The State of Brazil's Children 2006

Children up to the age of 6 years

The Right to Survival and Development

unicef

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The United Nations Children's Fund (UNICEF)

Marie-Pierre Poirier
UNICEF Representative in Brazil

UNICEF Representative Office in Brazil
SEPN 510 – Bloco A – 2º andar
Brasília, DF – 70750-521
www.unicef.org.br
brasilia@unicef.org

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UNICEF TEAM
Project coordination: Manuel Rojas Buvinich, Rachel Mello and Halim Antonio Girade
Collaborators: Adriana Alvarenga, Aline Andrade, Alison Sutton, Ana Márcia Diógenes, Ana Maria Azevedo, Andréia Néri, Fábio Atanásio de Morais, Francisca Maria Andrade, Gisele Dias, Helena Oliveira, Jacques Schwarzstein, Jane Santos, Letícia Sobreira, Marcelo Mazolli, Maria José Medeiros, Mário Volpi, Patricio Fuentes, Ruy Pavan, Salvador Soler Lostao and Vilma Cabral
Photographs: UNICEF/Brazil/Luca Bonacini

IBGE TEAM
Ana Lucia Sabóia and Barbara Cobo Soares
Consultants: Maria Dolores Kappel and Ivo Monsores

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www.crosscontent.com.br
contatos@crosscontent.com.br

Coordination: Andréia Peres and Marcelo Bauer
Reporting and editing: Aline Falco, Cristina Yamazaki and Luiz Sampaio. Collaborators: Erica Abe and Joana Ricci
Review: Regina Pereira and Rosimeire Ribeiro
Art: Cristiano Rosa (editing), David Michelsohn, José Dionísio Filho and Nicéia Lombardi (layout)

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VIOLATIONS

FOREWORD

Working toward a better present and future for children entails engaging in the struggle for a more democratic, egalitarian and non-discriminatory society; for a model of social and environmentally sustainable development; and for a world of peace and social justice. These goals are among the ideals pursued by UNICEF, established under the Convention on the Rights of the Child, approved in 1989 by the General Assembly of the United Nations, and ratified by 192 countries.

These principles were also endorsed by Heads of State and of Government upon the signing of the Millennium Declaration (2000) and of the document entitled *A World Fit for Children* (2002). In Brazil, the Statute of the Child and Adolescent, of 1990, reflects the content of the Convention, whereas the Child-Friendly President's Plan, launched by the government in 2003, incorporated points from the Millennium Development Goals and *A World Fit for Children.*

The annual report on the ***State of Brazil's Children*** is another UNICEF contribution to this debate. This year, emphasis has been placed on the first 6 years of a child's life, a phase of fundamental importance for wholesome development of the individual. To this end, integrated child-development programs provide an efficient form of intervention to help children, families, communities, and nations breach the intergenerational poverty cycle. Those first years are forever, and Brazil must give priority to its almost 23 million citizens in this age group.

As a signatory of the Millennium Declaration and of the document entitled *A World Fit for Children,* Brazil has assumed a commitment to achieving significant improvement in its child welfare indicators. Although the situation has progressed in most areas, the figures still reveal causes for concern. Infant mortality rates are one of the indicators which, viewed from a historical perspective, display significant improvements. Between 1994 and 2004, they dropped by 32.6%, to 26.6 per thousand live births. Nonetheless, Brazil's IMR remains the third highest in South America. The goal set by the government for 2015 is attainment of a level of no more than 16 deaths per thousand live births.

The proportion of children with low body weight for their age, the principal indicator used in Brazil to assess child malnutrition, was 7% in 1989, and had declined to 5.7% by 1996. In this category Brazil can be proud that it has surpassed the targets set by the World Health Organization (WHO), and has better rates than Asia (32.8%), Africa (27.9%) and Latin America as a whole (8.3%). Nonetheless the rate is considerably higher than the desirable rate (4%). As a signatory of *A World Fit for Children,* Brazil has also pledged to reduce by one third the proportion of children below the age of 5 years that are undernourished.

Furthermore, Brazil faces other challenges, such as universalization of the right to birth registration, and provision of prenatal care and safe delivery services for expectant mothers. Birth registration, an essential measure for ensuring the rights of citizenship for newborn children, is far from universal. According to the Brazilian Institute of Geography and Statistics (IBGE), each year, almost 750,000 children (over one fifth of all children born) reach their first birthday without ever having been registered. Without birth registration, the child simply does not exist to the State, and is thus ineligible for various services and benefits ensured in law. The Child Friendly President's Plan, launched in 2003, has pledged to conduct a National Birth Registration drive to ensure universal birth registration.

Guaranteeing, protecting, and respecting the rights of children in their first 6 years of life is a task not only for governments and social organizations. Along with other segments of society, businesses have a responsibility for providing dignified and healthy living conditions for children and their families. Other segments, such as members of professional organizations or faith-based communities, also have much to contribute. Moreover, the central role of families must be prized. With this in mind, UNICEF aims to strengthen knowledge, practices and skills of family members, so as to enable them to foster the full development of their children.

The scenario of progress and challenges described herein is also reflected in the figures of the latest Child Development Index (CDI). With support from IBGE, UNICEF presents Brazilian society with comparative listings of municipal and state CDI ratings for 1999 and 2004. The ranking of states and municipalities by CDI serves as an acknowledgement of successful efforts carried out in so many locations, and provides an incentive for administrations and local communities to target initiatives toward the development of their children.

Examination of the CDI reveals that substantial improvements have been attained in the living conditions of Brazil's children in many municipalities. The success of various public policies targeted at children throughout Brazil clearly illustrates that it is indeed possible to overcome adversities, and to ensure conditions and prospects for each and every child and adolescent.

Marie-Pierre Poirier
UNICEF Representative in Brazil

Children still vulnerable

Although infant mortality has declined in Brazil great challenges remain, such as disparities between regions and social groups, and the precariousness of services for mothers and newborns

Reducing child mortality is one of the main policy goals for children in all countries. Attention generally focuses on the first year of life, when the greatest number of deaths occur. As basic indicators of human development, the infant mortality rate (i.e., the number of children that die prior to completing 1 year of life, per thousand live births) and the under-5 mortality rate (also known as the child mortality rate), reveal much about a country's living conditions and healthcare services.

In Brazil, the infant mortality rate has declined steadily. In 1980, according to IBGE, it was 82.8 per thousand. In 2004, the year for which the most recent estimates are available, it was 26.6. Between 1994 and 2004 alone, infant mortality declined by 32.6% *(Table 1)*.

Though this decline is to be welcomed, Brazil's infant mortality rate remains high, since it implies that, each year, nationwide, almost 100,000 children die prior to completing one year of life. A comparative survey conducted by UNICEF in 2005 found that Brazil has the third-highest infant mortality rate in South America, behind Bolivia and Guiana.

Brazil's infant mortality rate, according to the World Health Organization (WHO) classification, is 'average' (between 20 and 49 per thousand).

Table 1

Decline of the infant mortality rate in Brazil (1994-2004)*	
1994	39.5
1995	37.9
1996	36.4
1997	34.8
1998	33.2
1999	31.7
2000	30.1
2001	29.2
2002	28.4
2003	27.5
2004	26.6

Source: IBGE.
* Number of deaths per thousand live births

Table 2

Infant mortality rates by region and state (2002)*	
Brazil	**28.4**
Central-West	**20.4**
Distrito Federal	17.5
Goiás	20.7
Mato Grosso	21.5
Mato Grosso do Sul	19.2
Northeast	**41.4**
Alagoas	57.7
Bahia	38.7
Ceará	35.1
Maranhão	46.3
Paraíba	45.5
Pernambuco	44.8
Piauí	33.1
Rio Grande do Norte	41.9
Sergipe	40.6
North	**27.7**
Acre	33.2
Amapá	24.9
Amazonas	28.8
Pará	27.3
Rondônia	24.6
Roraima	17.8
Tocantins	28.4
Southeast	**20.2**
Espírito Santo	20.9
Minas Gerais	20.8
Rio de Janeiro	19.5
São Paulo	17.4
South	**17.9**
Paraná	20.7
Rio Grande do Sul	15.4
Santa Catarina	18.2

Source: IBGE, Synthesis of Social Indicators 2003 and Synthesis of Social Indicators 2004.
* Number of deaths per thousand live births

A World Fit for Children
www.unicef.org/brazil/wfc.htm

Child Friendly President's Plan
www.mj.gov.br/sedh/ct/planoamigo/planoamigo.htm

Table 3

Neonatal (27-day) and post-neonatal (28- to 364-day) mortality rates by region (2002)		
	Neonatal	**Post-neonatal**
Brazil	**18.2**	**9.6**
Central-West	14.0	6.5
Northeast	24.6	16.9
North	17.5	10.2
Southeast	14.0	6.1
South	11.8	6.1

Source: IBGE, Synthesis of Social Indicators 2003.

WHO regards rates above 50 per thousand as 'high', and those below 20 per thousand as 'low'. Low infant mortality rates are to be found not only in countries of the developed world, but also in such neighboring countries as Venezuela (18), Argentina (17), Uruguay (12) and Chile (8).

Brazil must continue to reduce infant mortality if it is to meet the goals for 2015 expressed in the United Nations publication A World Fit for Children (2002): reduce by two thirds the mortality rate among children under 1 year and under 5 years old.

The child mortality rate normally follows the infant mortality rate very closely. Brazil's under-5 mortality rate dropped from 53.7 (per thousand live births) in 1990, to 33.7 in 2002, which closely parallels the infant mortality rate for the same period, which fell from 47.5 to 28.4. To meet the UN's 2015 goal, Brazil must reduce under-5 mortality to 17.9, and infant mortality to 16 (per thousand live births).

Brazil's compliance with pledges under *A World Fit for Children* is monitored by the Child Friendly Monitoring Network *(Rede de Monitoramento Amiga da Criança),* that comprises entities engaged in the defense of children's rights, including UNICEF. According to the Network, reducing child mortality is one of the goals that Brazil is likely to fulfill. The Child Friendly President's Plan (Plano Presidente Amigo da Criança e do Adolescente, 2003), which provides the outline of the Brazilian Government's strategy for fulfilling the Millennium Goals, specifies an infant mortality rate of no more than 24 per thousand in 2007. If current trends are maintained, it is probable that this goal will be attained without great difficulty.

Achieving lower rates of child mortality alone, however, is not enough. Though it is necessary to reduce national child mortality rates, other important challenges also need to be addressed. The first of these is to reduce disparities in infant mortality throughout Brazil. When the situation in certain regions of the country or among specific social groups is considered, infant mortality rates are often much higher than the national average. Moreover, a deeper analysis of the problem reveals that, despite progress in recent years, services for deliv-

ery remain precarious. Whereas the number of deaths in the second month of life have declined significantly, mortality among newborns has remained relatively unchanged, thus revealing the need to intensify monitoring of prenatal, delivery, and postpartum care.

