PROGRAMME ON SUBSTANCE ABUSE

A two-way street?

Report on Phase II of the

PSA Street Children Project

DIVISION OF MENTAL HEALTH AND
PREVENTION OF SUBSTANCE ABUSE
WORLD HEALTH ORGANIZATION
ABSTRACT

The WHO/PSA Street Children Project began in 1991, and in 1992, a meeting was held in Geneva with participants from the initial participating sites from seven countries: Brazil, Egypt, Honduras, India, Mexico, the Philippines and Zambia. A report on the work to date was prepared in 1993 ‘A one-way street?’. Phase II of the project was initiated at a meeting in Geneva in 1994, where there was participation from various UN agencies, other international governmental and nongovernmental agencies, governments and research and training institutions. The focus of Phase II was to: continue the development and implementation of the WHO/PSA methodology; develop and pilot a training package for street educators; develop and pilot a monitoring and evaluation manual for street children agencies.

This report ‘A two-way street?’, evaluates Phase II of the project. Approximately seventy governmental and nongovernmental agencies directly participated in the project representing seventeen countries (Australia, Brazil, Canada, Colombia, the Czech Republic, the Dominican Republic, Egypt, Honduras, India, Mexico, Nicaragua, Paraguay, the Philippines, the Russian Federation, Tanzania, Uganda and Zambia). Additional countries have participated in certain components of the project.

Local data has been collected from at least 2500 street children through focus groups and other rapid assessment techniques, and over 5000 street children have been directly involved in project activities, with many more indirectly involved.

Over 700 individuals have received training based on the WHO/PSA methodology, mostly using the training package, sections of which have been translated into Czech, Hindi, Marathi, Russian, Spanish, and Swahili.

The evaluation found that a number of revisions were required to the training package, information flow needed to be improved, community advisory committees needed strengthening in some sites, more attention to monitoring and evaluation activities was required, as were more opportunities for exchange among the participating sites and for the increased participation of street children in all aspects of project functioning. In addition, there was the need to develop a more regional structure, possibly by greater involvement of WHO regional advisers, establishing regional training and research centres or networks, and model programmes.
Who taught you to beg?: "Hunger - the street taught me how to beg." (Cairo street boy)

"We have vices, but we work very hard. We cannot expect the government to take care of us, we need to do something for ourselves." (Mexico City street boy)

Song: "Twabonabona nnyo Kukubera Kukasasiro Bangi netu daaga Lwwabutamanya. Singa twamanya netutajja Kusariro Osanga te twandibbye." ("We suffered a lot when we came to scavenge on the garbage heap. Many of us suffered because of ignorance. If we had known we wouldn't have come to the streets.") (UYDEL Kampala)

"Children attribute harassment by the security personnel to lack of shelter. The boys often get arrested as thieves when they go to the verandas at night, while the girls have to save themselves from arrest by consenting to sex demands by the security personnel." (Report from UNOGT Kampala)
About substance use: "Everything gets too big...the noise gets too loud, crowds get too much, it gets even hotter...it really is not worth it...but it passes the time." (Mumbai street boy)

"You can see the moon this small and then see it grow and then not see it anymore." (Mexico City street boy)

"You are not hungry, cold or alone... you can't imagine how boring the world is without drugs." (Prague street boy)

Poem: "Woe to you street kid, sun scorched, rain soaked, relying on the garbage can for food, fellowship and warmth. Because people call you a wild cat - muyaye." (UYDEL Kampala)

"It was death I was trying to escape, but it is death I have found." (HIV+ Mumbai street boy)
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1. INTRODUCTION

1.1 WHO/PSA Street Children Project - a brief history:

In 1991, the Programme on Substance Abuse of the World Health Organization responded to requests to assist in providing better interventions for street children and youth who use psychoactive substances. There were concerns about the impact of substance use among this growing and vulnerable group of children and young people on their health and overall development. Many organizations felt powerless or inadequate in the face of increasing use of psychoactive substances by these young people, who had already experienced so much in their short lives and who often bore great burdens as a result. Their lives were often precarious and filled with violence, and they were often subject to marginalization, discrimination and even exclusion from health and welfare services.

For the purposes of the Street Children project, a number of distinct groups of young people have been subsumed into the category 'street children': (a) those young people living on the streets, whose immediate concerns are survival and shelter; (b) those young people who are detached from their families and living in temporary shelters, such as abandoned houses and other buildings, youth refuges/shelters, or moving about between friends; (c) those young people who remain in contact with their family, but because of poverty, overcrowding, school drop-out, peer influence or sexual or physical abuse within the family will spend most days on the streets; and (d) those young people who are in institutional (residential) care, who have come from a situation of homelessness and are at risk of returning to a homeless existence.

Often these children, especially those who use substances, are treated as criminals because they are homeless. Others have chosen, for whatever reasons, to spend most of their time on the streets only returning home to sleep. Many are arrested for vagrancy or rounded up by the authorities when visiting dignitaries are due to arrive, or when there is a decision to remove them for other reasons. Sometimes they are placed in institutions as neglected children. Most workers agree that these responses do not really assist, and often make the situation worse by exposing the children to more violence and opportunities to learn much more about crime and substance use.

Other solutions that have been tried relate to supply reduction strategies aimed at reducing or eliminating the availability of substances. These tend to be ineffective; supplies remaining and often increasing; and many of the substances used by street children are readily available; for example, glue, solvents, petrol, commercial and domestic liquor, tobacco, cough syrups, and so on.

There is also ample evidence that when preferred substances are in short supply, or eliminated all together, others are found to take their place. Often these replacement substances demonstrate a high degree of inventiveness on the part of the street children. For example, in Lusaka, Zambia, there are reports of street children collecting raw sewerage, and inhaling the gases produced after it has been placed in containers for some days (it is referred to as 'jenkem'). In Rio de Janeiro, Brazil, street youth mix alcoholic beverages (cachaca) with glue and other aerosols (bin). In India and Philippines, there are reports of children moistening carbon and Xerox paper and placing the paper over their faces and inhaling.

In Egypt it has been reported that children inhale fumes from burning certain sedatives, referred to locally as 'cockroaches', and in Morocco inhale fumes directly from car exhaust pipes. In Saskatoon, Canada, youth carry around sections of garden hose to place into gasoline tanks to inhale fumes. In Kampala, Uganda, some children inhale aviation fuel after it has been variously treated by them. Across the world street children inhale a wide range of readily available and licit solvents, such as shoe-makers and 'repairers' glue.
It is obvious then, that if most attention is directed toward reducing the supply of both licit and illicit substances, this may have little impact on the substance use of street children, other than to lead to a change of preferred substance(s) used, some of which may be more hazardous to health.

Also found to be rather ineffectual are naive attempts at ‘drug education’ which aim to educate or scare young people away from substance use, or merely attempt to teach them refusal skills. Evaluations of such approaches have mainly yielded neutral or negative outcomes in developed countries, and there is no reason to assume the outcome would be any different in developing ones. These approaches also tend to ignore the functional nature of much substance use, especially that of street children, and the contexts within which it is initiated, escalates, is maintained, and possibly becomes problematic.

Consequently, the Programme on Substance Abuse developed the Street Children Project which attempts to provide a comprehensive approach to understanding and responding to substance use by street children.

An initial meeting was held in Geneva in February 1992 of representatives of key organizations involved in working with street children from seven countries: Brazil, Egypt, Honduras, India, Mexico, Philippines and Zambia. At this meeting the goals and objectives of the project were developed and the methodology refined. Phase I of the Street Children Project then began, with the main aim of trialing the methodology and providing feedback and data.

The overall project aim was agreed to be: to improve the health, welfare and quality of life of street children in the selected sites.

The specific aim of the project was: to facilitate the work being done by existing agencies which currently provide services for street children, with a particular focus on improving strategies for the prevention, assessment and management of substance use related problems in this population. The project aimed to:

- assist local organizations in identifying the needs of street children;
- assist local organizations in planning a coordinated and comprehensive response to the identified needs, and thereby develop appropriate prevention and treatment strategies;
- facilitate local organizations in developing and/or strengthening structures which will involve the local community, and particularly street children, in the development and implementation of local projects;
- facilitate the work of local organizations in improving the accessibility of primary health care and welfare services for utilization by street children who use psychoactive substances; identify those obstacles which impede access to these services for youth; and to ensure that this population is not discriminated against;
- facilitate, through training, an improvement in the skills of health care workers and other community members in dealing with the health problems of street children, particularly those problems related to substance use;
- improve the community’s attitude toward and understanding of the problems of street children through the activities of the local organization, and therefore reduce the likelihood of discrimination of this population, particularly for those who use substances;
- promote the utilization of operational research, as feasible, in order to facilitate information gathering and programme management;
- promote the use of empowerment methodologies by local organizations as an important mechanism for dealing with substance-use-related problems among street children;
- identify and collaborate with appropriate agencies, which work with street children;
• establish a community advisory committee at each site with representation from services which work with or are in contact with street children including: local welfare and other agencies involved in emergency relief; housing; education and vocational training; local medical and other health care services; the criminal and/or juvenile justice system; the local community including the business sector; and street children themselves;
• develop a mechanism for establishing representative focus groups of street children and a structure within which these groups may be conducted;
• develop a strategic plan for the coordination of activities (including prevention, treatment and rehabilitation) directed at improving the health (in its broadest sense) and welfare of the local population of street children;
• engage formally or informally an appropriate medical service by the local organization to provide primary medical care to the population of street children;
• develop an advocacy role for the community advisory committee with the purpose of:
  - improving community attitudes toward and understanding of the problem
  - recognizing and tapping into sources of funding and other resources
  - reducing discrimination against street children
  - influencing government policy and practice at all levels
  - identifying obstacles to change;

• develop and utilize operational research methods, as far as possible, to test the alternative methodologies of intervention; and
• develop and utilize empowerment methodologies by local organizations where appropriate.

Briefly, the methodology agreed on was as follows:

• establish a community advisory committee, if one does not already exist, and ensure broad representation;
• ensure that staff are trained in the WHO/PSA approach;
• establish and use a mechanism for engaging and consulting with street children to identify needs and appropriate responses, particularly through focus groups;
• develop in a participatory manner a strategic plan;
• establish participatory monitoring and evaluation processes if not already existing; and
• establish a capacity to provide for the identified health needs of the children.

An evaluation report on Phase I was completed in 1993 (A *one way street*?: report on phase I of the street children project, WHO/PSA/93.7) which made recommendations and suggestions for Phase II.

The first evaluation showed that the methodology was well received, was practical and feasible. Sites conducted focus groups which they found to be highly useful and effective in gathering data to utilize for the development of action plans. In particular, they discovered information about substance use that had been unknown to them, and which had serious implications for their target populations (e.g. new and more hazardous substances being used and changes from non-injecting to injecting drug use). The Modified Social Stress Model was seen as a particularly significant contribution, as it led to a more broad-based understanding of substance use by individual children, groups and the community as a whole.

The recommendations from the evaluation of Phase I, included: a call for another and expanded meeting of all sites (new and old); the review of the focus group instruments (Questions and Issues Menus) with an aim of reducing their length; encouragement for cooperation between UN agencies and other international governmental and nongovernmental organizations; the need to increase
efforts to develop procedures to more rigorously monitor and evaluate projects; the need for training materials; the desirability to focus more on resilience among the children; and the need to increase the participation of street children in all aspects of the projects.

In summary, the sites were enthusiastic and ready to proceed to Phase II. Securing funding, however, hindered the timing of the next steps. Despite this difficulty, more sites joined the project having found their own financial resources. Also, during this time WHO/PSA initiated implementation of the recommendations from the first evaluation. In particular, considerable work was undertaken to refine the Questions and Issues Menus, and prepare draft contents for a training package and one for monitoring and evaluation of projects. Preparations for a resilience study were undertaken.

After funding had been obtained from the International Organization of Good Templars (IOGT), a meeting was held in Geneva in April 1994 for all original and a number of new project sites. Also at the meeting were representatives from a variety of UN agencies and other international agencies, international and local nongovernmental organizations, research and training institutions, governments and observers. There were over 100 participants from 32 Member States and Governments, including 22 representatives from 19 participating sites in 15 countries. Apart from WHO, seven United Nations agencies were represented: including ILO, UNDCP, UNESCO, UNHCR, UNICEF, UNICRI, and UNV.

The meeting endorsed the goal, objectives, conceptual model and methodology of the project. Focus groups were regarded as the core for rapidly assessing situations with young people. It was also stressed that the ‘health, welfare and quality of life’ of street children was the goal of the project, and that attention to substance use raised many opportunities to provide broad interventions to achieve this goal.

Highlighted was the need to pay much greater attention to working with families, as many of the children (up to 80 per cent in some sites) returned to the families regularly, if not daily. Also highlighted was the need to focus more on the particular needs of street girls and young women on/in the streets and issues of sex, sexuality and risk behaviour among both male and female street children. As for Phase I, site visits by WHO/PSA staff and consultants were highly valued and their continuation strongly requested.

This meeting shaped Phase II of the project and set its aims as:

- continuing to implement and develop the methodology agreed upon at the last meeting, and
- developing and piloting two resource handbooks: *Street Children, Substance Use and Health: Training for Street Educators package; Street Children, Substance Use and Health: Monitoring and Evaluation of Street Children Projects.*

Following the meeting, the training package was further developed in Manila and the monitoring and evaluation handbook in Mexico City. Both these resources were then further developed and finalized in Geneva.

1.2 Funding for the Street Children Project:

Initially, UNDCP provided funding to WHO/PSA to initiate the project. However, this could not be sustained and alternative sources were canvassed.

The International Organization of Good Templars (IOGT) contributed substantial resources, and assisted in the expansion of the project.
The MENTOR Foundation, a privately funded foundation working in association with WHO and engaged in prevention of youth substance use, enabled the second phase of the project to be completed and supported the First Ladies Initiative in the Region of the Americas.

At each site additional support and funding was provided by a range of different local organizations. At some project sites WHO/IOGT/MENTOR funding acted only as seed funding with most funding raised locally. Some sites were supported solely through local funding. In a number of sites the government was the major funding body for the project.

1.3 Tasks required for Phase II of the WHO/PSA Street Children Project

(a) Implementation of Street Children Project Methodology

This involved the implementation of the project methodology with the revised instrumentation, which entailed:

- Focus groups with both service providers and street children. It was anticipated that focus groups with street children might be conducted every four months. Thus, there would be a series of focus groups, three per year with roughly the same population(s). Other groups could be held as the need arose. Not all questions from the Questions and Issues Menus were necessary to ask within each series of groups, but at least once all should have been covered. This was to assist in developing a local profile of street children who are, or could be, provided with services at the participating sites. However, the substance use and risk behaviour sections were to be covered by all groups.

Focus groups with service providers, other than the organization’s own staff, were to be conducted at least twice per year. These groups were to contain as wide a range of service providers as possible. An aim was to lead to increased or consolidated networking, as well as yielding information of importance. Not all the menu questions were to be used; the choice was up to the individual site. However, within all groups the substance use and risk behaviour sections were to be covered.

- Consolidation, renewal and/or expansion, or development of Community Advisory Committees.
- Revision of Action Plans, if necessary, particularly in the light of any significant new information yielded by the focus groups.

A report was to be provided on the above activities by December 1995.

(b) Piloting of the Draft Training Package for Street Educators.

The second task was to implement, as far as possible, and report on the Draft Training Package. Participating organizations were to conduct initial and ongoing training for their own staff utilizing some or all of the modules of the draft package, but at a minimum the modules on Substance Use and Interventions. In addition, organizations were to offer, where possible, training to other workers and volunteers, provide sessions to tertiary and other training courses, the police, teachers, welfare workers, and so on. At least two internal and two external training programmes were to be conducted. A report on training was expected by December 1995.
(c) Evaluation of the Draft Monitoring and Evaluation manual.

The third task was to implement, as far as possible, and report on the Draft Monitoring and Evaluation manual. It was anticipated that organizations would develop, or possibly refine if already in existence, monitoring and evaluation strategies from the draft manual for their own organizations. Ideally, they may also assist other organizations. A report describing monitoring undertaken and the strategies on outcomes of evaluation of impacts was to be provided by December 1995.

(d) A fourth, and optional task was to participate in some cross-cultural research on street children by developing local profiles according to a set of standard questions.

The reports requested in (a), (b), and (c), above related to: background information on agency and site; the overall implementation of the Street Children Project, including information on focus groups, community advisory groups and action plans; piloting of the training package; and piloting of the monitoring and evaluation handbook. A set of questionnaires was developed to provide feedback on the training package and the monitoring and evaluation handbook, and information on the trainers and trainees. Also a project evaluation framework and format for reporting was developed for the site visits and for participating organizations to use in preparing their final reports to WHO/PSA.

1.4 Sites

As of July 1996, the sites listed below comprise the WHO/PSA Street Children Project. Many more are in contact with WHO and will join soon. New sites will most likely be developed in the Republic of South Africa, Central and South America, India, Nepal, South East Asia, Europe and in the Arab region.

1.4.1 WHO/PSA funded

WHO/PSA provided direct funding to a number of sites which were contracted to complete the series of specified tasks outlined above. Cairo/Alexandria (Arab Republic of Egypt), Kampala (Uganda), Lusaka (Zambia), Manila (Philippines), Mexico City (Mexico), Moscow (Russian Federation), Mumbai (formerly Bombay, India), Mwanza (United Republic of Tanzania), Prague (Czech Republic), Rio de Janeiro (Brazil), Tegucigalpa (Honduras) and Thiruvananthapuram (India).

1.4.2 ‘First Lady’ sites

These sites are an initiative of the wives of heads of state and government of the Americas, and are under the patronage of the First Ladies of the respective countries. At this stage there are four sites: Asuncion (Paraguay), Colombia (13 cities), Dominican Republic (Santo Domingo), and Managua (Nicaragua).

1.4.3. Others, independently funded

These sites mostly requested to become involved in the WHO/PSA Street Children Project or were identified and invited to join at their own expense. In some cases these sites did not require additional funding as the methodology of the Street Children Project easily fitted into current operations. For others, extra funding had to be sought. As they were not funded directly from WHO/PSA, these sites were free to choose particular components of the project to implement and report on. The sites included: Cairo - Village of Hope (Arab Republic of Egypt), Dar es Salaam
(United Republic of Tanzania), Halifax (Canada), Kampala - UNOGT (Uganda), Lusaka - Commonwealth Youth Programme (Zambia), Saskatoon (Canada), and Sydney (Australia).

The following accounts are based on reports prepared by the sites and those of visiting consultants and WHO/PSA staff. The type and quantity of information provided varied, despite a request that it be prepared in a particular format. Some funded sites complained about the workload required to prepare their reports. This was despite having submitted proposals and budgets which were funded, and the signing of contracts which included the dates for provision of reports on specific aspects of project implementation.

As a result of the variation in the details provided, there are gaps in the information. This is undesirable as it makes it difficult to provide an overall picture of the implementation of the project.

For some sites, however, information is lacking due to later starting dates. These later dates have been due to a combination of reasons, including late arrival of materials, late arrival or absence of translations, late arrival of contracts and late arrival of funds. At the central coordinating level, funding difficulties contributed to significant delays, particularly with regard to the undertaking of site visits.

WHO/PSA was also unable to provide the level of supervision desirable or requested due to financial constraints. Site visits were minimal, and some sites have only had the benefit of one visit by a consultant or WHO/PSA staff member, in some cases for a period of only two or three days. The newest sites have also not had the benefit of attending the first or second meetings for the project held in Geneva. Thus, they have not had the opportunity to discuss ideas and share strategies to overcome obstacles that those who attended the meeting(s) had.

All of this has resulted in difficulties in implementation at some sites which have only become obvious at a much later stage when a site visit was possible. It has also resulted in some sites feeling rather neglected as they attempted to implement a methodology and use a conceptual framework which may have been quite unfamiliar to them, or clashed with what they were receiving from elsewhere.

Nevertheless, many of these sites have achieved remarkable results in implementation and provision of detailed and helpful reports, and are to be commended.

The implications for the next phase of the Street Children Project are that there will need to be greater supervision and technical support. Some of this can come from an increase in independent site visits, but also from inter-site visits, as well as by establishing regional resources, supervision and support.

2. AGENCIES/ORGANIZATIONS AND SITES

The agencies/organizations implementing the project are quite varied. Some are established, predominantly welfare-oriented service providers (e.g. Alexandria and Cairo), some are based on community development methodologies (e.g. Manila), and others focus more on children's rights (e.g. Mwanza). Yet others are collaborations between governmental and nongovernmental organizations, such as ministries of health or education, and one or more nongovernmental organisations (e.g. Managua, Moscow and Prague).

In some locations, the project fits within a national project for street children (e.g. Colombia and Philippines), in others the nongovernmental organization is a part of an international NGO (e.g.
ADIC-India, ADIC-Tanzania, UNOGT Uganda, and the Moscow site are all members of IOGT. Some sites are discrete local NGOs (e.g. TASH Foundation in Mumbai, and Project Alternatives and Opportunities' in Honduras), or belong to particular religious groups or congregations (e.g. the Salesian agencies in Colombia).

Some are alliances of a number of street children organizations and research institutions (e.g. Asuncion, Brazil, Paraguay and Rio de Janeiro). In Cairo, one project is supported by the Arab Council for Childhood and Development (ACCID), which is planning to gradually introduce street children projects in other countries in the Arab region. In Central and South America, the project in some sites is an initiative of the Wives of Heads of State and Government of the Americas, and under the patronage of the First Ladies of the respective countries.

This section presents basic data on each of the sites in a standard format, as far as possible. First, contact details are provided, followed by the goal/mission and objectives of the implementing agency/organization. This is followed by information as provided on the target population, staffing and then a section which attempts to capture something of the context within which implementation is occurring. The section on context makes comment, where possible, on the population, numbers of street children, living conditions, location of the agency/organization, general substance use of the population, and then specifically of street children and youth, and their health status. Then follow sections on the activities being undertaken, the integration of the Street Children Project into the existing agency/organization and the numbers of street children involved. All of this information was requested from each site, but, as noted above, variously reported.

The activities provided by each agency/organization tend to have some elements in common, especially the attempts to meet basic needs (such as food, clothing, some shelter and non-formal education and recreational activities). They tend to vary in the attention paid to health issues, especially in ensuring a link to, or on-site provision of, medical/health services (e.g. Tegucigalpa and Thiruvananthapuram both have medical officers on the staff). Some provide residential accommodation and associated services only, others residential and other services which are available to non-residents (e.g. Mexico City and Prague). Some emphasize education and children's rights (e.g. Mwanza), and others are basically outreach services which work primarily within the streets and markets where the street children are found (e.g. Managua and Mumbai).

The level of integration of the project into existing activities and structures also is varied. In some situations new structures and programmes needed to be developed (e.g. Colombia, Managua and Moscow), in others it integrated easily into existing activities (e.g. Cairo, Kampala and Sydney).

The staffing at the sites reflects differing orientations, ideologies, funding and availability. In some locations social workers predominate (e.g. Manila) and in others psychologists (e.g. Prague and Rio de Janeiro). Some sites employ ex-street youth, without formal qualifications, many of whom were encouraged to be involved in gaining relevant formal qualifications (e.g. Cairo, Manila and Thiruvananthapuram). More comment on the participation of street youth in projects will be made later.

Approximately 70 governmental and nongovernmental agencies are participating directly, reaching approximately 20 000 street children. In total there appear to be at least 5000 children directly involved in some activities connected to the components of the WHO/PSA Street Children Project to date.

Each site is now presented individually, according to the structure outlined above.
TANZANIA

Dar es Salaam

Alcohol and Drug Information Centre - Tanzania (ADIC-Tanzania)
International Organization of Good Templars (IOGT)
c/o College of Business Education
PO Box 1968
Dar es Salaam

Contact: Mr Thompson Mwakyanjala
Tel: ++255-51- 66184
Fax: ++255-51- 66096

This site has encountered considerable difficulties, and little of the WHO/PSA methodology has been implemented. A site visit was arranged, but when the consultant arrived, she could not make contact with the organization. The visit was eventually abandoned. After much correspondence on the part of PSA, a brief report from Mr Mwakyanjala was received, and is the basis for comments below.

ADIC-Tanzania has been attempting to collaborate with six other established NGOs: Child in the Sun, Tuamoyo, Dogo-Dogo Centre, Volunteers of Salvation (VOSA), Kwetu (Salvation Army), African Education Fund (AEF).

Goal/mission/objectives: Vary according to collaborating agency, and include: providing services to the needy and female sex workers, education and evangelism.

Targets: Vary according to agency, and include: street children, displaced, orphaned and abandoned children, poor communities, and female sex workers.

Staff: Staffing varies for the collaborating agencies mentioned above, and include religious leaders, teachers, administrators, social workers, and cooks.

Community and substance use: The population of Dar es Salaam is over one million, and the total population of Tanzania is in excess of 29 million.

A study was undertaken on substance use by street children in Dar es Salaam. One hundred and eighty one children were interviewed (145 male and 36 female), but not in line with the WHO/PSA Questions and Issues Menus, nor in line with the Modified Social Stress Model. The following information is based on that study.

Street children are exposed to many substances and are often used as couriers. Locally brewed alcohol, mainly ‘gongo’ or ‘Supa ya mawe’ are commonly used, as is cannabis (‘bhangi’). A local liquor made from coconut tree products is also used (‘mnazi’). Some cocaine and heroin use have been reported, and may be associated with changing international drug trafficking routes; however, use of methaqualone (Mandrax) was not reported despite its passing through the country en route to other nations. Glue, petrol, solvents and other inhalants are used by the street children.

Substance use is believed to be a coping mechanism and a source of pleasure and entertainment. Negative impacts of substance use were reported as: violence, impaired thinking ability, abdominal pains, loss of sight or hearing, skin diseases and other infections.
Family disruption and abuse are believed to be factors associated with the numbers of children on the streets of Dar es Salaam, the children coming from most parts of the country.

The agencies involved are located in various sections of Dar es Salaam, ranging from densely populated urban areas to more spacious sections of the city.

No further information provided.

**Programme activities:** The activities listed here are provided by the collaborating agencies of the network mentioned above.
- shelter
- basic services (e.g. food and clothing, bathing and washing facilities)
- education - formal and non-formal
- literacy classes
- vocational training in construction, gardening, carpentry, mechanics, etc.
- counselling
- drop-in facilities
- health and medical care
- evangelism.

**Integration of WHO/PSA Street Children Project into agency:** As mentioned above, ADIC-Tanzania has collaborated with a network of six other established NGOs and ADIC-India. Now that the internal difficulties facing ADIC-Tanzania appear to be settled, renewed efforts to establish the Street Children Project, in collaboration with the agencies listed above, will begin.

