

The implementation of the United Nations Convention on the Rights of the Child: global commitments and local realities

ELIZABETH COX¹

HELP Resources, Wewak, East Sepik Province, Papua New Guinea

SUMMARY

Papua New Guinea (PNG) is a signatory to the United Nations Convention on the Rights of the Child (CRC) and the World Health Organization Alma Ata Declaration of Health for All by 2000. The inherent rights of all children include accessible, affordable and quality health care and protection from all forms of violence, abuse, neglect and maltreatment. In 2000 PNG is challenged in implementing the CRC and has deferred achievement of targets in the Alma Ata declaration until 2010. Constraints to CRC implementation include lack of public awareness about the Convention, even among people whose work directly relates to child issues; deterioration in many essential social services; massive social change; and decentralization of health care systems without adequate accompanying support. New health problems, including alcohol and drug abuse and AIDS, now face many children and adolescents, but the problems that have existed for generations, particularly acute respiratory infections, tuberculosis and malnutrition, have not yet been dealt with. It is unlikely that primary health services can be rebuilt as they were 20 years ago and for most children throughout PNG the basic right of access to quality health care is not a reality. Programs for training village-based child health and child protection workers, who are volunteers and who are integrated into the loose health network that currently exists, would fill some of the gaps. More recognition and funding are needed from governments for church and non-government organizations involved in successful existing maternal and child health programs. There needs to be a substantial public awareness program on child rights, establishment of a mandated national coordinating body and a realistic timetable for CRC implementation. Both political will and administrative action are desperately needed.

Introduction

In March 1993 Papua New Guinea (PNG) ratified the United Nations (UN) Convention on the Rights of the Child (CRC). This signaled to the world a commitment to advocating, legislating, administering and protecting children's rights. These inherent rights of all children include the right to accessible, affordable and quality health care (Article 24) and the right to protection from all forms of violence, abuse, neglect and maltreatment (Article 19) (1).

In 2000, PNG is challenged in implementing the CRC. Both family and state are failing to provide basic services, guidance, care and

protection for many children, with serious consequences for their physical and mental health. One constraint is an enormous foreign debt after a decade of financial crises. Holes have developed in the safety nets that were originally provided by the traditional extended family and in the statutory legal and institutional provisions for child welfare that were partially put into place by the Australian colonial administration.

Traditional family responsibilities that ensured concern and care for children's welfare are being undermined by new, individual needs and aspirations and radically altered family living arrangements. Many people now live in loosely aligned groups, often misrepresented as

¹ HELP Resources, PO Box 1071, Wewak, East Sepik Province 531, Papua New Guinea

families, where members may not be able to financially support each other. Children's sense of belonging and security and their health and welfare are the fallout from such new arrangements.

There is an unprecedented crisis in the delivery of basic social services. The foundation of rural primary health care and the rudimentary social welfare services established during the period 1950-1980 have been eroded by post-Independence policies and administration, to the extent that many now barely function.

The United Nations Convention on the Rights of the Child

The CRC provides for rights to survival, protection and development for all children within the state's jurisdiction under the age of 18 years, based on core principles of non-discrimination, the best interests of the child and respect for the views of the child (Articles 2,3,6,12).

States party to the Convention must take appropriate measures towards implementation of the Convention. Priority steps include a comprehensive review of all existing legislation; formation of a multisector national body including government and non-government organizations (NGOs), to coordinate implementation; public awareness on the CRC; consultative formulation of a National Plan; mobilization for participatory implementation; and obligatory reporting to the UN Committee on the Rights of the Child (2).

Implementation must occur in the first instance through the maximum use of available domestic resources. Overseas development assistance should support the implementation where local resources are inadequate.

In the decade after the Convention was ratified there have been a wealth of accessible practical handbooks to assist governments and NGOs to guide national implementation. This material is based on experiences of implementation by other countries and is made possible through the feedback processes of the UN Committee on the Rights of the Child (3).

PNG's limited progress with implementation

The PNG government has failed to begin many basic processes for the implementation of the CRC. This may suggest a lack of consciousness or commitment at the highest levels of government to see child rights as a high priority. It also suggests a lack of capability by the public service to secure the political endorsement and support that is necessary to fulfil state commitments. The PNG government currently does not adequately provide for the majority of children needing special care and protection.