REGIONAL CHALLENGES

Declining infant mortality in Brazil can be attributed to a series of improvements in living conditions and in children's healthcare, to achievements in the areas of food security, nutrition, and basic sanitation, and to vaccinations. Such improvements have not benefited the population in a uniform manner however. In geographical terms, the Northeast is the most vulnerable region of Brazil in terms of infant mortality. Indeed, infant mortality rates in the Northeast are twice as high as those in the South, Southeast and Central-West *(Table 2)*. In the Semi-Arid region, which comprises a major portion of the Northeast and the north of the States of Minas Gerais and Espírito Santo, the Brazilian municipalities with the highest infant mortality rates are to be found. Figures from the Ministry of Health referent to 2001-2003, show that in certain municipalities in the Semi-Arid region, infant mortality rates are higher than in such African countries as Sudan (i.e., 63 per thousand).

Regional disparities are also evident in the proportion of deaths occurring after the first four weeks of life. Infant mortality can be broken down into neonatal mortality (up until the 27th day of life) and post-neonatal mortality (between the 28th and the 364th day). Since post-neonatal deaths are very closely linked to the socioeconomic status of the population, their numbers have been reduced to very low levels in the more developed countries, but remain a significant proportion of overall infant mortality in poor countries.

In Brazil, both these phenomena can be observed. In the Southeast, South, and Central-West post-neonatal mortality rates are around 6 per thousand *(Table 3)*. In the North and (above all) in the Northeast, this rate has not as yet declined significantly, thus underscoring the persistence of such basic problems as child malnutrition, and deaths from diarrhea and pneumonia.

Infant mortality rates may also differ within a given region, depending upon the social group involved. At the national level, in 2000, infant mortality among the poorest 20% of the population was over twice the rate for the richest 20% *(Table 4)*. Race is another determining factor. Among the children of white women, in 2000, the infant mortality rate was 39.7% lower than among the children of black women, and 75.6% lower than among the children of indigenous women *(Table 5)*. According to estimates prepared by the National Health Foundation *(FUNASA)*, between 2000 and 2004, infant mortality among the indigenous population declined by almost half. Nonetheless, it remains very high by Brazilian standards: 46 per thousand, in 2004.

> Declining infant mortality in Brazil can be linked to a series of improvements in living conditions and children's healthcare

To achieve greater equity in reducing infant mortality in Brazil, it is necessary to place a regional focus on social-welfare and healthcare programs, and to strengthen services provided for the more vulnerable groups. This regional

Table 4

Infant mortality broken down by family income (2000)	
20% richest	15.8
20% poorest	34.9
Brazil	**30.1**

Source: IBGE, data crossed by Celso Simões based upon Census 2000 data.

Table 5

Infant mortality broken down by race/color of the mother (2000)	
White	22.9
Black	38.0
Indian	94.0
Brazil	**30.1**

Sources: United Nations Development Programme (UNDP-Brazil), Brazilian Racial Atlas 2004 and Funasa.

Table 6

Neonatal (27-day) and post-neonatal (28- to 364-day) mortality as a proportion of total deaths of children up to 1 year of age in Brazil (1984-2003)

	1984	1990	1993	2000	2003
Neonatal	39.7%	47.9%	49.9%	63.6%	64.6%
Post-neonatal	60.3%	52.1%	50.1%	36.4%	35.4%

Source: IBGE, Synthesis of Social Indicators 2004.

approach has now been adopted by the Federal Government, for example, in the coverage provided by the *Bolsa Família* program, which currently distributes monthly cash benefits to 'poor' and 'extremely poor' families. Created in 2003, as a consequence of the unification of various income-transfer programs in effect throughout Brazil, the *Bolsa Família* has targeted the Northeast as its top priority. Of the 7.5 million families served by the program in August 2005, 49.2% live in the Northeast.

The Family Health Program (PSF), which provides healthcare services for families by means of health teams that work within communities, also places a major focus on the states of the Northeast. Proportionally, the share of the program devoted to the Northeast is still growing. In 1998, 38% of the PSF teams were deployed in the Northeast; by 2002 this proportion had increased to 41%. A survey published by the Ministry of Health, in 2005, shows that the impact of the PSF on infant mortality has been greater in Northeast and North than in other regions of Brazil where infant mortality rates are lower. The same survey indicates that increased coverage of the PSF teams has contributed more toward the decline in infant mortality rates than expanded access to treated water supply, or the availability of new hospital beds.

> A major portion of such deaths occur in the first month of life, thus emphasizing the importance of factors linked to pregnancy, delivery, and postpartum

CARE DURING PREGNANCY

Another aspect that must be considered when attempting to reduce infant mortality in Brazil is the fact that, currently, a major portion of such deaths occur in the first month of life, thus emphasizing the importance of factors linked to pregnancy, delivery, and postpartum. Since the 1990s, there has been a steady decline in post-neonatal mortality, in contrast to the relatively constant rates of neonatal mortality. This process has reversed the composition of Brazil's infant mortality rate: neonatal deaths, which had been proportionally less numerous, now account for over 60% of the total *(Table 6)*.

The high proportion of neonatal deaths is related to changes in the causes of child mortality in Brazil. In recent decades, as the share of infectious, parasitical and respiratory diseases and malnutrition has declined, the principal causes of infant mortality and of under-5 mortality have become a group of perinatal complications (problems originating in the first week of life). This category encompasses preterm births, asphyxia during delivery, and neonatal infections.

A recent survey[1] shows that, between 1995 and 1997, perinatal causes accounted for 48.5% of all under-5 deaths in Brazil. Among children below 1 year of age, they accounted for 55% of deaths in 2003, according to the Ministry of Health. Second on the ranking of groups of causes of infant mortality are congenital malformations, infectious and parasitic diseases, and respiratory diseases *(Table 7)*.

In order to reduce neonatal mortality and the prevalence of perinatal causes, it is necessary that pregnant women receive adequate prenatal care, and that delivery and post-delivery services be strengthened. By means of such measures, a major portion of child deaths in Brazil could be avoided. Figures from the Ministry of Health indicate two distinct trends in relation to prenatal care. Between 1995 and 2002, the proportion of women that attended no prenatal care

1. Published in *Revista Brasileira de Epidemiologia*, São Paulo, v. 4, 2001, pp. 3-69.

Table 7

Infant mortality in Brazil, broken down by groups of causes (2003)	
Perinatal causes	55.0%
Congenital malformations	14.0%
Infectious and parasitic diseases	8.0%
Unknown causes	8.0%
Respiratory diseases	7.0%
Other causes	4.0%
Endocrinal, nutritional and metabolic diseases	2.0%
External causes	2.0%

Source: Ministry of Health, Secretariat for Health Surveillance, 2003.

appointments during pregnancy fell by almost two thirds *(Table 8)*. At the other extreme, the percentage of expectant mothers that attended over six prenatal care appointments (the minimum number recommended by the Ministry of Health) varied, but no significant change was observed during the period *(Table 9)*.

There was thus a decline in the number of women that received no prenatal care at all during pregnancy, but there was not a corresponding rise in the number of women that regularly attended prenatal care appointments in accordance with recommendations. The contribution of prenatal care toward reducing child deaths depends not only upon the number of appointments, but also upon the stage of pregnancy at which the first appointment is conducted and, more importantly , upon the quality of monitoring. In Brazil, though the indicators do not provide sufficient information for a qualitative analysis of prenatal care, clearly, greater investment is needed to ensure that mothers and children receive adequate services.

Aside from prenatal care, the provision of appropriate delivery and postpartum care could considerably reduce the persistently high numbers of neonatal deaths in Brazil. This must entail better preparation on the part of health services for the provision of care for mothers and newborns. Currently, the great majority of Brazilian children are born in hospitals. In 2002, according to the Ministry of Health, hospital deliveries accounted for 96.7% of all births in Brazil, not including deliveries performed in other types of healthcare facilities. Measures required to reduce risks for newborns encompass such actions as regionalization of healthcare, better equipment for hospitals, capacity building for health professionals on how to deal with complications at delivery, and investments to enhance the quality of information on neonatal deaths in Brazilian hospitals.

In Brazil, clearly, greater investment is needed to ensure that mothers and children receive adequate services.

At the federal level, the principal initiative currently underway to strengthen prenatal, delivery, and postpartum care is the National Pact to Reduce Maternal and Neonatal Mortality, signed in March 2004. This pact encompasses the Ministry of Health, state and municipal secretariats of health in Brazil's 27 states, non-governmental organizations, and UNICEF. The pact aims not only to reduce neonatal mortality, but also maternal mortality, a

Table 8

Percentage of Brazilian mothers that attended no prenatal care appointments (1995-2002)	
1995	10.73%
1996	9.85%
1997	8.02%
1998	7.14%
1999	5.81%
2000	4.93%
2001	4.54%
2002	3.77%

Source: Department of Information and Informatics of the Unified Health System (Datasus).

Table 9

Percentage of Brazilian mothers that attended over six prenatal care appointments (1995-2002)	
1995	49.74%
1996	50.28%
1997	49.76%
1998	49.45%
1999	50.69%
2000	45.97%
2001	47.33%
2002	49.14%

Source: Datasus.

problem that reaches alarming proportions in Brazil *(See the text on Mothers at Risk).* The initial goal of the pact is to reduce maternal and neonatal mortality by 15% by the end of 2006.

To this end, a series of measures are to be taken, including: capacity building for health professionals and managers so as to promote the reorganization of maternal and neonatal care, support for initiatives targeted at high-risk mothers and newborns, and the establishment of committees for the investigation of maternal and child deaths throughout the country. Up until June 2005, fifteen seminars were held in the states, and one in the Federal District, to consolidate the pact, and a national seminar was held for health professionals working with urgent and emergency pediatric care. Furthermore, actions were carried out to benefit 78 municipalities with over 100,000 population, identified as requiring priority attention. For these municipalities, the Federal Government earmarked 31 million reais for the project to Expand and Consolidate Family Health (PROESF), to promote capacity building, and the qualification of health professionals as multiplying agents at maternity wards.

Integral healthcare services for women can considerably reduce risks to the lives of children

The scope of actions carried out under the pact will depend upon the degree of engagement of the states and, especially, of the municipalities, where the policy for mothers and newborns must effectively be deployed. Successful initiatives are already in evidence in this area, especially in the capital cities of the states. An example is the Perinatal Committee of Belo Horizonte, that has been engaged in promoting integral delivery and postpartum care since 1999.

The committee has implemented improvements in the structure of maternity wards, enhanced the qualification of health professionals, closed maternity units that did not meet quality standards, and promoted regionalization of healthcare so as to ensure immediate services

Mothers Lives at Risk

Measures to reduce mortality among newborns may also help reduce the alarmingly high numbers of women who die of complications during pregnancy or delivery in Brazi

Insufficient attention to prenatal, delivery, and postpartum care is responsible not only for high rates of neonatal mortality, but also for persistently high rates of maternal mortality in Brazil.

