it possible to prevent these children being exposed to the dangers of drugs and HIV/AIDS? These are not merely questions but rather a challenge – a challenge for which we can find glimmers of hope and practical solutions in the field of preventive education. This is precisely what we shall attempt to study in this document.

The problem of street children facing drugs and HIV/AIDS cannot be dissociated from the conditions in which these two afflictions develop. The first part of this document covers these. We shall see how drugs and HIV/AIDS find fertile soil in which to spread, and why certain populations, in this case young people, become their main victims. In order to determine more precisely the specific nature and characteristics of street children, this document will describe the underlying causes of their situation as well as their living conditions in the street and their strategies for survival there. We shall then understand why they are particularly exposed and extremely vulnerable to drugs and HIV/AIDS.

In order to be as accurate as possible and provide specific information, this study will be confined to six sub-Saharan African countries: Benin, Côte d’Ivoire, Guinea, Mali, Senegal and Togo. These countries were selected on account of their participation in a subregional workshop on street children, drugs and HIV/AIDS, which generated a new synergy and enabled relevant information on these subjects to be updated.¹

The second part of the document concerns preventive education and how it can be applied to the problem of street children. Following the presentation of two possible approaches, one aiming to reduce risk factors and the other emphasizing protective factors, two strategies are put forward. The first concerns the street children’s understanding and awareness of the risks to which they are exposed. The second aims to improve their ability to apply their knowledge by changing their living conditions and acquiring personal skills.
STREET CHILDREN, DRUGS, HIV/AIDS

A. A FEW FACTS ABOUT DRUGS AND HIV/AIDS

I. Drug abuse: an ever-increasing affliction

Drug use in Africa is not a recent phenomenon. Some drugs, such as cannabis, have long been grown for local, socially controlled, use. The taking of these drugs, which usually accompanies traditional rituals and ceremonies, is surrounded by secrecy, and anyone guilty of indiscretion incurs heavy penalties. It is not necessarily the expression of either pleasure-seeking or exclusion, but rather represents one strand in the social fabric holding together the community groups that have recourse to it.

Since the mid-1980s, cyclical factors specific to these countries and the international context have changed the situation, with a consequent increase in both supply and demand where drugs are concerned.

Drug syndicates have opened up new drug routes outside “traditional” channels. West Africa, with its numerous advantages, has thus gradually become a transit zone. It possesses the necessary infrastructure (ports and airports), is well placed geographically and presents a favourable environment, with the public authorities caught unprepared and having such limited technical and financial resources that they are unable to monitor or control the drugs traffic. A certain proportion of drugs in transit remains behind to pay intermediaries and has thus greatly contributed to the growth of a local market.

Furthermore, the impoverishment experienced by farmers as a result of economic depressions and especially by their being unable to sell their produce at a satisfactory price on the world market has driven some of them to grow cannabis – a particularly profitable activity – to supplement their income. In Guinea, for example, a sack of cannabis earns the family farm as much as a year of traditional farming. In Côte d’Ivoire, where cannabis production is thriving among cacao producers, 0.1 ha of cannabis provides a net income that is equivalent to the value of 13 to 16 tonnes of cacao (some 30 ha). This production is destined mainly for the local market. It travels through various more or less organized channels to reach users in urban areas.

While the market availability of drugs has been rising, demand has been expanding, especially from urban youth – young people who are marginalized, a prey to boredom and existential problems, especially regarding social integration and finding employment in societies undergoing serious economic crises and offering them little in the way of future prospects. In Côte d’Ivoire, for example, they are young people aged between 16 and 25 who work as apprentices, clerical workers and traders. In Guinea they are manual workers, usually in the informal sector (24.30%), but also schoolchildren/students (21.83%) and traders (19.37%). The level of education of these users is generally low. They may also be students who resort to psychoactive substances at examination time in order to boost their intellectual capacities, sustain their effort and alleviate stress.

Among young people, the peer group plays an important role, and it is generally as a result of its influence that drug use begins. Consumption then increases, often in a group and sometimes, as in Mali and Togo, in specific places known as “ghettos” (deserted houses).

Drugs are chosen according to their desired effects and group habits, which are largely determined by the users’ resources. Because it is easily available and relatively affordable, cannabis is the drug most used; hard drugs (heroin and cocaine) are restricted to dealers and a certain elite. Misuse of psychoactive medication is increasing, and chemical drugs such as ecstasy are growing in
popularity with young people. These drugs come largely from Eastern Europe and Asia, their composition is often dubious, and their harmfulness is on a par with the striking effects that they produce. Alcohol and tobacco, whose abuse presents serious risks but which are seldom treated as drugs because they are legal, are also widely used. Combined with illegal drugs, they heighten the latter’s effects and toxicity. Multiple drug use is quite a common practice. At Donka Hospital in Guinea, data show that 80% of the patients received between 1984 and 1994 were admitted for drug abuse and that 87.70% of these patients were multiple drug users (33% used two substances, 40.25% three substances and 13.75% four substances); moreover, 95.58% were tobacco smokers and 94.8% consumed alcohol. In Mali, the figures are similar, with 82% for multiple drug users, 52% of whom drink alcohol and almost 100% smoke.

Drug use among young people is to be explained in part by the shortage, or rather the absence, of available information about the dangers of the substances and the risks associated with their consumption. Awareness programmes are few and far between, often too specific, and remote from young people’s experience. Punishment is usually preferred over prevention.

The subject is surrounded by a certain taboo. If a family is confronted with drug use by one of its members, it often considers this to be a case of possession by spirits and prefers to deal with the “problem” discreetly, relying on traditional methods. This approach, although mostly effective, cannot prevent drug use in the first place (which education and information to some extent can). Nor is it available to the majority of young users, who live in an urban environment, far from their communities and sometimes having broken with their families. The treatment options for these young people are often limited to hospital psychiatry departments, which unfortunately have neither the expertise nor the resources to help them.

Drug abuse is therefore on the way to becoming a serious problem, that these countries will have to face. Young people’s craving for psychoactive substances, whether for enjoyment, to forget their problems or to imitate their friends, should give us pause for thought; it is definitely the symptom of a social dysfunction that goes well beyond the drugs themselves. It may be indicative of an existential void and an identity crisis in a population to which today’s society gives only a marginal role. Whatever the underlying causes, it is a problem that must be fully taken into account when preparing drug-control programmes and policies.

II. HIV/AIDS epidemic: young people in danger

A few facts

The first cases of HIV/AIDS were detected as early as the mid-1980s in these six countries. Since then the epidemic has grown in scale, as confirmed by the most recent UNAIDS data.
### HIV/AIDS indicators

<table>
<thead>
<tr>
<th>Country</th>
<th>Estimated number of adults and children living with HIV/AIDS, end 2001</th>
<th>Number of AIDS deaths, 2001 (adults and children)</th>
<th>HIV/AIDS prevalence rate (%) in adults (15-49)</th>
<th>Estimated number of children (0-14) living with HIV/AIDS, end 2001</th>
<th>AIDS orphans (0-14) currently living</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>120,000</td>
<td>8,100</td>
<td>3.6</td>
<td>12,000</td>
<td>34,000</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>770,000</td>
<td>75,000</td>
<td>9.7</td>
<td>84,000</td>
<td>420,000</td>
</tr>
<tr>
<td>Guinea*</td>
<td>55,000</td>
<td>5,600</td>
<td>1.54</td>
<td>2,700</td>
<td>21,037</td>
</tr>
<tr>
<td>Mali</td>
<td>110,000</td>
<td>11,000</td>
<td>1.7</td>
<td>13,000</td>
<td>70,000</td>
</tr>
<tr>
<td>Senegal</td>
<td>27,000</td>
<td>2,500</td>
<td>0.5</td>
<td>2,900</td>
<td>15,000</td>
</tr>
<tr>
<td>Togo</td>
<td>150,000</td>
<td>12,000</td>
<td>6</td>
<td>15,000</td>
<td>63,000</td>
</tr>
</tbody>
</table>

*UNAIDS 2000 data for Guinea


Sexual activity is the main mode of transmission. In Benin, for example, 92% of sufferers have been infected in this way, while 6% were infected perinatally and 2% by blood transfusions, tattooing, scarification, circumcision, excision with contaminated equipment, or during organ and tissue transplants.⁵

### Factors promoting the pandemic in these countries

Cultural, political and economic factors, as well as those inherent in the nature of the infection, have furthered its advance.