**Number of children:** Data not provided. Some agencies deal with beneficiaries other than street children.

**Mwanza**

**Kuleana Centre for Children’s Rights**

PO Box 27  Contact: Mr Mustafa Kudrati/Mr Dipak Naker
Mwanza  Tel: ++255-68-50486/50911/50510/50763
Fax: ++255-68-42402/50912
e-mail: kuleana@tan2.healthnet.org

**Goal/mission:**
- to promote awareness and advocacy about children's rights, with particular attention to the girl child;
- to facilitate children's rights to voice and self expression;
- to strengthen programming capacity in child rights in Tanzania;
- to provide essential services and support the rights of street children in Mwanza.

**Objectives:**
- to conduct and design tools for qualitative, action based research on child rights;
- to develop, publish and distribute innovative, child centred learning and awareness materials;
- to create community awareness and influence policy development on child rights;
- to strengthen staff and community capacity in child rights programming;
- to provide basic services to and support the rights of street children in Mwanza;
- to strengthen existing information base and accessibility;
- to participate in networking and information-sharing exchanges;
- to strengthen and implement effective planning, evaluation and organizational assessment processes at Kuleana;
- to strengthen and implement transparent stock, accounting and auditing practices.

**Target:** Street children in Mwanza.

**Staff:** Approximately 45 spread across three centres. Qualifications not reported, but appear to be in anthropology, sociology, law, education/health promotion and social work.

**Community and substance use:** Mwanza has a population of 100 000 out of a total population of Tanzania of over 29 million. Mwanza is situated on Lake Victoria and close to the Tanzanian borders with Burundi, Rwanda, Uganda and Zaire.

While the number of street children in Mwanza is unknown, Kuleana provided services to 1000 in one year. Numbers appear to be growing rapidly, with children as young as four being seen on the streets, due to increasing poverty, urbanization, and the impact of HIV/AIDS in weakening the extended family. In addition, family violence is pushing some children to the streets.

The main substances used by street children and adults are relatively cheap and readily available. They include: *bangi* (hashish/marijuana), *gongo* (illegally brewed local beer/spirits), petrol, tobacco, and to a lesser extent leaves from *bukoba* (chewed) and heroin. Substance use is believed to be widespread among the street children of Mwanza.

**Programme activities:**
- research
- documentation
- shelter
- public awareness and capacity building
- direct service provision
- training
- advocacy.

**Integration of WHO/PSA Street Children Project into agency:** Tends to remain a discrete activity.

**Number of children involved:** Approximately 100 children use the centre at any one time, with about 1000 individual children per year making contact.

**UGANDA**

**Kampala**

**Uganda Youth Development Link (UYDEL)**

PO Box 12659  
Kampala  
Contact: Mr Rogers Kasirye-Lugoloobi  
Fax: ++256-41- 267 836

**Goal/mission:** That youth be sustainably empowered to be self-reliant, in a way that best suits their potential, and to be useful and acceptable members of their communities in both development and moral dimensions.
Objectives:
- to develop special programmes for urban street youth which are targeted toward the improvement of their condition and moral rehabilitation;
- to cooperate and maintain contact with other organizations or persons whose aims are in line with UYDEL's objectives, and together develop strategies which will be used to develop the youth in a manner which is consistent with human development;
- to facilitate the development of the youth through their training in relevant skills, education, information gathering and research, and cooperative and individual enterprises;
- to encourage work with families, communities, schools and government in ensuring that the youth are enabled to develop their full potential as individuals and in groups through their involvement in creative activities;
- to raise the profile of the needs of street children to the public, relevant organizations and donors and to work together with such relevant authorities and agencies to promote and develop strategies to meet such special needs;
- to educate the public about the dangers of drug abuse and the need to develop better alternative programmes geared toward the reduction of drug supply and demand among the community and youth in particular;
- to develop and implement special programmes for street youth where necessary.

Target: Street children and their families, other service providers, and the general community.

Staff: Five full-time and approximately 15 volunteers. Most staff have qualifications in social work, sociology or social development.

Community and substance use: The population of Kampala is approximately 1.5 million and is multi-racial. Approximately 70 per cent of the population live in low income slum communities in overcrowded conditions. Families with up to eight children are the norm, with little knowledge of family planning. Approximately 40 000 people are HIV-positive, and most families have experienced the HIV/AIDS-related death of at least one family member. Literacy levels are low (about 65 per cent illiteracy).

Estimates of the number of street children in Uganda range between 4000 to 10 000, with the number of girls increasing; although boys outnumber girls by 10 to 1. Kampala has about 2000 street children. The children work as hawkers, pick pockets, scavenge from garbage bins, fetch water, carry luggage in the taxi park, and some pound herbs for traditional healers in the slums. Most have contact, or could have contact with their parents or other relatives; those from remote rural areas have lost contact.

UYDEL is located in Kalerwe in the Kawempe division, a slum area on the outskirts of Kampala. Substance use is believed to be widespread, with some substances relatively cheap and readily available (e.g. cannabis). The main substances used by street children are volatile solvents (e.g. aviation fuel (kongo, mafuta), glue (fina), tobacco and cannabis (njaga, jai, bhang, kay, nnwa, kasitiki, kasambi). Khat (mairungi, nakati, milla), alcohol and heroin (brown sugar, njoga, kuba, mpiso, nkoko) are also used. At least nine out of 10 children use one or two substances.

The migration of refugees has brought other substance use patterns. For example, some from Somalia have introduced khat and heroin. It is believed that increasing widespread unemployment is associated with an increase in substance use, increased cigarette advertising is implicated in increased smoking.
Health concerns include: malaria, tuberculosis, diarrhoea, dental problems, skin and respiratory infections, sexually transmissible diseases and HIV/AIDS. It is believed that there are 1.5 million HIV infected persons in Uganda with about 1 in 10 of the sexually active population in urban areas. Over 100 000 children are thought to be HIV-positive.

Programme activities:
- Street Children Project - outreach, recreation, resettlement, small income-generating schemes, counselling, training of service providers, establishing networks, advocacy, family reunification, peer-to-peer strategies, development of peer leaders, and a particular emphasis on working with street girls;
- Family Enhancement Project - assistance to families experiencing HIV/AIDS and/or alcohol and other drug-related difficulties, such as counselling, referral, and seeking sponsorship for schooling;
- Employment Assistance Project - fundraising, working with the informal sector, training, research, referral and job-seeking advice.

Integration of WHO/Street Children Project into agency: The WHO/Street Children Project forms the core of UYDEL's activities with street children.

Number of children: There are approximately 800 street children who have been reached by UYDEL to date; about 300 at any one time.

Uganda National Organization of Good Temperants (UNOGT)
PO Box 8134 Kampala Contact: Dr Mathias Muwanga
Fax: ++256-41- 254 597 Tel: ++256-41- 254 354

Goal/mission: Educating the public about the dangerous effects of substance use.

Objectives:
- to educate the public about the dangerous results arising from the consumption of intoxicants, smoking, and use of non-medically prescribed drugs;
- to set a good example by creating sound living habits in the community;
- through rehabilitation, to induce alcohol drinkers and cigarette smokers to abstain from doing so;
- to work for and promote laws against the traffic in alcohol and other drugs;
- to cultivate spiritual freedom, wider tolerance and cooperation in all fields of human life;
- to work for lasting peace in Uganda and the world over.

Target: The main youth target is young people of school age. Others include street children between the ages of four and 18 years, children from destitute families, adults and families with substance use related problems, and prisoners.

Staff: A director, a projects manager, two street educators and others (e.g. teachers, vocational instructors) and volunteers, with qualifications in economics, business, arts and education.

Community and substance use: The population of Kampala is roughly 1.5 million. Approximately 70 per cent of the population live in low income slum communities in overcrowded conditions. Families with up to eight children are the norm, with little knowledge of family planning. Approximately 40 000 people are HIV-positive, and most
families have experienced the HIV/AIDS-related death of at least one family member. Literacy levels are low (about 65 per cent illiteracy).

UNOGT estimates about 4000 (and acknowledge that others put the figure between 10 000 and 15 000) street children in Uganda, some of whom are homeless and others who return to their families at the end of the day. These children tend to be regarded by the authorities, and the public, as ‘a reservoir of criminals and bandits’. There appear to be about 2000 part-time (return to families at night) and 500 full-time street children in Kampala. There has been an increase in the number of female street children, although they are less visible.

Substances used by the community include cannabis, locally brewed spirits, and some khat and heroin. Street children tend to use solvents (thinner and aviation fuel).

Programme activities:
- seminars in schools
- teacher training workshops
- vocational training
- promote public debate
- initiate income generating projects for the poor
- counselling of substance dependent people, especially those within the prison system
- outreach on the streets.

Integration of PSA Street Children Project into agency: As the agency is focusing on substance use, integration has been easy.

Number of children involved: About 120 street children and 300 children in local schools involved in UNOGT activities.

ZAMBIA

Lusaka

Commonwealth Youth Programme Africa Centre (CYP)
Great East Road Campus
University of Zambia
PO Box 30190
Lusaka

Contact: Dr Richard Mkandawire
Tel: ++260-1- 252 733/153
Fax: ++260-1- 253 698

Virtually no information, other than that gained by a consultant during a site visit is available. Despite an initial enthusiasm for the project, including involvement in Phase I, the continued involvement of CYP is questionable.

Goal/mission: The CYP works toward a society where young people, women and men are empowered to develop their potential, creativity and skills as productive and dynamic members of their societies and participate fully at every level of decision-making and development, both individually and collectively promoting the Commonwealth values of cooperation.

Objectives CYP:
- to support efforts of member governments in the formulation of policies and development programmes which effectively address the issues and concerns of young men and women;
to assist member governments in establishing and strengthening youth ministries and independent youth networks to support policy and programme development based on the active participation of both young men and women;

- to enhance the involvement of young women and men in all CYP's planning and decision making processes;

- to support the efforts of youth NGOs and collaborate with international organizations in the promotion of youth development activities;

- to enable young women and men to participate effectively in planning and decision-making processes of their own countries and in regional and international fora;

- to support and recognize initiatives by young women and men for their own social and economic development and for the development of their communities, and

- to promote greater awareness among young people of the role of the Commonwealth in international relations.

**Target:** Young people aged up to 30 years.

**Staff:** Four programme staff and five senior support staff performing administrative functions. Qualifications not provided.

**Community and substance use:** Lusaka is the capital city of Zambia, and has a population of approximately one million, out of a total Zambian population of over 9 million. CYP estimates about 35 000 street children in Zambia, many are on the streets due to the death of their parents, or a parent, from an AIDS related illness.

Substance use appears to be widespread among the community and street children population. Substances most commonly used are: cannabis, solvents (petrol and glue) and locally brewed alcohol. Other substances used are methaqualone (Mandrax), heroin and cocaine.

**Programme activities:**

- training

- youth health and welfare promotion with a focus on HIV/AIDS prevention, youth employment and enterprise, literacy, the environment and young women and development.

**Integration of WHO/PSA Street Children Project into agency:** Poor, apparently not seen as a priority by the agency.

**Number of children involved:** Data not provided.

**Zambia Red Cross**

PO Box 50001

Contact: Mrs Chipo C.S.Lungu

Ridgeway 15101

Tel: ++260-1- 250 607

Lusaka

Fax: ++260-1- 252 219

A number of difficulties have impacted on the ability of Zambian Red Cross to fully implement the street children project. It appears that these may now have been resolved and the project may be renewed. In the interim, there is little information available.

**Goal/mission:** To conduct activities in accordance with the fundamental principles of the Red Cross/Crescent: humanity, impartiality, neutrality, independence, voluntary service, unity and universality.
Objectives:
- to furnish aid to the sick and wounded in times of war and peace;
- to organize relief services to all victims of disaster whether natural or man-made;
- to assist the authorities in improvement of health services and prevention of diseases;
- to perform all the duties which evolve upon a National Society in accordance with the provisions of the Geneva Convention and their additional protocols.

Target:
- communities which receive little assistance from other organizations
- villages which face drought and other types of emergencies
- street children
- school-based young people
- out-of-school young people.

Staff: Not provided.

Community and substance use: It is believed that the number of street children is increasing, and the increase corresponds to the increasing number of AIDS-related deaths in Zambia.

Many of the street children work on the streets, but return home at night to sleep. Most of the visible street children are male.

Programme activities:
- primary health care - includes health education, AIDS-control related programmes, health promotion and training health providers
- first aid - first aid services at public functions, first aid training to industries, institutions and members of the public
- welfare services - assist aged and handicapped members of the community by cleaning homes, collecting water and firewood
- blood donor recruitment
- disaster preparedness and relief
- tracing and uniting families
- ambulance services at sporting and other public events
- information/public relations
- fundraising
- training.

Youth specific activities:
- youth work camp - water/sanitation
- environmental awareness - efficient waste disposal
- youth training course
- school sponsorship
- non-formal education - literacy
- provision of transit homes
- outreach
- youth skills enterprise initiative
- skills training - carpentry
- sports and recreation - football.
Integration of WHO/PSA Street Children Project into agency: Poor, due to high staff turnover and no staff member consistently responsible for the project.

Number of children involved: No figures available.

BRAZIL

Rio de Janeiro

NEPAD/UERJ

Rua Fonseca Teles 121-4 Andar
Sao Cristovao
CEP 20940-200
Rio de Janeiro

Contact: Dr Evelyn Eisenstein,
Dr Marcos Baptista
Tel: (55 21) 284 8322
Fax: (55 21) 264 1142

While Nucleo de Estudos e Pesquisas em Atencao ao Uso de Drogas - Universidade do Estado do Rio de Janeiro (NEPAD/UERJ) provide technical and other support and undertake training and research activities associated with the street children project, a number of NGOs which are directly involved in the provision of services to street children are associated with NEPAD, especially in conducting focus groups. The agency most involved is the Associação Beneficente Sao Martinho (Sao Martinho Foundation) in central Rio, and another is Centro de Atenção Total a Adolescentes (CETA) in Duque de Caxis, a satellite city of about one million people.

Goal/mission: NEPAD/UERJ is a facility for Drug Abuse Treatment and Research. Its aim is to provide treatment for illicit substance users and their families, to conduct research on the epidemiology of substance use and to develop intervention programmes aimed at the community.

The Sao Martinho Foundation provides street (social) educators, centre-based activities, formal and non-formal education, residential shelter, recreational activities, child rights advocacy, and prevention activities within the communities (favelas).

CETA is a multidisciplinary centre providing preventive and treatment services to adolescents (aged 10 to 19 years).

Target: All substance users.

Staff: NEPAD has seven psychiatrists, eight psychologists, eleven administrative staff, two epidemiologists, three occupational therapists, one lawyer, two educators, one social worker.

Sao Martinho has a range of staff including street educators, house-parents, religious, educators, and health workers.

CETA has a range of staff including, psychiatrists, psychologists, social workers, and health educators. It has links to major medical facilities for auxiliary and specialized services.

Community and substance use: Rio de Janeiro is the second largest city in Brazil, with a population of over 10 million, out of a total population of Brazil in excess of 150 million. A
large proportion of the population lives in favelas - slum communities which intrude into the older established areas of the city. The number of street children is unknown, but most live in difficult circumstances with widespread availability and use of substances. Over half remain in regular contact with, or live with their families.

Most substances are available, but the street children tend to use the cheapest and readily available varieties, particularly solvents, alcohol and tobacco, followed by cannabis and cocaine.

NEPAD is located in the Sao Cristovao neighbourhood of central Rio de Janeiro, and is characterized by factories, commercial buildings and slums.

**Programme activities:**

**NEPAD:**
- outpatient treatment
- external treatment
- day care unit (6 beds) mainly for HIV+/AIDS clients
- research
- training.

**San Martinho Foundation:**
- street outreach/education
- residential shelter
- centre-based activities
- formal and non-formal education
- recreational activities
- child rights advocacy
- prevention activities within the communities (favelas).

**CETA:**
- a range of adolescent health interventions, with a particular emphasis on substance use, sexuality and violence, including assessments, primary health care and referral
- health education.

**Integration of WHO/PSA Street Children Project into agency:** Easily fits as NEPAD has links with five NGOs with shelters for street children, and already is a research and training facility.

**Number of children involved:** In research, there were 22 children involved. The associated NGOs are in contact with hundreds of street children.

**CANADA**

*Halifax and Saskatoon*

Canada participated in Phase I of the WHO/PSA Street Children Project, with sites in Montreal and Toronto. No funding was provided by WHO/PSA. Canadian participation was invited for Phase II, and Health Canada agreed to pilot-test the training package and the monitoring and evaluation handbook. Halifax and Saskatoon were selected as representing the eastern seaboard and central Canada respectively. These cities had already been involved in surveys regarding the needs of youth in and out of home in Canada. A site visit was made to Saskatoon, but not to Halifax. Brief information on the sites will be provided below, and the outcome of the training will be presented in the sections on the training package and the monitoring and evaluation manual.
Saskatoon

EGADZ
Saskatoon Downtown Youth Centre Inc.
301-1st Avenue North  Contact: Gale Cozun
Saskatoon  Tel: ++1-306- 931 6644
Saskatchewan S7K 1X5  Fax: ++1-306- 665 1344

Goal/mission: Saskatoon Downtown Youth Centre Inc. is a non-profit interagency organization to address the needs of 'youth at risk'.

Target: 'Youth at risk' defined as: youth under 20 years of age, who hang out more than three days a week downtown and are addicted to the streets although they may not live on the streets. They are 'at risk' of being non-productive members of society and live in an 'at risk' environment. Their lifestyle indicates they do nothing in their leisure time. It was believed that 10 per cent of the youth in the Saskatoon community would be considered 'at risk'.

Staff: Core staff: executive director, administrative assistant, programme coordinator, three youth workers, recreation/volunteer coordinator and custodian.

Special project staff: Back-to-School Programme: coordinator, youth worker (3/4 time), two youth workers (summer only). Day Support Programme: project team leader, two youth workers (1/4 and 3/4 time). Street Outreach: two outreach workers full-time, and one part-time. Teen Parenting: coordinator (1/2 time) and an assistant (1/2 time). Literacy: coordinator and volunteer tutors. The Youth Centre has 42 active volunteers.

Community and substance use: Saskatoon has a population under 200 000. It is situated in central Canada and has a large indigenous population, especially on reservations in the surrounding areas. A huge number of the indigenous population are attracted to the city.

Tobacco, alcohol, cannabis and inhalation of volatile solvents are the main substances of use by the street youth population. An anti-nausea preparation, referred to as 'gravels' is currently popular as a substitute of use by street youth. A commonly prescribed medication for attention deficit hyperactivity disorder, methylphenidate (Ritalin) was also being used.

There was limited use of heroin and pharmaceutical preparations apparent, some indications of an increase in injection of substances, and fluctuating use of cocaine and hallucinogens.

There appear to be a large number of commercial sex workers; EGADZ has contact with about 190, 11 of whom are males 19 years and over, 5 are males under 19, 65 are females over 19 and 86 females under 19.

Programme Activities: The activities are provided by a number of the agencies which form the interagency and other organizations and agencies. For example: Saskatoon Board of Education, Catholic Board of Education, YMCA, Radius Tutoring, Mainstream School, City of Saskatoon Leisure Services Department, Addiction Services, Indian and Metis Friendship Centre, AA, the Federation of Saskatchewan Indian Nations, Social Services, Mobile Crisis, Interval House.

- education and life skills
- employment and work readiness
- recreation/leisure/culture
- health and counselling
- food and shelter
- referrals.

**Integration of WHO/PSA Street Children Project into agency:** Not integrated at this stage, but staff participated in the training using the WHO/PSA packages.

**Number of children involved:** The interagency provides structured programme services to over 1400 youth per year, and reported over 16 500 contacts in informal programme services.

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**Halifax**

**Community Youth Network**
c/o Options
2786 Agricola Street, F22
Bloomfield Centre
Halifax, Nova Scotia B3K 4E1

**Goal/mission:** Community Youth Network (CYN) is an organisation of individuals and agencies who have organized themselves to meet the diverse needs of youth in Halifax. The CYN provides relevant programmes and resources to its membership, reflects the concerns of youth to government and other groups in Halifax, and tries to improve cooperation, information sharing, and networking in the community.

**Target:** Youth ‘at risk’.

**Programme activities:**
The Network has categorized their services as:
- Educational (community outreach, literacy, academic upgrading, drug abuse prevention, and recreation);
- Transitional (job training and placement, work programmes, skills training); and
- Intervention (food banks, shelters, violence counselling, suicide intervention, drop-in centres).

**Integration of WHO/PSA Street Children Project into agency:** Not integrated at this stage, but staff participated in the training using the WHO/PSA packages.

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**COLOMBIA**

**Santafe de Bogota**

‘Project Colombia’
c/o WR, Bogota
Santafe de Bogota

Contact: Ms Angela Maria Perez
C/O PWR Representative in Bogota
Tel: ++57-1- 616 0177
Fax: ++57-1- 218 0696

The project in Colombia is an initiative of the IV Conference of Wives of Heads of State and Government of the Americas and the Mentor Foundation, and is under the patronage of the First Lady of Colombia. The project is new and consequently not fully developed as yet. Financial problems impeded the initial stages, and the various cities, listed below, have reached different stages of implementation.
However, extensive work has taken place, especially in conducting focus groups and establishing networks in 10 cities: Barranquilla, Bucaramanga, Cali, Cucuta, Floridablanca, Medellin, Pasto, Pereira, Popayan and Santafe de Bogota.

Other than the Office of the First Lady (within the Presidencia de la Republica), the government sectors which are involved are: the National Ministry of Education, the Ministry of Health, the National Department of Planning, the Office of Child Welfare, the Social Security Network IDIPRON, and the Colombian Institute of Family Welfare. The NGOs include: the Red Cross, Albergue Infantil, Asociacion Cristiana de Jovenes (YMCA), Corporacion Accion y Futuro and Germinado (in Pereira), Comuna del Nero (in Cucuta), Torbido Maya (in Popayan), Cuidad Don Bosco (in Medellin), Service Juvenil Bosconia (in Cali), Paz y Cooperacion and Scout de Colombia (in Bucaramanga), Punto Corazon (in Barrancabermeja) and Urdimbre (in Pasto).

**Goal/mission:** To improve the health, welfare and quality of life of the street children of Colombia.

**Objectives:** To organize and develop the project methodology, undertake a situation analysis for each city, formulate strategic plans for each city, develop and implement interventions, monitor and evaluate local actions and revise plans as necessary.

**Target:** Street children in 13 cities.

**Staff:** Varies according to city. Details not provided at this stage.

**Community and substance use:** The greater Santafe de Bogota has a population in excess of five million, out of the total Colombian population of over 40 million. Medellin, Cali and Barranquilla have populations over one million, Bucaramanga, Cucuta and Pereira have populations of about half million. These are the largest of the cities of Colombia, but they are not the only cities with children; there are street children in all the cities of Colombia.

Some children have come to Santafe de Bogota, and other cities, as part of the rural-urban migration with their families, others alone. The families are usually poor and some have been displaced by guerilla activities and conflicts between drug cartels, the cartels and the government and foreign interests. Most are not prepared for city life and cannot find employment. Some men then turn to crime, and the women to commercial sex work. Thus, their children are exposed to poverty, violence, crime and prostitution from an early age.

It is estimated that there are at least 5000 street children in Santafe de Bogota and about 15 000 across the urban areas of Colombia as a whole. Many of these children use substances, particularly solvents, pasta de coca and cocaine hydrochloride. Little more information is available at this stage.

**Programme activities:** To date these have mainly been to establish the project in five stages:
1. Organization and development of project methodology and implementation.
2. Situation analysis for each city, using the WHO/PSA methodology; the Modified Social Stress Model and focus groups.
3. Formulation of strategic/action plans for each city.
4. Development and implementation of interventions defined in action plans.
5. Evaluation of local actions, feedback and revision of local action plans.
Some training has taken place for staff to run focus groups in 10 workshops organized by the National Ministry of Education. Some local situation assessments have been undertaken and two city/regional committees have been established, one to raise funds and one for project implementation.

**Integration of WHO/PSA Street Children Project into agency:** The project is new to Colombia and required new structures and funding to be organized. It represents an initiative in joining GOs and NGOs in such an endeavour.

**Number of children involved:** Not known at this stage, but over 600 children have been involved in focus groups to date. The collaborating NGOs and GOs have been providing services to many children for many years. However, the street children project is new.

**DOMINICAN REPUBLIC**

**Santo Domingo**

c/o Despacho Dr Jose Andrés Aybar Sánchez  
de la Secretaria de Estado de Educacion,  
Bellas Artes y Cultos, Santo Domingo  
Contact: Mr Bienvenido Silfa Cabrera  
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The project is a First Ladies Initiative. Although the President is a bachelor, he commissioned the implementation of the project to the Secretaría de Estado de Educación, Bellas Artes y Culto (SEEBAC).

**Goal/mission:** To implement the WHO/PSA/Mentor Street Children Project.

**Target:** Children living and working on the streets of Santo Domingo.

**Staff:** There are no paid staff members, only two volunteers.

**Community and substance abuse:** In 1992, the population of Santo Domingo was almost 7.5 million. In the same year it was estimated that there were 1000 children on the street, and 58 000 children in the street. Forty-five per cent of the total population are minors in a situation of extreme poverty.

Glue (chiri) is the most common substance used by the street children, however, some of the children also use crack and cannabis. Many of the street children start using glue from the age of five or six years.

Children get money for buying food and glue from begging, descuidos (carelessness of people) a word used to describe stealing, and from prostitution. It is estimated that 25 455 youth under the age of 18 years, are involved in 'neo-prostitution'.

Since Dominican law penalizes child prostitution in hotels. Foreigners run private homes, which are not registered as hotels, where children are invited with alcohol, tobacco and cocaine. Police protect tourists, because they bring money to the country while children are unprotected and usually abused and exploited by policemen.

A frequent problem among glue sniffers is epilepsy, but they also suffer a variety of deprivation-related and infectious diseases. Access to health services is denied to them. Their main complaint, however, is the abuse by policemen, who undress and beat them.
Programme activities: The activities are provided by a number of NGO's. These activities are not very clear from the report, however, they do include: street work, and referrals to appropriate resources; sports and recreation activities; education and vocational training; and some work is done with the families of the children.

Integration of PSA Street Children Project into agency: Launching the project was not easy, especially in gaining the trust of the street children and the police. There were also many difficulties and delays in terms of funding, and translation of the manuals into Spanish. The project is connected to several NGOs, however, coordination with government sectors has not yet been possible. It is hoped that this will soon change with the new government.

Number of children involved: Not reported.