Greater action in upholding and protecting child rights is demonstrated among churches and other non-government health, education, social welfare and rural development agencies. In many remote regions churches sustain the health system. Some churches and NGOs also provide child welfare services throughout the country. Such services include crisis care for street children, help for those in conflict with the law, care for children with disabilities or AIDS, and help for those who have been subject to sexual abuse, violence or exploitation. Non-government agencies are often overloaded and underfunded, spending time managing crises rather than assisting with development of policy or institutions.

PNG has no significant public awareness program on child rights, no mandated national coordinating body and no national plan of action. The government has fallen far behind in its reporting obligations. In 1997-1998 a 'CRC Committee' was formed to draft the initial report (4). A comprehensive draft was completed in April 1999, but has yet to be endorsed by the Department of National Planning and Monitoring, approved by Cabinet or submitted to the UN.

Several significant steps taken to date have been initiated, facilitated and funded by international donor programs. United Nations Children's Fund (UNICEF) initiated the national Crash Child Survival Program shortly after ratification and has recently funded a review of legislation relating to children. It has also funded efforts to re-establish the state's birth and death registry. AusAID is currently

funding an adviser to the Department of the Attorney General, to develop structures and legislation to give practical effect to the CRC.

The articles of the CRC provide PNG with an important framework for the provision of basic health and education services. The state is obliged to incorporate child rights into the curriculum, policies and practices of all institutions and professions dealing with children. However, many professional workers in PNG whose roles include a duty of care to children (health workers, teachers, child welfare officers, police, magistrates, lawyers) are unaware of the convention and the linked international treaty obligations that PNG must fulfil. No effective approach to training on child rights that fits the PNG context has been developed. Translating the CRC into Melanesian Pidgin and packaging it into popular media has been done by small local NGOs with limited resources (5-7).

The articles of the CRC are interrelated: there is a clear link between health, welfare and child protection issues, in particular in the rights spelt out in Article 19 and Article 24 of the CRC.

Article 24 states that all children have the right to the highest attainable standard of health and access to care and medicines when they are sick. It also states that adults who are responsible for children should do their utmost to ensure illness prevention by providing adequate child care and protection, nutrition and hygiene. Further, the state should provide basic health services and do its utmost to reduce infant and maternal mortality and malnutrition. The state should provide basic education for parents on child health, child development, breastfeeding, hygiene and sanitation, and support family planning and the promotion of reproductive health.

Implementation of Article 24 is directly related to a number of other articles: Article 5 (parental guidance); Article 17 (access to information and media); Article 18 (parental responsibility and state assistance); Article 19 (protection from all forms of violence); Article 23 (rights of children with disabilities); Article 27 (right to an adequate standard of living); Articles 28 and 29 (right to education and the

specific aims of education including equality, development and peace); Articles 32 and 36 (freedom from all forms of exploitation); and Article 39 (recovery and reintegration).

Taken together, these articles of the CRC oblige government and civil society to ensure that all children in PNG can access reliable and affordable health care and health education and will be protected from violence in the family, in society and at the hands of the state.

Critical issues in child health and the delivery of health services

PNG is a signatory to the WHO Alma Ata Declaration calling for Health for All by 2000. Important goals for improved child health were set at the 1990 World Summit on Children and progress towards those goals has been reported to periodic international conferences. Recently, however, the target date for achieving PNG's child health goals has been deferred to 2010.

Over the past two decades, there has been a decline in the national health care system, as the rural aid post network built largely on male, village-based aid post orderlies (APOs) trained in the 1950s and 1960s has gradually collapsed. 15 years ago, the national Department of Health introduced a substitute and 'upgraded' tier of community health workers (CHWs), but many CHWs work in hospitals or health centres in urban and periurban areas, rather than in remote aid posts.

This loss to the community-based health care system has been accompanied by a decline in the provision of routine, mobile maternal and child health services, with large proportions of rural people missing out on regular antenatal services, maternal and child immunizations, child-growth monitoring and child health education.

Many services no longer exist in most parts of the country. The areas served largely by government health services have been harder hit than those served by church health agencies. In 1999, 1000 rural aid posts had been closed down and 3000 rural APOs and CHWs retrenched. Many rural areas have not seen mobile maternal and child health (MCH) clinics for years.

Deteriorating health infrastructure and declining morale among health workers have reached an irrevocable stage. The partial reduction of core government immunization services to a flurry of costly, donor-funded National Immunization Days is a poor substitute for the systematic provision of immunization, antenatal care, growth monitoring and health education through regular mobile health clinics.