Silence and ignorance encourage the spread of HIV/AIDS. One characteristic of the population of this region is precisely that it lacks information or is misinformed about the infection. HIV/AIDS is often associated with the power of higher forces against which human beings are impotent, and misconceptions abound: “AIDS is just a figment of the imagination to discourage lovers”; “It’s a spell cast on the infected person”; “Condoms are a white man’s trick to prevent blacks having children”; “The disease is transmitted through physical contact, kisses, insect bites, food, toilets, etc.”; “Traditional medicine can cure HIV/AIDS”; “Drugs and alcohol kill AIDS”; “To get rid of AIDS you just have to pass it on to someone else”.

The taboo surrounding sexuality and the cultural ideas relating to it add to the difficulty of establishing the truth. The example of the condom – the only effective shield in sexual intercourse but whose use meets with resistance – is significant. Condoms are accused of blunting sensations and causing diseases. But this opposition also arises from a cultural conflict: the condom makes it necessary to throw away the sperm, a vital substance rich in significance. Thus using a condom and then disposing of it in a dustbin is, in some sense, tantamount to showing contempt for the very essence of life.
Insufficient information, traditional beliefs and misconceptions have therefore provided fertile soil for HIV/AIDS. They are not, however, the only factors involved.

Limited mobilization in the highest echelons of government, where politicians are not adopting the necessary emergency measures and are being slow to react to, or even officially recognize, the existence and scale of the epidemic, is another factor. This wait-and-see policy may be attributed to the shortage of available resources, the fear of a setback and its political consequences, or else the refusal to associate a term of office with this disease. However, the example of Senegal, the West African country that has been most successful in controlling the pandemic, demonstrates to what extent high-level political involvement is necessary and decisive.

The official position of representatives of certain religious persuasions itself fosters ignorance and misinformation. These representatives tend to contrast the concepts of “family, children and love” with methods of contraception (including condoms), or else safe sex between married partners with the risks of extramarital sex, thus suggesting that marriage and fidelity offer protection against HIV/AIDS. Yet marriage in itself provides no protection against HIV/AIDS, since the virus can be transmitted between married partners if one of them is HIV-positive. These statements therefore help to strengthen opposition to condoms and perpetuate confusion about modes of transmission and risk factors.

The spread of HIV/AIDS through these countries has also been facilitated by demographic factors such as the migration of single men to urban centres, the prolonged celibacy of young men, and a high birth rate. In these circumstances, sex with prostitutes may be the preferred option. However, prostitutes have very high prevalence rates (in the main urban areas, prevalence rates for sex workers reached 40.8% in Benin (1999), 36% in Côte d’Ivoire (1999), 36.6% in Guinea (1994), 21% in Mali (2000), 7% in Senegal (1998) and 78.9% in Togo (1992)).

In conclusion, HIV/AIDS is favoured by its very singularity. The clinical symptoms of AIDS may appear at any time up to ten years after the infection. During this period, infected persons may transmit the virus if they are not told that they are HIV-positive and if they take no precautions; and in Africa the majority of people infected are unaware of the fact.
Estimated HIV/AIDS prevalence rates (%) in young people (15-24), end 2001

<table>
<thead>
<tr>
<th>Country</th>
<th>Adults (15-49) living with HIV/AIDS (%)</th>
<th>Estimated prevalence rate in young women (15-24)</th>
<th>Estimated prevalence rate in young men (15-24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low estimate</td>
<td>High estimate</td>
<td>Low estimate</td>
</tr>
<tr>
<td>Benin</td>
<td>3.6</td>
<td>2.97</td>
<td>4.46</td>
</tr>
<tr>
<td>Côte d'Ivoire</td>
<td>9.7</td>
<td>6.67</td>
<td>9.95</td>
</tr>
<tr>
<td>Guinea</td>
<td>1.54</td>
<td>na*</td>
<td>na</td>
</tr>
<tr>
<td>Mali</td>
<td>1.7</td>
<td>1.35</td>
<td>2.81</td>
</tr>
<tr>
<td>Senegal</td>
<td>0.5</td>
<td>0.43</td>
<td>0.65</td>
</tr>
<tr>
<td>Togo</td>
<td>6</td>
<td>4.74</td>
<td>7.12</td>
</tr>
</tbody>
</table>

*na: not available

Young people: front-line victims

Young people constitute a population that is particularly affected, as the data indicate. In some cases they have prevalence rates above the national average.

A shortage of information and the silence surrounding sexuality are largely to blame. In these six countries, young people become sexually active between the ages of 16 and 17 on average without necessarily having received any sex education and without being properly informed of the possible risks and implications of sexual intercourse. Yet in this period of discovery young people may tend to change partners frequently and experiment a lot, both of which constitute major risk factors.

Young people therefore urgently require information on HIV/AIDS and the steps they should take to protect themselves. They must be given information but also supported in changing their behaviour. This means, in particular, making condoms more easily available, initiating discussion of sexuality within families and including sex education in the school curriculum. The argument that educating young people about sexuality encourages them to have intercourse is often put forward to justify silence. This is an error. It has been demonstrated that young people who have received sex education develop more responsible attitudes and are more likely to begin their sexual activity later and take precautionary measures to avoid risks.
B. STREET CHILDREN

I. From solidarity to exclusion

Definitions

Street children are children who live in the street and are left entirely to their own devices. They have run away from their homes or been left with no other alternative. According to the World Bank, there are 1 million of them in sub-Saharan Africa. In Senegal, where they are known as “fakh mann”, they number 10,000 according to United Nations estimates, and in Côte d’Ivoire (according to the NGOs) 142,000 in 1991 and then 175,000 in 1995, including 40,000 in Abidjan. The data vary, depending on the source and the advantage to be gained from inflating or minimizing the problem. Most information relies on estimates, since it is extremely difficult, given the children’s characteristics (runaways, suspicious of strangers, on the move, etc.), to obtain quantitative data that is accurate and reliable. This deficiency also stems from the problem of defining street children.

Street children are a social phenomenon with shifting boundaries. A distinction is commonly drawn between two groups of street children: children “on” the street and children “of” the street. The former (the majority) work on the streets but maintain the link with their homes, to which they return in the evening. Children “of” the street, on the other hand, have broken with their families and society and live in the street.

The reality is not that simple, however. The distinction between “children of the street” (commonly termed “street children”) and children “on the street” has been adopted more for “operational” reasons than as an exhaustive statement of the problem. It is impossible to sum up the complexity of the phenomenon in a single expression, not only because there exists a wide variety of situations but also because being a street child is not a fixed state. There are still questions to be asked. Should the typology use an approach based on the causes of breakdown, street survival methods and activities, or the child’s social status? At what stage does a child become a “street child”? Can children who live alternately in the street and at home be called street children? All these are questions for consideration, and require us to use the term “street children” with an awareness of its limitations.

The situation in which the street children phenomenon develops is similar from one city or one country to the next: a high level of poverty, unbalanced development between town and country or between countries (conducive to exploitation of the poorest); unrestricted large-scale urbanization; a sometimes uncontrolled transition of societies to Western modernity coupled with a very high social cost (dissolution of solidarity networks, disintegration of the African extended family); insufficient educational provision (failing to meet needs and disdained by parents who consider work to be more instructive).