The indicator used to measure this problem is the maternal mortality ratio, i.e., the number of deaths of women, while pregnant or within 42 days of termination of pregnancy, (per 100,000 live births) from causes related to pregnancy, delivery, or postpartum care.

According to the latest official estimates (2002) the Brazilian maternal mortality rate is 74.8, far higher than the rate that the World Health Organization (WHO), deems acceptable (i.e., 20 maternal deaths per 100,000 live births). This official estimate takes into account not only reported maternal deaths, since it is acknowledged that underreporting of such deaths is common throughout the world. For this reason, the Ministry of Health multiplies reported deaths by a correction factor. Currently, the correction factor used (1.4) is the one suggested by a survey carried out in 2002 by the Brazilian Center for Classification of Diseases, entitled Maternal Mortality in Brazil's state capitals: Certain Characteristics and an Estimated Adjustment Factor. Though the survey applies only to state capitals, for lack of a more comprehensive parameter, this correction factor has been applied to the whole of Brazil.

Reducing maternal mortality is among the goals both of the UN's *A World Fit for Children*, and of the

for expectant mothers in all parts of the city. Today, all maternity wards in Belo Horizonte are prepared to receive mothers with complications during delivery. Through such improvements, the mortality of infants in the first 6 days after delivery dropped from 10 to 6 per thousand, between 1999 and 2001.

THE ROLE OF THE MOTHER

All policies targeted at reducing infant mortality must take into account the fundamental role of the mother in prevention of child deaths. Integral healthcare services for women can considerably reduce risks to the lives of children. Thus, it is important not only to ensure prenatal care and safe delivery (important as these may be) but also to ensure that mothers are able to breastfeed their children. The international recommendation that children be exclusively breastfed up to the age of 6 months, and that breastfeeding continue up to the age of no less than 2 years, is seldom complied with in Brazil. According to the latest data from the Ministry of Health, in 1999, only 9.7% of children were exclusively breastfed up to the age of 6 months.

According to the aforementioned study by epidemiologist Cesar Victora, if the number of children that are not breastfed between birth and 11 months of age were reduced by half, 9.2% of the deaths of children under 5 years from pneumonia could be avoided.

The international recommendation that children be exclusively breastfed up to the age of 6 months, and that breastfeeding continue up to the age of no less than 2 years, is seldom complied with in Brazil

Increasing the proportion of children that are breastfed does not depend only upon the effectiveness of awareness-building campaigns that have been held regularly in Brazil since the 1980s. It also depends upon compliance with Brazilian laws designed to protect breastfeeding mothers,

Brazilian Government's Child Friendly President's Plan. As stated in the former, the goal is to reduce the number of maternal deaths by three quarters by 2015; whereas the target stated in the latter is to reach a level of no more than 55.9 maternal deaths per 100,000 live births in Brazil's state capitals, by 2007. Actions targeted at fulfilling these goals may also contribute toward reducing mortality among newborns.

The two problems need to be treated as consequences of the same scenario of precarious prenatal delivery and postpartum care, and such initiatives as the National Pact to Reduce Maternal and Neonatal Mortality take this approach. To address maternal mortality, better prenatal care and hospital services for expectant mothers and newborns (both of which are contemplated under the Pact) offer opportunities for changing the prevailing situation since, according to the Ministry of Health, 92% of maternal deaths could be prevented.

To provide greater knowledge as to the principal causes of maternal deaths in Brazil, and to draft strategies for tackling them, State Committees for the Prevention of Maternal Mortality have a fundamental role to play. Founded in 1989, the committee of the State of Paraná provides an excellent example. Comprised of representatives of 25 entities, the committee carries out surveillance and investigations on the causes of maternal deaths, and pursues preventive measures, such as public-awareness campaigns in hospitals. The State of Paraná has committees in all its 22 healthcare regions, and in 182 of its 399 municipalities.

Thanks to the work carried out by these committees, maternal mortality declined 3% per year on average in the State between 1994 and 2002, and today much more knowledge of the problem is available. In 2004, 92% of the deaths of women of childbearing age were investigated.

which foresee: maternity leave lasting 120 days, provision of appropriate facilities for nursing children close to the mother's workplace, rest periods during the course of the working day when mothers can breastfeed their children (two per shift, lasting half an hour). Though provided for in law, such rights are not enjoyed by large numbers of women, and especially not by those working in the informal sector.

Another aspect that has great impact on child mortality is the schooling level of the mother. Various studies have concluded that, the more years of schooling the mother has, the greater the chances of her preventing the death of a child in its first 5 years of life. Census data (IBGE 2000) shows that the under-5 mortality rate among children of women with no more than 3 years of schooling (regarded as functionally illiterate) was 2.5 times greater than among children of women with eight or more years of schooling (*Table 10).*

Table 10

Under 5 mortality rate in Brazil broken down by years of schooling of the mother (2000)	
Up to 3 years	49.3
From 4 to 7 years	30.2
8 years or more	20.0

Source: IBGE. Synthesis of Social Indicators 2003.

Table 11

Average number of years of schooling for women* in Brazil (1993-2003)	
1993	5.1
1996	5.4
1999	5.9
2002	6.4
2003	6.6

Source: IBGE, National Household Survey (Pnad).
* Women 10 years old or older.

The more years of schooling the mother has, the greater the chances of her preventing the death of a child in its first 5 years of life

The average number of years of schooling for Brazilian women is increasing. Between 1993 and 2003, it rose by 29.4% *(Table 11).* Nonetheless, there is plenty of room for improvement. Since UNICEF considers this factor of importance for ensuring the lives of children, it has included among the indicators that comprise the Child Development Index (CDI) the percentage of children below the age of 6 years whose mothers have low schooling levels.

The importance of the mother's role in preventing child mortality is also the focus of work that UNICEF carries out for strengthening family competences in Brazil. With the aim of contributing toward reducing infant, child, and maternal mortality, in 2003, UNICEF designed Kits for Strengthening Brazilian Families, comprising five albums of information and guidance on child care, from prior to birth to the age of 6 years. Some of the themes addressed in these kits, such as the importance of prenatal, delivery and postpartum care, child nutrition, and simple health measures that can be taken by the family, are directly related to this approach.

In the hands of Community Health Agents, leaders of the Children's Pastorate, and teachers at day-care centers and preschools, these kits had, by 2005, benefited some 2 million families in sixteen Brazilian states. A book entitled *The Municipality and Children up to 6 Years of Age* seeks to reinforce this work, by strengthening social partners at the municipal level that provide services for children.

The Right to Life

Community action helps Alagoas meet the challenge of high infant mortality rates

The State of Alagoas has managed to reduce infant mortality by targeting actions directly toward children in high-risk situations, and such preventative approaches as staff training and dissemination of information on child development. Though the trend points toward a substantial decline, underreporting is common and there are discrepancies in the rates furnished by the three data sources: the Brazilian Institute of Geography and Statistics (IBGE), the Information System on Mortality (SIM), and Basic Services Information System (SIAB). In 2000, these systems reported the following rates: 60 per thousand; 39.3 per thousand, and 49.9 per thousand, respectively.

At UNICEF's request, epidemiologist César Victora conducted a survey that combined data from the three information systems. Despite discrepancies in the indices and a lack of efficient coverage, the study concluded that, between 2000 and 2002, the mortality rate had dropped by 28%: from 46.3 to 33.5 per thousand.

This decline in infant-mortality trend is upheld by initiatives such as the one that saved the life of José Firmino, 1 year and 10 months old, who lives in Murici, a municipality with a population of 21,000, located 55 kilometers from the state capital. He was born with low body weight and so vulnerable that the doctors pronounced his life to be in grave danger. Says his mother, Aparecida Firmino dos Santos (38 years old) who had already lost two of her eight children to diseases caused by malnutrition and poor hygiene: "I had no idea what was wrong. They never even saw a doctor. They simply had diarrhea and died". Illiterate, and living in a low-income community with no sanitation, she was surprised to learn that the fate of her youngest child could be different. "Today it is hard to believe he was so ill. He is now almost well", she reports joyfully.

José Firmino survived thanks to the system for monitoring children in high-risk situations, and to surveillance activities implemented by the municipality in 2004. The boy was monitored on a weekly basis by José Carlos dos Santos, a Community Health Agent of the Family Health Program (PSF). As a resident of the same community, he assessed changes in the boy's weight, and offered guidance to his mother. He taught Aparecida dos Santos basic healthcare measures necessary for guarding the health of her son, such as basic hygiene and how to administer oral rehydration therapy. He also taught her to schedule periodic medical appointments, and to pay careful attention to possible symptoms of disease.

JOINT EFFORTS

The system for monitoring children in situations of high risk harnesses the efforts of Family Health Program teams, community representatives, municipal administrations, and families,

with the aim of reducing infant mortality. In each community, monthly meetings are held to assess the status of children and provide guidance for parents. "It helps that we all live in the same place and know the children, so we are aware when things are all right and when they are not", says community health agent José Carlos dos Santos, who serves 130 families within his community, under the supervision of doctors and nurses of the PSF, and knows the name of each child.

The system for monitoring children in situations of high risk harnesses the efforts of Family Health Program teams, community representatives, municipal administrations, and families, with the aim of reducing infant mortality

Such activities are reinforced by the fact that health teams are on duty every day of the week, in close contact with Guardianship Councils, and that they award priority to families in healthcare, psychological counseling, and nutrition programs.

As a consequence, there has been a sharp decline in infant mortality rates. In 2004 there were nine PSF teams working in the communities and, of the 263 high-risk low birth-weight children, 1.9% died. This marked a 32% drop in relation to the previous year.

AN INTEGRATED VIEW

Promoting closer community links has also contributed toward reducing infant mortality in other parts of the State of Alagoas. In the Semi-Arid portion of the state, a small-scale project launched in 1987 by *Movimento Pró-Desenvolvimento Comunitário*, a local NGO in the town of Palmeira dos Índios, has given rise to a network encompassing various municipalities. This network, known as Fazer Valer os Direitos em Alagoas, focuses on issues relating to child development, education, and social welfare, and is committed to reducing infant mortality. Since 2000, with UNICEF support, this initiative has combined the efforts of municipal administrations and civil-society organizations in six municipalities: Cacimbinhas, Estrela de Alagoas, Igaci, Palmeira dos Índios, Quebrângulo and Viçosa.

Under coordination of *Movimento Pró-Desenvolvimento Comunitário de Palmeira dos Índios* (an NGO), the network seeks to promote integral care

for children and adolescents, and to develop family and municipal competences in such areas as social welfare, education, and health. The scope of issues covered ranges from family-income generation to prevention of cervical cancer.