Not surprisingly, PNG has high and, in some areas, increasing infant and maternal mortality. Rates of child malnutrition have worsened rather than improved (8). Many women and girls are subject to overwork, and forms of physical, psychological and sexual violence, and deprived access to basic information and services on reproductive health and child health (9). An AIDS epidemic is imminent and girls and young women at the beginning of their reproductive lives may be the most seriously affected (10). The spectre of a generation of AIDS orphans and the attendant massive child health issues loom large in the medium-term scenario for PNG's system of health care.

In an effort to redress the current crises in child health services the government has accepted massive AusAID project aid, establishing huge new and centralized projects in rural health, women and children's health and sexual and reproductive health costing more than 100 million dollars over 3 years. This rescue strategy carries the risk of dependence on external grants for the provision of the most fundamental and routine of health services and may generate a mentality among health workers that nothing can be achieved without money. From these projects very little institution or capacity building has yet occurred at the lower levels of the health services.

Are there alternative strategies? It will be some time before any flow-on effects of major donor projects reach the villages where children and women are dying. We may need to try an additional approach. There is a great need in villages for health workers who have basic skills in the early recognition of sick, malnourished or low-birthweight children, and who have the skills to deliver babies safely and

ensure maternal safety. Lay village health workers can be taught to read immunization tables and know when babies require vaccines. There are already some small-scale (10-40 villages) and medium-scale (40-200 villages) community-based volunteer health worker projects that have been initiated by churches and NGOs to do such things. Such programs demonstrate that carefully selecting, training, equipping and strategically supporting village health workers who have minimal formal education can provide basic health care for thousands of people who have always missed out on the mainstream health services or have lost access due to the closure of rural aid posts. At the very least these projects increase village-based knowledge about health issues among the stakeholders who have been previously uninformed.

The contribution of volunteers towards promoting and protecting maternal and child health could be substantial. These programs require doctors, nurses and administrators to play their part in developing the potential and capacity of villagers to provide health care. Management of community-based health care programs is decentralized; it is built on faith and confidence in the capacity and reliability of local people, and on the provision of non-cash incentives, personal praise and local supervision. Community-based health care is likely to be especially effective in reducing child and maternal mortality if integrated into an improved primary health care system, particularly immunization services. Whether these will work in the longer term is uncertain, but it is equally uncertain whether government health care systems can be revitalized or sustained by the top-down management style that often accompanies large donor-driven programs. Further formal evaluation of the objective effects of community-based interventions and how they can best integrate into other systems is essential.

Family and state care

The CRC places value on **all** children and accords inherent rights to all. It requires progress towards the protective laws, policies and institutional arrangements for children. These were established in rudimentary form during PNG's colonial era, but are outdated,

culturally and contextually inappropriate and not affordable. In most places, many such laws are little known and rarely enforced.

The role of the extended family and wider community is extremely important to child health and welfare in PNG, but this is not dealt with adequately in the Convention. This is a critical issue as the role and value of children and the structure of the family in PNG society are in a stage of flux and reinterpretation as part of the transition from rural to urban and from subsistence to cash lifestyles. Parents and their children are now often separated for prolonged periods of time, sometimes permanently, for a range of social, economic and cultural reasons. When a child has health problems it is often not clear who or where the natural parents are, or who is the carer acting *in loco parentis*. Many children grow up having no-one to provide for them at home or to stand by and support them through the normal challenges of growing up and the lures and pitfalls of adolescence.

Customary adoption practices have been distorted to fit changing conditions and adult needs. What is called 'adoption' these days most often is without any basis in customary or state law. It is this informal and often illicit transfer of children that may lead to their discrimination, neglect, abuse and exploitation.

Throughout the CRC there are references to the responsibilities of parents and the state. The state should assist when parents cannot cope. The PNG state does not provide adequate basic services or opportunities for all children. Families, community and state systems and institutions discriminate against children on the basis of gender, parentage, ethnicity, intellectual capacity and educational achievement.

Currently there are no plans, policies or services for many new child and adolescent health problems. Marijuana-induced psychoses and violent crimes are reported in provincial and Port Moresby hospitals (11). There are only three practising psychiatrists in PNG and one grossly under-resourced mental health institution. A privately established Mental Health Association is currently assisting with this crisis.

Although appropriately much effort must be given to reducing child mortality, substantial effort is also required to provide for children with long-term disability. There is a large burden of disability resulting from common central nervous system infections, orthopaedic infections, cerebral palsy, non-fatal congenital abnormalities and sensory deficits. Sadly most children with disabilities are deprived of their right to participate in mainstream education, and special education services for children are few.