In most cases, street children begin their career on the streets by working. This is a common situation in Africa, since one child in three under the age of 15 is economically active (48 million children). However, not all these children are destined to become street children or are even in a situation where they risk becoming so. Working children and street children have in common the fact of living in poverty; for some, poverty is the reason why they work, while for others it is the ground in which the problems leading to the street take root and grow. Street children do not run away from their homes because they are poverty-stricken; they try to escape an environment that is hostile and detrimental to them and a setting which provides neither love nor protection and which is damaging them. Thus the reasons most frequently put forward to justify running away are:
- 10 -

- indifference, physical or psychological ill-treatment, and sexual abuse,
- broken home and/or detrimental family (re)composition,
- craving for adventure and independence.

Children may also end up in the street as a result of tragic events; this is true of children orphaned by AIDS, refugee children and children who are not recognized by society because they have been brought into the world by adultery, incest, parents in prison, drug addicts or prostitutes, for example.

Commonest causes of leaving home

Indifference, physical or psychological ill-treatment, and sexual abuse

The home is not always a safe and protective place for children. In some cases, it can become a scene of conflict accompanied by physical and psychological ill-treatment or even sexual abuse. According to SOS Violences Sexuelles (a Côte d’Ivoire NGO), some 15 to 20 thousand women and children are raped every year in Côte d’Ivoire.\(^{15}\) The rapists usually belong to the victim’s immediate circle: a relation, or a member of the child’s foster family. This ill-treatment is often associated with family dysfunction, with inactivity on the part of the parents, who make their children scapegoats for their own suffering, or with abuse by certain adults who take advantage of a foster child’s vulnerability. Some of these children run away from their homes and, because they have no other alternative, end up on the street.

Broken home, family (re)composition detrimental to the child

Typical of urban life are a certain individualism and marital instability, which are rarer in village communities. Separations are commoner in cities and harder to surmount, since the family circle, being far away, cannot provide its customary support. A family breakdown may then be accompanied by a considerable deterioration in living conditions and the adoption of survival strategies that are more demanding for the children. Where insecurity is greatest, the single parent is less available and may start to ill-treat the children, while the latter are forced to work more and take on new responsibilities. This generates tension and conflict that may lead to a split.

In other cases, separation of the parents may be followed by the arrival of a new spouse, possibly accompanied by his or her children. This alters the dynamics of the home, sometimes to the detriment of the original children. The latter may then feel rejected or unloved and get the impression that they are losing their rightful place and status within the home, or else that they are becoming nothing short of scapegoats in the new family set-up. This situation may also arise in polygamous families with the arrival of a new wife.

Craving for adventure and independence

Children for whom the family is a straitjacket and school (if they attend it) is of little interest are tempted to “try their luck” in the street. They see it as a means not only of escaping parental authority but also of living “free” and being able to try out all sorts of forbidden pleasures. They are usually familiar with the street environment, having worked there and established links with other young people. They are usually described by their families as “difficult”, “insolent”, “disobedient” and “violent”.


Escape from armed conflict

Armed conflict does not spare civilians, indeed, they pay a heavy price. Families are destabilized and sometimes forced to flee their community, town or country to escape death. Thus, over the past few years, thousands of people from Liberia and Sierra Leone have found refuge mainly in Guinea and Côte d’Ivoire. According to the Office of the High Commissioner for Refugees, in 2001 the latter two countries had on their territories 433,139 and 120,691 refugees respectively. Women and children are particularly vulnerable in these situations. In Guinea, 70% of refugees are women and children, some of whom arrive unaccompanied. Left to themselves, they are vulnerable to all sorts of abuse and may well end up on the streets if circumstances so dictate.
The special case of foster children

In African culture the child belongs not only to its parents but also to a kin group of common descent, whether matrilineal or patrilineal. Rather than the parents alone, it is therefore the members of this group who are responsible for the child’s care and upbringing. Accordingly, it is common practice for a child to be entrusted – as a token of solidarity, to seal alliances or to maintain social ties – to a member of this group, such as a widowed aunt who is childless, an uncle who lives in the city or a cousin who has a business. In exchange for petty services, the children become apprentices, work as servants (“vidomegons” in Benin, for example), are employed as street vendors, or learn the Koran if they are placed in Koranic schools (talibes). This fostering, which is respectable on several counts, enables the children to grow up in more favourable surroundings, acquire skills and open their minds to a new environment while taking the pressure off their biological families, who regard this, in the long run, as an opportunity to improve their own situation.

Unfortunately, the promises of protection and training are not always kept and the placement may be deflected from its original purpose. The child is then exploited as a jack-of-all-trades, is subjected to hazardous living conditions and may even be the victim of ill-treatment.

Such lapses are sufficiently familiar to be well-documented: in Senegal, for example, 33,669 apprentices would seem to be “sham apprentices”;\(^{18}\) in Benin, a survey has revealed discriminatory treatment of foster children (heavier workload and longer working hours than the host family requires of its own children);\(^{19}\) in Mali, the “garibus” spend their days begging. Pupils of Koranic schools are not spared either: a study of 5,000 such children in Benin has indicated that they show signs of chronic fatigue\(^{20}\) and associated disorders; and in Senegal it seems that 100,000 children live “in poverty, malnutrition, itinerancy and psychological and physical coercion”.\(^ {21}\) Cases of foster children “suffering from serious bodily injuries, which often require medical treatment” have been exposed by child welfare programmes.\(^ {22}\) Reports mention cases of rape, undernourishment, survival in inhuman conditions, lack of wages and exposure to hazardous substances.\(^ {23}\)

In the worst cases, the children are victims of actual human trafficking, organized by networks extending across national borders and which abuse the trust of parents in need. Destined to work as servants or farm labourers, the children are treated like chattels as soon as they leave their villages; they may be transported in dangerous circumstances that some do not survive: “the children come in dugout canoes, with 50 or so in each canoe; there are often deaths”\(^ {24}\) and “if, by good fortune, passengers reach their destination ..., they are landed, each client comes to collect his goods and the escorts disappear forthwith”.\(^ {25}\) In Côte d’Ivoire, for example, it appears that more than a thousand such children work in plantations, diamond mines (Tortiya) and gold mines (Issia),\(^ {26}\) being made to work over 18 hours a day. These trafficked children include 10,000 to 15,000 Malians.\(^ {27}\)

Whatever the degree of ill-treatment or exploitation, such situations may be the cause of children ending up on the street.

II. Life on the street

HIV/AIDS victims

The HIV/AIDS epidemic is not only a health problem; it has extremely worrying social repercussions, including a dramatic increase in the number of orphans. Traditionally, African children who lose their parents have been looked after by members of their extended family. Today this is no longer a reliable alternative because of the disintegration of the extended African family. The latter may, in any case, be weakened by HIV/AIDS and no longer able to receive all the
orphans related to it. In Côte d’Ivoire alone, 420,000 children aged under 15 are HIV/AIDS orphans … and some of them will come to swell the number of street children.  

The move to the street

The move to the street seldom occurs before the age of 7; the transition may be gradual, with children living alternately at home and in the street. In this case, the adjustment will be all the easier because they have already worked on the street and possibly made friends there.

However, such a departure is usually not a choice. Children leave to live in the street because they have no other alternative, given the problems at home. They cannot be taken in by a member of the extended family, admittance to a public institution is unlikely, and for foster children a return to the village is impossible. In the latter case, children are afraid to disappoint the hopes vested in them, or else months or even years of separation have so distanced them from their families that they are afraid to take the first step towards reunion. For girls, reintegration into their community may prove impossible, owing to strong suspicions that they have contracted HIV/AIDS in the city.