The concept of integral care encompasses: capacity building for interdisciplinary teams; support for the Program for Humanization of Prenatal and Delivery Care; encouragement for Mother's Groups, and guidance as to the importance of breastfeeding and adequate nutrition. So far, 8,328 children up to the age of 6 years have received direct or indirect benefit. One of these is Stéfanie Gabriele Tenório Oliveira, the first daughter of Gracielli Tenório Oliveira (21 years old).

For all her youth and inexperience, Gracielli attended meetings of the Mother's Group throughout her pregnancy, under the auspices of the *Fazer Valer os Direitos* network. At these meetings, she learned basic childcare techniques, which she is applying for baby Stéfanie, now 2 months old. "I learned how to take care of her from the first day, how to bathe her, and how to feed her, and not allow my milk to dry up", says Gracielli.

ACHIEVEMENTS

The process of registering Stéfanie's birth began right after delivery. In the reception area at the Santa Olímpia Maternity Home, in the municipality of Palmeira dos Índios, there is an outpost of the Registry Office. The goal is to ensure that every child born should leave the maternity home with a birth certificate.

Furthermore, baby Stéfanie benefited from the improvements the maternity home has undergone in recent years. As a result of partnerships with the Pediatric Society, the Federal University, and the University Health Sciences Foundation of Alagoas, the entire staff have undergone training. Post delivery, mothers remain in the maternity ward together with their baby sons or daughters. Their are eight beds available in the Neonatal Intensive Care Unit, and health teams are on duty day and night, thus making the maternity home a reference for 23 municipalities in the region.

All these improvements are the fruits of mobilization and articulation among institutions and the public authorities. Among the organizations that have contributed to the initiative are: the Association of Rural Women Workers of Palmeira dos Índios, the Alternative Farming Association of Igaci (Aagra), the Children's Pastorate, Xucurus Social Center, the Attorney General's Office, and the Regional Medical Council of Alagoas. Municipal councils of children's rights, of social welfare, and of health also participate in the group, and all of them take part in the management group that decides which actions should be taken by the project.

The *Fazer Valer os Direitos* Network receives support not only from UNICEF, but also from World Vision (Visão Mundial), *Fórum Lixo* and *Cidadania em Alagoas*. Other partners include the Child Shelter Foundation (Fundanor) of Palmeira dos Índios, the Community Support Center of Tapera, in União a Senador (Cactus), the municipal administrations of Tapera and Senador Rui Palmeira, and the Association for the Protection of Children and Adolescents at High Personal and Social Risk (Pró-Ser), in the municipality of Bom Conselho (PE). Another seven municipalities in the region are currently preparing to participate in the project.

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Small victims

Accidents and aggression are the main causes of death of children between the ages of 1 and 6 years in Brazil, accounting for almost a quarter of such deaths

A fall from the cradle. A blow with a broom. A car accident. A drowning. A rape. Though these events are all different, they share a common characteristic: together, accidents and aggression are the principal causes of death of children between the ages of 1 and 6 years in Brazil.

Violence against children comprises any action or omission that causes harm, wounds, or disturbs their development. It must be assumed that there is an unequal and asymmetrical power relationship between adults and children.

Historically, physical aggression has always played a part in the upbringing of children, and was justified by the argument that they were being protected from danger, or being made into 'good' adults.

The majority of cases of violence against children occur within the space in which they spend most of their time, i.e., the home. The family, as the prime protecting environment for children, may nonetheless be the venue of non-protecting relations, for a whole series of complex economic and/or cultural factors.

Such non-protecting relations within the family environment may be classified in at least three ways:

- Educational practices that entail physical violence (punishment, slaps, blows etc.).
- Accidents, negligence, and the syndrome of shaken or abused infants, including sexual abuse.
- Actions or omissions resulting in death.

These are also the principal factors that cause children to draw away from their family environments, thereby becoming liable to other forms of violence in the streets or in shelters. Overcoming such problems requires commitment from all segments of society, and a focus that goes well beyond the individual level. All of society needs to be engaged in bringing about medium and long-term cultural change. The principles of a salutary and non-violent education need increasingly to be stimulated and disseminated.

In Brazil, only by consulting official morbi-mortality figures, broken down by age, is it possible to understand the dimensions of such violence. In order for events to be quantified, it is necessary that each be either the subject of a record at the healthcare services, or of a complaint to the public security services. Thus, one of the major problems for assessing levels of violence in private spaces is underreporting on the part of healthcare or public security services.

Since such violence generally occurs within the home, it may often persist for months or even years before it is uncovered. One factor that contributes to such underreporting is a quite common belief among adults caregivers, that slaps, punishments and other forms of physical violence are justifiable components of normal upbringing. Moreover, small children are unable to complain of the violence to which they are subjected and, despite progress achieved in the legal and citizenship areas, their word is often considered warped by fantasy.

The most recent desegregated data on domestic violence in Brazil date back to 1988. In 1989, IBGE published a national household sample survey showing that the home is where physical aggression against children and adolescents most often occurs. A book published in 2005 by the Ministry of Health's Secretariat for Health Surveillance, entitled *The Impact of Violence on the Health of Brazilians* (2005), presented a survey in which some 200,000 children and adolescents reported that they had suffered some form of physical aggression. In 80% of the cases, the perpetrators were family members or persons known to the child.

There are two systems for reporting violence against children and adolescents: the Information System on Children and Adolescents (SIPIA), and the Hotline *(Disque Denuncia)*, both of which are managed by the Under-Secretariat for Human Rights of the Secretariat General of the Presidency of the Republic. Regardless of source, these reports also reveal that, in the majority of cases, violence against children is perpetrated by family members, and takes place in the home.

Information System on Children and Adolescents (SIPIA)

www2.mj.gov.br/sipia/

1. Suely F. Deslandes, Simone G. de Assis and Nilton C. dos Santos, Violências Envolvendo Crianças no Brasil: Um Plural Estruturado e Estruturante, em *Impacto da Violência na Saúde dos Brasileiros*, Brasília, Ministry of Health, 2005.

AVOIDABLE DEATHS

Throughout the 1990s, accidents and violence, classified internationally as external causes, have been among the principal causes of the deaths of children up to the age of 9 years[1]. From 1996 to 2003, they accounted for 21.11% of the deaths of boys and girls between 1 and 6 years old, according to data from the Ministry of Health's Information System on Mortality (SIM), *(Table 1)*.

Traffic accidents led the ranking of events behind these causes, and accounted for 27.3% of deaths from external causes of children between 1 and 4 years old, in 2002 *(Table 2)*. A deeper examination of the data on traffic accidents causing the deaths of children reveals that most child victims were pedestrians (i.e., they were run over).

Another point that merits attention is the significant number of deaths of children below 7 years of age from unspecified causes: that encompassed 32.5% of all deaths from external causes in 2003, according to the Ministry of Health's Mortality Information System. According to the International Classification of Diseases (ICD 10) intoxication, side effects of burns, and operations of war, are among the causes that comprise this percentage.

This lack of specification is explained more by the form in which such external causes are presented and classified, than failure to attribute importance to the data. The figures suggest that this percentage, as the largest cause of death in a given year for children below the age of 7 years, ought to be the subject of deeper and more careful analysis. A more precise break-

Table 1

Principal causes of death of children between 1 and 6 years (1996-2003)

Infectious and parasitic diseases	14.87%
Neoplasias	6.74%
Respiratory diseases	16.76%
Congenital mal-formations	5.99%
Diseases of the blood	1.93%
Endocrine, nutritional and metabolic diseases	4.15%
Diseases of the nervous system	6.52%
Other diseases	6.17%
Undiagnosed diseases	15.76%
External causes of morbi-mortality	21.11%

Source: Mortality Information System (SIM), Ministry of Health.

Table 2

Deaths from external causes of children and adolescents, by age group (2002)

	< 1 year	1 to 4 years	5 to and 9 years	10 to 14 years	15 to 19 years
Traffic accidents	9.04%	27.3%	46.25%	33.65%	20.89%
Falls	4.08%	4.42%	3.75%	2.92%	1.05%
Drowning and accidental submersion	3.19%	26.48%	22.52%	20.92%	7.13%
Exposure to smoke, fire and flames	3.81%	6.12%	3.0%	0.49%	0.21%
Poisoning, intoxication by exposure to noxious substances	0.62%	1.34%	0.4%	0.14%	0.11%
Lesions and self-inflected wounds	0%	0.05%	0.1%	3.72%	4.48%
Aggressions	7.98%	5.14%	5.76%	20.61%	54.9%
Undetermined causes	13.03%	9.51%	6.36%	6.85%	7.0%
Legal interventions and operations of war	0%	0%	0%	0%	0.29%
All external causes	58.24%	19.64%	11.86%	10.71%	3.94%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: SIM, Ministry of Health.

down of the data might reveal new threats to the health of small children and even, should this prove to be the case, serve to reorient policies for the prevention of accidents and violence against children in this age group.

According to the Brazilian Pediatrics Society (SBP), the concept of an accident as being an unforeseeable event is incorrect and counterproductive, and tends to obscure more rational perceptions. Current trends regard accidents, in the great majority of cases, as being neither fortuitous nor unavoidable events. Likewise, other specialists argue that "many accidents involving children could be classified as violence", and question whether such accidents are really 'accidental'[2].

An article entitled The Impact of Violence on Brazilian Children and Adolescents[3], suggests that many of these accidents are in effect negligence and failure to take adequate precautions when supervising children.

The National Toxic-Pharmacological Information System (SINITOX), of Fundação Oswaldo Cruz (FIOCRUZ), reveals that 25% of cases of poisoning reported in 2001, whether fatal or not, involved children below the age of 5 years. The principal agents were medicines and cleaning products.

With respect to this particular cause of child deaths, much could be done by parents. The public authorities could also approve laws that help foster prevention and safeguard the lives of children. There are, at present, two bills before the National Congress, one of which forbids the sale of liquid alcohol, and another that would institute Special Childproof Packaging for chemical products and medicines that pose risks to children's health. Such packaging would make it more difficult for children below the age of 5 years to open the packaging or remove the product.

Avoiding other common types of 'accidents', such as falls and drowning, depends primarily upon the vigilance of parents and caregivers. Having examined the profile of deaths of children below the age of 9 years, public health specialists[4] point out that, in most cases of death from burns or falls from windows, no adult was present at the time of the accident.

It is important to reflect upon the extent to which accidents involving children could be avoided, but families alone should not be held responsible for such deaths. All too often, parents do not have sufficient information to perceive the hazards their children face. Conducting campaigns on how to avoid accidents and teaching adequate prevention methods are ways of raising awareness.

The deaths of boys and girls from deliberate violence, however, can be quantified. Aggressions, defined as wounds inflicted by another person with intent to maim or kill, corresponded to 5.14% of deaths from external causes of children between the ages of 1 and 4 years, in 2002.