HONDURAS

Tegucigalpa

Project Alternatives and Opportunities
Contacts: Dr Donald Kaminsky, Tulane University School of Public Health and Tropical Medicine and Executive Director FUNDAR (Foundation for Development, Friendship and Responses), and Dra Lizeth Coello, Executive Director Project Alternatives and Opportunities.

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Project Alternatives and Opportunities is an amalgamation of two programmes ('Alternatives' and 'Options').

Goal/mission/objectives:
- to provide an alternative service model based in the community for working children and their families and abandoned street children;
- to advocate for children's rights at the local, national and international levels;
- to offer protection for children working in the streets in the informal sector;
- to promote youth participation;
- to share widely experiences at the local, national and international levels;
- to offer an integrated prevention approach to the major problems of youth and substance abuse, STDs/HIV/AIDS and violence.

Target: Abandoned street children, mostly male, aged 7 to 22 (though most are between 12 and 17); working children, about half male, aged 3 to 18 (most 8 to 15); young brothers and sisters of the working children, aged zero to five; slum children, in and out of school, male and female aged 6 to 13; and families.

Staff: Executive Director, physician/nurse team, psychologist/social work team, eight street educators (team for the markets and the streets), arts and craft instructor, nurse, secretary, accountant, counsellor (for open community day centre); social worker, two primary school teachers (for work in marginal barrio slum area); social worker, two street educators/primary school teachers (in peer-to-peer education programme); and volunteers.

Community and substance use: Tegucigalpa is the capital city of Honduras, with a population in excess of 700 000 out of a total population of Honduras of over five million.
The city contains many slum communities, and much of community life is focused around numerous markets where street children and slum families work and play.

Project Alternatives and Opportunities operates out of multiple community sites. These include: major markets where the informal sector operates with vegetables, fruits and other foodstuffs and goods are sold by stationary and ambulatory vendors; the streets of the city; a recreational island in the centre of the city where street children can go for counselling and medical care; two schools and a community centre in a slum marginal barrio; and, most recently, an open day-centre which is located in the centre of the city, very near major outdoor market areas.

There may be about 250 to 300 children who live in the streets in the centre of the city. There are thousands of working children in the streets in the informal sector. The completely abandoned children are almost all male. The working children are about half male and half female. There are slightly more children under 12 than over 12 years of age.

The working children have excess morbidity for all the usual problems of their age group, i.e. dermatologic problems, upper respiratory morbidity, dental problems. They also have a number of allergic manifestations. The abandoned children have the same health problems, but also they have significant trauma (e.g. injuries from employment, gangs and the police, including bullet wounds) and STDs as a part of their morbidity patterns.

Substance use patterns have not altered much over time, with the inhalation of glue being predominant for abandoned street children. Alcohol, cannabis, tobacco, as well as sedatives, are also used. As the children age, they tend to become multiple substance users. Although cocaine is available, it is apparently rarely used by the street children in the above age groups. Working children have lower levels of use. In the adult population, alcohol and tobacco are the major substances of concern.

Street violence appears to be on the increase over the past two years, where random shootings of children by adults has occurred. This has occurred especially when the children have been under the influence of substances and involved in criminal activity. There also seems to be an increase in violence among the children themselves.

Programme activities:
- primary health care based in the community and an open centre
- health education
- non-formal education
- recreation
- nutrition programme
- psychological and social work case management
- mobile library
- primary school reinforcement to prevent early drop out
- child to child (youth to youth) peer education and leadership; development (80 children/youth have been trained to date)
- school for parents
- special events
- youth clubs
- street outreach work.

Integration of WHO/PSA Street Children Project into agency: Easily fits into the objectives and activities of Project Alternatives and Opportunities.
**Number of children involved:** More than 3500 street and working children have been involved with Project Alternatives and Opportunities. On any given day, about 500 children are reached/involved in some project activity.

**MEXICO**

**Mexico City**

**Division of Epidemiological and Social Studies - Mexican Institute of Psychiatry**
Antiguo Camino a Xochimilco 101
Mexico City
Contact: Dr Rafael Gutierrez
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Although the project in Mexico City is managed by the Mexican Institute of Psychiatry (IMP), operational activities are provided by ‘El Caracol’ (The Transitional Recreational, Educational and Training Centre).

**Goal/mission/objectives:** The main functions of the Division of Epidemiological and Social Studies of the Mexican Institute of Psychiatry are to develop psychological, psychiatric and epidemiological research on substance use and mental illness. ‘El Caracol’ is the main focus of the street children project, as it is a major agency working with and providing services for street children in Mexico City, including outreach and residential service provision.

**Target:** ‘El Caracol’: all street youth, particularly those aged 15 to 23, who are surviving without their families or other adult support. Specific areas of the city are targeted, namely ‘El Castillo’ an abandoned earthquake-damaged building, which houses about 30 street children; ‘Las Coladeras’ drains, where groups of 15 to 30 children live; the Sonora cinema and market; the Mercado de la Merced, a large market in an old area of the city; and the Metro Monteczuma.

**Staff:** The staff of ‘El Caracol’ are all volunteers, including the director who is a journalist. Other staff are part-time teachers, university students and concerned citizens. Due to their need to earn an income, there are difficulties in ensuring regular work hours; although these volunteers, including social science students and teachers, seem able to contribute about 40 hours per week to the work of ‘El Caracol’.

IMP have two staff members dedicated to the research on street children and associated activities (training and support). Both are psychologists.

**Community and substance use:** Mexico City has a population in excess of eight million, and is the capital city of Mexico which has a total population of about 81 million. Around 40 per cent of Mexicans are under 15 years of age. The poorest and under-educated have higher fertility rates and less access to education and other basic services.

Mexico has been undergoing a series of economic crises which have impacted on the poor and tended to exacerbate their difficulties. Family overcrowding has increased as attempts are made to reduce the amount spent on housing, and children often have to contribute to the meagre family income by working. Thus, their education suffers and exploitation becomes commonplace.

Street children have been conspicuous in Mexico City since colonial times; their situation has been documented and, more recently, filmed. They were originally seen as abandoned or
orphaned; ‘innocent victims of the sins of others’ and usually as ‘mestizos’ (born of both Spanish and Indian). The response was protection and engulfment by religious orders and charities, but by the mid-1500s there was a change toward them being characterized as ‘badly inclined’ and the consequent response one that was more punitive. By the end of the 18th Century, they were described as ‘disperse children abandoned to vice’ and regarded as lazy, truants and beggars, and by the end of the 19th Century were often segregated and housed in special facilities.

By the mid-1900s these young people were conspicuous on the streets again and had become involved in substance use. It has been estimated that about 20 per cent of the informal market sector comprises minors, and in 1990 there were nearly 15 000 children working between the ages of 12 and 14 in Mexico City, and about 240 000 aged between 15 and 19 years. Over 12 000 more can be categorized as street children who work more irregularly, not at all, or are engaged in criminal activities or begging to support themselves or contribute to the income of their family. If working, they are often found as shoe-shiners, street and traffic performers, wind-screen washers, and traffic vendors. The 1995 census found that 13 373 minors work in public grounds (68.5 per cent male and 31.5 per cent female).

Many of these children have been arrested for actual or alleged crimes or vagrancy or solvent use. Solvents (especially toluene) are the main substances used by the street children, as well as alcohol and tobacco. Cannabis is also used and there is some limited use of cocaine. Their health is often poor, with frequent injuries from accidents and fights, and skin and upper respiratory infections are common.

Street children live with their families or in abandoned buildings (often ones damaged by earthquakes) or other makeshift shelter. Involvement in commercial sex and crime is common, and STD-prevalence is high. Much sexual activity is unprotected.

Programme Activities:

‘El Caracol’ provides:
- street outreach
- residential shelter until the young person can live independently
- primary health care
- recreational activities
- referral
- health education/promotion, especially related to substance use, sexual risk practices and basic hygiene
- provision of food and clothing
- counselling
- vocational training and income generation schemes (printing, glass recycling, hairdressing and bakery)
- non-formal educational, especially remedial literacy and numeracy
- advocacy and public awareness raising, especially in relation to the deaths of street youth.

IMP undertakes research, training and support of ‘El Caracol’, and networking with other NGOs.

Integration of WHO/PSA Street Children Project into agency: The project has been well integrated into the activities of both El Caracol and IMP.
Number of children involved: ‘El Caracol’ was in contact with about 200 children over the past 12 months, and has accommodation for 15 youth aged 17 to 23 and 5 aged 15 to 17 years.

NICARAGUA

Managua

Programa de Atencion ninos(as) de la calle
Direcccion de Atencion Integral a la Ninez y la Adolescencia 
Ministerio de Salud
‘Concepcion Palacios’

Contact: Lic. Clara Aviles Flores
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Fax: ++595-2- 440 613

The project in Nicaragua is an initiative of the IV Conference of Wives of Heads of State and Government of the Americas and the Mentor Foundation, and is under the patronage of the First Lady of Nicaragua. The project is new and consequently not fully developed as yet. The project is being delivered through the collaboration of the Ministry of Health (MINSA), the Ministry of Education and NGOs.

Goal/mission/objectives:
- to provide care, prevention, medical and psychological rehabilitation to substance-using children, particularly in the Mercado Oriental and Ivan Montenegro markets of Managua;
- to promote educational and recreational as well as cultural activities;
- to promote participation of different sectors in the development of the programme;
- to promote community participation in the resolution of its health problems.

Target: Street children aged 7 to 20 years, with an emphasis on those aged 10 to 15, in targeted market areas of Managua.

Staff: Limited at this stage, until more training is completed. Currently there appears to be a psychologist, a social worker, an educator and a medical officer provided by MINSA and volunteer street educators at the market. Other staff will be added. Details of the staffing of the two residential facilities was not provided. There are a number of volunteers, including vendors at the markets.

Community and substance use: Managua, the capital of Nicaragua, has about one million inhabitants which is about a quarter of the total population of the country. About 45 per cent of the population is aged under 15 years. Intra-country migration to Managua, particularly during and since the end of the civil war in 1990 and earthquakes in 1972, is rapidly increasing the population, putting strain on services and amenities, and increasing the number of street children and street families.

It is estimated that there are in excess of 7500 ‘traffic children’ working in the traffic, begging or selling. Other children work with rubbish/scavenging in Managua. Other estimates suggest that 30 per cent of these children have parents who do not want them and 20 per cent have no family (killed or separated during the civil war). Other figures paint a difficult scenario.

A report on children in exceptionally difficult circumstances in 1991 estimated that there were 107 500 children living at the survival level - working in the formal or informal sector or involved in marginal activities - with 35 000 of them in urban areas. Over 267 000 children were victims of the armed conflict and over 180 000 affected by natural disasters. On any day,
about 30,000 children are on the streets of the urban areas of Nicaragua, and about 25 per cent of children of primary school age are not in school.

In one study of Sector IV Oriental Market in Managua in 1995 there were 1900 children on the streets (980 using inhalants, 770 involved in 'delinquency', and 150 in commercial sex) and 2500 working in the informal sector.

The market areas of Managua provide the focal point for street children; they are where food and activity can be found, as well as substances and opportunities for crime.

Substance use patterns vary throughout the country, with more coca product use on the north coast. The main substance used by street children is shoe-makers' glue. The health of the children varies and they are prone to the usual skin and respiratory infections, injuries due to their work and violence on the streets and STDs due to unprotected sexual activity.

**Programme activities:**

**MINSA and Ministry of Education:**
- training
- provision of equipment (e.g. first aid kits)
- support to project
- medical assistance
- family visits
- school enrolments
- recreational programmes
- health education
- assistance to cultural programmes
- focus groups
- networking.

**NGOs:**
- residential shelter
- recreational programmes
- nonformal education
- vocational training (e.g. carpentry).

**Integration of WHO/PSA Street Children Project into agency:** The Street Children Project has been enthusiastically incorporated into the activities of the Ministry of Health. Collaboration has developed between the Ministry and various NGOs involved in services for street children. These include Las Chicas (a residential programme for street girls) and Si a la Vida (a residential programme for street boys). The Ministry of Education is also a collaborating partner as is FONIF (Fondo Nicaraguense de los Ninos y la Familia, funded through a lottery). The Ministry of Health has provided first aid kits to the street educators, training and coordination and support services (e.g. food and family reunion).

**Number of children involved:** Details not provided, but about 250 children have been involved in focus groups and it is estimated that the project reaches approximately 700 street children in Managua.
PARAGUAY

Asuncion

Proyecto de Prevencion de Abuso de Substancias en Ninos de la Calle
Departamento de Salud Mental Contact: Dr Carlos Alberto Arestivo
Ministerio de Salud Public y Tel: ++595 21 206736
Bienestar Social
Peru, No 1903
Asuncion

The project in Paraguay is an initiative of the IV Conference of Wives of Heads of State and Government of the Americas and the Mentor Foundation, and is under the patronage of the First Lady of Paraguay. The project is new and consequently not fully developed as yet. It involves collaboration between four NGOs and a newly established government agency.

Goal/mission/objectives: To implement the WHO/PSA Street Children Project.

Target: Street children in Asuncion, and other cities.

Staff: Information not provided.

Community and substance use: Asuncion is the capital city of Paraguay, and has a population of about one million out of the total Paraguayan population of over five million.

Programme Activities: To date activities have mainly focused on networking with NGOs and various governmental departments, training of street educators and conducting some initial focus groups. The various NGOs involved provide a wide range of services to street children, including shelter, food, clothing, formal and nonformal education, recreation, health promotion, and vocational training.

Integration of WHO/PSA Street Children Project into agency: A number of NGOs working with street children have been formed into a core group together with various relevant GOs to implement the project.

Number of children involved: Not reported.

EGYPT

Cairo

Village of Hope Society
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Nasr City Fax: ++20-2- 340 8013
Cairo
Egypt
Goal/mission/objectives: The Village of Hope Society in Cairo was established in 1988 as an NGO for the care of orphans and homeless children in Egypt. It started its outreach programme for street children known as the RAY project in 1990 through a reception centre in a popular area, known as Shoubra, in the heart of Cairo. It was identified that there was a direct need for extending the variety of services for street children; especially those who needed to be off the streets for an extended period of time until they could find suitable solutions to their problems. Consequently, a short-term assessment shelter for street children was opened in Hadayek, connected to the reception centre in Shoubra. A further reception centre with crisis accommodation was opened in Sayda Zeinab in early 1996.

Target: Predominantly male children up to 18 years of age in crisis situations, including street children, homeless children, orphans, etc. The community at large is also targeted in certain activities.

Staff: Six administrators, 24 social workers and psychologists and 18 volunteers who cover all project sites. Two staff are ex-street children who are regarded as potential street educators.

Community and substance use: Cairo is the capital and largest city in Egypt with a population over 11 million. Rural-urban migration is increasing and many of the new arrivals live in shanty areas with poor facilities and infrastructure and high levels of crime and substance use.

The Shoubra and Sayda Zeinab reception centres, the Hadayek shelter, and the group home of Hadayek are all located in popular areas of Cairo. The community school at Mokkatam is located on the outskirts of Cairo in a new development. These communities are of a middle and lower-middle socioeconomic status. The two Nasr City shelters and the second group home in Nasr City are all located in Nasr City, which is a new district of Cairo, with people from upper-middle and higher socioeconomic backgrounds.

The Shoubra, Sayda Zeinab, and Hadayek districts are filled with shops and workshops which make them suitable areas for street children to congregate and live, due to their density of population and availability of work. Nasr City and Mokkatam are quite different, being newer developments.

The actual numbers of street children are hard to determine, due to the varying interpretations of the term and the mobility of these young people. However, UNICEF estimate 20 000 street children in Cairo, most from rural areas. Family breakdown, child abuse and neglect, poverty (often resulting in child labour), and dropping out of school all contribute to the number. Some children are encouraged to move to the streets by peers who are now street children.

Life on the streets is as hard as elsewhere, with children being exposed to all manner of hazards and social problems. Many turn to substance use to cope, and the substances being used include glue, cough mixtures, tobacco and ‘illicit narcotics’; hashish is used less frequently due to its cost.

Skin diseases are the main health problems experienced, together with injuries resulting from violence and other aspects of street life and work.

Family contact is minimal, and boys predominate due to the greater protection of girls and their removal off the streets to be used as commodities (as servants and in illegal businesses, including commercial sex).
The average age of the children is between 11 and 12 years, with a range of 5 to 17 years. The children usually beg, work collect plastic and other scrap for recycling or selling such as tissue paper.

Programme activities:
- day care
- overnight shelter for crisis cases
- shelter (long-term and short-term)
- food and clothing
- advocacy
- medical care
- reunification
- counselling
- skills development
- vocational training
- formal education/community school
- literacy education
- child-family counselling
- job placement
- recreation
- community development
- street education

Integration of WHO/PSA Street Children Project into agency: Well integrated into the agency's activities.

Number of children involved: Ninety two street children to date, including about 40 in focus groups, with between 100 to 200 in the near future. Village of Hope estimate an annual number of between 500 to 600 children per year come in contact with the range of their services.

Cairo and Alexandria

Caritas-Egypt
13 Dr Abdel Hamid Said Street
Cairo
Egypt

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Fax: ++20-2- 773 461

Goal/mission: Caritas-Egypt is a social service/development organization dedicated to helping society's most helpless to reach their full potential as human beings. It tries to address the total development of the individual - economic, social, cultural - regardless of race or creed.

Target: For the street children component - children in juvenile detention facilities. Caritas-Egypt is in the process of establishing a reception centre for street children in Alexandria.

Staff: The complete staffing of Caritas-Egypt (full-time and part-time) is over 900. It is not clear how many are connected to the street children component, as data was not provided.

Community and substance use: As mentioned above for the section on ACCD, Cairo is the capital and largest city in Egypt with a population over 11 million. Rural-urban migration is
increasing and many of the new arrivals live in shanty areas with poor facilities and infrastructure and high levels of crime and substance use.

Caritas-Egypt has tended to work via two of the residential institutions for neglected and delinquent young males in Cairo and one in Alexandria. These facilities are large (100 to 300 boys in each centre).

**Programme activities:**
- help and emergency services, including food programme, housing and refugees
- medical and social rehabilitation services
- health promotion and education
- economic development
- public relations and awareness

**Integration of WHO/PSA Street Children Project into agency:** The agency has an ‘anti-drugs’ programme, and this is the section responsible for the Street Children Project.

**Number of children involved:** In theory all children of the three residential institutions for neglected and delinquent children could be involved in Caritas activities. It is unknown how many have been involved in the street children component, as data was not provided other than for the focus groups and individual interviews by Caritas Youth.

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**CZECH REPUBLIC**

**Prague**

**Prague Centre for Youth KLICOV - Crisis Department MOST**

Cakovicka 51  
190 00 Praha 9  
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**Goal/mission/objectives:** The Centre for Youth is a facility managed by the Ministry of Education. It provides services for children with diverse problems. Most young people connected with the centre have behavioural and/or family problems, substance-use-related difficulties, and/or have run away from home. The centre was established in 1984 under the former Communist Government as an experimental programme for difficult youth, but has changed focus since.

There are four departments: a substance use treatment centre, an open juvenile detention facility, an out-client centre, and MOST, which provides shelter, street visits, a day programme, recreational programmes, parent and family counselling, washing and showering facilities and meals.

**Target:** Young people between 14 and 20 years of age, with psychological difficulties and problems in their families, young people who have run away and are living on the streets, and substance users.

Seven ‘groups’ of ‘street children’ have been identified:
(1) Substance users: youth who have moved to the streets due to their substance use. Most use 'pervitin' or 'pico' - methamphetamine - with most use by injection. These youth are to be found in squats, parks, squares and all-night clubs. Some live in ‘secret apartments’ and are involved in the manufacture as well as use of drugs. Much of their day is spent in drug-related activities; looking for sellers, buying, selling, using.

(2) ‘Canal’ youth: these youth live in underground spaces where there is an interconnection of hot water pipes, other plumbing, and various types of cables. They are often identified with the ‘Punk’ movement. Many have run away from children’s residential centres or homes for children with behavioural problems.

(3) Suburban youth: youth from new suburbs of Prague with multistorey housing complexes built during the 1970s. They rarely sleep in the streets, but spend most of their day or after school in the streets. Parents are typically working and arrive home late in the evening. Substance use is less intensive (or absent) and they are known to the authorities as ‘kids with keys around their necks’.

(4) Young male sex workers: these youth spend most of their time in bars/clubs or the central railway station. They often sleep in the accommodation of their customers or squats. The majority identify as heterosexual and many come from small towns, where their parents live and think that they are working in various legitimate occupations in Prague. They return home at times with money and gifts. Some tend to use ‘pervitin’ and heroin, mostly via injection. Others are more experimental users and tend to prefer alcohol, tobacco and cannabis, with occasional use of ‘pervitin’.

(5) Young homeless: these young people live on the streets for extended periods of time and find it difficult to change their behavioural patterns. They tend to be similar to older homeless populations, despite their youth. They usually come from highly dysfunctional homes, have run away from institutions, and may engage in street prostitution and some substance use, mainly alcohol, glue and toluene.

(6) Gypsies: a group about which little is known and services for them are minimal. They tend to be discriminated against, whole families live on the streets, and there is a high prevalence of glue and toluene inhalation.

(7) Refugee children: mainly from Romania and the former Yugoslavia. They are often found begging in the city centre. Some steal. This group is poorly serviced.

The above-mentioned groups are the main targets of MOST.

Staff: The Centre for Youth Klicov has 40 staff (including MOST) within four departments, all housed in the same building (Alternative Centre - a 14-bed substance use treatment centre for youth aged 15 to 20 years; Juvenile Detention Centre - an open 20-bed centre for youth aged 15 to 18 who have been sentenced by courts; Circle (Prevention Centre) - an out-client service for young people and their families providing social work and psychotherapy (individual, family and group); and MOST (= bridge).

The staff involved in the street children component of the project comprise three MOST staff and staff from a number of collaborating agencies. The crisis department, MOST, has ten staff (six for the residential component, three for out-clients, and one social worker). ‘Special/social pedagogue’ degrees (possibly a combination of special education, social welfare/work, and psychology) predominate. Others have qualifications in social work (although this is a new degree offered in the Czech Republic) psychology, psychotherapy and economics.

Community and substance use: Prague is the capital city of the Czech Republic with a population of about one million. Rapid changes have been occurring since the Communist period. Beside the economic and political ones, there have been many social changes. These
include less state involvement in structure of families and their lives. Parents now have to work longer hours to provide for their families that which was previously provided for by the State. This is believed to be associated with increased family breakdown and more children on the streets.

In addition, the Czech Republic is experiencing a significant impact from refugees arriving from Romania and the former Yugoslavia, and organized crime, including drug trafficking, from the former USSR. Again, this increases the street children population, and can involve them in the drugs and sex trade.

The street child phenomenon, then, is relatively new to the Czech Republic, as is the shape of the emerging substance use and its related difficulties. The substances causing most concern are the psychostimulant ‘pervitin’ (methamphetamine) and heroin, especially as both tend to be used by injecting. The hallucinogen, LSD, is used in the ‘club scene’ and glue, and toluene by younger children. Alcohol and tobacco are widely used by all, and multiple substance use is becoming more common.

The number of street children in Prague was estimated to be between 500 under 15 years of age and 1500 aged 15 to 18 in 1995. Only about 50 per cent of the children originally come from Prague.

Programme activities:
(MOST Centre):
- residential (crisis) programme (LOD = boat)
- street visits (no formal outreach programme is offered)
- day client programmes (therapeutic groups, counselling, psychotherapy)
- recreational programme
- creative activities (e.g. art and music)
- parent and family counselling
- ‘Cafe Club’ one evening per week
- washing and showering facilities
- meals.

MOST has strong links with other agencies which provide outreach and other activities for street youth, including: KROK - two street educators targeting younger youth in new housing estates (Modrany); K-Centrum SANANIM - a comprehensive substance use service with a needle and syringe exchange programme outreaching to young injectors; Prague Municipality - street educators; DOMINO - a community youth centre in a new housing estate area (Barandov) in contact with gypsy youth; Nadeje - a Christian NGO working with homeless people.

Integration of WHO/PSA Street Children Project into agency: Has easily been incorporated into the programmes and activities of MOST and other Centre for Youth sections.

Number of children involved: Not estimated.
RUSSIAN FEDERATION

Moscow

Moscow City Society of Temperance and Health (MCSTH)
18 Chekhov Street
Moscow 103006
Contact: Professor Vadim P. Zaitsev
Tel: ++7-95- 205 2353
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The Moscow Street Children Project is being implemented by MCSTH which is under the aegis of the International League of Temperance and Health (ILTH). ILTH is a democratic umbrella international NGO which brings together regional, national and local temperance organizations from the Commonwealth of Independent States, Poland and the Baltic States.

Goal/mission/objectives: MCSTH is a public organization with a focus on education of school children and adolescents, assistance to school and health care personnel regarding health education and substance abuse prevention, providing assistance to families and children with an alcohol dependent member, and providing treatment. The overall aim of the Moscow Street Children Project component is to improve the health, welfare and quality of life of street children in Moscow.

Target: Street children in general between the ages of 7 and 18, some of whom live with their families, but spend much of their day in ‘basements’ or the streets. Some are to be found in the Moscow Collector-Distributor Centres for Adolescents, many of whom are from various locations of the Commonwealth of Independent States and elsewhere, especially zones of armed and/or religious/ethnic conflict. There is a special emphasis on street girls.

Staff: Head of project (psychiatrist, psychologist), deputy head, psychologist, administrative support. Other organization are involved, particularly the Moscow Collector-Distributor for Adolescence (a police operated reception-dispersal centre) which has a staff comprising special police and educators.

Community and substance use: Moscow has a population of about ten of the Russian Federation's 150 million people. The significant changes over the last few years coinciding with, and subsequent to the break up of the former USSR, have brought a number of difficulties. Many Russians found themselves as ‘foreigners’ in the new countries of the Commonwealth of Independent States (CIS) and many migrated back to Russia, often with no employment and a lot of insecurities. Traditions broke down and there has been a loss of stability, the threat of poverty and often a need to change employment. Parents work long hours and are often not at home much to interact with their children.

Tensions between and within states, often based on religious/ethnic conflicts, have led to more refugees arriving in Moscow to avoid situations of armed and civil unrest. Families have had to provide more for themselves after the dismantling of much state control and service provision, and organized and disorganized crime has flourished.

International drug traffickers both within and outside the Russian Federation have taken advantage of the internal re-organization and confusions and have developed routes of supply through much of the former USSR and into and through Moscow. Substance use has emerged as a significant problem, and has changed its patterns. Previously alcohol was the main substance of concern, now use of cannabis, opioids (especially an opium preparation made through processing opium poppy straw), amphetamines, mecathionine (ephedrine) and various
pharmaceuticals is widespread and volatile solvents (especially the glue ‘Moment’) are being used by street children and other young people. Use via injecting is increasing. Some older and wealthier youth are injecting and sniffing heroin and cocaine.