Fewer girls flee their homes for the street. It is not that they are spared ill-treatment or other grounds for running away, but culturally their existence is organized around domestic and family tasks, and this gives them fewer opportunities than boys for experiencing life outside the home. Moreover, they develop a strong attachment to the private sphere, unlike the boys, who are thrust into the outside world to work but also to become socialized. And this outside world is very often the street, because in African culture the street is not merely a place of transit. It is a space of great social importance, crucial to the learning and acquisition of interpersonal skills. This is one of the reasons why the option of living on the street is more open to boys than to girls.

Life on the street

A child does not live alone on the street; he or she joins a gang consisting of other children and/or teenagers. This makes it easier to face day-to-day problems and meet basic needs collectively, besides which, psychologically, the group compensates for the huge deprivations from which the majority are suffering. The gang fills a gap and becomes a genuine substitute family. The bonds linking the children become almost like family ties, and, as a symbol of this new existence, each is given a nickname by which he or she will henceforth be known.

The children live in places that offer a modicum of physical protection: under bridges, in disused warehouses, deserted houses, makeshift shelters, underground passages, etc. These makeshift dwellings are always close to strategic places teeming with the human and economic activities from which the children derive their means of subsistence. They include, for example, the vicinity of bus stations, markets, airports, road junctions and shopping centres.

Days are organized around the quest for money to survive, and vary according to who or what is encountered. The children’s main activities are begging, washing and watching parked cars, polishing shoes, selling small items, carrying luggage, cleaning markets, collecting refuse, etc.  

Some prostitute themselves and others steal. These lapses are not a matter of course, and when they do occur it is because they are favoured by circumstances: for example, a red-light district near to where the children live, or else the child’s age and the composition of the gang. If children are surrounded by young people who practise criminal activities they may be forced to join in or allow themselves to be led astray. The likelihood increases as the children grow up, since, as they change physically, the pity that they arouse gives way to suspicion, fear and even rejection. They find it harder to support themselves, since people prove less generous with their gifts, and they are obliged
to find other alternatives to survive. A spell in a detention centre is also a risk factor, since such places are better known for establishing contacts and forging links between young people in conflict with the law and training the youngest ones in crime rather than rehabilitating them.  

The money obtained is used individually, mainly to meet basic needs (food) and to buy drugs. Saving is not an option, since the sums concerned are often too small, the children do not plan for the future and, above all, if they did they would risk being the victims of theft and racketeering.  

The dangers and difficulties of life on the street

As regards their general state of health, the children present a very sorry picture: they may be suffering from malnutrition, skin and lung diseases or sexually transmitted illnesses. The risk of accident is high owing to the unhealthiness of the places where they live and the use of drugs that dull their vigilance and slow their reactions. Injuries usually go untreated through lack of access to health services. It is only when the disease or injury becomes incapacitating and therefore calls into doubt the ability to survive in the street that a child seeks help – when it is often too late to ensure a full recovery.

Adults represent another threat to the children. The street can be a violent environment where it is constantly necessary to demonstrate one’s strength. Stigmatized by society and marked out by their vulnerability, street children are all the more exposed to all kinds of abuse in that they must face them alone and cannot count on any protection. Who will bother about their arrest or disappearance? And if they are found beaten to death, who will be roused to indignation? Other people’s reactions seldom extend beyond agitation. It is therefore alone, with their friends from the gang, that they must struggle for survival, protect their dwelling places, defend themselves against attack, escape police raids, etc. These threats, quite apart from the fact that they create permanent insecurity, also generate stress and anxiety.

Effects of street life on the development of children and adolescents

The experience of the family prior to life in the street has negative effects on a child’s mental balance. It is traumatizing and occurs at decisive points in the construction of personality and development of skills. Self-esteem, which is an essential component of personality and which, to take shape, needs to be nourished with affection and recognition, develops in a thoroughly uncongenial atmosphere. The image of themselves that the children receive is negative and disparaging, their environment is hostile and malicious, and instead of support they are met with rejection and indifference. This results in extremely low self-esteem among all street children, which is apparent through close contact and when the children’s trust has been won. Their emotional deprivation is also a constant. It is expressed through excessive tenderness, a continual demand for love and affection and a longing for physical contact.

Their capacity to overcome traumatic situations and survive in such extreme conditions demonstrates, moreover, a remarkable ability to adjust and a particularly high level of resilience.

For street children the adolescent stage, when they come to it, presents added risks. During this difficult period, self-discovery and the pursuit of independence are tested by pushing back the boundaries of the forbidden as far as possible, sometimes at the risk of children’s lives. This is the case, for example, with the games – amounting almost to initiation rites – that consist in hanging on to moving buses (boro d’enjaillement) or crossing streets blindfold (“crossing the desert”).  

It is during this period that the individual is most receptive to peer pressure, in part because external role models may fill the gap left by an identity crisis; thus the environment, if negative, may easily encourage deviant or high-risk behaviour by young people. It is also a time when sexuality is
discovered and there is the greatest likelihood of starting to take drugs. In a “normal” setting, i.e. when adolescents are supported through dialogue and understanding, when they are cherished, loved and guided, the risks of deviance are minimized and these young people pass from adolescence to adulthood enriched by their own experiences and those of their circle.

For street children, adolescence is a complex stage beset with dangers. As much through their past background as through their present environment, they are in a vulnerable position with regard to the risks inherent in this period. Their first sexual experiences are premature and often take place under duress. There are many potential partners, and intercourse is encouraged by the close proximity of life in the gang. Drugs circulate and are used in the street child’s circle. Peer influence is not necessarily positive but is, in any case, extremely strong since the children’s very survival depends on the relationship with their peers. Excluded by society, they also continue to suffer stigmatization and their identity as young adults is built on an extremely negative image of themselves.
C. STREET CHILDREN IN RELATION TO DRUGS AND HIV/AIDS

I. Drug use as a survival strategy

Research has demonstrated that drug use is determined by the complex interaction of personal, family, social and environmental factors. In each of these areas, street children show clear evidence of deprivation.

<table>
<thead>
<tr>
<th>Drug risk factors for street children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal factors</strong></td>
</tr>
<tr>
<td>• Psychological vulnerability and distress, emotional deprivation, low self-esteem, little value attached to one’s person or life.</td>
</tr>
<tr>
<td>• No plans for the future, little hope of positive development, no schooling (which might allow some improvement to be envisaged).</td>
</tr>
<tr>
<td>• Adolescence.</td>
</tr>
<tr>
<td>• Day-to-day survival-related stress and anxiety.</td>
</tr>
<tr>
<td>• Lack of information on drugs and the risks of using them.</td>
</tr>
<tr>
<td><strong>Family factors</strong></td>
</tr>
<tr>
<td>• Bad family relationships or family breakdown.</td>
</tr>
<tr>
<td>• Lack of support, supervision and appreciation.</td>
</tr>
<tr>
<td><strong>Social factors</strong></td>
</tr>
<tr>
<td>• Social exclusion and stigmatization.</td>
</tr>
<tr>
<td>• Peer-group dependence.</td>
</tr>
<tr>
<td><strong>Environmental factors</strong></td>
</tr>
<tr>
<td>• Drug circulation, availability and accessibility.</td>
</tr>
<tr>
<td>• Drug use in peer group.</td>
</tr>
</tbody>
</table>

Information gathered in the field confirms that the majority of street children take drugs. It is difficult to obtain accurate statistics since, when questioned on the subject, for fear of punishment the children prefer to deny that they take drugs, although readily admitting that some of their friends do.
Reasons why children take drugs

- To resist and relieve pain, cold and hunger.
- To reduce stress, anxiety and fear.
- To increase physical strength, courage and stamina.
- To escape the everyday world and its problems.
- To adopt peer-group practices.
- To have fun and relax with friends.
- To experiment with new sensations (the appeal of the forbidden).