2. Deslandes, Assis e dos Santos, *op. cit.*
3. Maria Helena Prado Mello Jorge and Edinilza Ramos de Souza, *Violência Faz Mal à Saúde*, Ministry of Health, 2004.
4. Deslandes, Assis and dos Santos, *op. cit.*

A major portion of the cases of violence against children do not result in death but, nonetheless, have a strong impact on the health and development of the child. According to WHO's World Report on Violence and Health (2002), small children are more vulnerable to aggression, be it fatal or not, within the home. Aside from physical violence, other forms of non-fatal violence that occur within the family circle are: negligence, sexual abuse, and psychological violence.

A preliminary document from the National Committee for Tackling Sexual Violence against Children and Adolescents shows that, between February and September 2005, there were 1,942 complaints of violence against children up to the age of 6 years, on the Hotline *(Disque-Denúncia)* of the Under-Secretariat for Human Rights of the General Secretariat of the Presidency of the Republic. Most of these were complaints of physical violence and negligence.

The following table shows this data broken down by age group, which appears to be a more significant factor than racial or ethnic origin *(Table 3)*. With respect to gender, the majority of victims are girls.

Table 3

Complaints of violence, broken down by type, age group, and race of the victim

Age	Category	Asiatic	White	NI*	Indian	Black	Brown
0	Negligence	0	2	3	0	2	1
	Physical violence	0	4	0	0	0	1
	Psychological violence	0	2	1	0	0	1
	Subtotal	**0**	**8**	**4**	**0**	**2**	**3**
1	Sexual violence	0	5	0	0	1	5
	Negligence	0	41	2	0	16	27
	Physical violence	0	41	2	0	11	26
	Psychological violence	0	17	0	0	3	5
	Subtotal	**0**	**104**	**4**	**0**	**31**	**63**
2	Sexual violence	0	14	0	0	4	6
	Negligence	0	48	3	0	22	52
	Violence with death	0	0	0	0	0	1
	Physical violence	2	61	3	0	16	53
	Psychological violence	0	25	1	0	4	14
	Subtotal	**2**	**148**	**7**	**0**	**46**	**126**
3	Sexual violence	0	21	0	0	5	13
	Negligence	0	47	0	1	23	59
	Physical violence	0	56	2	1	25	60
	Psychological violence	0	19	0	0	8	12
	Subtotal	**0**	**143**	**2**	**2**	**61**	**144**
4	Sexual violence	0	15	2	0	5	16
	Negligence	0	43	4	0	17	57
	Violence with death	0	0	0	0	0	1
	Physical violence	0	55	2	0	23	77
	Psychological violence	0	23	2	0	6	22
	Subtotal	**0**	**136**	**10**	**0**	**51**	**173**
5	Sexual violence	0	17	0	0	4	10
	Negligence	0	60	1	0	18	63
	Physical violence	1	69	0	0	23	78
	Psychological violence	0	23	0	0	8	9
	Subtotal	**1**	**169**	**1**	**0**	**53**	**160**
6	Sexual violence	0	21	0	0	7	6
	Negligence	1	43	0	1	12	44
	Physical violence	1	53	1	1	18	68
	Psychological violence	1	21	1	0	2	13
	Subtotal	**3**	**138**	**2**	**2**	**39**	**131**

Source: Preliminary document of the National Committee for Tackling Sexual Violence against Children and Adolescents, based upon data from the *(Disque-Denúncia)* Hotline. Race corresponds to information provided by the informant.
*Race not informed

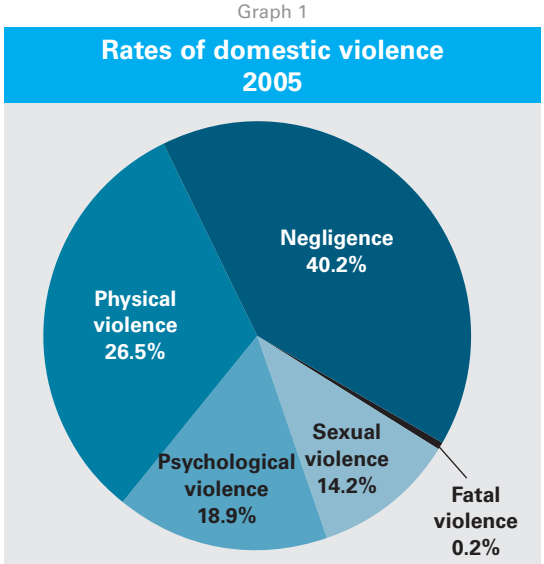
According to a survey carried out by the Laboratory for Children's Studies (LACRI), at the Institute of Psychology of the University of São Paulo (IP/USP), of the types of domestic violence to which children and adolescents up to the age of 19 years are subject, and one of the most frequently reported, is negligence[5]. Negligence accounted for 40.2% of reported cases of violence in 2005 *(Graph 1)*. Survey results reflect the situation in sixteen Brazilian states and the Federal District. It is, however, important to stress that the figures represent no more than the tip of a huge iceberg.

The LACRI survey also shows that physical violence is the second most frequently reported type of domestic violence. The WHO report shows that the most common symptoms of the physical violence that afflicts small children are fractures in places where they do not usually occur. There are also many cases of children of up to 9 months of age that suffer from the Shaken Baby Syndrome, caused by violent shaking of the child, and that may lead to bleeding, or even death.

Also according to the LACRI systematization, sexual violence is one of the least commonly reported types of domestic violence against children and adolescents. The low numbers of reports may be a consequence of a taboo that surrounds the subject.

5. Negligence signifies omission in terms of providing for the physical and emotional needs of a child or adolescent. It is characterized when the parents or caregivers fail to provide adequate food or clothing for a child, etc. when such failure is not the consequence of poverty or factors beyond their control. Source: Maria Amélia Azevedo and Viviane Nogueira de Azevedo Guerra, *Infância e Violência Fatal* em Família, SP, Iglu, 1998.

Graph 1



Source: Laboratory for Children's Studies (LACRI) of the University of São Paulo (USP), Synthesized Table of Domestic Violence Reports, 2005 (see the Brazilian statistics link at www.usp.br/ip/laboratorios/lacri/).

Data from the Brazilian Multi-professional Association for Protection of Children and Adolescents (ABRAPIA), which managed the *Disque-Denúncia* hotline until 2003, show that of the 1,560 complaints of sexual abuse received between 1997 and 2003, 18% of the victims were under 8 years old. Though this small sample can not be extended to Brazil as a whole, it nonetheless provides an indication of the dimensions of the problem on the national level.

A qualitative study[6] carried out with children treated at the Reference Center for Women's Health and Child Nutrition, Feeding and Development, of the Pérola Byington Hospital in São Paulo (one of the principal Brazilian reference centers for these issues), indicates that, up to the age of 10 years, the type of violence is predominantly indecent assault, without any type of physical aggression or even genital contact. According to the survey, the principal perpetrators of such violence are family members and people that have close contact with the child, and the environment in which such violence generally occurs is the home.

At the Joint Parliamentary Commission of Enquiry (CPMI) that investigated sexual exploitation of children and adolescents in Brazil, many adolescent girls testified that they had suffered sexual abuse within the family as children, and that such violence, alongside other vulnerabilities, had resulted in their becoming involved with sexual exploitation networks.

Despite the scarcity of data on commercial sexual exploitation of children, a recent study carried out by the Reference Center for Studies and Actions for Children and Adolescents (CECRIA)[7] identified 26 specific routes along which exploitation of children has taken place[8].

Few sanctions and little accountability

It has been estimated that, worldwide, 20% of women and 10% of men suffered sexual violence during childhood. The estimate of the number of perpetrators punished, on the other hand, is much lower: a mere 6%. In Brazil, owing to the protracted nature of court proceedings, it is likely that this proportion is even smaller[9]. When considering violence against children up to the age of 6 years, it must be presumed that the number is even smaller still, owing to the difficulty of presenting evidence.

With a view to promoting integrated management of rights and policies for children and adolescents, as a consequence of articulation between governmental and non-governmental organizations, a System for Guaranteeing Rights has been established, in compliance with provisions of the Statute of the Child and Adolescent. Despite the importance of their strategic role in diagnosing and facing up to the issue of sexual violence against children, the components of this system have not yet been deployed in a sufficiently comprehensive manner.

Special Police Precincts for Protection of Children and Adolescent (DPCA) have been established to receive complaints and investigate crimes against children and adolescents, to prevent exploitation and ensure their rights. In compliance with the principle of integral protection, these special precincts provide services in an environment quite unlike normal police stations, and have made a positive contribution toward reducing the numbers of unresolved cases.

6. *Estudo de Fatores Relacionados à Violência Sexual Contra Crianças, Adolescentes e Adultas*. Jefferson Drezett, Centro de Referência da Saúde da Mulher e de Nutrição, Alimentação e Desenvolvimento Infantil, Doctoral thesis, 2000.
7. Maria Lúcia Leal and Maria de Fátima Leal, Pesquisa sobre Tráfico de Mulheres, Crianças e Adolescentes para fins de Exploração Sexual Comercial (Pestraf), Brasília, Cecria, 2002.
8. *Impacto da Violência na Saúde dos Brasileiros*, Ministry of Health, 2005.
9. Lúcia Cavalcanti de Albuquerque Williams, *Abuso Sexual Infantil*, São Carlos, Laboratório de Análise e Prevenção da Violência/Department of Psychology / Federal University of São Carlos (UFSCar), 2001.

The number of such special police precincts is however very small. In 2003, there were only 24 in sixteen states and in the Federal District[10]. The prospects for expanding the number are somewhat remote, since the number of specialized courts that hear cases of crimes against the rights of children and adolescents is even smaller. Indeed, there are only four for the whole of Brazil.

Violence in shelters and schools

Aside from the home environment, daycare centers, shelters, and preschools are also environments where children may be exposed to violence. Statistical information on this phenomenon, however, is extremely rare. The lack of systematized data can be attributed to structural weakness of the bodies that comprise the System for Guaranteeing Rights, or to a failure to prioritize the rights of small children and protect them from such violence.

In preparing this report, UNICEF requested information on complaints received and investigations into violence at daycare centers, preschools and shelters, involving children up to the age of 6 years, from the Operational Support Centers (CAO) for Children and Youth, which are auxiliary bodies linked to the State Attorneys' Offices *(Ministérios Públicos)*, and from Public Defenders offices of the states and of the Federal District.

The only response received was from the CAO of the State of Goiás, which reported that only two cases were currently being prosecuted within its jurisdiction. Those of other states reported that they had received no complaints, and claimed that they lacked support for systematization of the data.

Seven of the Public Defender's offices responded to UNICEF's request, but only two had received any reports of violence at daycare centers, preschools or shelters. The Public Defender's office of Paraná receives an average of one complaint per month. In Rio de Janeiro, the Coordination for Defense of the Rights of Children and Adolescents (CDEDICA) informed that it receives some two reports per month of injuries suffered by children in such environments.