Young people on the streets of Moscow have increased in number, face poverty; high levels of unemployment as state owned industries become privatized and the economy re-establishes; and overcrowded living conditions, and a strain on educational facilities. Street children are often rounded up by the police and placed in collector-distributor centres. Some are then returned to their countries or areas of origin (including Chechnya, Afghanistan, Tadjikistan and other Central Asian Republics), and while waiting (on average 30 days) they are involved in educational and other activities at the centres.

Estimates vary, but there may be between 50 000 and 200 000 street children in Moscow. Many suffer skin conditions and evidence traumatic injuries and malnourishment. Involvement in commercial sex is becoming commonplace, especially for the females. Some are involved in organized prostitution. Child physical and sexual assault is often in their background, as is parental alcohol dependence. Street children tend to congregate at railway stations, in building basements and foyers. The basements provide a warm and secluded place to hide, meet, sleep and use substances and engage in sexual activities. STD prevalence is high as are risks for HIV/AIDS and unplanned pregnancies. The report from Moscow indicated that young girls are at risk from the police and medical and other health professionals, as well as any typical risks encountered in street life.

Programme activities:
- drug education for schoolchildren and adolescents;
- training of health care personnel and teachers in drug prevention and health promotion;
- assistance to families of individuals with alcohol related problems;
- coordination of drug treatment personnel;
- assistance to children with parents with alcohol related problems.

Integration of WHO/PSA Street Children Project into agency: Now fits in well and has developed MCSTH project work in new areas and necessitated networking with agencies dealing with troubles and troublesome young people.

Number of children involved: Not reported.

INDIA

Mumbai (Bombay)

TASH Foundation
B-404, Sandeep Park-2 S.T. Road, Deonar
Mumbai (Bombay) 400088 Maharashtra
Tel: (91) 22 556 5888/556 8837, Fax: (91) 22 556 2964
Email: tash@bom2.vsnl.net.in

Chairperson TASH: Mr Chandran
Acting Chairperson: Dr H.L. Kaila

SEARO
Goal/mission: Technology and Social Health Foundation (TASH) is a nongovernmental organization formed with the essential objective of facilitating social health research study programmes in the most vulnerable sections of the society, and one that has the potential to facilitate the process and the pace of all round improvement in the deprived sections of society.

Objectives: To facilitate scientific project and resource management and systematic research and documentation in the areas of:
- social and personal development of the vulnerable, the underprivileged, the disabled and the exploited;
- education and training using relevant technology;
- health and physical development;
- interpersonal, vocational skills and personality development;
- ecology and community empowerment;
- networking with NGOs, governmental organizations (GOs), UN bodies and international organization.

Target: Children (including street children and child labour), families, communities, disabled and underprivileged.

Staff: Coordinator, social worker, five street educators (including former street youth and slum youth), two teachers, research assistant, book keeper, volunteers and other staff as necessary such as physicians, nurses, yoga instructors and communication experts. Qualifications of staff include: psychology, management, administration, sociology, science, social work, counselling, statistics, education, computing, technology and spiritual life experiences.

Community and substance use: Mumbai (formerly Bombay) is the capital of Maharashtra State, and is the principal metropolis in India, with a population in excess of 10 million. It is often seen by the population of India, and neighbouring areas, as a city of opportunity and employment. It has been romanticised in film and via the spreading of urban myths. The reality for most who come seeking a better future is the opposite. Poverty is endemic, a large proportion of the population (over 50 per cent) live in impoverished and unhygienic urban slums, often along major railway lines.

Over half of the population has migrated to the city from elsewhere, and about half of these migrants come from states other than Maharashtra. Many of the street children are migrants, coming from particularly poor states, such as Bihar, neighbouring states such as Gujurat, and from as far away as Bangladesh and Tamil Nadu. Poverty is the major push to come to Mumbai.

The TASH Foundation is based in Chembur in the northeast of the city and, as one of its activities, works with slum and street children mainly in nearby slum communities of Govandi (e.g. Budh Nagar, Bhimwadi Lumbani, Bagh, and Tata Nagar), railway stations such as Chembur, Govandi, Juhu Beach and at Kurla, where a number of the children have settled into accommodation provided by the YMCA.

The slum settlements have a combined population of about half a million people. One sub-group are predominantly mill workers, salaried and long-term residents, but have very inadequate, crowded living conditions. Another sub-group live in makeshift accommodation
and undertake irregular and casual manual employment. The third sub-group are transients who mainly live along the railway tracks and peripheral land.

Estimates of the number of street children in Mumbai range from 50,000 to 200,000; basically nobody knows. As in other areas, about 75 per cent of these children live with their families (or parts of their families) in the slums. Most are boys, work and are involved in such activities as scrap and waste collection, carrying goods, vending small personal and household items, vending and/or preparing food, domestic service, cleaning, singing/playing music on trains and begging.

The train and bus stations provide the focal points for street children; they are where new children arrive from other states and countries, where most customers are to be found, and are busy lively places. The cinema forms a focus for entertainment, as does Juhu Beach and the tourist area of Colaba.

All substances are used, but street children tend to use those which are relatively cheap and available, such as tobacco, glue, solvents, various forms of pan (masala), some alcohol and cannabis, with ‘brown sugar’ (heroin), LSD and Mandrax (methaqualone) less often used. Trends are difficult to discern, as data collection is not adequate. However, there were anecdotal reports that ‘Todex’ (apparently a balm for strain/pain) is being used, spread on bread; Xerox ink; and Madhur’/’Munacca’ a dry grape stuffed with sugar and opium; but not necessarily by street children.

The proportion of street children using substances is unknown, but use of cheap and accessible substances is believed to be widespread. It is estimated that between 60 to 80 per cent of street children use some type of substance. It is believed that different areas of Mumbai have differing patterns of use. The main city railway stations (e.g. Grant Road, Kamathipura, Mumbai Central and Victoria Terminus) and surrounding areas and the major suburban stations, such as Bandara, tend to have greater use.

**Programme activities:**
- fostering the development of talents, communication skills and integration of children in difficult circumstances, through emphasis on formal as well as informal education;
- nonformal education and study classes;
- developing, providing and accessing simple technology for use in underprivileged communities, and individuals such as the aged, handicapped and disabled;
- research cum action projects on children, adolescents, women and the aged;
- organizing conferences, seminars and workshops on selected themes;
- outreach (street work);
- supporting and funding nurseries (Balwadis), study groups, women's groups and adult education in the slum communities;
- networking;
- celebrations;
- vocational guidance and training;
- job placements;
- organizing leprosy detection, treatment and education camps;
- counselling;
- yoga sessions;
- education - nonformal;
- research and documentation.
**Integration of WHO/PSA Street Children Project into agency:** Fully integrated into TASH activities.

**Number of children involved:** Estimated to be 500, 175 street children and 300 slum children. Other children, with some overlap, are involved in a leprosy project (up to 500).

**Thiruvananthapuram**

**IOGT-ADIC India**

TC 26/2203 Spencer Junction
Thiruvananthapuram
Kerala State

Contact: Mr Johnson Edayaramnula
Tel/Fax: ++91-471- 475 693

**Goal/mission and objectives:** The objective of ADIC-India is to work for the prevention, treatment, rehabilitation, aftercare and follow up of alcohol-, tobacco- and other drug-related problems, as well as focusing on HIV/AIDS-related work. The activities of the organization are based on the principle of universal human brotherhood; according to which all are entitled to the right of personal freedom, happiness and opportunity for self-expression and development.

**Target:** General population, with an emphasis on youth particularly those in especially difficult circumstances.

**Staff:** Principal investigator, two programme officers (one position vacant), two street educators (one a trainee, both ex-street youth), medical officer, part-time yoga instructor, two project officers (administration). Qualifications in social work, management, literature, medicine/ homeopathy, yoga, computing, languages, teaching, and advocacy.

**Community and substance use:** Thiruvananthapuram is the capital city of Kerala State, which reports having the highest literacy and suicide rates, and the best health care delivery system in India. The total population of the state is around 30 million, with Thiruvananthapuram's population almost one million. The state has slightly more urban dwellers than other states.

ADIC-India contends that Kerala also has the highest consumption of alcohol in India. The population contains more Christians than northern states, and many young people and families coming from neighbouring states such as Tamil Nadu.

While having a prosperous and ordered appearance, Thiruvananthapuram has pockets of poverty and slums, but they tend not to resemble those of Calcutta and Mumbai. Nearby is Kovalam Beach, a major tourist destination and site of substance use and distribution. Many people from Kerala work overseas and bring back substance use behaviour typical of the areas within the countries where they have employment.

ADIC-India estimates the number of street children in Kerala at 5000 with over 300 in Thiruvananthapuram. They are involved in many occupations such as shoe shining, domestic and hotel work, bearing, vending (e.g. cooked food, fruit, nuts and flowers), waste/scrap collecting, fishing, leatherwork, begging, cleaning.

Poverty and family difficulties (e.g. family breakup, death of parents and violence, including sexual abuse) push them to the streets to earn and live. Going to the cinema is a major
recreational activity. Many of the street children have close links to prostitutes, and act as pimps for them, and local hoodlums and drug traffickers.

Their health varies, but their lives may be better than children in other Indian cities. They subsequently appear to look healthier and better formed physically. Any apparent health difficulties tend to be skin and respiratory infections and malnutrition; Sexually Transmitted Diseases (STDs) appear to be surprisingly uncommon among the street children.

The major substances of concern are tobacco, alcohol and cannabis (ganja) among street children. Inhalation of solvents on a wide scale has not been reported. The use of ‘brown sugar’ (heroin) is evident in the adult population (mostly inhaled), but more frequently used are alcohol (including local ‘toddy’), cannabis and pharmaceuticals. There is some evidence of a reduction of tobacco use in the population.

There are, however, anecdotal reports of a growing trend toward injection of buphrenorphine hydrochloride (Temgesic/Tedigesic) among young adults, possibly as a result of local medical practitioners prescribing it for those dependent or experiencing problems with ‘brown sugar’.

ADIC-India main office is centrally located in Thiruvananthapuram and the night shelter is in a slum community (Chengalchouola) within easy access to the main railway and bus stations and the city centre.

Programme activities:
- outreach - street work
- night shelter
- Street Children’s Union (Jyothisgamaya)
- family reintegration
- income generating schemes (e.g. lottery ticket and newspaper selling, tailoring, handicrafts, cafeteria, screen printing)
- vocational training/job placement
- community service activities (e.g. providing fresh food prepared and delivered by street youth to poor, elderly, physically disabled slum dwellers (Sree Satya Sai charitable Centre), and Clean City Project)
- documentation and resource centre
- counselling
- legal aid
- banking/savings accounts
- issuing identity cards
- prison project (including ‘de-addiction’, counselling and health services - Navjyoti de-addiction Centre)
- psychiatric hospital located ‘de-addiction’ centre - Mukthi de-addiction centre
- drug-free campus campaign
- project DARE
- recreation and sporting activities
- yoga and meditation
- non-formal education
- alcohol-free village project
- promotion of alternative therapies
- international days and events to promote and educate the public about substance use related problems
- provision of honours and awards for service to the community
- advocacy.
Integration of WHO/PSA Street Children Project into agency: Fully integrated, as the agency is a substance use specific one.

Number of children involved: Street children 70, slum children 20, juvenile/observation home 68, and several hundred in the prison.

AUSTRALIA

Sydney

St Vinnies for Youth
325 Marrickville Road
Marrickville
Sydney, NSW
Contact: Fr Chris Riley
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Fax: ++61-2- 9564 2768

Goal/mission/objectives: To provide access to supervised overnight accommodation and basic needs such as food, clothing, hygiene and health care. Other services provide for specific areas of need: alcohol and other drug treatment, extended residential experience, wilderness experience, education and leisure.

Target: Male and female young people aged 15 to 18 years, who are chronically homeless, who have usually exhausted other service provision, and who may have substance use-related difficulties which may require residential treatment.

Staff: Main programme (St Vinnies for Youth - residential programme): one director, two senior youth workers, nine youth workers, one street (outreach) youth worker, one book-keeper, plus many volunteers. Qualifications in teaching, youth work, social work, welfare and development studies, residential and community care, direct care and community support, science, theology and life experience.

Dunlea (up to two week stay residential substance use treatment facility): Five full-time residential workers and numerous volunteers. Qualifications in youth work, social welfare, alcohol and other drug studies, psychology.

Community and substance use: The main services of St Vinnies for Youth are located in the inner and south-western suburbs of Sydney. Sydney is Australia's largest city with a population of over 3.5 million, and the capital of the state of New South Wales which contains nearly 6 million of the total Australian population of about 18 million. The population is multi-cultural, with significant numbers of citizens having backgrounds in the United Kingdom, central and Mediterranean Europe, and south-east Asia. Many refugees from war zones have come to Australia (e.g. from the middle-east and south-east Asia). Sydney contains areas of extreme wealth and poverty; with most Australians being in the middle income group.

Due to its size, location and industrial activities, Sydney attracts people from all over Australia, many of whom become marginalized and live on government welfare payments and in state housing stock. Many young people out of home live in state and NGO funded 'youth refuges', or with friends or in abandoned buildings, cars or parks. Few, however, have no possibility of shelter. Some head for the excitement of the 'red light district' (Kings Cross)
which has a concentration of young homeless, commercial sex, crime and substance use and dealing.

A national report into youth homelessness estimated that within a 12-month period there could be up to 31 500 homeless young people in New South Wales, with about 16 000 of them in Sydney. On any one night there are an estimated 200 to 500 homeless youth in the inner city area. However, accurate figures are hard to come by as the young people in question are transient and use the services of more than one agency. Most do not work and rely on government benefits and welfare agencies.

The prevalence of physical, sexual and emotional abuse of these young people is very high, as is the level of substance use and suicide attempts and completes. While on the streets, nutrition and hygiene can be poor and respiratory and sexually transmitted diseases occur frequently. Mental health issues are also elevated in this population.

The most commonly used substances are those which are legal and readily available: alcohol and tobacco. These substances are used widely in the Australian population, but use of both is declining, except for tobacco use by adolescent females. Australia also has a high prevalence of use of over-the-counter preparations (especially analgesics) and prescribed medications (especially the benzodiazepine group).

Most homeless youth use both licit and illicit substances. The illicits include cannabis, diverted or illegally obtained benzodiazepines, amphetamines and other psychostimulants (e.g. ecstasy - MDMA), heroin and hallucinogens. Injecting is common as is some sharing of injecting equipment. Use while ‘on the streets’ is higher than at other times.

The correlates and consequences of substance use by homeless youth include: violence, HIV/AIDS infection, poor/unstable interpersonal relationships, risky sexual behaviour, suicide attempts and completes, chronic homelessness, inability to sustain education, employment or training, poor health, mental illness, crime and incarceration.

**Programme activities:**
- short- and long-term residential programme for chronically homeless young people;
- short-term (up to two weeks) residential substance use treatment programme;
- street outreach;
- non-formal school;
- wilderness experience;
- two farms (one for young women and one for young men) who require extended care;
- referral and advocacy.

**Integration of WHO/PSA Street Children Project into agency:** The agency already has a major focus on substance use, the PSA components fit easily within agency functioning. Focus groups/data collection have begun, training and monitoring and evaluation packages have been reviewed, and training workshops are to begin.

**Number of children involved:** St Vinnies accommodates about 600 young people per year (some are re-admissions), and Dunlea has had 132 admissions from July 1995 to May 1996.
PHILIPPINES

Manila

CHILDHOPE Asia/ Families and Children for Empowerment and Development (FCED)
C/- 1210 Penafrancia Street Contact: Ms Teresita Silva
Paco Tel: ++63-2- 50 3754/ 525 3537
Manila Fax: ++63-2- 521 7225/ 525 2037

Goal/mission: Childhope were contracted to deliver the training for street educators and pilot the training package. FCED were to implement the street children project methodology.

The mission for FCED states: ‘We are committed to:
- empower street and urban poor children and their families to develop and manage health, education, livelihood and protection programmes and services in their respective barangays (local government areas);
- provide opportunities for values clarification and education for children, youth and parents with particular emphasis on spiritual values and human rights;
- motivate and facilitate the development of self-managing community structures and people's organizations such as the local councils ‘for the protection of children’ and a cooperative association or a women's bank;
- provide opportunities for the education, skills training and increased income of street children, youth and their families.’

Objectives: At the end of the project, the 12 identified depressed barangays (communities in which street children and their families live) of Penafrancia, Paco, Manila, will have a set of viable, effective structures that are initiating, implementing and evaluating community programmes and projects to meet the needs of street children and their families.

Specific objectives:
- each of the 12 assisted barangays will have an organized and self-managing local committee for the protection of children, with sub-committees on health, education, livelihood, and protection, with other sub-committees managing projects and services to meet the needs of street children and their families;
- 200 to 300 street and urban poor children and their families in the barangays will have participated in values clarification and non-formal education sessions on the rights of the child, spiritual values, health and adolescent sexuality, responsible parenthood, substance abuse prevention, micro-business management, para-legal procedures, etc.;
- 500 children and youth working and/or living on the streets will be in contact with street educators and participate in counselling, non-formal education sessions, and referred to temporary shelters or assisted to reconcile with their families;
- at least 200 families of street and urban poor children will avail of social credit/livelihood loans and be assisted to develop viable economic structures as a continuing source of credit;
- 200 street and urban poor children and youth to receive educational assistance to be able to return to or remain in school;
- street and urban poor youth trained in vocational skills for employment or self-employment.

Target: The community of Penafrancia in Manila which comprises approximately 20 000 persons within about 3750 households spread across 21 barangays with community leaders;
and areas with a high concentration of street children (e.g. Binondo, Divisoria, Paco, Quiapo, Santa Cruz, Taft Avenue).

Clientele: street children with and without families, children of street families, parents of street and urban poor children.

Staff: Supervising social worker, community organization trainer, street educators (three, two of whom are ex-street children), community educators (2), values education coordinator, bookkeeper, plus community organization volunteers. Qualifications of staff are in social work, psychology, nursing, commerce and business.

Community and substance use: Manila is a city of approximately 6 million (although estimates vary), contains a number of cities within its boundaries (e.g. Caloocan, Pasay, Quezon City, etc.), and is the capital city of Philippines. Many of the population arrive from the provinces hoping to find a better future in Manila. Most of these migrants live in squatter settlements, particularly along rivers and canals, or in urban slums, and attempt to make a living via employment in the formal and informal sectors. There are pockets of extreme and conspicuous wealth and poverty.

In the twelve slum communities covered by the project, about 80 per cent of the women are working, but as few as 10 per cent of the men. Generally in Manila, 60 per cent of the men are working and 40 per cent of the women also join the workforce to augment the family income. Many children do not attend school, due to financial difficulties and the need for them to work to assist the family. Some of the families contain 6 to 8 members, with only one parent working. Some families have members working overseas, and do not see these members (fathers, mothers, older siblings) often, with consequent family dislocation and disruption.

Up to 80 per cent of the population are squatters whose accommodation structures are illegal and could be demolished at any time by the authorities. Sanitation varies, but is often poor with garbage collection and local government clean-ups irregular and unsustained.

Estimates vary, but there appear to be about 60 000 street children in Metro Manila. Of these about 70 per cent live with their families, 25 per cent live on the streets (with irregular or no family contact) and 5 per cent are completely abandoned. Poverty is a major factor in the push to street life, but family discord and disruption, various forms of abuse, natural disasters (especially in Luzon), and armed conflict (particularly in the south) also play a role.

Most of the street children are also working children. They work on the streets selling food, candies, flowers, cigarettes, newspapers, they mind and wash cars; shine shoes, and scavenge, carry packages, clean market stalls, fetch water from pumps, or work as labourers, in hotels and other businesses. Some also beg, pick pockets, steal, deal drugs and are involved in commercial sex.

Health risks and problems are common and include: respiratory, skin and eye infections, malnutrition and skeletal problems due to poor nutrition and accidents.

The main substances of use are those cheap and readily available such as glue (Rugby) and a variety of solvents, and cigarettes. Cannabis use is extensive, but more so from mid-adolescence on, as is the use of alcohol. Shabu (amphetamine) is used by the older adolescents, and while it is mainly used orally or nasally, there are some anecdotal reports of a change to injecting by some. Cough syrups and pharmaceuticals are also used, as are other concoctions (e.g. Sprite shaken with diazepam, buri (matting) with urine and water). In the
slum communities, the use of Shabu worried the children mostly due to its apparent effects on the users.

FCED is located in the Paco area with many barangays containing a high concentration of urban poor with children who spend much of the day on the streets, and within easy access to areas with a high concentration of street children (e.g. Binondo, Divisoria, Paco, Quiapo, Santa Cruz and Taft Avenue).

Programme Activities:
- community organization and development
- income generating schemes
- sponsorship for education and vocational training
- effective parenting education
- street education
- training
- advocacy
- community organization volunteer training programme
- recreation and sporting activities
- training junior street and health educators
- social credit/loan assistance
- child minding programme
- cooperative development.

Integration of WHO/PSA Street Children Project into agency: The PSA approach fits in easily with that of FCED. Childhope has a well-established reputation and experience in training.

Number of children involved: About 207 children have participated in drug prevention programmes, with about 49 selected to be trained as junior street and/or health educators. The other activities of FCED involve almost all the target community and its children.

3. STREET CHILDREN FOCUS GROUPS/DATA GATHERING

Rapid assessments are often needed to gain information quickly on such things as: the attitudes and beliefs of a group; to find out about the patterns of behaviour of small, but significant sub-populations such as street children; to explore possible solutions to a difficulty; and to inform and shape action plans. The techniques used also indicate that the opinions of a particular population, with whom interventions are being developed are taken seriously and valued. Rapid assessment techniques include focus groups, key informant studies, observation, interviews, case studies and surveys.

The focus group method has been proved to be very useful with populations such as street children. Sites involved in Phase I of the WHO/PSA Street Children Project used focus groups and gained a lot of useful information which was used for strategic action planning. The method is easy to organize and relies on the use of focal questions to open discussion on the topic/issue of concern.

Small groups of approximately 8 to 10 participants meet with a facilitator who guides the session. WHO/PSA developed lists of possible questions, called the Questions and Issues Menus, which are structured according to six components of the Modified Social Stress Model; stress, normalization of substance use, effects of substance use, attachments, coping strategies and resources. The menus
contain key questions followed by probes which can be used to further explore a particular topic or issue.

It was recommended that a series of focus groups be held, preferably with the same participants, so that all topics could be covered without too much pressure to finish the task. It was also recommended that focus groups be held at regular intervals, so that any significant changes can be identified quickly. These could include new patterns of substance use, new substances being used, new stressors, new coping strategies, or new resources becoming available.

In Phase II of the Street Children Project, focus groups or other forms of data collection have included about 2500 participants to date. The focus groups have primarily used the WHO/PSA Questions and Issues Menus, in full or part. Other forms of data collection have involved over 280 other street children. What follows are comments by site on what was undertaken.

However, the ‘voice of the children’ has not been presented in most reports. There are few direct quotes, but there is much in the form of summary and interpretation. In a number of cases virtually no information was provided at all on the content of the groups. Thus, the voice of the street children involved in the project to date is generally muffled or absent. It is hoped that in future reporting ample quotes are provided so that one can gain from the actual words of the children, rather than hear an adult’s interpretation or translation alone.

What is also missing from most of the reports is any emphasis on developing and understanding the resilience exhibited by street children. At times mention is made of coping strategies, but in the main, the strategies reported rely on external support or advice.

What is also apparent, except in a few cases, is that focus groups do not meet regularly nor are they conducted at regular intervals so that data can be validated, any changes occurring can be ascertained and myths tested.

It is obvious from the reports that the focus groups were conducted in many different ways. Some were a series where all of the Menus were covered over time, other attempted to gain data in one session. Some groups were more question and answer sessions, and others had the feel of creative semi-structured discussions. Yet others appeared to be didactic, educative sessions with a minimum of data collection and participation, and others more like therapy groups. While this variation is understandable, it makes for difficulties in the analysis of any data collected.

It is hoped that, in the future, certain focus groups may be designated for data collection, using the most appropriate style of group format for individual sites, or that more general groups would contain some opportunity to gather data. It is especially important that a more standardized format be developed to collect data on substance use, health issues and risk behaviour. This should form part of the activities of Phase III.

The data provided below is also made up from information obtained from other forms of assessment such as surveys, interviews, observation, narrative methods and drama. These are all valid methods of obtaining information. A mix of approaches can add a lot to information collection, in that a mix can break down any monotony, increase energy levels, allow for those who find talking in groups difficult, and utilize differing staff and street child participant skills. However, sites are still encouraged to use focus groups as a core activity.

No attempt will be made here to summarize what follows, as this could obscure important differences between sites. Direct quotes from street children are provided where they were included
in reports from the sites, and selected quotes from workers/researchers have been extracted from the reports.

**AFRO**

**TANZANIA**

*Dar es Salaam*

As mentioned in the previous section, a study was undertaken on substance use by street children of Dar es Salaam. One hundred and eighty one children were interviewed (145 male and 36 female), but not in line with the WHO/PSA Questions and Issues Menus, nor in line with the Modified Social Stress Model. What follows is based on that study.

Street children are exposed to many substances and are often used as couriers. Locally brewed alcohol, mainly 'Gongo' or 'Supa ya mawe' are commonly used, as is cannabis ('bhangi'). A local liquor made from coconut tree products is also used ('Mnazi'). Some cocaine and heroin use has been reported, and may be associated with changing international drug trafficking routes; however use of methaqualone (Mandrax) was not reported despite its passing through the country en route to other nations. Glue, petrol and other solvents are used by the street children.

Substance use is believed to be a coping mechanism and a source of pleasure and entertainment. Negative impacts of substance use were reported as: violence, impaired thinking ability, abdominal pains, loss of sight or hearing, skin diseases and other infections.

Family disruption and abuse are believed to be factors associated with the numbers of children on the streets of Dar es Salaam who come from most parts of the country.

*Mwanza*

About 69 children were involved in focus groups, individual interviews, drawing and narrative methodologies and via life histories. There were 36 males involved in focus groups; 12 from the Street Children's Centre, and 24 from other places, aged 10 to 13 in one group and 15 to 18 in another. There were six females involved in a focus group at the Street Children's Centre. Three children were involved in narrative research, 10 in the life history method and 10 in individual interviews.