Thus the children use drugs to take the edge off their hunger when there is nothing to eat, lessen the pain of an injury that refuses to heal, keep themselves going and take away the shame of rummaging through dustbins, feel strong and invulnerable in the face of threats and confrontations, and because they want to have fun and relax with their friends. Paradoxically, although they represent a genuine danger to their lives, drugs are the essence of life for these children. The reasons given for drug-taking reveal its key function in survival strategy. But, over and above this, the use of psychoactive substances may spring from more deep-seated causes and be symptomatic of the children’s suffering and the identity vacuum that drugs would seem to fill.

The children’s limited funds point them towards cheap and easily accessible products. These are, first and foremost, volatile substances that are sniffed or even swallowed, followed by alcohol and tobacco and, to a lesser extent, cannabis and psychotropic drugs. Abidjan street children, for example, use solvents and paint-thinners (some cases of children drinking petrol have also been recorded), medicines (sometimes combined with solvents) and Côte d’Ivoire alcohol. Because of its price, koutoukou cannabis is used more rarely, for special occasions. In Dakar (Senegal), children inhale solvents (guinze) and occasionally take psychotropic drugs (pions) or cannabis.

Volatile substances exist in four main product families: glues, aerosols, gases and paints/solvents. The latter are not subject to any restrictions or regulations with regard to sale or consumption, since they are not drugs but rather basic consumer products that are liable to abuse.

The dangers of drug use depend on the product and the use made of it. Among street children, substance-taking is generally neither casual nor moderate. There is thus a strong likelihood that it will be harmful and habit-forming.

Whatever the drugs, and whatever the frequency with which and the circumstances in which they are taken, their use presents risks.
## Examples of drug-use risks

### Social risks
- Greater risk of accident owing to attention deficit and slower reactions.
- Risk of arrest for use of illegal substances.
- Loss of judgement, which may encourage offending, wrongdoing and dangerous acts.

### Health risks
- Physical and psychological dependency.
- Reduced physical capabilities.
- Reduced mental capabilities.
- Irreversible damage to nerve tissue (inhalants).
- Uncontrolled reactions, bizarre behaviour, depression, amnesia (psychoactive drugs, amphetamines).
- Respiratory system disorders (tobacco, smoked cannabis, inhalants).

## II. HIV/AIDS: a permanent threat

There are no specific data on street children and HIV/AIDS; no special studies have been made, and the children’s contacts with the health services are so sporadic that it is impossible to establish a prevalence estimate. Their characteristics and living conditions are sufficiently well known for us to be able to assume that they are exposed to HIV/AIDS, especially through sexual activity. For example, they frequently suffer from sexually transmitted diseases, a phenomenon indicative of unprotected intercourse. On the other hand, the fact that they are excluded from health services spares them the risk of transmission through transfusion or intravenous injection. Nor are they exposed to the risks associated with sharing needles, since for the most part they do not take injectable drugs. They may nevertheless use objects that pierce the skin, such as razor blades or needles, for making scarifications or blood pacts, and these objects may be contaminated, thus representing a risk.

### Risk factors for virus transmission among street children

The main transmission risk for these children is therefore sexual intercourse. They move in an environment conducive to the spread of HIV/AIDS, where the risk factors are well known:

- Misconceptions such as, for example, that only intercourse with prostitutes carries a risk,

- A patent lack of information about sexuality, the issues involved and the risks,

- Cultural ideas about sexuality that prize multiple conquests by boys,

- Limited access to condoms and a certain resistance to using them when information about prevention has been provided.
However, these are not the only risk factors. The conditions in which street children live and the constraints to which they are subject increase their vulnerability to HIV/AIDS.

### Vulnerability factors associated with street children’s living conditions

- A promiscuous lifestyle with a large number of potential partners.
- Precocious sexuality.
- Use of drugs under whose influence inhibitions are lost and risk-taking increases.
- A high prevalence of untreated sexually transmitted diseases (favouring virus transmission because they weaken the mucous membranes).
- A struggle for survival that monopolizes all the children’s energies and relegates HIV/AIDS to the background.
- The need to respond immediately to the many existing threats. Since HIV/AIDS is not an obvious danger in the short term, it is not taken into account.
- The impossibility of imagining the future: hence the difficulty of taking account of an infection with delayed effects which jeopardizes a future that is already uncertain.
- The need to submit to the gang’s norms and requirements in order to survive; if sexual intercourse without condoms is the rule, it will then be difficult to act otherwise.
- Economic needs that may force street children to prostitute themselves.
- Exclusion from the school system, where preventive sex education courses may be organized for young people.

The psychological characteristics of street children add to their vulnerability. Severe emotional deprivation is often at the root of an over-investment in love affairs and may predispose the children to emotional dependence. The partner fills a gap, and it is not so much feelings of love that underlie the relationship as the need for recognition. The children will therefore do anything to avoid a conflict or a split, they will attach great importance to what their partners think and want, and they will consequently submit to their wishes.\(^38\) If a split occurs notwithstanding, the child will feel the need to invest rapidly in a new relationship. This situation presents risks, such as an increased number of partners and the acceptance of rules laid down by the latter (for example, refusal to use a condom).

Moreover, low self-esteem, resulting in a tendency to attach no value to one’s own person or life, leads the children not only to neglect themselves and fail to protect or look after themselves but also to be in need of emotional relationships and submit to their partners’ demands.

These psychological factors represent an obstacle that HIV/AIDS prevention must overcome, since to protect oneself it is necessary to attach at least some value to one’s own person and be in a position to “negotiate” use of a condom. Low self-esteem and obedience to partners do not allow this. The emotional need, which is immediate and urgent, often proves to be more decisive than the information provided on the dangers of HIV/AIDS which might prompt precautionary measures.
THE RESPONSE OF PREVENTIVE EDUCATION

A. GENERAL CONSIDERATIONS AND LESSONS LEARNT

The challenge of preventive education is to prevent or change behaviours presenting a risk to a person’s health or even life. The psychosocial theories on which this education is partly based abound in analysis and interpretation of behavioural determinants. These theories will not be discussed here, since they already have a literature of their own.39

Two approaches do, however, deserve comment. The first is concerned with risk factors, i.e. the factors that play a decisive role in risk behaviour. In drug use, for example, they have been identified as, among other things, a sense of exclusion, poverty, age, peer-group behaviour and drug availability/accessibility.40 Taking this theoretical framework, preventive action aims to lessen the impact of risk factors or eradicate them. This approach, although it remains valid, has revealed its limitations with, in particular, the impossibility of influencing certain factors and of maintaining behavioural changes in the long term.

A more recent approach enables these limitations to be overcome. It puts the individual centre-stage as an active player rather than a passive subject of prevention. Preventive intervention now focuses not on risk factors but on individuals themselves, and consists in strengthening what are called protective factors. These factors are the individuals’ personal skills enabling them to make the best decisions for themselves and their lives: they may include the ability to overcome difficulties and avoid the risks of certain types of behaviour. These factors use an individual’s own positive qualities, such as high self-esteem, an ability to control emotions and negative or destabilizing feelings,41 and social skills such as ease of communication with others. Their acquisition is favoured, inter alia, by a stable, protective and appreciative family circle, a peer group with a positive influence, and a friendly and capable school environment. The scope of such intervention extends well beyond preventing risks specific to drugs and HIV/AIDS. It aims to encourage a disposition for positive development, for example through the ability to cope with problems, make choices that will not compromise the future, take decisions, be positive about the future and be prepared to ask for help when necessary.42 In other words, rather than trying to create a capsule around the individual by minimizing the impact of risk factors, preventive action helps the individual to develop “tools” or “protective factors” to cope with them effectively.

“Protective factors” in some sense counterbalance or neutralize “risk factors”. The more they are developed in an individual, the less risk factors will have an influence and constitute a threat to that person.43

Some mistakes to avoid

Extensive experience in the field of preventive education, whether successful or only of limited usefulness, has given us some idea of what should be avoided in order to optimize intervention.