These responses indicate that the principal focus of Public Defenders' offices remains adolescents in conflict with the law. Owing to an excessive workload, few of them have taken up the challenge of ensuring protection for small children whose rights are threatened or violated. Thus, actions relating to children in daycare, preschools and shelters are not common.

DIAGNOSIS AND FACING UP TO THE PROBLEM

In Brazil, the public authorities advanced in their approach to the problem of violence against children in 1998, when they began to address the issue as a matter of public health, and the Ministry of Health summoned various segments of society to participate in the debate. The consequence was

10. *Delegacias de Proteção e Infância*, UNICEF/Saraiva, 2004.

Pioneering work

Reference Center seeks to rebuild family ties among aggressors and victims

For the past ten years, the Reference Center for Victims of Violence (CNRVV), maintained by Instituto Sedes Sapientiae of São Paulo, has worked with the prospect of instilling aggressors with awareness of the need to reform, thereby restoring a wholesome family environment. The aim of providing psychological therapy is to work on the aggressor's understanding of his/her role within the family, inculcating a better perception of the status of children, and instilling a more respectful view.

Role-play games, videos, and group work are the basis of the strategy for awareness building. In this way, the aggressors, their victims, and other family members receive psychosocial therapy separately. It thus becomes possible to open up a space for joint discussion.

Aggressors are referred to CNRVV by the Courts. Generally, they have either lost custody of their children, or been temporarily separated from the family. The center attempts to encourage rapprochement. No preordained schedule is set for such reconciliation to take place. Everything will depend upon the course of treatment. After the aggressor returns to the family, the reintegration phase is also monitored by professionals from the center.

the launching, in 2001, of the National Policy for Reducing Morbi-mortality resulting from Violence and Accidents.

This policy acknowledged the seriousness of the issue, and proposed the following guidelines for tackling it more effectively:

- Promote adoption of safe behaviors and healthy environments.
- Monitor cases of accidents and violence.
- Systematize, consolidate, and expand pre-hospital care.
- Provide interdisciplinary and inter-sectoral care for victims.
- Structure and consolidate care for recovery and rehabilitation.
- Capacity building for human resources.
- Support the development of resources and research.

This national policy establishes actions for prevention and specialized care for groups that are particularly vulnerable to violence, such as the child population. It also provides for classifications and diagnoses of violence and the reporting of cases of ill treatment to the authorities responsible for the defense of the rights of children and youths.

On the basis of this policy, in 2004, state and municipal Centers for the Prevention of Violence and Promotion of Health were established. These Centers are responsible for preparing municipal and state plans for prevention of violence and promotion of health, and also for networking with various sectors, with a view to preventing violence and conducting actions for promoting the health of the most vulnerable segments of the population, namely children and adolescents.

Such centers are being established in those municipalities deemed to be at highest risk for violence and, by October 2005, 65 had been installed.

Less than one year after the launching of this policy, Ministry of Health Order 1.968, of October 25, 2001 introduced compulsory reporting for all offenses against children and adolescents. Since that time, medical services that treat suspected or proven cases of ill treatment of any type against children and adolescents are obliged to notify the Guardianship Council, which must, in turn, refer the case to the competent authorities.

Such reporting, and its consequences, fulfills two functions. It ensures that child victims of violence are referred for the best possible forms of treatment, and produces information for a diagnosis, thereby assisting in the formulation of more efficient and effective policies.

Cultural and structural barriers

Various obstacles remain to the incorporation of such standards into daily practice. The first of these are difficulties and resistance on the part of health professionals to identifying and reporting cases of ill treat-

Even when systematic treatment is no longer needed, the services continue. Professionals from CNRVV make periodic home visits to the families. "Our intention is to persist until all resources for recovery have been exhausted", says psychologist Dalka Ferrari, coordinator of the center. Up to October 2005, 14 aggressors, out of a total of 141 people, had received services.

Aside from its main installation in the municipality of São Paulo, the Center also has facilities in other towns in the surrounding metropolitan area, where it holds workshops for the prevention of domestic violence.

CNRVV was founded in 1994, with the aim of contributing toward the integral development of children and adolescents facing situations of domestic violence. Thus, it also works with victims and family members, other than the perpetrators of aggression.

"It took me some time to understand the truth. We are always seeking a solution to problems, but there is no magic formula", says N*, 38 years, one of the family members served in São Paulo. Mother of a boy and a girl, she discovered in late 2002, when she had already separated from her husband, that her children (who at the time were 5 and 9 years old) suffered constant sexual harassment at the hands of her husband. She felt guilty for not having noticed earlier. "I failed to protect them", she says. After having sought individual treatment of various types, she was eventually received at CNRVV, where her children were also referred for treatment. Gradually, family relations have improved, and she now can cope with the past.

*Name withheld by request of the interviewee.

ment. Medical schools rarely train their students to identify cases of violence, and many doctors still believe that combating violence is a matter for the police.

Little by little, such attitudes are changing. According to a study published by the Ministry of Health[11], state and municipal secretariats of Health have sought to invest in capacity building for professional staffs. There has been a great proliferation of courses and lectures on the theme, thus revealing general acknowledgement of the problem and a willingness to face up to it.

Examples of such awareness include a number of campaigns for the prevention of accidents and violence, carried out since 1998 by the Brazilian Pediatrics Society (SBP) in partnership with governmental institutions and international agencies. Such campaigns include dissemination of information to the general public, and distribution of leaflets to guide the conduct of doctors.

Other examples include a primer on violence, distributed to Community Health Agents throughout Brazil, along with training on how to identify characteristic signs of violence in their patients, instructions on how to refer such cases to the Family Health Program (PSF), and how to alert the local child protection network.

Poor integration

Lack of coordination is another factor that severely hampers referral of complaints. Through the Guardianship Councils of Rio de Janeiro, the State Attorneys' Office *(Ministério Público)* was informed of only 20% of the total number of complaints received and confirmed in 2001[12]. In only 7% of such cases was there any feedback from the Attorney's Office or further referral of the issue. Moreover, very few child victims or family members were referred

11. Atuatção dos Modelos de Saúde: Dois Exemplos Como Inspiração, by Suely Ferreira Deslandes and Romeu Gomes, in *Violência Faz Mal à Saúde*, Ministry of Health, 2004.

A family for each child

Prejudice, lack of information and articulation impede adoption of many children in Brazil

Adoption is the last of the measures acknowledged by the Statute of the Child and Adolescent for ensuring a child's right to family life. Only after having exhausted all possibilities for remaining with or returning to the family of origin, is placement in a surrogate family considered as a manner of ensuring the child's right to full development. Prejudice, lack of information and articulation raise barriers to the adoption of many children in Brazil.

These barriers are indeed formidable, beginning with the diagnosis of the issue. Data is unavailable even on the official number of adoptions that take place in Brazil. This is so partly because the system of adoption is decentralized, and practically relegated to the municipal level. The Children's and Juvenile Courts and court districts in the interior of the states are responsible for monitoring prospective adopters and adoptees, and any adoption procedures underway. In general, the data is not even stored at a central location by state authorities.

Grey areas

No national data is available on child candidates for adoption, or on families seeking to adopt them. It is thus impossible to know how many there are or who they are. The only existing registration systems are in the municipalities, and each court district has its own system.

Among the goals of the National Plan relating to adoption is the establishment of a national register of children available for adoption or who have been adopted, and of families wishing to adopt a child, since this would facilitate adoption across state lines. The lack of such a national register makes it difficult for prospective adopters to adopt a child from a state or court district other than the one in which they live. This tends to facilitate international adoptions which, according to the Hague Convention on International Child Abduction (1993), should be a last resort.

It is foreseen that the national register of families wishing to adopt a child and of children that are candidates for adoption will be in operation in the first half of 2007. Six States (Pernambuco, Minas Gerais, Goiás, Pará, Espírito Santo and Ceará) are already bringing their databases into compliance with the system.

Ideally, in the event that no prospective adopter can be found for a specific child in a given town, he/she could be offered for adoption in other municipalities throughout Brazil. Since 2004, the Brazilian govern-

for medical or psychological care. Generally speaking, very little dialog takes place between professionals in the health services, members of Guardianship Councils, and other bodies such as the Courts, schools, and the Attorneys' Office, that have roles to play in the protection of children.

This lack of dialog greatly hampers provision of integrated care. Nonetheless, some towns, such as Curitiba, Niterói (RJ), Goiânia and Manaus, have managed to establish fairly effective child protection networks.

Services for families

The National policy for Reducing Morbi-mortality, Violence, and Accidents foresees the adoption of preventative measures, with systems of detection and treatment in cases of domestic violence, and stresses that they should involve a set of intersectoral actions, focused upon the family.

The national policy foresees expansion of interdisciplinary services, comprising medical, psychological, and social support for families, with services especially targeted at families with a history of violence, similar to those offered in some areas of Brazil.

In order to break the cycle of violence, it is necessary that services focus upon the family as a whole, and not just children. According to a study carried out by UNICEF, in partnership with the Jorge Careli Latin-American Center for Studies on Violence and Health (CLAVES) entitled *Familias: Parceiras ou Usuárias Eventuais?* there is increasing demand for actions to assist families overcome their problems.

In 2004, this study examined 10 governmental and non-governmental services, in the five Brazilian regions, and highlighted the importance of focusing systemic therapeutic approaches, involving the entire family, and not limited only to child victims and their mothers.

12. Kleber Silva, *Notificação de Maus-Tratos contra Crianças e Adolescentes pela Secretaria Municipal de Saúde do Rio de Janeiro aos Conselhos Tutelares.* Master's Dissertation presented at Instituto Fernandes Figueira, Fundação Oswaldo Cruz, Rio de Janeiro, 2001.

ment has sought to implement this idea, by means of Module III of the Information System on Children and Adolescents (SIPIA) which centralizes information on prospective adopters, child candidates for adoption, adoptions carried out, and the monitoring of court cases relating to adoption throughout Brazil. Municipalities would pass on information to the states, which would be responsible for ensuring its incorporation into the national records.

Deployment of this system is still at a very preliminary stage. From the perspective of the SIPIA coordination unit, the main difficulty is a lack of infrastructure at the Children's and Juvenile Courts, that are responsible for inputting data into the system. Technical adjustments are being effected with a view to preparing for deployment of the system.

Another issue that tends to complicate the adoption process is the profile of child sought by prospective adopters. According to the Under-Secretariat for Human Rights of the Presidency of the Republic, most families require a child that is: white, no more than 2 years old, with no health problems, and without siblings. Boys and girls with this profile account for less than 3.3% of the total of children in shelters in Brazil, according to the National Survey of Shelters for Children and Adolescents of the SAC Network.

The role of Adoption Support Groups is of fundamental importance for bringing about the necessary cultural changes. Generally comprised of people who have adopted children themselves, these groups offer services and support for prospective adoptive fathers and mothers, and in the period immediately following adoption.