The data gathering took place in outdoor settings or at the Kuleana centre over three weeks, and the focus groups lasted about one and a half hours. Participants were selected on the basis of their relationships with research staff and most were boys. An abbreviated questionnaire was developed based on the Street Children Project Questions and Issues Menus. Children were provided with snacks and/or the monetary equivalent of what they would earn on the streets during the time they participated. Another survey of 500 street children took place involving Kuleana, and provides some useful demographic data.

The main findings were: the majority of street children in the survey were male (94 per cent) and the modal age range was 12 to 15 years. The reasons identified for being on the streets - maltreatment by step-parents, beatings by biological parents, poverty, excessive drinking by parents, lack of freedom at home, death of parent or parents. Lack of safe places to sleep, frequent arrests for loitering and theft, being forced to have sex with older boys and the police and local guards (sungusungu), and difficulty in finding food were found to be some of the negatives in street life.

*When caught by the police, both girls and boys offer to have sexual intercourse in exchange for*
freedom. Others pretend to be crazy and smear themselves with excrement in order to avoid arrest' (report from Mwanza). Ninety three per cent had been beaten and a similar percentage arrested. A greater number had been beaten by the Sungusungu.

As mentioned above, the main substances used by street children and adults are relatively cheap and readily available. They include: hangi (hashish/marijuana) with 78 per cent reporting use, gongo (illegally brewed local beer/spirits) with 60 per cent use, tobacco (81 per cent regular use), and to a lesser extent leaves from bukoba (chewed), petrol, other solvents and heroin.

Functional reasons were given for substance use, and included: to forget feeling cold or hungry, to have the strength to work, to get courage to fight and/or steal, and for entertainment. ‘Substance use reduces some of the problems street children face and enables them to cope with life on the streets. It reduces the feeling of pain, cold and mosquito bites. They get strength to work and the courage to fight and steal. Substances are used to give comfort and relief from the reality of life on the streets’ (report from Mwanza).

The children identified negative consequences, including respiratory problems with petrol inhalation, increased fighting, unwelcome perceptual distortions, accidents, and dependence.

Among the health problems identified were: worms, dysentery/diarrhoea, skin infections, malaria, STDs, and injuries.

UGANDA

Kampala

UYDEL
Focus groups have been conducted in two phases by seven research assistants. In Phase I twenty groups were held, and in Phase II eleven, each group lasting about one and a half hours. Over 400 children have been involved in the focus groups. Groups were mostly held out of doors in recreation areas, but some were held in a drop-in-centre and one in a remand centre for juveniles. Questions used were derived from the Street Children Project Questions and Issues Menus, with adaptations. Participants were initially paid about US$ 0.30 to attend, but participants in subsequent focus groups were not given incentives to attend.

The main findings included that death of parents, police harassment, violence, illness (especially respiratory, skin and gastrointestinal infections) and accidents, dental problems, and finding food and shelter were major life events and everyday stresses. For the young women, involvement in commercial/surival sex or sexual assaults were frequent and concerning. Mosquito bites were mentioned frequently, and indicate some concern regarding the spread of malaria.

Most wanted to work, own their own land and house, and gain an education. Most were depressed that they could not see this eventually happening, on top of all the other difficulties they faced daily. Many engage in informal sector employment, and contact with family is maintained where possible. Selected adult friends provided some safety and a model.

Substance use was found to be very prevalent among the children, as were associated problems; physical illnesses, violence, crime, risky sexual activity, accidents, and ‘running mad’ (ogwa-siro). The substances were used to deal with cold nights, increase appetite, for fun, to forget worries and to obtain courage.
"Reasons for taking drugs included among others: to overcome the night and the chilliness; to make you happy if you have been depressed; they give appetite; to avoid worries; they give you help to cope with our rigid and harsh conditions; they give you strength and confidence; they help you speak out and become creative; they help you feel better; they help you commit crimes" (report from UYDEL).

As mentioned earlier, the main substances used by street children are solvents (e.g. aviation fuel (kongo, mafula)), glue (tina), tobacco and cannabis (njaga, jai, bhang, kay, nwua, kasitiki, kasambi), but khat (mairungi, nakati, milla), alcohol and heroin (brown sugar, njoga, kuba, mpiso, nkoko) are also used. The migration of refugees has brought other substance use patterns. For example, some refugees from Somalia have introduced khat and heroin. It is believed that increasing widespread unemployment is associated with an increase in substance use, as has been increased cigarette advertising.

Risk taking is common: "The children acknowledge that fights are frequent, mainly when the bigger ones want to take their possessions when under the influence of drugs. The street youth have girl friends their own age, one boy said that he is a womaniser. Sometimes older women entice them and one boy was forced to sleep with an older woman 'just to make her happy'. They openly confessed they were sexually active and said that they liked girlfriends who were daughters of 'baloodi' (wealthy men) because these girls were protected in their flats by their parents and they believed that they did not have HIV!" (report from UYDEL).

UNOGT

Four focus groups for street children have been run in 'children's depot' settings, lasting up to one and a half hours with about 50 male participants in total aged between 8 to 20 years. The groups initially tended to be more educative than data-gathering and issues-based. Refreshments were provided. The Modified Social Stress Model and the Questions and Issues Menus were utilized in part for the groups.

The main information gained indicated that the children came to the streets due to family problems such as violence, death of parents (usually from an AIDS-related illness), evacuation due to armed conflict, and poverty. Street life provided companionship, freedom, entertainment, and means of making a living.

Substance use also provided some negatives: "Shelter was ranked second among the priority needs. Children sleep on verandas and corridors without any sheets/blankets. When it rains it is very tormenting for them. They attribute harassment by the enforcement/security personnel to lack of shelter. The boys often get arrested as thieves when they go to the verandas at night, while the girls have to save themselves from arrest by consenting to sex demands by the enforcement/security personnel" (report from UNOGT).

Health concerns were: wounds (mainly from fights), accidents, skin infections, STDs, headaches, and dental problems. They are often denied access to medical treatment ‘... no one wants to attend to a street child’ (report from UNOGT). There are an estimated 1.5 million HIV infected individuals in Uganda, and many children have been orphaned as a result, and some are also infected.

There is also emerging a lack of cultural identification: "Having grown up on the streets, these children tend to lose their cultural identity; e.g. the cultural traits that would lead to the identification of one's tribal group is lost. The child only identifies with his or her street mates, thus evolving a street culture commonly known as 'Bayaaya' in Uganda" (report from
UNOGT). However, many children had or could have contact with their parents, except those from remote areas.

Ninety five per cent of the children reported some degree of substance use. The main substances used by the street children include tobacco, cannabis, and solvents (thinners and aviation fuel). The children mostly denied use of locally brewed spirits, and khat and heroin which tended to be used by older youth and adults.

ZAMBIA

Lusaka

Commonwealth Youth Programme (CYP)

No formal focus groups since initial ones held in 1993. However, 31 street children (29 males and two females) participated in a broader study by CYP of substance use among street children aged 15 to 25 years in Lusaka from two compounds - Mtendere and Matero.

The young people indicated that being on the streets was a way of searching for an identity, earning a living and contributing to the family's income. Most worked; as vendors, cleaning cars, filling pot-holes or pick pocketing. Smoking tobacco, drinking alcohol and socializing were part of daily activities. Kachasu (a locally brewed alcohol made from maize porridge, yeast, sugar and bread) was preferred, in part due to its low cost. About half of the subjects reported that they were dependent on dagga (cannabis), and they used it to restore energy, improve appetite, and gain a 'high'.

Over three quarters had been arrested for theft, assault or loitering.

Zambia Red Cross

Eight groups were run, but were more like education sessions with children already in other Zambia Red Cross programmes. Sessions lasted about two and a half hours and refreshments were offered as incentives. Items from the Questions and Issues Menus were selected and adapted, but the focus was on collecting some information on substance use (what was available, who supplied, cost, means of use, and reasons for use) and health consequences (e.g. overdose).

The main findings were that children used available and cheap substances to avoid feeling cold, to get to sleep, to suppress hunger and for courage (especially for commercial sex work). The most commonly used substances were inhalants/solvents: glue (Bostic), nail polish, petrol, and 'blow' (a mixture of glue and petrol). Cannabis was also used regularly as was tobacco, locally brewed alcohol (kachasu). Staff discovered that some were using 'jenkem', made by fermenting raw excrement, waste and/or sewerage over a few days and then inhaling it.

A total of 120 children participated in these focus groups, and a large (400 child) street intercept study is being undertaken, which could yield more information.
BRAZIL

Rio de Janeiro

Focus groups were held in collaboration with an agency (Fundacao Sao Martinho) in three shelter-homes with street children (Casa Santao Amaro, Casa das Meninas, Casa Silvio Romero). They were facilitated by a physician and snacks were provided. There were 13 male and 9 female participants, aged from 10 to 18 years (mean 13). Over 62 per cent had lived on the streets for over one year.

The main findings were: over two thirds saw drugs as a problem for their communities, and over three quarters saw drugs as a problem for themselves (although 40 per cent reported no use). Just over a quarter used some substance every day, with those most frequently used being tobacco and cannabis, followed by glue and alcohol. Cocaine was regarded as a ‘bad drug’ by almost half of the participants.

Accidents, deaths of family members and family rejection were regarded as the most significant life events, and nearly one third had made a suicide attempt. Most did not wish to return home. Two girls out of the 9 had been pregnant and had abortions, although this is an illegal practice in Brazil. Many other health risk situations were also related: fights and accidents after drug use (36 per cent), sleep disturbances (36 per cent), sexual or physical abuse (27 per cent), STDs (14 per cent), and use of arms and knives (9 per cent).

Their life was considered threatened in 64 per cent of cases, and 23 per cent had already had trouble with the police. 'Death Squads' are a real problem and homicides are now considered the main external cause of death for poor male youth aged 15 to 19 years in Rio de Janeiro city.

To date a total of 120 street youth have participated in focus group discussions.

CANADA

Halifax and Saskatoon

Not applicable.

COLOMBIA

Focus groups have been held or are planned in: Barranquilla (4), Bucaramanga (8), Bogota (17), Cali (20), Cucuta (1), Floridablanca (4), Medellin (12), Pasto (8), Pereira (8), and Popayan (4).

By September 1996, a total of 86 focus groups will have been conducted with approximately 4 to 10 children in each group, and each group will have had an average of 12 sessions. A total of approximately 400 children will have regularly participated in the complete exercise, while an additional 600 to 800 children will participate in several, but not all focus groups. The same children do not attend all the focus groups, due boredom, threats of murder, their high level of mobility or are easily distracted by other factors.
DOMINICAN REPUBLIC

Santo Domingo

Three focus groups were planned, two in Santo Domingo, and one in Bocachica, however, due to police interference, only one focus group has been conducted so far. This was done in Santo Domingo.

Some findings were that the children sniff an average of half a litre of glue per day, spending about US$ 0.50 to US$ 1.00 a day. They attribute some magical qualities to the substance, e.g. it improves sexual performance, it protects from pain and cold, and it gives courage.

They know the substance is harmful, and that it is associated with injuries and violence, but they claim that it is not possible to quit the habit without help. 'We use chiri (glue) when we feel good and when we feel bad, when one is hungry, ill or sad, because the glue removes the bitterness of the street and one can forget bad things.'

They also commented that 'People reject us because of our habit, they humiliates and beat us'. 'Policemen take us to prison and abuse us because we sniff glue'. The children are also known to use crack and cannabis, and they receive alcohol and tobacco from the tourists.

HONDURAS

Tegucigalpa

Six focus groups have been conducted with approximately 50 participants in total. Each group met for between 9 to 13 sessions, totalling 64 group sessions. The groups were organized at sites near where the children work or congregate, and participants were selected on the basis of their interest, availability and representativeness of particular risk groups. Each session lasted about one and a half to 2 hours. Groups were facilitated by various members of the staff team; physician, psychologist, nurse, social worker, street educator. The Questions and Issues Menus were used, and a group meal or outing to the movies was the incentive offered.

One group was held in the streets for substance users - 8 participants, 12 to 19 years (mean 15), 5 male and 3 female; in two markets (San Pablo and San Miguel) for adolescent leaders - 8 participants, 10 to 16 years (mean 13), 6 male and 2 female; one for adolescents who work in the San Isidro/Colon market and who attend school for half a day - 8 participants, 12 to 17 years (mean 15), 4 male 4 female; one for adolescents who work in the Belen market and attend school half a day - 8 participants, 10 to 15 years (mean 13), 7 male and 1 female; former substance using street children now is residential care (Casa Alianza) - 8 participants, 13 to 17 years (mean 15), 6 male and 2 female; and one with adolescents who are regarded as vagrants - 7 participants, 13 to 15 years (mean 14), 5 male and 2 female.

Selected findings include: the importance of mothers; the great significance of the loss when mothers have died; God is important as a source of strength; deep hostility and homicidal thoughts in relation to step-fathers; suicidal thoughts and attempts are relatively common; the level of violence in their lives (especially from the police); a common fear was of being killed (by the police or gangs); their lack of access to education and health facilities; the denial of their rights by the authorities; the use of substances by the working children is at a relatively low level; that glue remains the substance of choice among the street/abandoned children; and that substance use gave courage, helped you to forget your problems, stopped your loneliness and misery, took away the cold, and induced some pleasant hallucinations.
The negative effects of substance use were identified as loss of respect, dizziness, general weakness, crime, and loss of conscience.

MEXICO

Mexico City

Three focus groups have been conducted each lasting about one and a half to 2 hours. Two of the groups were for children on the streets and were held in market areas (the first with 12 participants aged 9 to 23 years at Delegacion Cuauhtemoc, the second with 12 participants aged 8 to 19 at Mercado de la Merced), and one was held at El Caracol with 14 participants aged 14 to 22, all male. The El Caracol group met 4 times, the La Merced group twice.

Another group of 21 youths aged 5 to 23 was observed at Delegacion Cuauhtemoc. Most were toluene inhalers and cannabis users. Many were under the influence of solvents or actually using during the first groups, but reduced or eliminated such behaviour in subsequent groups. Refreshments and recreational activities such as picnic outings and boating were used as incentives.

The WHO/PSA Questions and Issues Menus were used to structure the groups, and a total of about 60 youths were involved in the focus groups. Some of the findings:

Stress came from police violence, boredom on the streets, and lack of safe accommodation.

Effects of substance use: negative ones included accidents and fights; positive ones forgetting about poverty, hunger, being cold, being bored, violence and danger, becoming calm, sharing a group identity, and some good hallucinations. Some hallucinations were also frightening as the following examples illustrate:

Juan Carlos (13) on using solvents: 'you can see the moon this small and then see it grow and then not see it any more'.

Andres (aged 11): 'My best hallucination was to see little green flowers, elephants and the Pink Panther. The last time they put me into the centre (juvenile detention centre) we were sniffing glue with a few friends and a guy invited me to sniff toluene and so I did. Suddenly I couldn't see my friends any more, I couldn't see anyone. I saw I was in this dark room, as though there was no one, it was really dark, and then I saw some little lights which got closer. Then the lights got bigger and just as I was about to get close to them I fell into a cave. When I fell down there was a bunch of skeletons and they got up and told me I was going to die and that I didn't have much time left, and that I wasn't going to live beyond that night. I wanted to scream and talk to my friends, but the words stuck in my throat. I wanted to shout, but I couldn't. I didn't know if there was anyone there or if they could hear me or not. The thing is that on that day I thought I was going to feel bad forever, and I wanted the trip to stop. That was a pretty wild experience, don't you think.'

Some stories raised opportunities for discussion of reasons to reduce or eliminate use:

Tomas (16): 'Death, which as far as I can remember was an elegant lady, but not wearing black. She was tall with elegant clothes, a bit like a devil with diamonds, really tall with blazing red eyes. The only thing I could see was her face and she held out her hand to me and I started to talk to her like this: 'How are things? Hello ma'am, what are you doing? How've you been? I want you to take me with you one
Some participants talked of what they believed to be tolerance developing to solvents:

Alejandra (23) who has been inhaling solvents since age 11: ‘I need to use more toluene... it doesn’t have the same effect as before. I don’t hallucinate anymore, it just makes me relaxed. If I want to hallucinate, I start sniffing glue out of a bag, but I don’t usually do it because it’s very dangerous, it dries up your brain quicker. When I can’t get toluene, I’m irritable, nervous, I feel sick and vomit. I can’t sleep and I sweat a lot at nights. I know this happens because I stop sniffing glue, but it wears off after a while.’

Normalization of substance use: solvents are freely available and relatively inexpensive, so is cannabis, though somewhat more expensive. Cocaine was available, but more expensive.

Attachments: the main attachments were other street children who engage in similar behaviour, be it pro-social, anti-social or mixed.

An example of an interaction regarding the situation of the children:

Street educator: What do you enjoy doing more than sniffing toluene?
Small boy: To sit down and eat breakfast or lunch.
Older boy: But you can do that at home every day.
Small boy: But man, what home? I have no home.

The focus groups also identified situations where street children had assisted each other:

Juan (14) who lives in a car said: ‘One of my friends was walking around and he was really having a bad trip and he spent the whole time crying and I wanted to talk to him because he kept looking at me very strangely and asking me ‘What’s up?’ I started to tell him what I thought about him, I mean who his family were, who he was and what he felt. He didn’t answer but I used to talk to him like that whenever I saw him. One day the kid started running and I went after him and he went to have a drink of water and he started crying and guess what, he started talking. I was really taken aback. He said, ‘You know what? I feel better.’ He started to talk to me and said, ‘All those things you used to say to me, they helped me get started again.’

Sometimes the assistance can involve risks itself:

Ricardo is a 16-year-old who lives with a group on a vacant lot. He said: ‘I’ve got a friend and as soon as he arrived from our village this man started to give him marijuana. He really got into it. Once I invited him out and we got really stoned. The whole group of us were there with 50 pesos of marijuana and he started to smoke and suddenly he stands up. We say, “Why is he standing up, we’re having a good time aren’t we?” He fell flat on his face, really badly, and we said, ‘Looks like he’s on a
bad trip.” So we slapped his face really hard and he still didn’t wake up. I was so scared I threw him into the river to wake him up. He said, “What’s happening?” so I said, “Have some milk, because otherwise you won’t wake up.” The same thing always happened...I think he must have done that about 100 times.’

Other stories involve folk remedies:

Jose is 17 and left home at the age of ten. He recalls, ‘There in my district, in Neza, where I used to get together with my friends, the girls used to smoke marijuana too. Quite a few really. The girls used to have bad trips. Once this girl felt bad and started crying, so I said, “What’s the matter?” and she didn’t answer, just went on crying. So another guy said, “Let’s slap her face so she really cries.” “No, get some milk instead and bring for about 4 liters” I said. So someone went to get the milk, we all chipped in and they bought it, but she didn’t want to drink. But that was the only way she’d get better.’

The children also tended to place the inhalants they used into a hierarchy: ‘Chemo’ (glue) and ‘Activo’ (toluene) gave the most pleasant effects and had a good flavour. Next came thinners, but it was reported to have a bad taste. Last came gasoline as one needed more to get an effect and it’s odour and taste are regarded as unpleasant.

NICARAGUA

Managua

To date, 250 children have been involved in a series of focus groups at five locations: seven at the Mercado Oriental, two in and around Roberto Huembes market, one at the bus station of Ivan Montenegro market, five at Si a la Vida and two at Las Chicas. The groups have had about 15 to 20 participants each and ran for about 45 minutes. Most groups met more than once, and most participants were aged 10 to 14. The older children are often in gangs and the safety of the street educators became an issue. Strategies are being developed to engage this older and more difficult and needy population.

The Questions and Issues Menus were used, with modifications, and the groups provided an opportunity for health education and delivery of interventions in some cases. Snacks and drinks were provided.

Brief findings were reported and included: children are on the streets because they want to be, to support their families, to get money for their education; they see involvement in the project as helping them get a better future; they saw the street educators as helpful. No information was provided from the groups on substance use and risk behaviour.

PARAGUAY

Asuncion

Five focus groups have been held with street children aged 10 to 16 years; four for males and one for females. There were 5 to 12 participants in each group, with 60 participants overall. The groups meet about every two weeks, and take about one full day to complete their tasks (6 to 8 hours). So far, the children have discussed the stresses in their lives, touched on their substance use and have found the groups to be safe, fun and educative.
EGYPT

Cairo

Village of Hope/Arab Council for Childhood and Development
Six focus groups have been held so far. Five were held at the reception centres and the sixth on the street. The structure and content was consistent with the Questions and Issues Menus, except the areas which contained questions about sexual behaviour. Each session lasted about one hour. The participants were aged 8 to 13 years in the first four groups, and 12 to 14 years in the last two. The number per group was between 8 and 10. No incentives were offered. Some children feared being beaten if they revealed certain information in the groups.

The main findings were that street harassment, violence and abuse from older street boys constituted major life events and everyday stresses.

Substance abuse was found to be widespread, especially among the older boys (13 and older). It was found that the children use glue, cough mixtures, tobacco and illicit narcotics. Hashish is used less frequently due to it being more expensive.

Substance abuse, especially glue sniffing, is most favoured as a congregational activity, where a number of children share the activity together, whether in buying or sniffing the substance abused. Substance abuse is also highly connected with group acceptance and respect.

Cairo and Alexandria

Caritas
Two focus groups were held at the El Guiza Delinquents Institute. The groups lasted about one and a half hours comprised 10 males each aged 12 to 15 years. The facilitators were social workers at the Institute. Only sections of the Questions and Issues Menus were used, mainly those to do with enduring life strains. Most of the sessions appeared to focus on the needs of the children, as identified by them. No incentives were provided.

A further 23 focus groups were held in different centres in Cairo, and a further one was held with children from an orphanage. An average of five sessions were held with each group, with approximately six or seven participants per group.

At another stage, 12 Caritas youth were trained in the PSA approach and used the Questions and Issues Menus more completely to interview 194 males in five different institutions for neglected and delinquent children in Cairo and Alexandria; 138 from Cairo, 50 from Alexandria aged 9.5 years to 23 years of age (mean fourteen and a half years).

Most came from poor rural areas (62 per cent) and most worked regularly, with a minority attending school. About 30 per cent had been living with their families. Some were beggars, some had been involved in drug distribution, and a few had been commercial sex workers. Most exhibited signs of depression and most acknowledged an attachment to their mothers. The police and peers provided most difficulties for them on a daily basis, as did finding food and shelter.
All of the children had experimented with tobacco and 62 per cent were regular users, 42 per cent used cannabis, 14 per cent alcohol, and 35 per cent glue and volatile substances.

A total of 1800 children have been targeted for the project, involving 60 focus groups, with 30 children per group.

**EURO**

**CZECH REPUBLIC**

**Prague**

Two focus groups with youth in squats (numbers not provided) were held, one with 'kanal' (the 'kanals' are underground spaces where water and drainage pipes and electrical and other cables are located - they are warm and dry and provide a living/ hiding space for the children) youth (9 participants; 6 male, 3 female aged 17 to 20), five at MOST centre (35 participants in total; 29 male, 6 female aged 16 to 21), a weekend with focus groups was held in association with K-Centrum in a rural area with substance-using-youth (7 participants; 5 male, 2 female aged 18 to 25) and less formal discussions were held with male sex workers (5 participants all male aged 17 to 20). The Questions and Issues Menus were used as a basis.

The groups and interviews were held at the centre, in bars, in ‘kanals’ and at a farmhouse. The incentives were food, cigarettes and the opportunity to use the centre’s facilities.

The main substances identified as being of concern were alcohol, solvents, heroin, cannabis, pharmaceuticals and amphetamines. Most of the young people had used solvents (mainly toluene) and injection of pervitin was common. By using these substances, some young people said: ‘you are not hungry, cold or alone’ and ‘you can’t imagine how boring the world is without it (drugs)’. They identified negative effects such as ‘bad hallucinations’, flash-backs, depression (even suicidal ideation and attempts) and sore throats. Needle sharing was common, as was unsafe sex.

The major everyday stress was finding accommodation, even for just one night. Sometimes this involved sleeping with a client, if involved in commercial sex. For the young women there was fear of being sexually assaulted or forced into commercial sex. The major fear in the latter, was being taken to ‘Highway 55’ in northern Bohemia and forced to prostitute themselves there.

Stealing was a common activity as was begging. However, few had left home due to poverty. Mostly it was due to conflict with step-parents or abuse that the young people identified with their decision to leave home. Many had been institutionalized (mainly juvenile detention facilities or psychiatric hospitals).

**RUSSIAN FEDERATION**

**Moscow**

Seven focus groups have been formed involving 49 young people, mostly from within the Collector-Distributor Centre. The Questions and Issues Menus were used in the main and the groups lasted about three hours. An incentive prize for the most active participant and drinks and snacks were provided. The groups tended to be rather structured and more of a data-collecting nature, although attempts were made to create an informal, safe environment. However, the presence of project staff
from the collector-distributor centre, stenographers and a cassette tape recorder may have had an effect.

The first group had six participants (five males and one female) aged 14 to 17 years, with families, who spend much time in basements and truanting from school. Two meetings were held with this group, who came for more economically advantaged backgrounds. The second group comprised four females aged 13 to 15; the third, five males aged 14 to 17; the fourth, eight males aged 13 to 15; the fifth, eight females aged 13 to 15; the sixth with ten females aged 11 to 17; and the seventh, eight males aged 14 to 18 on their first day at the Collector-Distributor Centre.

The impression gained were that the participants had lost any meaning in life, were a 'lost generation' who felt that 'this is the end'. The females came from more conflicted and traumatizing backgrounds and, if they had escaped to Moscow, were re-abused in the new environment which they hoped would offer more.

'Razborki' (fights) between different groups of children from different areas or with different interests are common, and the streets can be dangerous at night. Substance use is common and relieves stress and strain. Improvement of mood and relief from boredom is sought, as are interesting hallucinations and 'otklyuchka' (deep relaxation and sedation). Alcohol use is widespread: 'all the young men now drink', 'you get a drink, you don't want to eat, you lie down and sleep.'

As mentioned above, beside alcohol, cannabis, opioids (especially an opium preparation made through processing opium poppy straw), use of 'Mulka' (papaverous straw mixed with milk) amphetamines, ephedrine (and a variant, 'screw' prepared by boiling ephedrine) and other pharmaceuticals is widespread. However, volatile solvents (especially the glue 'Moment') and cannabis are more regularly used by street and other young people. Use via injecting is increasing. Some older and wealthier youth and injecting and sniffing heroin and cocaine.

INDIA

Mumbai: 'I am not sure which is worse - starving at home or having food but no home' (street girl in Mumbai).

'I miss them, but I don't know what I like about them... there was a lot of yelling and hitting in our hut' (Mumbai street boy).