Information is not enough

Although information and communication are essential components of preventive education, they cannot be its sole ingredient.44 Disseminating information on risks and harmful effects (of drug abuse and unprotected intercourse in this case) is not enough to bring about behavioural changes. Just because the population, and more specifically street children, are informed and aware of the risks to which they are exposed, they are not automatically going to alter their conduct.
Avoid using fear, anxiety and guilt to convey the message

As far as information and communication campaigns in particular are concerned, their impact will be determined by the tone, content and relevance of the message. In some cases, they may be counter-productive. For example, if the target populations are adolescents, messages that highlight strong sensations, danger and prohibition may make risky behaviour appealing. Young people may be more interested in the presentation of a drug’s striking effects than the dangers associated with its use. The deterrent effect may be nil, or the message may even backfire by encouraging actual drug-taking.

Moreover, campaigns relying on shock value have also proved to be only moderately effective, since although behaviour may change for the better initially, the change is generally not maintained over time.

For street children in particular, campaigns whose messages focus on danger, threat and, above all, guilt only intensify their daily anxieties and distress. Such campaigns tend to be rejected and cast discredit on those associated with them.

Campaigns must be targeted and followed up

Untargeted campaigns, intended for the population as a whole, have a very limited impact. Although they have the merit of maintaining a state of vigilance, which is not unimportant, they nevertheless fail to reach the specific groups who are the most vulnerable and most in need of information, such as street children.

Furthermore, when campaigns are unrelated and sporadic, the information conveyed is quickly forgotten and the impact rapidly wears off. Campaigns must therefore be recurrent and supported by follow-up action such as access to health services, medicines and condoms.

The target population must be involved

The target population must be taken into consideration and play an active part at every stage of a preventive education programme or activity (design, planning, development and evaluation). With a subject as sensitive as HIV/AIDS, which involves the sexuality taboo, intervention imposed from outside has often led to failure. Active participation of the target population enables the pitfalls of ethnocentrism to be avoided and ensures a better grasp of the message and greater awareness of the risks, which is conducive to a change in behaviour.
B. TOWARDS PREVENTIVE EDUCATION AS A RESPONSE TO THE PROBLEM OF STREET CHILDREN

1. Objectives and proposed strategies

Preventive action among street children is a huge field. In this document we put forward two potential strategies. They do not claim to provide an exhaustive response to the problems raised but attempt to explore possible guidelines.

The objective is to reduce street children’s vulnerability to drugs and HIV/AIDS.

The two possible and complementary strategies proposed are the following:

- **Strategy 1**: Improve the children’s knowledge of the risks associated with drugs and HIV/AIDS.
- **Strategy 2**: Develop the children’s ability to apply their knowledge.

The first bears on transmission of knowledge about drugs and HIV/AIDS and realization of the risks, while the second concerns practical application of that knowledge and behavioural change.

### Situation analysis

#### Data on street children and HIV/AIDS

- What is the level of understanding about HIV/AIDS?
- What are the misconceptions and rumours about HIV/AIDS?
- What is the level of understanding about use of condoms? If condoms are not used, why not?
- What are the typical features of sexual behaviour?
- What are the possible outcomes of a consultation in a health centre (screening for STD or HIV/AIDS)?

2. Situation analysis – essential to action

Before beginning any action, it is first necessary to have accurate information on the target population, its characteristics and the specific risks to which it is exposed. For this reason a situation analysis is recommended.
### Situation analysis

#### Data on street children and drugs

- What drugs are used?
- What method is used to take them (sniffing, smoking)?
- What are the patterns of use (group, individual, place and time of day)?
- How frequently are they taken?
- What is the cost of the drugs used?
- What is the level of dependence (on the basis of criteria such as time of day when drugs are first taken, irritability and anxiety outside periods of use, need to take drugs to feel well, etc.)?
- What reasons for taking drugs are given by the children?
- What role does drug use play within the peer group?
- What is the level of understanding about the risks?
- What are the problems/difficulties experienced because of drugs?

### Situation analysis

#### Data on protective factors for street children

- What are the gang’s shared values?
- What are the religious or other beliefs?
- What are the positive emotional attachments or relationships?
- Who are the confidants, the leaders and the approved positive role-models?
- What are the children’s personal qualities, skills and abilities?
- What are their dreams and aspirations?
- What kind of reception have they been given by associations, centres, etc.?

It may also be expedient to have more general information on the group, such as its composition (gender, age, etc.), what it does to survive, the main problems faced by its members (police violence, conflict, specific history, etc.), the children’s participation in any rehabilitation programmes, availability during the day, etc.
From the given text:

**Where to find information**

- Existing analyses and studies: Although the literature on street children is relatively meagre on this particular subject, it may be useful to consult what does exist.

- Childcare workers and reception-centre staff: Through their direct contact with the children, these field workers have accurate and up-to-date information. It is not always written down or treated methodologically and may be obtained through interviews or, where possible, by studying fact sheets on the children.

- The children: They are the main source of information. In view of their characteristics (runaways, suspicion of strangers, etc.) and the information sought, relating to intimate aspects (sexuality) or deliberately concealed details of their lives (drug use), certain principles must be respected to secure their collaboration. For example (1) do not force them to answer questions or say more than they wish; (2) organize a meeting with the group (rather than its members individually) in a favourable place and at a favourable time of day; (3) word questions in simple language; (4) outlaw “interrogatory” questionnaires; (5) encourage answers and observe body language.

Situation analysis is not an end in itself; it is merely a means of obtaining the data needed for designing programmes. It must therefore be neither too costly nor too time-consuming to produce and must, above all, be followed by practical action.

**3. Guidelines for two possible strategies**

**Strategy 1: Informing the children about HIV/AIDS and drugs**

**What information should be provided?**

Providing information is one strategy for changing behaviour, but it will work only if the knowledge has an emotional anchorage. The information conveyed to the children must therefore not only raise the level of their knowledge but also, and above all, be coupled with a realization of the risks to which each is exposed by his or her conduct. In other words, the intervention must lead the children to think that “it could happen to me” and must not be confined to merely transferring information.

The content of each intervention will therefore vary according to the characteristics of the target population; it must reflect the children’s experience and problems as closely as possible. Thus there is no point in expatiating on intravenous transmission of HIV/AIDS if the children are exposed through unprotected sexual intercourse – or dwelling on the harmful effects of heroin if they are sniffing glue. The content must therefore be determined on a case-by-case basis. A few general examples are provided here.

Although this information is essential because it helps to establish the truth and combat misconceptions, it remains sketchy for the children, since no obvious connection is made between these afflictions and their own lives. Once informed, they know what drugs and HIV/AIDS are, but they are not necessarily aware of their own vulnerability or, in particular, of the need for them to change their behaviour. This can be brought home only by creating a tangible link between the objective data and their own lives.
<table>
<thead>
<tr>
<th><strong>Examples of drug information</strong></th>
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<tbody>
<tr>
<td>• What is a drug?</td>
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<tr>
<td>• What is the difference between a lawful drug and an unlawful drug?</td>
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<tr>
<td>• What is drug abuse?</td>
<td></td>
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<tr>
<td>• What is physical dependence and what is psychological dependence on drugs?</td>
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<tr>
<td>• What are the effects and risks of using inhalants, cannabis, alcohol, tobacco, etc.?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Important messages for street children</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Drug use reduces physical capabilities, despite the impression to the contrary. It therefore entails greater vulnerability to violence and threats from the environment; the risk of accident is also increased.</td>
<td></td>
</tr>
<tr>
<td>• Using drugs means running the risk of being arrested by the police.</td>
<td></td>
</tr>
<tr>
<td>• Using drugs may increase the risk of contracting HIV/AIDS since it may make you forget to take precautions or use a condom.</td>
<td></td>
</tr>
</tbody>
</table>
Examples of HIV/AIDS information

- What is HIV and what is AIDS?
- Main modes of HIV transmission.
- HIV/AIDS prevention.
- HIV screening.
- Existing treatments, which are expensive, constrictive and often not accessible.