There are few formal counselling or support services for children or parents in distress. Government welfare services are diminishing at a time when they should be expanding. Child welfare officers take a very limited, law-bound and reactive approach rather than engaging in proactive intervention or the formulation of preventive strategies and policies.

Thousands of children are under enormous emotional pressure in their home. Parents and carers increasingly resort to harsh words, excessive physical punishment and verbal humiliation, abuse and threats as a form of disciplining children when they find themselves having to deal with new issues such as drugs, alcohol and changing sexuality.

Throughout PNG thousands of children are no longer living with their natural parents. In Morata settlement in Port Moresby reports of abandoned babies and infanticide are common (Anou Borrey, personal communication). Health workers and administrators in Port Moresby and East Sepik report that babies are regularly sold for cash (Jill Sakupati, personal communication).

Thousands of young people in PNG today are without basic care and shelter. Many adolescent boys and girls are on the streets of the cities and in the enclaves of large resource extraction projects (fisheries, logging and mining) where they may be engaged in commercialized, exploitative and high-risk sexual activity. They are often exposed to abuses including gang rape and are vulnerable to contracting sexually transmitted diseases, including HIV. Associated drug and alcohol addiction, anger, recklessness and violence

often lead to self-destructive behaviour and place other children at risk of disease, injury and death.

A way forward

Promoting, upholding and protecting child rights is a family, community and state responsibility. Many of PNG's family traditions and state laws, policies and institutions no longer fit the changing times and new needs of children. The extended family and the core services of rural aid posts, routine MCH clinics and child welfare services are disintegrating. Parents need information and state support to cope with the new social and economic conditions and the critical challenges and health risks facing their children.

It is arguable that large injections of overseas aid will not effect significant or sustainable improvement in maternal and child health in the short or medium term. The churches and NGOs that are currently responding to crises and providing services by default must be acknowledged and supported by government.

A network of community-based, volunteer child health and child protection workers would fill some of the gaps in the current systems of child health and protection. Such workers would need intensive training and appropriate basic resources, but this will be affordable and achievable if the host communities are mobilized, if existing active NGOs are supported and if people with local expertise are utilized.

Community-based child health and child protection services, developed within the framework of the CRC, would require effective links to the mainstream health services

(particularly immunization services) and the enforcement of child protection laws. These government services must be considerably strengthened.

Governments working with the people, utilizing the church and NGO infrastructure and a more close involvement with families, could ensure that the rights and health of children are protected in these and future difficult times.

REFERENCES

- 1 **United Nations Children's Fund.** First Call for Children: the Convention on the Rights of the Child. Geneva: UNICEF, 1993.
- 2 **United Nations Children's Fund.** Implementation Handbook for the Convention on the Rights of the Child. New York: UNICEF, 1998.
- 3 **United Nations Children's Fund.** A Sourcebook for Reporting under the Convention on the Rights of the Child. Bangkok: UNICEF, 1997.
- 4 **National Government of Papua New Guinea.** Draft initial report to the UN Committee on the Rights of the Child. National Government of Papua New Guinea, Port Moresby, 1999.
- 5 **HELP Resources.** Ol Rait Bilong Olgeta Pikinini. Port Moresby: HELP Resources, 1999.
- 6 **Baua Baua.** Tok Tru Bilong Laip. Cassette and songbook. Wewak: Baua Baua, 1996.
- 7 **Baua Baua.** Birua Long Paradais. Cassette and songbook. Wewak: Baua Baua, 1999.
- 8 **Saweri W.** Papua New Guinea's food and nutrition situation. Draft notes based on the 1987 National Urban Household Survey. Department of Health, Waigani.
- 9 **Garap S.** Struggles of women and girls – Simbu Province. In: Dinnen S, Ley A, eds. Reflections on Violence in Melanesia. NSW and Canberra: Hawkins Press and Asia Pacific Press, 2000.
- 10 **Jenkins C.** Youth in danger: AIDS and STDs among young people in Papua New Guinea. Papua New Guinea Institute of Medical Research, Goroka and UNFPA, Port Moresby, 1997.
- 11 **Johnson FYA.** Clinical observations on substance abuse related health problems at the Port Moresby General Hospital, National Capital District, Papua New Guinea. *Med Law* 1994;13:251-262.