Individual and focus group discussions were held with 288 children aged 8 to 16 years (38 female and 250 male) on the streets, in agencies, in slums, and at railway stations, facilitated by postgraduate psychology students of two Mumbai universities. The Questions and Issues Menus were used, almost in their entirety.

Some of the main findings were: substance use varies by location, the pervasive nature of poverty, the high levels of police corruption and exploitation of the children, the impact of HIV/AIDS, the extent, meanings and generally unsafe nature of the sexual activities of the children, and the need to work with families and provide education.

The children reported many tragedies in their lives: days of endless labour in the rural villages and smaller cities from where they came; civil unrest and riots; physical and sexual abuse; deaths of
loved ones; natural disasters; and problems fitting in with step-parents. In Mumbai they found harassment by the authorities, more violence and exploitation, and marginalization. They felt denied opportunities open to others, especially education and health services.

The children worked as rag pickers, selling small items on trains, shoe shining, as coolies, entertainers and beggars. Much of their time is spent avoiding the police, finding food and shelter and places to bathe. Most of the boys are involved in sexual activity from an early age, and much of this is for survival as much as for pleasure. The same situation applies for girls. Sex is also used by the boys as a vehicle for power and status, especially toward younger boys and girls. Some of the girls dress as boys to gain some degree of protection.

Some of the sex results in STDs, including HIV. One boy who is dying (final stages of AIDS-related illness) had come from a rural village to Mumbai with endemic poverty. He had become involved in commercial sex by age 11. He said ‘It was death I was trying to escape, and it was death I found’.

Some children have self-mutilated: ‘I want people to see the pain inside me’ (street boy). Substance use, also, did not necessarily help: ‘... everything gets too big.... the noise gets too loud, crowds get too much, it gets even hotter..... it really is not worth it....... but it passes the time’ (street boy regarding solvent use).

**Thiruvananthapuram**

Groups were formed around types of work (e.g. lottery sellers, newspaper agency, etc.) and about 85 groups were conducted in 1995. There were approximately 10 participants per group and each met on a number of occasions. Up to 80 children have been involved aged 10 to 21 years. More recently seven focus groups have been held with 66 children; these groups followed the Questions and Issues Menus more closely. The groups were held for varying lengths of time, and were located near their areas of employment (e.g. bus and railway stations, a garage, a park, and at the night shelter). Most participants were male, except for the groups held at the night shelter in the slum community.

The earlier groups tended to be more educational and issues-focused, than data gathering according to the components of the Modified Social Stress Model. Films, famous people and politicians are used during the groups at times.

The preliminary findings are that the children tend to come from ‘broken homes’, and are on the streets to earn money. Substance use is common (tobacco, some alcohol and cannabis), their sexual behaviour risky and relationships with peers of negative concern.

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**AUSTRALIA**

**Sydney**

Both focus groups and individual interviews have been used to generate data from 37 individual young people (24 males and 13 females) aged from 14 to 18 years. Length of interviews and groups varied and participants included youth born in Chile, Fiji, Germany, Italy, New Zealand, Philippines, and the United States of America. Most had left school before completing minimal requirements (i.e. left before receiving ten years of schooling).
Major life events included physical and sexual abuse, ill-treatment, deaths of parents and/or significant others, suicide attempts, pregnancy, violence, and some natural disasters (e.g. bushfires and floods). Only 19 per cent had not experienced the death of someone close to them. No one was a refugee.

Everyday stresses and enduring life strains included: finding accommodation, food, clothing and entertainment, harassment by the police and other street people, keeping safe, substance availability and peer use, maintaining an income and loneliness.

Poly-substance use was the norm and the participants identified a number of difficulties which arose from use. These included: involvement in crime to support use, becoming involved in sale of illicit drugs, risky and commercial sex, ill-health, disease spread (e.g. HIV and Hepatitis C).

Substances used included combinations of alcohol, tobacco, cannabis, prescribed medications (mainly from the benzodiazepine group (especially diazepam, oxazepam, flunitrazepam, temazepam, and clonazepam) and some diverted dexamphetamine and methyphenidate (used for attention deficit hyperactivity disorder) and anti-psychotic medications (e.g. thioridazine hydrochloride and haloperidol), psychostimulants (mainly amphetamines and MDMA - ecstasy), hallucinogens, and heroin. Injecting was common and there was some equipment sharing, despite easy availability of clean equipment.

Level of use is much higher than the adolescent mean (e.g. use of heroin among high school students remains about 2 to 3 per cent, but for street youth regular use is about 36 per cent for males and 60 per cent for females, for psychostimulants, about 7 to 10 per cent use by older high school students, and regular use by 36 per cent of male and 60 per cent female street youth).

Substances are used to block out memories, escape reality, forget problems, have fun, relieve stress or boredom, to relax, to be different, or because they have become dependent.

Family remained important, though most reported major difficulties in maintaining positive contact and involvement (on their part, that of the parents/family, or both), only eight per cent had regular contact. Ten per cent had their own children, though most were in the care of relatives or the State. Sexual partners were significant people, albeit that many of these relationships did not endure. Involvement in education or training had not been very positive, though most wanted to have good and rewarding employment.

Many were interested in sport, music, writing poetry (two volumes of poems by street youth have been published by the agency), and other recreational activities. Most have been in contact with a variety of agencies which provide services for homeless youth, with various degrees of satisfaction with the services provided and the staff. Many return and keep in contact with particular staff members, who become like surrogate parents/siblings and provide a base. Health services were quite readily available and used, but mental health services were often viewed with suspicion.

PHILIPPINES

Manila

Focus groups using the PSA materials have only begun recently as materials arrived late. To date about 12 groups have been conducted for both male and female children aged 10 to 18 years in various settings prior to the arrival of the material, and three for slum children and one for street children since. They have been conducted at FCED office and on the streets. The groups are used for both preventive/educative and data collection purposes. The slum children groups lasted up to
five hours, and for the street children up to three; both with breaks and snacks/lunch. Rice has been
given as an incentive (slum children give the rice to their families, the street children trade it for
cooked food).

The focus of discussions is consistent with the components of the Modified Social Stress Model, as
adapted to suit local conditions.

The main findings included that shabu was the substance of major concern for the children
(previous alcohol was the major worry), mainly due to its impact on individuals in their
communities becoming unpredictable and, at times, aggressive. Also identified were stressors
located within their families (discord, violence, etc.), living conditions, the role of peers (barkada)
in experimenting and maintaining substance use, and the desired (functional) effects of the
substances themselves.

Some slum children, mainly girls, clearly identified their fear of physical and sexual violence toward
them, and of being kidnapped and taken hostage (currently very prevalent in Manila). Also
mentioned was some injecting, probably of amphetamines or benzodiazepines.

4. SERVICE PROVIDERS FOCUS GROUPS

Part of the recommended WHO/PSA methodology was to conduct focus groups with service
providers, as well as street children. These were to provide information which could be compared
to that of the street children focus groups and similarities and differences explored. They also aim
to provide information to inform action planning.

In addition, the service provider focus groups were found to increase networking, information-
sharing and reduce competition between agencies in Phase I of the WHO/PSA Street Children
Project.

In this phase of the project, service provider groups have not been conducted at all sites. In certain
sites the reason for this was logistic, but in others it was due to fears of increasing competition
between agencies if others found out that a particular agency was receiving WHO funding.

In one case the invitation to participate was rejected because WHO is perceived as an organization
dominated by developed countries, attempting to impose an ideology and methodology on less
developed ones with minimum financial support. This is a unfortunate view, but one that has
hampered agency cooperation at some sites.

Where participating sites themselves have chosen to view service provider focus groups as a less
important programme feature, they may have missed out on important possibilities. In
strategic/action planning, the views of other service providers are crucial pieces of information.
Likewise, the output from service provider focus groups enables staff to contrast data from the
children's groups with that from the service providers. As mentioned above, any apparent
differences can be explored.

It is possible that there has been a too narrow interpretation of 'service provider', and that there
should be a name change to 'service provider and community focus group'.

In the main, and similar to Phase I, increased opportunities for networking and sharing of
information occurred in the focus groups. While these are essential ingredients in developing non-
competitive, collaborative interventions for street children, and an opportunity to learn new skills
and information, service provider focus groups are also valuable sources of data useful for the planning process. It is not intended that they become sterile data gathering exercises, but that some groups or parts of groups should be devoted to such an endeavour.

Where held, most sites reported that increased cooperation and networking developed, and gaps in service delivery were identified. This assisted in non-duplication of services and more coordinated planning to meet the needs of street children.

The following outlines the situation at each site.

**TANZANIA**

*Dar es Salaam*

Nothing reported.

*Mwanza*

Twelve service providers participated in a focus group. Findings were essentially the same as for the children's groups.

**UGANDA**

*Kampala*

**UYDEL**

About 42 focus groups have now been held for service providers from a wide variety of agencies. The groups lasted about one and a half hours and involved information sharing and use of the Questions and Issues Menus. Increased cooperation and information sharing has resulted, and an expanded capacity to understand and respond to substance use among street children. The information obtained was essentially similar to that reported above for the street children focus groups.

**UNOGT**

Four service provider groups have been held, and mainly involved information sharing and development of strategies. The PSA models and issues were not used due to lack of staff training in them as yet.

**ZAMBIA**

*Lusaka*

**Commonwealth Youth Programme**

None reported.

**Zambia Red Cross**

None held at this stage.
BRAZIL

Rio de Janeiro

None undertaken at this stage.

CANADA

*Halifax and Saskatoon*

Not applicable.

COLOMBIA

These have occurred informally at this stage, and mainly focused on the establishment of the project and networks.

DOMINICAN REPUBLIC

*Santo Domingo*

Eight representatives from three institutions are participating in service providers focus groups. Five meetings have been held so far, each lasting between one and two hours.

HONDURAS

*Tegucigalpa*

Eight sessions of one to one and a half hours were lead by the principal investigator over a two-day period with participants from 8 organizations, representing a variety of agencies and services. The complete Questions and Issues Menus were used.

The findings were essentially similar to those for Phase I and those for the street children groups.

MEXICO

*Mexico City*

A series of four focus groups were held for nine service providers of about one and a half hours each who were graduate student volunteers at El Caracol. The Menus were used to generate discussion, but it broadened to focus more on advocacy and risk. The findings were much the same as for the children's groups. The groups also seemed to offer an opportunity to de-brief.
NICARAGUA

Managua

A series of four focus groups was held based on the Questions and Issues Menus, with a focus on the situation of female street children. There were four distinct groups: girls working on the streets, mothers of working girls, street educators and teachers.

PARAGUAY

Asuncion

These have not really begun as yet. However, there are regular meetings of the coordinators every two weeks.

EGYPT

Cairo

Village of Hope/Arab Council for Childhood and Development (ACCD)

One group was conducted with service providers from the Village of Hope, which involved five participants and lasted for two hours. The findings correspond to those of the focus groups with the children.

Cairo and Alexandria

Caritas

None reported for Cairo, but in Alexandria, the Community Advisory Committee also participated in a focus group.

CZECH REPUBLIC

Prague

Three focus groups have been conducted with service providers. Each meeting took one day and 66 individuals participated from a variety of youth-specific agencies. Two were for Prague workers and the other for workers from all over the Czech Republic.

Gaps in service delivery were identified and included: refugee and gypsy children, and not enough needle and syringe exchanges.
RUSSIAN FEDERATION

Moscow

Four service provider focus groups have been held involving 20 individuals from a variety of organizations, including the Collector-Distributor Centre, hospitals for substance dependent people, police, local government, education, a children's rights centre, a labour union newspaper. Information was shared and the picture which emerged was essentially as for the street children's focus groups.

INDIA

Mumbai

Twenty one interviews were conducted with a variety of staff from a variety of agencies working with street children, by postgraduate students of two Mumbai universities. The findings were essentially similar to those for the street children focus groups reported above.

Thiruvananthapuram

Meetings of service providers are held according to need (over 24 and about five members per group), but mostly to share information and develop networks. The PSA material not focal at this stage.

AUSTRALIA

Sydney

None held to date, but are planned.

PHILIPPINES

Manila

None held to date, but the community advisory group functions as a quasi-service providers group.

5. COMMUNITY ADVISORY COMMITTEES

Establishing Community Advisory Committees, if not already in existence, was recommended as an essential component of the WHO/PSA Street Children Project methodology. These committees tend to include senior local government and nongovernment officials, especially those who can increase access to services for street children, and community members and service providers. Ideally, they also include street children.
The committee can share knowledge, advocate for the needs of street children, increase local debate on and awareness of the situation of street children, improve access, and provide a link between the project and the community. The committee also has a role in the monitoring of the project.

Most sites reported the presence of a group which could be seen to fulfil the functions of a community advisory committee as envisaged in the WHO/PSA methodology. A proportion of the committees were pre-existing management, support or advisory committees. Where functioning, increased cooperation and access to needed services was in evidence. In addition advocacy for the needs of street children occurred. Some committees mainly comprised well-placed government officials, with few local community representatives. Others were mixed, containing local community leaders, representatives from local businesses, health, education, religious, welfare, police and correctional sectors.

In some cases, the committees had current or ex-street children as active members; not merely as tokens. This situation is certainly the ideal, but in certain locations impossible to establish due to the opposition of those with power to be on a committee that contains children, especially street children.

Solutions to this dilemma have been developed in the form of a series of committees with differing functions, which allow for grassroots participation and the involvement of senior officials and members of the community (e.g. Tegucigalpa and Mumbai).

In Tegucigalpa, Thiruvananthapuram and Cairo separate structures have developed to allow a loud and effective voice of street children to be heard by the Community Advisory Committee. Tegucigalpa has a Youth Advisory Council and Thiruvananthapuram, a street children’s union (Jyothirgamaya).

The following outlines the situation at the various sites.

TANZANIA

Dar es Salaam

Nothing reported.

Mwanza

The CAC is the existing Kuleana Board, and comprises nine members from the areas of community development, early childhood education, elementary education, law, refugee work, public health and business. No street children are members.

UGANDA

Kampala

UYDEL

A CAC exists which includes 20 community members, service providers and street children. Members include police, lawyers, religious leaders, corrections and welfare workers, medical practitioners, journalists, urban authority workers, alcohol and other drug workers and street boys.
Sub-committees have been formed recently to deal with: training and research; street girls and peer leaders; resettlement and drop-in-centres; outreach and street work.

The committee has developed a high profile with advocacy activities, and has ensured that it functions as a transparent structure to avoid criticism, duplication and unnecessary competition. In particular, it has developed an action-oriented, ‘bottom based’ network, increased the power and awareness of member agencies, and raised awareness of the situation of street children in the broader community.

Committees at ‘slum levels’, one at Kalerwe (Paccoin) and another at Katwe (KAYDA) have been formed to identify and discuss problems of local street children.

UNOGT: A CAC exists and provides a forum to discuss the problems of local street children and their resolution. The members include local council officers, police, concerned citizens, opinion leaders and street children.

ZAMBIA

Lusaka

Commonwealth Youth Programme
None specific to the PSA project.

Zambia Red Cross
A CAC established in 1992 is now defunct, due to the death of the then coordinator. Its mandate was to advise on practical strategies to address the problems of street children within a particular compound. It had approximately 16 members, including community leaders, parents and drug enforcement officials. It was planned to involve young people, but this did not develop. Meetings were held once per month and lasted about two hours. This CAC will hopefully be renewed in the near future.

BRAZIL

Rio de Janeiro

None established as yet, but the components are emerging from association with a variety of direct service providers and government agencies.

CANADA

Halifax and Saskatoon

EGADZ has a board of directors, made up of representatives of governmental and nongovernmental agencies which have a vested interest in ‘youth at risk’.

Although not part of the WHO/PSA approach, Halifax has a Community Youth Network (CYN), which has been in existence for the last 10 years. This network aims to bring the community
together to discuss topics of concern on youth. They are also involved in community development strategies, and in research on youth, and this collaboration of youth-serving agencies provides a model for other Community Advisory Committees.

COLOMBIA

The individual city and national project committees form pseudo CACs, and have mainly focused on the establishment of the project to date. A National Advisory Committee exists, with members from the National Narcotics Board, Ministry of Communication, Ministry of Labour, National Council for Social Policy, and National Federation of Commerce.

DOMINICAN REPUBLIC

Santo Domingo

A National Advisory Council is planned, which will advocate for the project and coordinate activities. The Minister of Education has taken the commitment to be the focal advocacy point for the project. It is planned to include the police, the private sector, Pastoral Juvenil and Consejo Nacional de Drogas.

HONDURAS

Tegucigalpa

COIPRODEN, the major NGO network, is regarded as a substitute for a Community Advisory Committee. COIPRODEN has 25 NGO members of a multidisciplinary nature and has a mandate to advocate for children's rights. It meets regularly, and is used as a forum to discuss all youth issues, coordinate training events, fund raise, become a focal spokes group and attempts to avoid duplication of activities among member organizations.

The Youth Advisory Council also functions as a community advisory committee, but in this case represents the youth perspective. There are 17 members of the Youth Advisory Council representing five markets and a marginal barrio. The Council has a good relationship with the Office of the Mayor of Tegucigalpa.

MEXICO

Mexico City

IMP staff and El Caracol volunteers have been working as the core committee, with a particular sub-committee devoted to the WHO project implementation. Other academic institutions and NGOs have representatives on the committee (e.g. from programmes with a focus on adolescent health, female commercial workers, education, child protection and human rights). A broader CAC has been established with a firmer base in some of the communities from which the street children come and where they ‘live’.

NICARAGUA

Managua

Three Community Advisory Committees have been formed to cover (a) the Mercado Oriental, (b) Ivan Montenegro Market and (c) Barrio Las Tajeras. A fourth is planned for the area of the
Roberto Huembes Market. They meet every two to three months on average and members have received training in the WHO methodology.

PARAGUAY

Asuncion

Not established as yet.

EGYPT

Cairo

Village of Hope/Arab Council for Childhood and Development (ACCD)
Two CACs have been formed; one in Sayda Zeinab and the second in Hadayek due to location/community differences and distances between the two areas. Two meetings have been conducted by each CAC, aimed at advocacy, information sharing, encouragement to become involved in the work of the Village of Hope and developing networks and links. Substance use has not been discussed as yet. The members come from the communities within which the Village of Hope activities are conducted.

Cairo and Alexandria

Caritas
A project advisory committee has been established with representatives from the Ministry of Social Welfare (responsible for the residential institutions), Ministry of the Interior (responsible for the arrest and disposition of juveniles for begging, vagrancy and crimes), Ministry of Health, some nongovernmental organizations involved in special interest in homeless young people and academic institutions, sporting clubs, business and religious groups. No meetings have been held at this stage of the whole committee.

A similar structure has been developed for Alexandria, without members from the local community. This appears to be related to the fact that the work mainly takes place in institutions. A number of meetings of the Alexandria committee have taken place, which has members from Caritas Alexandria, Ministry of Media, Ministry of Education, Ministry of Culture, Television Alexandria, Social Defence Department of the Ministry of Social Affairs, and the Faculty of Social Service, University of Alexandria. Meetings have covered a range of topics, including the definition of street children, as Caritas has mainly worked with children in juvenile detention facilities, and research possible agendas.
CZECH REPUBLIC

Prague

None established, although several meetings have been held with key players such as officials from city and state departments, organizations and agencies, and other NGOs. A flexible working group has been established of staff from interested agencies, named ‘Street’. This group monitors needs and characteristics of street children and provides coordination and a network for the agencies.

RUSSIAN FEDERATION

Moscow

A Community Advisory Committee has been established for the street children project of MCSTH. This was apparently the first time that organizations in Moscow have come together to discuss and plan a coordinated approach to the street children situation. Many members are senior officials with an ability to influence decisions and increase access to services, such as: the Head, Drug Abuse Department, Drug Therapy Hospital No. 17; Departmental Head, Russian Prosecuting Attorney's Office; an Inspector, Prevention Service Division, Main Division of Domestic Affairs (Moscow); a Senior Inspector, ‘Lefortovo’ (local police department); and a senior researcher, Russian Academy of Education.

INDIA

Mumbai

There are a number of levels of CACs. One comprises the trustees of TASH and other academics, business people and professionals. Another functions at the slum level, and mainly comprises mothers, with some youth involvement. At this level, the committee is both an educative and developmental experience for the women, as well as a means of providing useful information to TASH. Both have a broader brief than the PSA project. Students meet and have some involvement in advocacy activities. Involvement of media with emphasis on the need to present a balanced picture of street children is planned.

Thiruvananthapuram

An extensive committee has been formed recently, comprising about 30 members from GOs (very senior Health, Social Welfare, Education, Police, Corrections, Juvenile Welfare Board, Narcotics Control Board, etc. officers), local government, commerce, banks, the press, service organizations, concerned citizens and street children.

Meetings to date have been informal and of sub-groups of the committee (i.e. a small number of members who meet to address a particular issue). More formal arrangements are planned. Objectives include advocacy, raising public awareness and increasing access to services, training and employment.
AUSTRALIA

Sydney

About to be established for Dunlea, St Vinnies has a management committee, which comprises members of the St Vincent de Paul Society, the Director of St Vinnies for Youth and other interested parties.

PHILIPPINES

Manila

The Interagency Committee has functioned for five years and serves as a community advisory committee. It now includes the PSA project. The committee has membership from local professionals and churches, government workers (health, welfare, police and education), locally operating NGOs and local community leaders. FCED staff are members, some of whom are ex-street children. Street children will be added in the near future.

Information is shared, plans drawn up and support and encouragement provided. Advocacy and access are addressed.

6. TRAINING PACKAGE: STREET CHILDREN, SUBSTANCE USE AND HEALTH: TRAINING FOR STREET EDUCATORS

A major task of Phase II was to trial the training package for street educators which had been developed. A training package had been recommended as a task flowing from the evaluation of Phase I. It had been prepared via site visits, including discussions with street children, service providers and trainers. A team in Manila produced a draft package which was further developed in Geneva. The core of the package comprised the sections on substance use, the modified social stress model, rapid assessments such as focus groups, and interventions.

Sites were requested to review the package and provide internal and external training using the contents of the package as training material. They were also to report to WHO/PSA on this experience and make recommendations for any changes evident.

A large amount of training has occurred during Phase II, but it has not always been consistent with the WHO/PSA package and approach. While there may be no serious difficulty with this, there does need to be some uniformity developed, especially in the use of language, ideology and concepts. For example, the terms ‘addict/addiction’ are not consistent with WHO’s approach; and classification of substance use disorders.

Likewise, as WHO/PSA’s main concern is health, well-being and quality of life for all, the Street Children Project methodology was developed within a health context. Substance use, then, and responses to it, are seen as possibly exacerbating existing health difficulties and creating new ones. Consequently, WHO/PSA is concerned with minimising any harms associated with substance use
whether the goal of the country, site or programme is abstinence or not. It recognizes that whatever the goal, substance use will probably still occur, and at harmful levels for some.

In addition, the Modified Social Stress Model is a means of reminding people that substance use is not context free, and nor is a mindless, anti-social activity. It clearly identifies that a variety of risk and protective variables interact with each other and influence the pattern of substance use for an individual or the community. Attention only to 'the drug/substance' and ignoring the other variables has not been found to be a useful approach.

It is understandable that educators and others believe that telling young people about the actual and apparent harmful effects of various substances can be helpful, but research shows that this approach does not have any lasting impact. Hence the emphasis in the training package on understanding the complexities which surround the initiation, escalation and maintenance of substance use, and the Modified Social Stress Model as a conceptual tool.

Overall, sites reported that the package was welcome and most useful. There were no indications that better packages existed. Suggestion to improve it were provided as were additional examples. These are discussed in a later section. This section of the report provides information on internal and external training provided, especially that which used the package.

Some of the training involved street children as presenters or consultants, and other training incorporated site visits. There appears to be a need for more of both these activities, to increase the participatory nature of the training. That is, to increase the participation of street children in the development, delivery and evaluation of any training which will have an impact on them.

The main criticism of the training package is that it does not contain enough information on how to train; i.e. how trainers can use the package to best advantage, by the provision of training tips. Much of the remaining criticism related to not enough country/culture specific examples. Competent trainers were able to take the core of the package and adapt it to local conditions. Less competent trainers tended to use the package like a text book, section by section, even page by page.

A criticism from some sites in more developed countries was that the emphasis and examples were predominantly from the developing world. This is correct, as the main target for the package was sites in developing countries where most of the sites are to be found. Nevertheless, competent trainers can extract what is relevant, adapt other sections, ignore the irrelevant and add what is required.

What follows is a brief site by site coverage of what training has occurred to date. Specific suggestions for additions and/or improvements to the package are also included.
TANZANIA

Dar es Salaam
No training reported.

Mwanza
The Training Package was translated into Swahili.
Ten street educator staff of Kuleana received training using the package, but to date no external training using the package has been undertaken. Internal training was very participatory and a three day residential workshop formed part of it. Street Kids International (SKI) material was incorporated. However, some of the SKI material is not consistent with the WHO/PSA approach.

The Kuleana report notes the poor understanding of substance use by service providers and the community, and the need for community participation in training and educative activities. It is hoped that the training package can form the basis for some of this necessary training.

UGANDA

Kampala

UYDEL
Three training workshops have been held; the first with 15 participants from UYDEL and other agencies working with street children. The second for 21 volunteers of another agency (KAYDA) including a street girl and a street boy and five ex-street boys who wanted to be trained as peer leaders. The third workshop was for 41 participants from Pacoin, a local agency dealing with street children, which then developed into a CAC.

Another external training workshop was conducted with 37 participants who work with street children in various capacities, many of whom were members of the Community Advisory Committee. There has also been peer training for 15 leaders in NGO projects using the WHO/PSA manuals, and a further 25 people are undergoing a six week training. A total of 140 participants have been trained as street educators.

UNOGT
Staff attended training provided by UYDEL. No internal or external training has been undertaken by UNOGT.
ZAMBIA

Lusaka

Commonwealth Youth Programme
No training reported.

Zambia Red Cross
Internal workshops have been conducted over a three month period with 12 street educators, mainly via guiding the participants through sections of the package. No external training has been undertaken.

BRAZIL

Rio de Janeiro

The training package was translated into Portuguese and one combined internal and external training workshop was conducted over five days at NEPAD. There were 26 (20 external and 6 internal) participants from eight agencies. Site visits for participants were incorporated.

The Modified Social Stress Model has been broadly adapted for focus group training in another health education project, and it is estimated that approximately 3000 health and education professionals will have access to this information, as part of their overall training in adolescent health, interventions and prevention of multiple risky situations.

CANADA

Halifax and Saskatoon

Well developed, delivered and evaluated training occurred in two three day training workshops at Saskatoon and Halifax. One workshop at each location used the training package and the other the monitoring and evaluation manual.