Important messages for street children

- Even healthy-looking people may be HIV-positive and transmit the AIDS virus to their partners.
- Nobody recovers from AIDS.
- No healer or plant can cure an AIDS sufferer.
- The only way of avoiding HIV/AIDS during intercourse is to use a condom.
- HIV/AIDS gradually reduces physical capabilities, thus making survival on the street more difficult.
- HIV/AIDS compromises an individual’s future, including starting a family, having children, etc.

From being receivers of information they must become the actors in a process of reflection that helps them understand the risks to which they are exposed individually and collectively. That reflection may be structured around questions relating to the children and their types of behaviour, such as the questions listed below. It is no longer drug use in general but “my” drug use, i.e. that of the child thinking about the question, that is considered. The same applies to HIV/AIDS, with children being led to question their own risk-taking.

Information/Considerations regarding the HIV/AIDS risks to which the children are exposed

- Do I have frequent sexual intercourse?
- Do I change partners often?
- Do I use a condom each time I have sex?
- Do I know how to use a condom properly?
- Do I feel able to ask my partners to accept the use of a condom?
- Have I already had a screening test?
- How must I change my behaviour to avoid exposing myself to HIV/AIDS?
Information/Thoughts for the children regarding their own drug use

- What drugs do I use?
- To what dangers am I exposing myself?
- What are the effects of the drugs that I take?
- Why do I use these drugs?
- At what time of day do I use drugs? How many times do I take drugs during the day?
- What bad experiences have I had because of drugs?
- What can I do to stop using drugs?

Choosing the methodology

The choice of methodology for these information activities is crucial. Let us take two examples:

**Case No. 1.** A childcare worker contacts some street children and invites them to a short briefing session on drugs and HIV/AIDS. The children make the effort and attend the meeting. The childcare worker, standing at the front, explains the dangers of drugs and HIV/AIDS, emphasizes the seriousness of these afflictions and tells them that they are in a high-risk category because of their behaviour and way of life, that they are taking a lot of risks and that they are putting their lives in danger. The childcare worker has prepared his talk well; he speaks for a whole hour. Once he has finished, the children still present ask questions: “What can we do about AIDS?”; answer: “You must use a condom whenever you have sex”; “And drugs?”; answer: “You must go to the specialist services for help to sort things out”; “Right, children, I must leave you. Now you know about drugs and HIV/AIDS, so don’t do anything silly, OK?”.

**Case No. 2.** The childcare worker goes to an area that is home to children whom he has met before. Today they have decided to discuss HIV/AIDS. The presentation of the data is brief, and the information is objective and neutral. Visual supports are used (large sheets with drawings based on information previously obtained from the group). To make clear the explanation of the condom, the children are invited to practise with pieces of wood. There is open dialogue with the childcare worker, and discussion between the children is encouraged. “Did you know these things about HIV/AIDS?”, “Do you use a condom whenever you have sex?”, etc.

The childcare worker then suggests that the children should engage in role-play representing two partners negotiating the use of a condom, one of the partners being fiercely opposed to it. Despite being play, this activity sparks serious discussion of the subject.

To round off, the childcare worker proposes to return the following week to discuss how all this has been put into practice and, in particular, the difficulties and obstacles encountered. He also promises to deal, in future meetings, with the subject of drugs. He leaves them with an invitation to come and see him: “You know where to find me during the day: at the XX centre. Don’t hesitate to drop in; and here’s another copy of the map showing how to find it”.

These two examples, although somewhat caricatured, illustrate two different methodologies, the former being less likely to achieve its objective.
In his eagerness to be exhaustive, the childcare worker giving the first presentation has disregarded what these children are like and the purpose of his intervention; the aim should be not to tell them “everything” about drugs and HIV/AIDS but to explain to them clearly that they are exposed to specific risks and that they can protect themselves.

The first presentation may also be criticized for:

- The guilt-inducing nature of its message
- Its failure to catch the audience’s attention
- The lack of dialogue with the children, who must be content with a passive role.

In the second presentation, the childcare worker has taken into account the children’s particular characteristics, namely:

- Their low level of education
- Their age
- Time constraints
- Their great distrust of adults
- Their specific risks in terms of drugs and HIV/AIDS.

Consequently, he has made appropriate and judicious choices with:

- A group activity
- Follow-up if the children so wish
- An active methodology in which the children learn by doing and by assimilating knowledge (use of condoms, role-play)
- A participatory method (dialogue, discussion, exchange, etc.)
- A simple, accessible and attractive presentation
- A positive attitude that creates a climate of trust and attention
- The decision to deal with a single topic (HIV/AIDS), thus avoiding confusion and limiting the information to be digested.

Other conditions may be combined to optimize the transfer of information:

- Show that behavioural change does not hamper freedom of action but, on the contrary, broadens it.
- Emphasize the benefits of behavioural change in terms of new abilities, satisfactions and prospects in contrast to continuing high-risk behaviours.
- The desired change in behaviour must be realistic and within the target population’s reach.
• The message must be repeated and must enable the children to identify with it.

Strategy 2: Developing the children’s ability to apply their knowledge

Information is only one aspect of preventive action. For the children to apply their knowledge about drugs and HIV/AIDS, two obstacles must be removed: their living conditions and their psychological vulnerability.

The existential constraints that have a determining influence on behaviour must be changed and allow the children to live in a more favourable environment with better prospects – or indeed just one prospect: the possibility of a future.

It is only once they have been relieved of their basic anxieties about survival and defending themselves in hostile surroundings that the children will be able to realize that tomorrow, and the next day, and the day after that, they will still be alive and able to make plans, which may thus warrant their taking preventive measures today. At a more personal level, they must acquire or improve their skills and achieve a level of self-esteem sufficient for them to feel able to overcome the difficulties of behavioural change and, above all, to sustain it over time. These are the circumstances – a change in their environment and development of their personal abilities – in which they will be able to apply their knowledge about drugs and HIV/AIDS, i.e. they will change their current high-risk behaviour in order to protect the future that they are now able to imagine for themselves. Rehabilitation programmes of whatever nature, provided that they respect the children’s dignity and integrity, are suitable for helping them to advance along this path. They can offer an alternative to the street and enable the children to acquire personal and occupational skills.

Thus, to carry weight, preventive education for this population must be structured around two complementary fields: transmission of information (Strategy 1) and a practical response to the children’s needs (Strategy 2). Under these circumstances, information and awareness activities will have a major impact and a start can be made on altering conduct. The children are reader to listen and learn; they see the possibility of a future for themselves; there is an obvious link between their own lives and the risks described, and they realize that drug use and HIV/AIDS are not compatible with the new life they are planning.

Even if the complementary approach of information work plus rehabilitation programme is used, success is not immediately guaranteed. Taking children off the street and helping them to rehabilitate themselves is not easy and there are many hurdles. These are intrinsic, i.e. they relate to the children, who commonly show strong resistance to participating in any sort of programme. Abandoning the street and, in particular, making a successful transition from the street to a reception centre is especially difficult. Fitting into a centre requires a change in behaviour and the acceptance of certain rules to which the children have difficulty submitting: they must agree to stop taking drugs, observe a timetable, take part in activities and adapt to new communal living arrangements. Yet at the same time the appeal of the street, where they have established strong emotional ties and which, after all, offers them advantages such as extensive freedom of action, remains powerful. When they first try, the children have great difficulty in accepting immediate sacrifices for a medium- or long-term future that they cannot yet imagine, and return to the street is frequent.

Barriers to rehabilitation are also inherent in the programmes, their quality and adequacy. There is often a gulf between what the children are offered and what they want and require; there may be an excessive and too immediate demand for change and an unsuitable approach to the problem. For example, closed reception centres – nevertheless considered the best option by some – run counter to solving the problem of street children. Children will only invest in a rehabilitation project if they
are persuaded of its benefits; however, if they are forcibly confined they will long for one thing only: to escape and rejoin their gang.