These groups have great potential for stimulating the adoption of older children or those that do not fit the usual profile. According to a study carried out by the Center for Capacity Building and Incentives for the Training of Professionals, Volunteers and Organizations that Work with Support for Families (CeCIF), that interviewed 30 adoption groups in the State of São Paulo in 2003, 71% of prospective adopters initially ask for a child of no more than 2 years old. After working with these groups, 6% of these prospective adopters end up accepting an older child. In the whole of Brazil, there are at least one hundred such groups.

Barriers to adoption are also being reduced as a consequence of the guidelines of the National Plan for Promotion, Defense and Guarantee of the Rights of Children and Adolescents to Family and Community Life. Among the actions foreseen under this policy are compulsory monthly reporting of local adoption records to the state courts, consolidation of SIPIA Module III, and closer integration between Children's and Juvenile Courts and Adoption Support Groups. The idea is to promote cultural change in relation to adoption, so as to make it more focused on the needs of boys and girls, rather than on the characteristics preferred by prospective families.

One of the main difficulties faced by the services is the monitoring of cases; another is deployment of networking actions

The study found that, generally, work with families tends to be limited to the mother, children and adolescents. The father and other siblings are not usually involved. Another weakness was lack of treatment for aggressors. At that time, throughout Brazil, only one institution *(Instituto Sedes Sapientiae's Reference Center for Victims of Violence – CNRVV)* in São Paulo, had carried out any systematic work with perpetrators of violence (see the text entitled Pioneering Work).

One of the main difficulties faced by the services is the monitoring of cases; another is deployment of networking actions. Among the principal complaints of the technical staff of organizations that work with victims of violence is reluctance on the part of schools to participate: they tend to be unwilling to comply with their fundamental role of providing early warning in cases of violence.

Breaching the cycle of violence, however, can not be achieved simply by providing psychosocial assistance for families. Those that provide services acknowledge the importance of programs aimed at generating jobs and income, for the effective restoration of a wholesome family environment.

Whereas domestic violence is regarded as the principal reason why children and adolescents leave their homes and go off to live out on the streets, poverty is what leads boys and girls to be removed from their homes and referred to shelters. Thus, aside from being denied the right to family and community life, such boys and girls become liable to other forms of physical and symbolic violence.

The exact numbers of shelters in Brazil, and of children under their care, are not known. Increasingly, towns are conducting surveys to determine these numbers, beginning with São Paulo, Rio de Janeiro, Maceió and Belém. The most comprehensive fig-

Integral monitoring

Since 1999, some 9,000 people have received training on how to identify and follow up cases of mistreatment and sexual abuse against boys and girls, in Curitiba

In Curitiba, it is now standard procedure to check all suspected cases of violence, and reports are submitted by a variety of bodies, including schools. Since it was founded seven years ago, the Network for Protection of Children and Adolescents in Situations of High Risk for Violence has sought to resolve the issue of the scant attention that such violence against boys and girls generally receives.

Since 1999, some 9,000 people have received training on how to identify and follow up cases of mistreatment and sexual abuse against boys and girls. During the course of such training, healthcare professionals, teachers, and members of Guardianship Councils and other bodies that work with children learn to recognize signs and lesions that may lead them to suspect that the child or adolescent is being subjected to domestic violence, to assess the severity of the violent act, and to acknowledge the most common characteristics of children and adolescents who are victims of such mistreatment. Furthermore, they learn to identify the profile of dysfunctional families and of aggressors, and how to broach the subject with the children and with members of their families.

United we stand

The protection network functions in a decentralized manner. The town is divided into nine regions, each of which is broken down into micro-networks, comprising hospitals, schools, Guardianship Councils and other bodies. Upon uncovering a case of suspected or verified violence, a doctor, social worker, dentist, psychologist, educator, or other professional, will fill out a compulsory reporting form.

The Guardianship Council and SOS Criança each receive a copy of the form or, when necessary, they may be notified by telephone. All cases are followed up and monitored by the public services that provide for the welfare of children and their families. In 2004, 2,219 reports of boys and girls at risk for violence were received. These were monitored by all the services that comprise the local wel-

ures come from the National Survey of Shelters for Children and Adolescents, carried out in 2003, by the Institute for Applied Economic Research (IPEA). This survey, which investigated 589 institutions that provide shelter for 19.373 boys and girls, was funded by the Continuous Action Services Network (SAC) of the Ministry of Social Development and Combating Hunger (MDS). This network, however, does not encompass all the shelters in each municipality, and its coverage extends to only 5.9% of Brazil.

Exceptional nature

Placement in shelters is only one of the eight measures foreseen under the Statute of the Child and Adolescent for protection of boys and girls whose rights have been violated. Actions that preserve ties between family members are considered preferable, and take precedence according to the law. Placement in shelters is defined as being a provisional and exceptional measure, to be employed in situations where a violation is being resolved, or during transition prior to placement with a surrogate family. Only when all other alternatives for maintaining the child within its natural family have been exhausted should referral to a shelter be considered.

Regrettably, this is not what usually happens in practice, however. According to the IPEA study, 87% of the children in shelters have families; and 58.2% receive regular visits from family members. The study did not draw up a profile of families of children in shelters; however, another study carried out at shelters in the city of São Paulo[13], showed that a major portion of the parents of the boys and girls in these institutions have low schooling levels, and are either unemployed or only marginally employed. Most cited the distance from the shelter and the cost of transport as barriers that kept them from visiting their children.

13. *Por Uma Política de Abrigos em Defesa das Crianças e dos Adolescentes na Cidade de São Paulo*. Núcleo de Estudos e Pesquisas sobre a Criança e o Adolescente/Departamento de Serviço Social/Universidade de São Paulo, 2004.

fare network. The school is notified of the problem by the Council and, in conjunction with the healthcare service, and those responsible for the extended school day program, the case is discussed and followed up.

"Follow-up is the longest part of the process", says educator Cybelle Andriolli Pereira, supervisor of a kindergarten and primary school, and local representative of the network. This is so because follow-up must be constant and all areas must participate. Once each month, representatives of all the institutions that comprise the local network meet to discuss the status of each of the cases identified.

One of the great achievements of the network has been the inclusion of fields for negligence and psychological violence on the notification form, since these were two facets that had not previously been regarded as forms of violence by the various professionals that work directly with the children.

"The network is also capable of reacting to cases of malnutrition, negligence with regard to health, and other omissions", says Cybelle Andriolli. In such cases, attempts are made to refer the family to a doctor, to courses targeted toward promoting healthy nutrition, and income-generation programs sponsored by the municipality.

Quest for solutions

Pediatrician Luci Pfeiffer, of the Pediatrics Society of Paraná, one of the pioneers in setting up the network, believes that there are still barriers to its full implementation. A lack of mental health services is one such failing. With a view to overcoming this problem, the municipal administration has signed agreements with NGOs for the provision of this type of treatment.

Another barrier has been the protracted nature of court proceedings. "Very often, the slowness of the courts results in child victims of violence having to live side-by-side with their aggressor", she says. Some attempts have been made to resolve this issue and, in 2005, members of the Children's and Youth Courts began to attend the network's monthly coordination meetings.

Under an initiative proposed by the Pediatrics Society of Paraná, specific notification and technical-report forms are being prepared for cases in which the victim of violence is a child or adolescent. "If the types of violence and their consequences are different when perpetrated against children or against adults, then the diagnosis should also take these factors into account", says Luci. It is her hope that such procedures will become standard throughout the state.

Serial violations

The overview provided by the IPEA study brings to light other violations of the Statute of the Child and Adolescent. As many as 24.1% of the children in shelters are there because their families lack the material recourses to take care of them. The second and third most common reasons for placement of children in shelters are their having been abandoned, and domestic violence. The Statute of the Child and Adolescent, however, states that boys and girls shall not be kept apart from their families for lack of material resources, and that, in such cases, the family shall be enrolled in a government-sponsored welfare program. As a group, poverty-related issues are responsible for 51.7% of the cases of children referred to shelters *(Table 4)*.

In general, the lack of follow-up, and of programs for family support and guidance, has led to over reliance on placement of vulnerable children into shelters. It stems from the angst of the low-income mother who must go out to work, but has no access to daycare for her children. She may end up taking a child to a shelter where he/she languishes indefinitely. It is also a matter of concern for members of Guardianship Councils and judges who, unable to find programs for referral of families, must cope with the dilemma of how best to protect a child whose rights are in jeopardy. The National Council for the Rights of Children and Adolescents (CONANDA) acknowledges that, the fact that a major portion of the children sent to shelters are there owing to poverty, evidences a misapplication of this measure.

Tabel 4

Main reasons why children are referred to shelters	
Lack of material resources	24.1%
Abandoned by parents or those responsible	18.8%
Domestic violence	11.6%
Parents or those responsible are substance abusers	11.3%
Living in the street	7.0%
Death of parents or those responsible	5.2%
Prison of parents or those responsible	3.5%
Sexual abuse perpetrated by parents or those responsible	3.3%
Absence of parents or those responsible owing to illness	2.9%
Parents or those responsible unable to provide care for a child or adolescent with physical or mental disability	3.6%
Parents or those responsible with disability	2.1%
Submitted to exploitation at work, trafficking and/or begging	1.8%
Parents or those responsible unable to care for child or adolescent with HIV	1.3%
Parents or those responsible unable to care for achild or adolescent substance abuser	1.2%
Submitted to sexual exploitation	1.0%
Parents or those responsible unable to care for a child or adolescent with cancer	0.7%
Parents or those responsible unable to care for a pregnant teenager	0.2%
No information	0.4%

Source: National Survey of Shelters for Children and Adolescents of the SAC Network. IPEA, 2003.

Compromising eternity

The exceptional and provisional nature of placement of children and adolescents in shelters, foreseen in the Statute of the Child and Adolescent, is generally not observed. The IPEA survey showed that over half of the children in shelters had been there for over two years.

The consequences of such long periods in institutional care may be damaging, and may severely undermine the cognitive development of the child, and even its capacity to survive. Aside from total dependence on other people, it is general practice in shelters that no one should have any personal property. Having spent a major portion of their lives in an institution in which no individuality is tolerated, how can a person be expected to adapt to life outside the shelter?

In an unprecedented ruling, in December 2004, concerning an 18-year old youth who had been confined to a shelter from the time he was 8 (as a consequence of domestic violence), judge Alexandre Morais da Rosa, of Joinville (Santa Catarina), condemned the municipality to provide for his financial support until he reached the age of 21. When the youth found he was no longer eligible to remain in the shelter, he was totally at a loss. He did not feel capable of facing life in the outside world because, according to the judge, he had been denied any prospect for building an independent life.