A private management consultancy was engaged by Health Canada to design, deliver and evaluate the training. There were 23 participants of the street educator training at Halifax and 21 at Saskatoon. There were 20 participants of the monitoring and evaluation workshop at Halifax and 15 at Saskatoon.

On the whole the packages were well received, but found to be more suited to developing country settings. To be of more use in the Canadian settings, more local content would need to be added. Some problems were also identified with language, a perceived gender bias and an emphasis on the individual rather than on the social and environmental. There was also a need recognized for the provision of a glossary.

It was also suggested that various sections might be targeted to particular workers: new and with little formal training, new but experienced workers, and administrative staff.
COLOMBIA

Ten regional training workshops were funded by the Ministry of Education using the WHO/PSA materials from Phase I of the project as the Spanish version of the training package had not arrived in time. As the project requires collaboration between GOs and NGOs, the training provided to date meets both internal and external requirements.

DOMINICAN REPUBLIC

Santo Domingo

No training has been conducted as yet, due to the late arrival of the Spanish version of the manuals.

HONDURAS

Tegucigalpa

The Spanish translation arrived late from Geneva, and formed the basis for the training undertaken.

Two internal training sessions were conducted for staff of Project Alternatives andOpportunities. There were 20 staff in the first session (a two-day session) and 19 in the second (a one day session).

Two external workshops were conducted and two more are planned. One workshop was held in Tegucigalpa and the other on the North Coast at Tela. Twenty three persons from 17 different organizations received training.

MEXICO

Mexico City

Three internal training courses were conducted with 26 participants in total. The first two workshops used the WHO/PSA street educators training package and the second, the monitoring and evaluation manual. A follow-up workshop was also held with 12 participants.

Three external workshops have been held. The first two used the street educators training package and had 25 and 23 participants each. The third workshop had 23 participants and used the monitoring and evaluation manual. Recently a further 30 participants from street children programmes were trained in a fourth workshop using the WHO/PSA manuals.

There are plans for additional country wide training in association with CONDADIC (Consejo Nacional Contra las Adicciones).
NICARAGUA

Managua

Training has been ongoing in Managua, and to date three training courses have been conducted with 85 participants with backgrounds in street education, health work, social work, education and community volunteer work. Training was provided over seven to ten days. Thirty five teachers have also been trained in weekly sessions.

PARAGUAY

Asuncion

Training has been provided to 40 street educators from 15 agencies in a ten hours session.

EGYPT

Cairo

Village of Hope/Arab Council for Childhood and Development (ACCD)

No extensive training has occurred as yet largely because the material was not translated into Arabic by ACCD. However, Caritas have translated the package into Arabic and could provide it to ACCD. Some internal training has occurred, but none external to Hope Village.

Cairo and Alexandria

Caritas

Documents have been translated. No training evident internally. In Cairo, an external training workshop was held in collaboration with El Guiza Delinquency Institute for 14 social workers. The training lasted seven days (one three-day-period and one-four-day-period) and the PSA package was used.

In Alexandria three training courses have been conducted; one for Caritas-Egypt volunteer university students (Caritas Youth) and two for workers and leaders of organizations interested in working with street children.

CZECH REPUBLIC

Prague

The package has been translated into Czech and two training workshops held utilizing the package for 38 participants from MOST and other agencies. Training lasted four to five days and included
site visits and interaction with street youth. MOST developed work books in Czech for the participants.

RUSSIAN FEDERATION

Moscow

Activities planned but not completed at this stage. Some sections of the package have been translated into Russian.

INDIA

Mumbai

The package has been translated into Hindi and Marathi. All staff have been briefed using the training package, in a staff seminar format over time.

An external training sessions was held for 32 participants, using some of the training package, but participants were mainly postgraduate university students (20/32). Another briefing was held for 24 students who participated in the focus groups and individual interviews of street children and service providers. Some external training was offered to five NGOs working with street children.

The project team used the opportunity to share the WHO/PSA methodology in the training programmes and conferences organized by the NGOs, GOs, university departments of psychology, social work and continuing education within India as well as abroad. A small group of action researchers from various disciplines working with children in Germany, Norway, USA and Southeast Asia were informed by the Project Director. The methodology drew some positive feedback.

Thiruvananthapuram

Four internal training sessions have been conducted with six staff at each session. The training package was used in the order as presented in the package.

Some external training has been offered to over 60 staff from 21 NGOs and 12 GOs, but not fully within the methodology and ideology of the PSA package.
AUSTRALIA

Sydney

Training to commence internally by end June 1996 as the package arrived very late. No external training undertaken as yet.

PHILIPPINES

Manila

Extensive external training has occurred for street educators using the PSA package for 13 organizations/agencies (12 NGOs and one GO). All participants work with street children providing community, centre or street based services. Three training sessions, each of three days, have been conducted over a six week period.

The trainees were aged 20 to 37, 11 male and 13 female, with backgrounds in social work, psychology, commerce/business, maritime work, nursing, education, theology, political science, industrial engineering, dressmaking, and refrigeration. Some had only received limited secondary education and five were ex-street children.

The sessions were carefully planned and facilitated by exciting and competent persons with direct experience with the target population of street children. Adult learning and participatory/interactive techniques were widely used.

SUGGESTIONS FOR THE TRAINING PACKAGE

Most sites considered a ring folder format to be the most useful, as such a format would assist in photocopying sections as handouts, etc. Some also requested key diagrams, tables and concepts to be in a form ready to use to make overhead projection transparencies. A better (more complete) index was recommended.

Most participants have requested their own copies of the package. The provision of a glossary was requested by a number of sites.

A number of sites requested more tips for trainers as they found it difficult to turn the package into workshops or a series of training sessions. Even the sites with competent trainers requested training tips. For example an expanded introductory section to provide more suggested guidelines for using the package in training, more tips in the text as to when to obtain local examples, and more suggested exercises for use during training to assist in the better acquisition of key concepts and information by trainees.
Some sites felt that there was too much emphasis on the ‘mental’ or psychological aspects related to the lives and experience of street children and substance use, and not enough on the environment and social context.

More information was requested on what is known to be true (i.e. on the basis of available good scientific evidence as opposed to myth) about the physical and other effects of specific substances. Related to this was a request to cover such aspects of ‘substance effect’ as the hallucinations experienced by many users which were desired and sought by some, and feared by others. Another comment related to there not being enough emphasis on the group nature of much substance use by street children, and how use in a group may relate to different factors than individual use.

In particular, sites have identified that the intervention section is not adequate. It needs to contain a full range of interventions and detail on how best to choose the appropriate intervention, and how to develop a broader range locally if not already in existence.

There were also requests for practical examples of interventions which are generally helpful for dependent substance users and those which are more helpful for persons who are dependent on particular substances, and interventions for particular groups of dependent users.

It may not be clear enough in the text of the package about the importance of adequate assessment to see if there is a substance use problem for the individual, or whether the difficulties being experienced by the street child relate more to social and other conditions. It may be that if the child has a safe place to live, has their health needs met, receives some vocational training, and feels valued any experimental substance use may cease. In other cases the substance use may be of such a regular, dependant and hazardous nature that specific residential treatment is required.

Whatever the case, it is important that any interventions occur after thorough assessment of the individual and their context. Children may not need to be placed in institutional settings if there is some family or other support available in the community. Residential placement should be a last resort, and used if other interventions are unavailable or have been shown to be ineffective. Institutional treatment tends to yield poor outcomes and can make a situation worse.

There was also a request for clarification of the Modified Social Stress Model. Apparently it is unclear in the text that risk assessment is not a matter of adding up the three elements on the top line (stress, normalization and substance effect) and dividing by or subtracting what is on the bottom (attachments, coping strategies and resources). Obviously, attachments can be positive or negative and that people can have a mix of positive and negative peers with whom they interact. So, attachments can be protective or increase vulnerability.

The elements of the model are set out in such a way to indicate that more risk may occur if an individual or group is exposed to significant stress in an environment where substances are cheap and readily available, and where they have few positive attachments, few coping skills and limited access to resources.

It was never intended that the model be used as a mathematical means of evaluating risk. It was intended to be a simple conceptual tool which reminded street educators that substance use is a complex phenomena and that attention to only one aspect (e.g. the substance or stress) and ignoring or minimizing others will probably not lead to a better outcome for the individual or group.
Interventions need to be based on a comprehensive assessment of the situation, for the individual, group or community, and not just target one element.

Some requested a series of appendices with contained ‘fact sheets’ and lists of resources and practical examples of interventions. Appendices could also include information on fundraising and resource mobilization.

There were some comments that the initial portion of the package was more suited for those who were attempting to set up a new service, than for those which were well established. However, it is not possible to produce two packages, so training tips should assist trainers to select what is relevant and ignore the remainder.

There were also comments, specific and general, on the use of language in the text. For example, ‘people like you’ in some questions in the questions and issues menus. This needs to be taken into account during revision, as does any possible gender bias. While it is fact that at most sites male street children outnumber the female street children, females should not be regarded as a ‘minority group’, but recognized as having some specific needs. The relationships between ‘street boys’ and ‘street girls’ also warrant further investigation and consideration.

It was clear during the 1994 meeting in Geneva, that sites wished the core of the package to be the substance use sections (understanding, assessment and interventions). The feedback suggests that this request has in part been met, but there is also a need for these sections to be reviewed.

Finally, debate is still evident on the use and meanings of the term ‘street child’ and ‘street children’. Whether terms such as ‘especially vulnerable’ are more useful or not remains to be seen. However, the issue requires further attention.

More detail is provided in the evaluation questionnaires completed by a number of sites. The comments relate to each section of the package, the illustrations and examples. This will greatly assist in the revision process, but will not be commented on in this report.

7. MONITORING AND EVALUATION

Another major task of Phase II was to trial the monitoring and evaluation manual which had been developed. This was another task flowing from the recommendations of the evaluation of Phase I. It had been prepared via site visits, including discussions with street children, service providers and evaluators. A team in Mexico City produced a draft which was further developed in Geneva.

Sites were to review the manual and apply the methods it contained to develop or refine where necessary their monitoring and evaluation strategies. They were also requested to provide a report to WHO/PSA on their recommendations and experience of using the manual.

Unfortunately little has been achieved in the area of monitoring and evaluation. Few sites have developed formal comprehensive systems for routine data collection, recording of activities, monitoring work and evaluation of outcomes. This must become a priority for phase III.
However, the manual was seen as very useful and appropriate and indications were that it would influence sites to proceed more rapidly with establishing effective monitoring and evaluation processes.

TANZANIA

Dar es Salaam

Nothing reported.

Mwanza

No work has been undertaken to date using this manual, but it has been translated into Swahili and it is anticipated activities will begin this year.

UGANDA

Kampala

UYDEL

Informal monitoring and evaluation activities are in place, with plans for further, formal monitoring and evaluation.

UNOGT

Some formal and informal monitoring and evaluation activities appear to be developing, and the PSA material is being greeted with some enthusiasm.

ZAMBIA

Lusaka

Commonwealth Youth Programme

Material not used. Own monitoring in place.

Zambia Red Cross

No formal system of monitoring and evaluation is in place. However, ZRC has plans to develop a system.
BRAZIL

Rio de Janeiro

The manual was translated into Portuguese and distributed. No feedback has been received at this stage. Monitoring and evaluation in NEPAD already exists as it is a research facility. The influence on service delivery agencies is unclear at this stage.

CANADA

Halifax and Saskatoon

The manual was extensively reviewed by service providers and a panel of experts, and used in the training provided at both Halifax and Saskatoon.

There were 20 participants of the monitoring and evaluation workshop at Halifax and 15 at Saskatoon.

The major feedback was that the manual is able to be used for training as easily as the training package. It does not contain many training tips and if it is intended to be used in a similar fashion as the training package, they would need to be provided.

Otherwise, the manual was regarded as very useful for its purposes. Again, a glossary would assist.

COLOMBIA

Not in place as yet, but forms part of the planning.

DOMINICAN REPUBLIC

Santo Domingo

Nothing to report at this stage.

HONDURAS

Tegucigalpa

Regularly occurs and has been built into the functioning of the organization. It uses programmatic monitoring so as to facilitate timely administrative, management and programmatic decisions. With the merger of the two organizations (Alternatives and Options) this has been crucial. It has also been found to be valuable with some of the newer street children organizations in Tegucigalpa. The manual has been found to be very helpful.
MEXICO

Mexico City

El Caracol already monitors and evaluates its activities. However, the monitoring and evaluation manual has been of some assistance. Time and money hinder greater effort and sophistication.

NICARAGUA

Managua

No work to date, but it is planned.

PARAGUAY

Asuncion

Nothing to report at this stage.

EGYPT

Cairo

Village of Hope/Arab Council for Childhood and Development (ACCD)
A more formal monitoring and evaluation system has been developed with the help of the PSA manual.

Cairo and Alexandria

Caritas
Nothing reported other than existing routine Caritas data collection, analysis and documentation.

CZECH REPUBLIC

Prague

Has been translated into Czech and made available to managers and coordinators. A monitoring and evaluation system was already in place, but the manual has been of some assistance.
RUSSIAN FEDERATION

Moscow

Activities planned, but not completed at this stage. The resource personnel to MCSTH have extensive research and evaluation experience and capacity.

General comments:

The only major recommendations regarding the manual were for training tips, similar to that for the training package. Other detail is provided in the evaluation questionnaires completed by a number of sites. This will greatly assist in the revision process, but will not be detailed in this report.

INDIA

Mumbai

Informal monitoring and evaluation exists at this stages, but the manual and an interest in computerising a monitoring and evaluation system may lead to something more formal.

Thiruvananthapuram

Formal systems are developing and documentation is becoming more thorough. Elements of the PSA package are being incorporated into what exists. The system is becoming more sophisticated. Staff document work regularly, and this is reviewed with the Director and at staff meetings.

AUSTRALIA

Sydney

Package arrived very late and only informal data collection and monitoring in place, which mainly captures demographics.

PHILIPPINES

Manila

Apart from routine data collection and monitoring procedures, little has been set in place. Materials arrived late, but work has begun.
8. ACTION PLANS

Another component of the WHO/PSA Street Children Project methodology is the development of strategic or action plans. These should emerge from the information gathered from the street children and service providers focus groups and the discussions of the community advisory committee. It was also recommended that street children be involved in the process of gathering and analysis information, developing plans, and monitoring and evaluation activities.

Strategic/action plans were developed and sent with site reports from Cairo (Village of Hope/ACCD), Colombia, Kampala (UYDEL), Managua, Mexico, Moscow, Mumbai, Prague, Tegucigalpa, and Thrivunanthapuram. However, few of them provided much detail, other than Colombia, Kampala (UYDEL), Managua, Moscow, and Tegucigalpa. Other sites either said that they had a plan, but did not forward it, or had none. Few also appeared to be linked to the data gathering via focus groups or other methods. Few also appeared to be linked with a developed monitoring and evaluation system.

In some cases planning had been difficult due to a late start and the limited period of the project, but even starting up a project requires some plan. A detailed one can be developed once data is collected and analysed.

The following is a listing of what was reported by each site, followed by some examples from sites where plans had been developed in more detail.

**Asuncion**: This site has not developed a plan as yet due their late start.

**Cairo** (Village of Hope/ACCD): This site has a plan, but not much detail was provided in their report.

**Cairo and Alexandria** (Caritas): Caritas reported that they have one, but nothing specific was provided to the WHO/PSA Street Children Project. However, Caritas Egypt has an extensive plan.

**Colombia**: Six cities have plans already, and all 13 will have by September 1996. Details, however, were not provided at this stage.

**Dar es Salaam**: None was provided, nor were there indications of a plan other than to attempt to resuscitate the network of local agencies working with street children.

**Halifax and Saskatoon**: Not applicable.

**Kampala** (UYDEL): UYDEL have developed a plan and it was provided with their report. The plan contains activities such as:
- sharing information and experience
- undertaking joint activities to reduce duplication of services
- identifying more children in need
- collective advocacy for street girls
- the encouragement of more volunteers
- re-unification of more children with their families
- substance use prevention activities
- media sensitization
- training of peer counsellors
- establishing more drop-in-centres
- developing income generating schemes.

The action plan includes a statement of purpose for each activity, the action required, the resources needed and success indicators.

**Kampala** (UNOGT): UNOGT reported that they have a plan, but it was not provided.

**Lusaka**: CYP has not provided a plan at this stage.

**Lusaka**: The Red Cross seem to have developed a plan, however no details were provided.

**Managua**: A plan has been developed and was provided. It has objectives which focus on the development and consolidation of networks and funding support, development of suitable resources, attention to legal issuers, the integration of children into their families and communities, extension of focus to a wider range of risks, substance use prevention activities, and monitoring and evaluation. The plan contains activities and a time line.

**Manila**: FCED have developed a plan with the community, but details were not provided in their report.

**Mexico City**: This site have developed a plan, and it was provided in text form in their report.

**Moscow**: This site has developed a detailed plan and provided it with their report. It is linked to the findings of the focus groups and lists their objectives as: research, intervention, females, coordination, training.

The research objective includes conducting more focus groups and circulation of the analysed results. The intervention objective includes raising the level of public concern toward the problem of street children in Moscow via use of the mass media and to sustain the work of the advisory committee.

The objective which relates to ‘street girls’ includes developing an effective method of intervention for girls held at the Collector-Distributor Centre for Adolescents, and the training of staff there and in the police departments of Moscow in better dealing with these young women.

To improve the quality of life of Moscow street children, the fourth objective involves distributing useful information to all organizations which deal with street children and training service providers. The final objective involves monitoring and evaluation of the other implementation activities of the other objectives.

The plan includes a time line for each of the sub-tasks for each objective and a budget.

**Mumbai**: TASH reported that they have a plan, but only very brief details were provided in their report.

**Mwanza**: None was provided, although it is believed that Kuleana would have a well developed plan for all its activities.
Prague: MOST provided a brief plan to do with coordination, training, research and networking and provided it in text form within their report.

Rio de Janeiro: NEPAD have a plan, which includes producing a smaller, culturally adapted training manual in Portuguese, and the implementation of a cross-cultural data bank.

Santo Domingo: This site has not developed a plan as yet.

Sydney: None was provided, but planning has commenced.

Tegucigalpa: Project Alternatives and Opportunities have a well developed and detailed plan and provided it with their report.

The plan contains activities focused on:
- physical, mental and social health of the street children and their families, by requiring a minimum number of consultations per month
- preventive health education, by provision of educative sessions in schools and the markets
- provision of assistance with nutrition, by daily lunch and fruit as snacks in all activities
- remedial and non formal education
- development of child/peer leaders, with special education in HIV and other STDs, child rights, substance use, social organization, technical education, and basic health care
- creative activities, such as art
- strengthening and development of mothers
- engaging market vendors in activities
- developing a capacity to minimize staff stress and respond to difficulties
- staff development
- developing the youth club.

All objectives are linked to activities which have targets and performance indicators, and designate who is responsible for implementation.

Thiruvananthapuram: ADIC-India have a plan and provided brief details in their report.

9. PARTICIPATION BY STREET CHILDREN

In line with the principles of Community Involvement in Health developed by WHO, the participation of people in all activities related to identification of health problems, the development and implementation of interventions and monitoring and evaluation activities is a core element. This has been incorporated into the various components of the WHO/PSA Street Children Project methodology.

The actual participation of street children in all aspects of project functioning, however, was not obvious for most sites, other than as research subjects or recipients of services. It had been hoped that by now a greater presence of street children would be evident in the projects. This is an issue that needs to be addressed in Phase III.
In a limited number of sites, more had been achieved: children were part of the community advisory committees (Kampala-UNOGT); separate youth committees existed which provided input to the CAC and in addition had other significant functions (e.g. Cairo and Tegucigalpa); and some sites employed ex-street children as street educators or in other staff positions (e.g. Cairo, Manila, Thrivananthapuram). At the Thrivananthapuram site the children themselves launched a union of street children (Jyothirgamaya). A schoolboy is a member of the Moscow CAC, who was a participant in focus groups.

The extent of participation by site follows.

**Asuncion**: Participation is not evident from the information provided.

**Cairo, Village of Hope/ACCD**: Two ex-street children are on staff. Street children have participated in an advisory group.

**Cairo and Alexandria, Caritas**: No active participation was apparent.

**Colombia**: Two street girls are being trained as street educators.

**Dar es Salaam**: Nothing was reported in relation to participation.

**Halifax and Saskatoon**: Not applicable.

**Kampala, UYDEL**: Street children are on the Community Advisory Committee, and participated in training.

**Kampala, UNOGT**: Street children have attended or are on the Community Advisory Committees.

**Lusaka, CYP**: Situation not known.

**Lusaka, Red Cross**: Street children who participated in the first phase, were then trained as peer educators.

**Managua**: The situation is not clear from the reports provided.

**Manila**: There is much involvement of the street children on all levels of the programme. Street children have been trained as junior health workers, and have undergone substance abuse orientation, and 45 street children are soon to be trained to assist street educators, especially regarding referral to health centres. Children will also soon be on advisory committees for both street- and community-based projects.

**Mexico**: At this stage, street children have mainly been involved as research subjects, but the methodologies used are very participatory. Some interested children are being targeted to become part of the Community Advisory Committee.

**Moscow**: A schoolboy is member of the Community Advisory Committee who participated in a focus group.
Mumbai: Street children are used in training and some undertake their own street work. They are invited and encouraged to make suggestions regarding the activities of the agency. They participate in an ad hoc fashion on the Community Advisory Committee.

Mwanza: From the documentation provided, participation appears limited, but children are consulted and kept informed of what is happening.

Prague: None apparent at this stage, from the information provided.

Rio de Janeiro: None apparent from information provided.

Santo Domingo: Participation is not evident from the information provided.

Sydney: There is only informal input from street youth at this stage.

Tegucigalpa: This site has a Youth Advisory Council (YAC) with 17 representatives from the areas where the project provides services. The YAC has an advocacy role within and outside the project. A wide range of contacts with other NGOs and some GOs, including the Office of the Mayor of Tegucigalpa have been developed by the YAC.

The YAC has six objectives: 1) to promote child/youth rights, 2) to demonstrate that children and youth have an important role to play in the community, 3) to represent Project Alternatives and Opportunities to other organizations, institutions and groups, 4) to promote youth development both locally and internationally, 5) to contribute to the development of other youth through educational activities, 6) to establish a network of youth from different markets and other areas and to promote this network through friendship and recreational activities.

The YAC has been very active, and has been involved in training in schools, churches, markets and clubs. They have mobilized a number of activities including installing waste disposal bins in the markets. They are also regarded in the community as opinion leaders and have been consulted by market associations for their advice on different issues.

Thiruvananthapuram: Two ex-street children are employed by the agency, and a union of street children has been established.

10. DAYS IN THE LIVES OF STREET EDUCATORS FROM KAMPALA (UGANDA), MANAGUA (NICARAGUA), MANILA (PHILIPPINES), PRAGUE (CZECH REPUBLIC), SYDNEY (AUSTRALIA), THIRUVANANTHAPURAM (INDIA)

This section provides a brief selection of the work at various sites. Obviously they do not indicate all of the activities street educators and others involved with street children undertake on any one day or week, month or year. They merely give a glimpse into the contexts within which work takes place.
UGANDA

Kampala

UYDEl

As the sun rises, very early in the morning, many street boys run to the garbage heaps (bins) at the central Matatu car park and Owino and Nakivubo, which sometimes take weeks to be cleared by the City Council, to sort out valuables. They also assist early passengers off-load and carry their goods. Many street children sleep late at night under the influence of substances for fear of arrest and exploitation. Many of the valuable items found are sold, and edibles eaten so that they will not further decay or be stolen while they sleep. Fred, the street educator passes by the markets, and other ‘depots’ such as the Equatorial Hotel, National Theatre, China Palace and Biwolongo and then reports to the office about 8h00 to meet with colleagues, discuss the previous day’s work and any issues arising, and plan for the day.

A street educator in Kampala may be in contact with about 80 to 300 street children. Eighteen depots now exist where children gather in groups ranging from 8 to 40 in number. Each depot is approached with caution, depending on the size, age and area, some groups are rowdy and disruptive. A sign of greeting is exchanged between Fred, the street educator, and the children at the depot. They call him ‘Coach’ because he has invited many of them to join in football matches which they enjoy.

The children often all want to talk at once, so Fred has to deal with that and then let them have some individual time with him for counselling/discussion. These can take up to 30 minutes. Many of the issues raised relate to bullying at night, exploitation and harassment.

Usually four to eight children have individual time with Fred at each depot. Sometimes he involves a group in a focus group discussion, sometimes in a learning activity. He also invites some children to the Cambodia Katwe Drop-In Centre where formal classes are held, hot meals, washing facilities, shelter, counselling, treatment, and recreation are provided. Almost 60 street children are residents of the Centre, and another 100 use the Centre's facilities, but are non-resident. ‘Cambodia Katwe’ is located in the middle of Hatwe, a large slum area of Kampala and was established as a result of the Community Advisory Committee. Most residents of the area have been sensitized to the street children situation and their attitudes have changed in a positive direction. Fred has done a lot of this work during his days on the streets. They now have a regular weekly meeting with Fred to share information, report on issues, and to enlist community participation and that of other service providers in their activities.

This day about six children present with health problems requiring medical attention. Many children who have been working have been spending their money on watching videos, gambling and drugs. Some money goes to buy food. Fred discusses alternatives to the videos, gambling and drugs with the children at a depot. He has arranged for a drug education video to be shown before some other videos.

Fred has also managed to gain access to playgrounds belonging to local primary schools and he has arranged some sports competitions for the children, organizing them into teams. He uses these activities to talk about drug use and other issues such as involvement in crime.
Some time street educators meet up in the one area and have group sessions with the children who know the times when educators will be there. This avoids duplication of services and activities.

Today Fred has to refer some children to legal aid after they had been arrested. Carol, one of the Probation Officers assists with this, and has been trying to reunite some of these children with their families or guardians. This has taken some time as the families are deep within the slums of Kisenyi and Katwe.

Fred then meets with some other street educators to share information and plan for a sports contest and a drama group. He also meets with a civic leader to advocate for the needs of the children. He then returns to the office to write his report and make notes on individual children, and de-briefs with his supervisor.

NICARAGUA

Managua

MINSA

Rosa begins her day with Alberto, another volunteer street educator at the Mercado Oriental. It is the largest market in Managua, and is considered to be one of the most dangerous areas in Nicaragua. A number of slum communities lead off from the market, which has an estimated 25,000 vendors, including 1500 child vendors and 900 children who inhale shoe glue.

First a small group of boys was located sleeping on the steps of one of the local churches next to the market. Rosa knows them as chronic glue sniffers, and when woken their eyes were red and glazed over and they were drowsy and mildly confused. One boy had his head shaved and when Rosa enquired, he said it was because his hair had been coated in glue. There was still some glue on his scalp.