There is no set method for helping a child off the street; there are as many alternatives as there are personal histories. Two aspects – one educational and the other psychosocial – should nevertheless be incorporated in order to optimize the chances of success.

The educational aspect of rehabilitation programmes

The object of rehabilitation is to make the children independent and able to come to terms with their existence. One of the best ways of doing this is to give them vocational training and help them to acquire vocational skills that they can turn to account in the labour market. The training offered should be based on market requirements and the children’s skills. It may fall within fields as varied as mechanics, carpentry, printing or even micro-enterprise management. It is this last option that has been chosen by the NGO Street Kids International to help street children in Sudan. The originators of the project were prompted by two established facts: the inadequacies of mail delivery on the one hand and the children’s knowledge of the capital’s streets and topography on the other. They thus had the idea of making the children’s skills available to businesses and the community by setting up a courier micro-enterprise.

What is particularly interesting about this project and in large part explains its success, is the fact that the children have played a central role in the process and have been involved as the main players and stakeholders. They were given brief management training and received some bicycles, to be paid for out of the first profits. They were not forced to do this work but had the option of becoming fully and personally involved in a project that was their own and that enabled them very specifically to improve their situation by changing their status from street children to managers of a business.

This project has other advantages: it is based on a local situation and established needs, the initial capital outlay was minimal, and the project is accessible to the children, among other things because it has grown out of their skills. In conclusion, it is worth emphasizing the indirect favourable impact of this type of programme in preventing the risks associated with drugs and HIV/AIDS, since it enables the children to invest practically in their future and to understand that these two threats are incompatible with their plans.

The psychosocial aspect of rehabilitation programmes

Several times in this document the key importance of psychological vulnerability (low self-esteem, emotional wounds, deep trauma, etc.) on behaviour has been emphasized. Conversely, having certain personal skills proves to be a protective factor and a force for positive development. Field experience shows that one of the main obstacles to rehabilitation is often the children’s psychic distress. They often experience suffering owing to a recognition of their failings and their inability to surmount certain difficulties, and, because they consider themselves worthless and undeserving of a better life, they lose heart, abandon the rehabilitation process and return to the street.

The psychological aspect is therefore crucial in preventive education. Programmes must incorporate it in order to place the rehabilitation process on a sound footing that will guarantee the child’s favourable development in the long term. Given the trauma suffered, psychotherapy will probably be necessary in most cases. For all children, the acquisition of psychosocial skills is essential.

Generally speaking, the activities for providing such skills aim to develop the following:
The various measures of preventive education for street children may be summed up as follows:

1. Emotional control: ability to recognize one’s emotions, identify their causes and control them, for example by mastering anger and aggressiveness, expressing frustrations non-violently and developing positive feelings about oneself.

2. Stress control: self-control, ability to concentrate, having a sense of responsibility.

3. Better interpersonal relationships: empathizing with others, listening, understanding and accepting their differences, being able to negotiate and solve problems in the event of disagreement, developing friendly and harmonious relationships and being able to communicate effectively.

According to the World Health Organization, for example, the main psychosocial skills acting as protective factors are the following: problem-solving ability; decision-making ability; a critical approach; effective communication; good interpersonal relations; self-awareness; empathy with others; stress management; emotional control.49

Adopting this psychosocial approach to the problem of street children entails, in the first place, changing attitudes towards them and acknowledging their strengths. The latter tend to be buried by negative considerations such as the children’s “violent”, “aggressive”, “antisocial” or “rebellious” character, their “dirty”, “drugged” appearance, etc. This perception is founded on a normative model to which street children cannot correspond because they do not live in “normal” conditions. Street children are not “aggressive”, “violent”, “antisocial” or “rebellious” by nature; they become so because their environment requires them to be so if they are to stay alive. To ignore this is to condemn them out of hand and to attempt merely to put them back “on the straight and narrow”. Yet if street children are considered in terms of their personal backgrounds and living conditions, they reveal exceptional qualities that are just asking to be used.

Understanding the children in terms of these qualities alters the approach, with “Your behaviour is antisocial and not fit for life in society; you are impulsive, dirty and aggressive; you’ve got to change all that” being replaced with “You have great qualities which have enabled you to survive in difficult circumstances and which you don’t suspect but which will enable you to pull through; I’m going to help you do that”. It is around these qualities or “strengths” that support for the children must be built, among other things because the positive attitude towards them will help to improve their self-image and, as a result, to develop a belief that change for the better is possible.

These strengths may be personal qualities but also positive values, commitments, beliefs, aspirations, dreams and any other positive element in the child’s life. Even if they do not really believe in it, they all, for example, dream of a better future; they aspire to become electricians, mechanics, carpenters, tailors, cooks, teachers, nurses or even doctors.50 These are so many factors that can be harnessed for change and serve as a basis for developing psychosocial skills.

In conclusion…

The various measures of preventive education for street children may be summed up as follows:

1. Provide objective information on the risks of drug use and HIV/AIDS.
2. Make the children aware of the risks to which they are exposed (“it could happen to me”).
3. Help to reduce the impact of extrinsic risk factors by offering an alternative to the street.
4. Help the children to develop a life plan and acquire vocational skills.
5. Recognize that high self-esteem and the acquisition of personal skills are protective factors with regard to drug and HIV/AIDS risks.

Last but not least, preventive education programmes must be evaluated, especially while they are being implemented, to ascertain whether objectives have been met, in order to detect any programming or methodological errors or the existence of obstacles, since this enables the necessary adjustments to be made where appropriate.

<table>
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<tr>
<th>Street children’s skills</th>
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<tr>
<td>• Ability to adjust</td>
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<td>• Resistance to hostility</td>
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<td>• Resourcefulness</td>
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<td>• Pragmatism</td>
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<td>• Ingenuity</td>
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<tr>
<td>• Initiative</td>
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<tr>
<td>• Sense of solidarity, sharing and generosity</td>
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<tr>
<td>• Sense of honour and keeping one’s word</td>
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<tr>
<td>• Loyalty</td>
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<td>• Will to live despite everything</td>
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CONCLUSION

In a situation where drugs and HIV/AIDS are gaining ground, street children are among the most vulnerable populations. Preventive education appears a possible alternative to a certain death sentence.

It must form part of a holistic approach that endeavours not only to provide information on risks but also to give children the means of putting their knowledge into practice. This entails physically protecting them from the street environment and helping them to exchange their anxieties about day-to-day survival for a life plan that will enable them to envisage a future. It also means encouraging the acquisition of psychosocial skills that make it possible to overcome rehabilitation problems in the long term and adopt safe behaviour. Preventive action therefore extends well beyond drugs and HIV/AIDS.

Given the problems faced by these children, preventive action might also take place at an earlier stage. It might be expedient to focus on reducing the risks of a child becoming a “street child”. The causes are well known, and action at this stage might nonetheless prevent the ruin of thousands of children, some of whom it will be impossible to rescue. To this end, is it not possible to combat poverty and the inequalities of development more effectively? Is it not possible to prevent poverty-stricken parents from having to place their children in foster homes with no guarantee for their future? When everything falls apart around a child, is it not possible to offer an alternative to the street? Can the provision of education not be improved to guarantee for all a level of knowledge that will give them a recognized place in society and a job? Is it not possible to break the silence that condemns young people to remain ignorant about their sexuality? And then, at a later stage, is it not essential to give child HIV/AIDS sufferers unrestricted access to the treatments currently available on the market?

We cannot conclude without calling for political involvement at the highest level, since it is only when the highest echelons of government give a firm, practical and lasting commitment to combat these afflictions that the latter will lose ground. This political commitment must not ignore that most underprivileged of populations: street children.
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