Further into the market, another boy, who was known to be good at maths, told Rosa that he was not attending any classes anymore. Rosa had a discussion with him about options.

Rosa then noticed a young boy standing apart from the group with a handful of money. He was introduced to her as the money changer. Another boy was selling toothpaste, toothbrushes and toiletry items. These two boys were not sniffing glue at the time, and this was unusual. Rosa and Alberto took the two across the road and bought them some food. This is part of an established communication and engagement process used by the street educators and develops trust. However, it becomes a strain on financial resources.

One of the street children came up to Rosa and told her that he had heard on the radio about a boy who had just been admitted to the nearby hospital with severe injuries following a sexual assault. Rosa and Alberto know that most of the unemployed street children sleep during the morning, wake in the afternoon, steal or beg and then buy glue. Many of them get robbed or physically assaulted while intoxicated.

Rosa and Alberto then detoured into an alleyway known as the ‘Street of Death’, which is used by commercial sex workers in the evenings. A boy of about 15 was lying on a bench
asleep. Rosa knew that he was a chronic sniffer who had been using glue for about 10 years and was very ill. Rosa monitors his situation, but he is unwilling to go for medical treatment. Rosa has arranged for a doctor to visit with them soon to see if the boy can be engaged in receiving some medical attention in his own surroundings. However, working in this area of the market is extremely dangerous due to the level of intoxication, gang membership and crime. Many boys were surrounding Rosa and Alberto while they attended the sick boy, and most were intoxicated on glue, confused and rambling.

They then met some boys who they had been working with over time and who now no longer used glue. They were happy and working selling food, and introduced two elderly women who were working as street educator volunteers. One was selling bottled vegetables and herbs from a small stall and the other preparing and serving food at an open eating area. Both had been working in the markets for many years and were well known to Rosa and Alberto. They were in contact with many market children and were very valuable volunteers. Rosa thanked them and gave them the address and time of the next training session and they agreed to attend. The training would be on the WHO/PSA approach and in first-aid and related health issues. They will also provided by MINSA with first aid kits and supplies and some money to buy food and medicine for the children if necessary.

Volunteers like these two women had an influence on other vendors some of whom were selling glue to street children, although they knew that this is against the law and not helping the children.

Rosa and Alberto then visited a shoe repair stall where two young boys aged about 11 were working. In front of the stall, small jars of locally produced glue were displayed in Gerber jars. The boys claimed that they were not selling the glue to market children because Rosa and Alberto had told them not to. Rosa did not believe them, but reminded them of the problems associated with use of glue in their community. The boys said that they had stopped using recently and had become practising Christians. Again Rosa was sceptical.

After this visit Rosa and Alberto returned to the centre and completed their report and updated individual records on street children who had become regulars.

PHILIPPINES

Manila

‘The common notion we have of the street is that it is like a jungle; where people who live here, especially the street children, need to struggle to survive. Children who live and work in the streets are also children - playful, active and full of laughter.’

(These lines came from Adrian Nerja, a street educator whom the children fondly call ‘Kuya Butch’. Butch himself was a street child in his younger years and now is a street educator, he is out to help street kids, getting them into the pace of living normal lives.)

A visit was made to the Divisoria Market with Butch. The place is known for purchasing retail and wholesale goods. It is also considered one of the more dangerous areas in the country. Street boys haggling with buyers, shoppers and vendors as they steal, beg, sell vegetables and other food or materials in order to seek out a living, is a common sight.
During the visit, various street children were met. We went around the places where most of the children hang out. The first stop we made was in front of a fast food restaurant, where Jeffrey (12) hangs out with his friends John Paul (8) and Larry (10). We further roamed around Divisoria and found Michael (10) in a hardware stall. He works as a push-cart boy near the place. He was rather shy, but he jumped for joy as he saw Kuya Butch approaching him. John Paul was the youngest and he was stammering as he spoke. He told us repeatedly that his policeman father had already died. Sensing that they would like a change in their way of life, the street educator recommended that the three of them, later on, be referred to Tahanan Outreach Programme and Services (TOPS) for counselling and treatment planning.

Most of the street children who are considered 'hard core' hang out in Ilaya and Padre Rada streets. They often sleep through the morning, waking in the afternoon to steal or beg to buy some rugby or glue. The girls are usually taken by pimps and told to prepare for a 'night out' as they seek for 'clients' or 'customers', who pay them P 1000 for a night of sexual pleasure. Some of these girls have already shown signs of resignation to this kind of activity, and due to financial constraints they are forced to meet with the pimps, who also hang out in the market place. Some of these pimps have vegetable stalls in the morning, and convert their stalls to 'recruitment' agencies for child prostitutes by night.

Along the street we met Danny (23), a solvent user. He puts together junk materials and sells them to prospective buyers. He has his own son now, who attends school through the Educational Assistance Programme (EAP), established by the Families and Children for Empowerment and Development (FCED). The street educators are doing their best to convince Danny to stop taking solvents permanently.

Walking further, we met a group of street boys who hang out in a bakery. Here we met Emilio, Rey, Christopher, Roberto, Sandy, Eric, Ronald and Jon-Jon. Their ages range from 10 to 15 years. They usually hang out in this bakery and were given some goodies on the condition that they keep away from riots and rough actions. We had a chat with them for a while, asking them if they would like to play games and sing songs. They were delighted and agreed to a day of activity. They are not taking solvents except for Christopher, who occasionally takes some drugs and whose facial appearance indicates that he has been taking solvents - red and glazed eyes, although at that moment he did not have a shot. He has a little difficulty in speaking. As we left them, Kuya Butch gave them some candies.

Sto. Nino church is adjacent to the street, and we went there to check if there were some lost children sitting by the steps of the church. Two weeks ago, Butch had seen Kim and Mark who were both lost. Mark was found by his mother, as Butch was walking with the children along the Divisoria Market. Kim, is currently with TOPS.

We passed through Muelle de la Industria Street, where some sessions in basic literacy and children's rights are held. There is a small bench with a wide space where the children could gather and work with their street educators. Walking further, we saw families who sleep in old metal and wood scraps pieced together. Some of them stay on thin benches with only plastic material as a roof, enough to cover the benches. They attach their 'homes' to a concrete building along the sidewalks. A father and his daughter sleep in the panes of a large window of the same building.

We went to Binondo to visit Mary Rose and her family. Mary Rose is also a beneficiary of the EAP. She is now in Grade 4. Along with Mary Rose, we visited Marlene, Marlon and Emmanuel.
We also had a little chat with their mother. This family come from Pampanga and they were victims of the Mt. Pinatubo eruption. The family transferred to Manila after their house was engulfed by the lava and the father died. They earn a little amount for livelihood by selling jackfruit seeds which they get from the Binondo Market.

We returned to our centre, debriefed with the workers and completed our street report.

CZECH REPUBLIC

Prague

Prague Centre for Youth - MOST Centre worker. An outreach day

I went to a place close to the Centre where ‘kanal’ youths spend their nights. Boys and girls about 18 years old were just climbing outside, and a girl immediately started to sniff solvent from a plastic bag. I did not know them, so I asked them whether they needed something. They were thirsty and dirty. I told them about MOST Centre and services like showers, clothes cleaning and possible counselling. They could hardly understand where they were so I showed them the way. They told me they would come later.

I heard that a bigger group of youngsters had appeared at the main railway station. For a long time we had not seen anybody around the station. I went there. In the early afternoon I noticed one punk there (Krisa), who I have known for a long time and who begs from tourists. I gave him a cigarette and asked him about the group. He told me there are three new girls from the countryside, but warned me that they were already sold to Ukrainian mafia and that it would be dangerous to approach them. He showed me one of them in the hall. The rest of the newcomers were four boys from northern Moravia, one was running away from a detention centre. All of them disappeared from the station last night and Krisa told me they all sniffed and drank a lot over the last few days, and afterwards they had their documents stolen. I asked him to tell them about MOST and me, and that I would come tomorrow.

Volunteer of MOST Centre - special task: contact with prostitutes

I went to a regular meeting with gay prostitutes in the X Bar. Tony asked me when I got indoors to leave the bar because today their pimps were drinking there. He said that they would come to the other bar later. I was waiting, and at 23h00 four boys came. I offered them cigarettes and they started complaining about pimps. I didn't know one of the boys so I asked the others to introduce me. They asked me for some condoms as their pimps had taken theirs from them. They did not know why. Tony told me that he was going to leave and go back to his home town for some time, but he was a bit afraid of his parent's reaction. He was 17 and his parents thought that he had a good job in an advertising company. Over the last few days, Tony had lost all his money in gambling machines. Tony was our contact person, so I asked Peter to be our new one. He agreed and we agreed on regular Friday meetings in the bar. I asked all of them to look for somebody from the prostitutes at the railway station who would be willing to speak with me.

MOST Centre worker: a day in the Centre

I started the day with meeting the residents of MOST. We had breakfast and continued with a brief reflection on the previous day and planning this day's programme. There were five boys and three girls; two boys had finished two nights stay and left to go back to their homes
in another town. The others had spent several weeks at the Centre. Two had short term jobs and one girl went to high school. There were three youngsters without a programme for the day. Two regular visitors came so we started a morning programme with them. They were modelling their lives from plastic material, and looking for solid bases or resources in them: 'Who and what are my resources and positive attachments?'

Then we prepared lunch and some left to look for jobs in the city which they had heard about from the social worker. The rest stayed in the Centre and slept because they were exhausted from the last few days in the streets.

At 14h00, about seven visitors came to spend an hour in the club room to wash their clothes and have a shower. We talked with them and with our volunteer and had coffee with them. Two were unknown to us. All seven came from two places - kanals and one squat. We mostly discussed their problems with the police and their substance use preferences. The people from the squat would never sniff solvents because they were amphetamine users and considered themselves to be better. The kanal people reminded them that when they did not have enough money they would sniff solvent like they did. I told them about K-Centre services for needle exchange and we spoke about the danger of brain damage.

At 16h00, the residents came back and in the afternoon programme we spoke of their experiences and new people. One boy was angry with his boss and told him that he would never return. Others did not agree and told him that he had been the same during his stay at the Centre - always bad tempered. I advised him to speak about it with his counsellor today.

We had supper and after some chores they asked me to repeat the relaxation session with music they experienced yesterday. I did it but most were too sleepy, so I had to wake them at the end.

Today a volunteer left and I started to answer calls. There were five emergency calls from two girls and three anxious parents of runaways. At 9h00 I left the Centre after morning group.

AUSTRALIA

Sydney

St Vinnies for Youth

The day begins with a quiet morning. Many of the residents arrived back late last night or in the early hours of the morning. Their patterns of sleep are in most cases reversed; tending to be out on the streets at night and to sleep during the day.

A few of the residents are enrolled in school and short courses and some others have some employment. They are assisted to ready themselves and leave the refuge; some are very sleepy and less than enthusiastic about their day ahead.

Russell, the outreach worker (street educator) arrives and makes numerous contacts with other services while the day-to-day running of the residential section unfolds. He has to contact a number of government departments (Community Services, Juvenile Justice and Housing) as a result of contacts with youth last night on the streets. He also contacts
schools, alcohol and other drug centres, recreational facilities, the police, medical facilities, counselling services and other accommodation agencies.

 Volunteers are assisting with the activities and needs of the residents who are now all awake. Some are very demanding and complaining, others more compliant. Cleaning, preparation of meals and arranging appointments for employment, training, education, medical assistance, legal aid and other accommodation are all taking place. They are also preparing for the evening activities which will involve some sport (basketball), music and art work. Some verbal arguments have now turned into a physical fight, and Russell has to assist in restoring the peace.

 At about 20h00 Russell, assisted by a volunteer, begins his evening work on the streets. He visits various areas of the city where street youth congregate, such as parks and railway stations. Most of the young people encountered are between 14 and 19 years of age, and most are male. He provides information on accommodation, needle and syringe exchanges, health services, and listens to stories of harassment, violence and sadness. Some youth also come to thank him for useful referrals and let him know that things are beginning to get better for them. Others, who were suspicious, now approach to ask for assistance.

 The first regular stop is the Central Railway station; the first stop often for those who have just left home. Some are waiting for the food van. Some just want a little attention. The younger ones are more enthusiastic (they still have their dreams), but the older ones are often subdued and more withdrawn.

 The next stop is Kings Cross (the major red light area of Sydney). Russell and the volunteer come across many youth intoxicated by heroin; others have been injecting amphetamines. Some require some assistance in finding health services, others just want to talk; others want accommodation - very difficult to find when the young person is intoxicated and dependent on heroin or other substances.

 Russell then moves to ‘The Wall’ - an area where mostly young males are involved in commercial sex. Young females work on the streets in commercial sex further down the street. Some of the young people are keen to see Russell, others do not want to talk and appear embarrassed by their current occupation. Others are very drug-affected and others hostile that the street educator may be interfering in their ‘work’. Most of the commercial sex workers have experienced physical and sexual violence in their families, and often on the streets as well. Most are poly-substance users. Russell listens, provides some advice and contacts, and links the young people to the outreach health bus which provides condoms, lubrication, and injection equipment (needles, syringes and sterile water and swabs).

 Back at Central Station, later, the food van has arrived and some of the young people are eating their first full meal of the day (or of the last few days). Russell talks with some new arrivals and some regulars. One is a 15 year old girl who has been suicidal and who had cut herself because her boyfriend left her. She has now found some accommodation and a new boyfriend. She wanted to let Russell know how she was doing. Russell is part of a ‘surrogate family’.
Some of the new arrivals want to be safe and Russell takes them back to the residential programme and documents his night's activities. In the morning he will have to notify the Department of Community Services, as some of the new arrivals are under 14 years of age.

INDIA

Thiruvananthapuram, India

ADIC-India

The day started with a crisis at the residential centre (night shelter). A fight broke out between Vinod and Syed Ali. This was becoming something of a habit for them and it needed to be settled with a firm hand. After settling the quarrel, I supervised the daily duties of the boys.

Meanwhile, the Yoga instructor came and all of us along with other children from the local community went up to the terrace to practice Yoga. Today there were 36 children for the Yoga class, most of them below 15 years. The group interacted well and the Yoga teacher was also able to relate to most of the children. After the Yoga session, we played cricket at the neighbouring school ground for some time.

After the Yoga teacher left, the day's menu was planned out with Syed Ali who is in charge of cooking for the week. Shaji, as usual, started smoking in the morning and neglected his duty to clean the house and surroundings. Shaji is also in charge of the Screen Printing Unit at the centre and I asked him to complete the pending work by the evening.

As soon as the Social Worker came, everyone gathered at the office for the usual weekly meeting. All of us at the centre have been overspending money for quite some time. The issue was taken up at the meeting. Soon after the meeting, both the Social Worker and I left for our field visit to the streets. A visit was made to Chalai. Chalai is the biggest market in Thiruvananthapuram and has the highest concentration of child vendors in the city. Most of them are engaged in work such as selling footwear, handicrafts, vessels, etc. Others are engaged in rag picking. A majority of these boys go back to their homes at night and only a small percentage of them are on the streets at night.

We met two new boys in the market. Both of them were engaged in rag picking. The elder of the two is from a broken family background and has been on the streets for about one month. He has studied up to Class IX and would like to study further. The other one left home because his mother used to beat him. He left home about three months back. Now both boys sleep in the unused garage near the Bus Depot.

We met three more boys near the theatre at Parthas Junction at East Fort. All three of them were smoking ganja (cannabis). Two of them have come down from Cochin where they were at the market engaged in rag picking. They said that they don't intend to stay here for long because they find Cochin to be a far better place. The third appeared to be very set in his style of living on the streets and didn't pay much attention to us. They said that they have met many people like us who have never done anything for them. When asked about using ganja, they said they use both ganja and tobacco. They also use alcohol (locally made toddy and arrak) occasionally. Cannabis is not very expensive and is easily available all over the city. It is the most widely used drug by street children besides tobacco.
A visit was then made to the city Bus Depot and Railway Station which are adjacent to each other. There we met a few of our Lottery Focus Group members. They handed over a part of their savings to be remitted in their State Bank account. After this, we left for our office. In the evening I went back to the centre. We played indoor games and then watched television. After supper, the day's activities were evaluated, and then we went to bed.

(Report by Kumar, 21, street educator and ex-street youth, ADIC-India, Thiruvananthapuram, who lives in the centre with up to 15 other boys and also acts as a big brother/supervisor there).

11. SOME CONCLUSIONS

Overall, Phase II of the WHO/PSA Street Children Project appears to have achieved its tasks remarkably well, despite funding and other obstacles. The number of sites increased dramatically, and many others are requesting to be included. There is a need to involve Francophone Africa and develop a wider spread of sites in south-eastern Asia. Nevertheless, the current sites represent a wide coverage of cities experiencing difficulties in meeting the needs of their street children.

The WHO/PSA Street Children Project now has a more secure funding base with the involvement of the Mentor Foundation, and approximately 70 governmental and nongovernmental agencies are directly participating. An achievement of significance has been the number of children involved in focus group and other rapid assessment techniques (at least 2500), and that many of these are from relatively new sites in South American countries. Over 5000 street children have now been directly involved in project activities, with tens of thousands being indirectly involved.

Another achievement, has been the extent of the training. Over 700 workers have received some training, mostly using the training package developed for Phase II. Also, the training package has been translated into Arabic, Czech, Hindi, Marathi, Russian, Spanish, and Swahili.

There were local adaptations and additions to the package which appear to be mostly consistent with the WHO/PSA approach. However, there does need to be more consistency in relation to the core material on substance use. Some sites have funding arrangements and other contacts with a variety of international and local organizations which, at times, have differences in ideology and strategies. This is an issue which requires attention in Phase III.

The training undertaken was documented at most sites, with some providing exceptionally detailed and valuable reports which will greatly assist revision of the package. Trainees were mainly what might be termed ‘street educators’, but many of these work in both centre-based and street-based activities. Other trainees were government officers with responsibilities for providing services to street educators, others were managers, and others included police, health professionals and researchers. Many of the trainees were from agencies other than those directly participating in the WHO/PSA project. Thus, there has been an extension of information technology transfer to many more than the 70 governmental and nongovernmental agencies that are directly participating.

On the down side, there has been less attention to developing strategic/action plans using the information obtained in the rapid assessment process, establishing monitoring and evaluation procedures, and in more fully incorporating the participation of the street children themselves in all activities.
Reports from many sites were prepared with great care and included photographs, newspaper cuttings and poetry or songs created by the children. It is hoped that there will be an increase in fuller actual participation in future reporting to WHO/PSA.

It is evident from the reports, that a focus on substance use is associated with attention to other issues of street children, their families and their communities. Substance use can bring concerned citizens together and, with educations, they can come to see how it is not necessarily 'The Substance' which is the problem, and that substance use cannot be tackled without attention to many other variables. They can also begin to understand that too much attention to the substance can distract them from understanding and better meeting the needs of their street children, and how criminalizing, marginalizing and institutionalizing them tends to make the situation worse for all.

What follow are some recommendations to consider in shaping Phase III of the WHO/PSA Street Children Project.

Administrative

1. It is recommended that more direct contact be with nongovernmental organizations directly providing services to street children. In the past contact has often been through a 'principal investigator' who may come from a university or elsewhere. While these people have undoubtedly contributed a great deal, they are often busy and information flow to and from sites can be slowed. It is recommended that such persons be involved in the project at another level; such as coordinating training and research activities.

2. It is recommended that the information flow be greatly improved. This is a recommendation mainly directed to PSA, but also implies that sites pay much more attention to meeting reporting deadlines. Due to staffing and administrative constraints at WHO, material often is forwarded at the last minute and via fax and phone. A number of sites have noted how costly this is to them and request that these modes of communication be used as a last resort.

3. It is also recommended that some form of newsletter be developed which regularly updates the project and to which they (the sites) can contribute. The contributions should include those of street children involved with agency activities. While it would be most efficient for WHO/PSA or Mentor Foundation to coordinate this, it could be more appropriate for a site with adequate resources to undertake the task.

4. It is also recommended that sites where Spanish is the main language used receive communication in Spanish. Such sites have reported on the expense and loss of time in obtaining translations of letters, faxes and materials. There are now a number of Spanish speaking sites, whereas originally there were two.

Programmes

5. It is recommended that there be more attention paid to creative ways of engaging and working with families. There is still not enough attention to families apparent in the activities of many sites. There appears to be more focus on individuals and groups. Many children go home at night. Strengthening families (both mothers and fathers) is an important activity in community development, education, income generating schemes, etc. For those abandoned or orphaned or
rejecting any family contact, a different approach is needed, including some supported and independent accommodation and the development of surrogate families.

6. It is recommended that there be greater attention to the development of peer to peer, and peer education approaches (in the real sense). At some sites this is a central programme feature, at others it remains an underdeveloped resource.

7. It is recommended that sites give greater attention to creative ways of increasing the participation of street children in all programme activities, including planning, advisory committees, interventions, and in monitoring, evaluation and reporting. Participation of children has been variable, but is growing. Some sites have separate youth advisory councils or unions of street children, but these are connected to the Community Advisory Committee or project. In addition, (ex-) street children have been employed as street educators, junior educators or trainees at some sites. For some children, they tend to have been perceived merely as research subjects; some resent this and want services and more involvement in the process.

8. It is recommended that some participating agencies be selected to be developed as ‘model programmes’. Such agencies could then provide site visits to others and assist with technology transfer, trial new interventions, methodologies and strategies.

Situation assessments, research and planning

9. It is recommended that data/information collection be strengthened. Data collection is still poor in a number of cases. There is a need for a mix of hard (enough) data, especially on risk behaviours and substance use, patterns of use, and more qualitative data. The information provided on substance use has been variable, with little of it in standard format which could be used and accepted as valid enough for planning purposes.

Funders and government agencies often make demands relating to ‘how many...?’ ‘how much of x, y and z occur...?’ and so on. While, at times, these appear to be unnecessary or irrelevant demands, they have implications for sustainability. Workers at times feel that such requests distract them from their core tasks. However, there are simple techniques for data collection and monitoring contained in the training package and monitoring and evaluation manual which can become routine and not time consuming. It is acknowledged that the production of facts and figures by participating agencies does not necessarily reflect the situation for street children for the whole city or country, and can only represent the agency or sample. However, it is essential for planning and reporting and justification of funding purposes.

Good quality data is also necessary for the development of ‘baselines’, especially on risk behaviour (e.g. substance use, unsafe sex, violence, etc.) so that changes can be monitored and impacts ascertained.

10. In light of nine above, it is recommended that some regional research centres be established and developed. Such centres could assist sites develop better data collection and monitoring processes, participate in action research projects, and lay the foundation for more formal impact evaluations.
Training

11. It is recommended that the training package be reviewed in light of the feedback contained in site reports and evaluation questionnaires. While the feedback was generally very favourable there are some matters that require attention. In particular, there is a need for more attention on how to use the package and the provision of training tips.

12. It is also recommended that some regional training centres be established to provide high quality training to trainers and staff involved in working with street children.

13. It is recommended that site-specific and inter-agency training increase the participation of street children in the provision of the training. The most effective training reported on to WHO/PSA, and observed during the visits of WHO/PSA staff or consultants, included street children as presenters.

General

14. It is recommended that WHO/PSA monitor the differing models of operation of the project in various countries and regions. There are: single agencies (e.g. Project Alternatives and Opportunities in Tegucigalpa, Honduras); nationally coordinated projects (National Project on Street Children in the Philippines, with UNICEF, the Department of Social Welfare and Development and the National Council of Social Development as co-sponsors); national delivery as in Colombia coordinated by government and collaboration with nongovernmental organizations; a national network as may develop in Republic of South Africa; a cross-region model a proposed by the Arab Council for Childhood and Development for certain countries of the Arab League. It may be that all are equally useful or that certain models have particular advantages.

15. It is recommended that efforts be made to reach a greater degree of uniformity of terminology and conceptual models in relation to substance use.

Some sites still seem obsessed with abstinence for all as THE outcome, rather than AN outcome. Also, as a goal for adolescents, abstinence may be quite unrealistic, though desirable. A focus on health and attempting to minimize the harms associated with substance use can be a more realistic and achievable goal, as can be dealing with the issues facing street children - shelter, accommodation, safety, working, exploitation, health. If these issues receive enough attention, the child may decide themselves to cease or reduce substance use. While they remain, substance use is a powerful and available means of attempting to find a solution to these issues; it can take away hunger, fear, provide courage, and help them get through the day.

Language/terminology has not been consistent with WHO terminology, nor that contained in the manuals. For example, terms ‘addict’ and ‘addiction’ are being used in some cases. At most, some children are regular or experimental users, few are dependent, and most do not meet criteria for ‘dependence’ in developing countries. Some, however, meet criteria for ‘harmful’ use. Additionally, there is evident confusion about the term ‘narcotic’.

It is important to determine the extent of substance use in individuals and groups, and not to catastrophize or make claims beyond the information available. For example, is it daily?, weekly?, experimental?, oral?, injecting?, has tolerance developed?, etc..... These issues impact on strategies and intervention to assist. Also the meanings and myths associated with use need to be
ascertained and explored, as well as reasons for use, since for different substances there can be different reasons.

16. It is recommended that Community Advisory Committees be renewed and/or strengthened where necessary. CAC have been found to be very useful for sharing, planning, increasing access, and advocacy. A variety of structures have developed, as outlined above.

17. It is recommended that more attention be given to developing focus groups and other forms of rapid assessment. Some sites have well developed procedures where groups meet regularly and often contain the same children. Sometimes these groups form around certain locations frequented by street children, while in other settings they contain children from the same type of employment.

Focus groups are extremely useful for data collection, therapy, planning, information sharing and education. They should not be didactic education nor question and answer type sessions.

18. It is recommended that there be some review of the Modified Social Stress Model. While the model has been widely accepted and appreciated and found to be useful, there have been some comments made suggesting that it can be understood in a variety of ways, which are not necessarily consistent.

19. It is recommended that case management procedures be better articulated in materials provided by WHO/PSA and at sites. Case management procedures provide for more ordered and focused work with individuals and groups, and do not have to become rigid and constraining. They involve attention to engagement, assessment, planning of interventions, review and termination, and should be participatory.

20. It is recommended that service provider groups or networks be renewed and/or strengthened where necessary. Such groups have been found to increase the sharing of information and technology transfer, build cooperation, and assist in coordinated action planning.

21. It is recommended that there be developed structures for exchange of both information and staff. Exchange of staff between sites for periods of time could be one mechanism, and tied to the training centres and model programmes, and the development of a mechanism for the electronic exchange of information could be considered. The latter would require provision of infrastructure to sites.