Undefined situation

The Courts are officially responsible for referring children to shelters. Guardianship Council may also,

in exceptional circumstances, order the placement of a child into a shelter if it deems it necessary to remove the child from the family. Moreover, shelters receive children referred directly by other bodies. In these last two cases, the shelter and the Guardianship Council must notify the Court of the placement within a period of no more than 48 hours, though it seems that this does not always happen. The IPEA survey showed that the Courts had been informed of only 54.6% of the cases of children placed into shelters.

Aside from the long periods of time that children remain in shelters, their anomalous legal status raises complex issues. Children in shelters have families, but do not live with them; and the lack of initiatives targeted at restoring them to their families makes it improbable that their right to family life will be restored to them. On the other hand, since the parents retain legal rights with respect to their children, such children cannot be referred to surrogate families. It is for this reason that only 10.7% of the boys and girls in shelters are eligible for adoption, and the longer it takes to define their status, the less likely it is that they will ever find a new family (for more information on adoption, see the text entitled "A family for each child). Thus their prospects of ever enjoying the right to family life, as guaranteed under the Statute of the Child and Adolescent, become increasingly remote.

Family life denied

Most of the institutions into which children are placed fail to observe the requirement of the Statute of the Child and Adolescent with respect to shelter i.e., preservation of ties with family members. According to the IPEA survey, only 5.8% of the shelters promote initiatives targeted at stimulating ties between the children and their families, or comply with guidelines of not separating groups of siblings.

Although many shelters offer families social welfare services, only 14.1% of them effectively promote the strengthening of family ties, through home visits, encouraging participation in Support Groups, and referral of children to family welfare programs. These are complex tasks, and most such institutions are simply unprepared to pursue them.

According to the national survey conducted by IPEA, only 6.6% of shelters use all the services available within the community, such as daycare, regular schooling, leisure activities, and health services. Many still adhere to a tradition that harks back to old-fashioned orphanages, where all activities were carried out within the institution. As a result, they end up restricting the participation of boys and girls in community-based activities, and thereby hampering their prospects of developing social ties.

Unperceived violations

In addition to these violations, other manifestations of violence occur within shelters, as a consequence of poor infrastructure, negligence and mistreatment.

In 2003, the Center for Orientation and Supervision of Entities (NOFE) of the Children's and Youth Courts of Recife conducted visits to shelters and identified children with symptoms of depression, chronic earache, and malnutrition. Surprise nighttime inspections at one institution for boys and girls of up to 3 years old reveled that the children were not fed in the evenings.

NOFE witnessed cases of physical violence: one child received blows for attempting to scale the wall of the institution. After this event, and after NOFE staff had interviewed children in shelters, it concluded that most of the shelters in Recife (at that time) still functioned as correctional institutions, and applied a culture of punishment, which often took the form of psychological mistreatment, including isolation. Since NOFE is the body responsible for registering and inspecting the town's shelters, providing guidance, and ensuring compliance with the Statute of the Child and Adolescent, such situations have been practically brought to a halt as a consequence of its activities. The only other town in Brazil that has a similar center, subordinated to the Children's and Youth Courts, responsible specifically for supervising shelters is Campo Grande (in Mato Grosso do Sul).

Dawning of a new outlook

Although it has been over a decade since promulgation of the Statute of the Child and Adolescent,

only recently has critical attention been devoted to the question of children in shelters.

At the beginning of 2005, the Operational Support Centers (CAOs) for Children and Youths, subordinated to the State Attorney's Office *(Ministério Público),* decided to set up a national forum and conduct a state-level survey similar to the one carried out by IPEA.

The IPEA survey was carried out at the request of a committee set up in 2002 by the (then) Ministry of Social Security and Social Welfare (now the Ministry of Social Development and Combating Hunger - MDS). In this scenario, the debate has proceeded. The idea is to promote adequate institutional care for children and adolescents, in line with the precepts of the Statute of the Child and Adolescent. Though the law acknowledges that it may be necessary to refer children to institutional care as a protective measure, their stay in such institutions should be for a limited time, and the welfare-dependence trap must be avoided by promoting actions that foster their emancipation, provide conditions for their full development, while facilitating their return to their family circle.

Reorganizing shelters is only one of the proposals for ensuring children and adolescents the right to family and community life

In certain situations, such as serious cases of domestic violence or death of parents, a period of time in a shelter may be unavoidable. Such stays must, however, be temporary. Thus, institutions that reduce the number of children they accept in order to provide more individual attention, which place priority upon the task of strengthening ties with their families, or their placement in a surrogate family, are more in line with the new policy orientation.

In order for such approaches to be implemented, municipal councils of children's and adolescents rights have an essential role to play. It is the responsiblity of such councils to register institutions that provide shelter, to define public policies targeted at the child and adolescent population, and to establish guidelines for ensuring compliance with the Statute of the Child and Adolescent.

In the municipality of Rio de Janeiro, for example, based upon a diagnostic study of programs that offer shelter for children and adolescents, in 2003, the municipal council for children's rights issued a publication entitled Policy for Shelters for Children and Adolescents, aimed at bringing shelters within its jurisdiction into compliance with the Statute of the Child and Adolescent. The guidelines set by the council included the requirements that shelters should: house no more than 25 children; have adequately trained technical staffs; preserve ties with family members; prepare the children for the day they leave the shelter; and not separate groups of siblings. A grace period of three years was set, during which shelters must seek to adapt to the new standards. After this time, the annual renewal of their licenses would be conditioned to compliance with the standards.

In Porto Alegre, the Municipal Council for Children's and Adolescents Rights promotes meetings of the local Forum of Shelters, which includes representatives of such institutions as Guardianship Councils, the Courts, the State Attorney's Office *(Ministério Público),* and the municipal administration. The main aim of such meetings is to establish and maintain a unified system of registry for the placement, release, and control of legal proceedings of all children referred to shelters. The council was also successful in earmarking resources for shelters, by means of the municipality's Participatory Budget process.

Forward-looking policy

Reorganizing shelters is only one of the proposals for ensuring children and adolescents the right to family and community life. In October 2004, a presidential decree created the Inter-Sectoral Committee for Promotion, Defense and Guarantee of Children's and Adolescents' Rights to Family and Community Life. This committee brings together players from the three levels of government, and those that participate in the System for Guaranteeing Rights, entities that provide services, and members of the Councils for the Rights and Social Welfare of Persons with Disabilities. The aim of this committee, which

receives support from UNICEF, is to draft a National Plan and policy guidelines for the promotion, defense and guarantee of the rights of children and adolescents to family and community life.

At the beginning of December 2005 CONANDA and the National Council for Social Welfare (CNAS) were finalizing the first draft of the National Plan for Promotion, Defense and Guarantee of Children's and Adolescents' Rights to Family and Community Life, and incorporating considerations and comments raised by State Children's Rights and Social Welfare Councils. The plan aims to promote policies in support of families, enhance the efficiency of the national adoption system, and set regulations governing the placement of children in shelters.

The place for children is in the family

One of the guidelines set by the Plan is legal acknowledgement of programs targeted at placing children into the care of families, rather than into shelters. This would imply that the child is placed provisionally into the care of a surrogate family, without breaking off ties with the child's natural family, while the child receives specialized treatment aimed at restoring him/her to the natural family, or while measures are being taken for permanent placement with another surrogate family. An (unpublished) study by UNICEF[14] found that some experiences of this type have been tried in towns such as Belo Horizonte, Campinas (SP), Franca (SP), Rio de Janeiro and São Bento do Sul (SC), always under supervision of the public authorities.

Generally, such programs for placement of children with families have sought to foster ties between the family that receives the child (on a volunteer basis, with an allowance for costs) and the child's natural family, up until the time when the child is ready to return, a period that should not exceed eighteen months.

When children are sheltered in a family environment, the chances of their suffering side effects (such as emotional and cognitive development problems) are smaller than when they are confined to shelters. Moreover, the prospect of their returning to their natural family is much greater.

INTEGRAL SERVICES FOR FAMILIES

The study entitled 'Families: Partnerships or Occasional Users?', conducted by UNICEF and Claves, emphasizes that families that present violent social dynamics are more liable to be socially excluded than those that do not.

Thus, the expansion, with greater coordination and integration, of programs and projects aimed at providing social support to families constitute the principal guidelines of the policy for promoting family life for children. The new focus of social-welfare policies, that now stress the role of the family as the basic unit of society, establishes a new paradigm for guidelines to be implemented.

The aim, within the context of the Unified Social Welfare System (SUAS), is to expand services targeted at instituting preventative approaches and strengthening family and community ties.

One of the proposed guidelines is to include families in income-generation or income-transfer programs such as *Bolsa Familia,* since increasing family incomes generally assists the process of re-socialization and restoring self-esteem. Closer integration with other programs in such areas as education, health, and culture could also enhance the socialization of family members.

Lastly, the policy for promoting the right to family life relies upon preparation and enhancing of instruments for gathering data on families, programs available, and methodologies. Thus, in order to effect a complete diagnosis it is necessary that the SIPIA and Unified Social Welfare Information System (INFOSUAS) be made more effective, and that there be interfaces with other computerized systems, such as those of the Ministry of Health that contain data on mortality rates.

This change of outlook and of culture, in the cause of promoting children's welfare, raises huge challenges for public managers and for all those that participate in the System for Guaranteeing Children's Rights. It is, nonetheless, of immense strategic importance for reducing violence, social inequality, and the constant violation of the rights of Brazilian boys and girls.

14. Irene Rizzini, Irma Rizzini, Luciene Naiff and Rachel Baptista, *Acolhendo Crianças e Adolescentes: Experiências de Promoção do Direito à Convivência Familiar e Comunitária no Brasil*, Centro Internacional de Estudos e Pesquisas sobre a Infância/Pontifícia Universidade Católica do Rio de Janeiro (PUC-Rio) and UNICEF.

An alternative to shelters

Grupo Viva Rachid, a non-governmental organization in Recife, provides psychosocial and economic support for low-income families, and ensures HIV-positive children and adolescents their right to family life

Carla*, 7 years old, and Joana*, 5, have HIV. They lost their mother to AIDS four months ago. Their grandparents, who are unemployed, eke out a living by selling cakes and recycling items from the garbage. Carla and Joana might have been forgotten or confined to shelters. However, every Monday, the girls and their grandmother ride a bus for almost an hour through the outskirts of Olinda (PE) to their destination: ***Grupo Viva Rachid***, a non-governmental organization based in Recife, whose mission is to preserve the family ties of children with HIV. It is thanks to the work of this NGO that the grandparents manage to take care of the girls.

Grupo Viva Rachid provides psychosocial and economic support for low-income families with seropositive children and adolescents. Aside from providing specialized therapy and information on the disease, it provides 'baskets' of enriched foods. For children between the age of 6 months and 1 year, it distributes a milk formula as a surrogate for breast milk. In October 2005, some 150 families were receiving services offered by the organization.

For Carla and Joana, such support began even before they lost their mother. They never knew their father. Since the girls' mother, who was already afflicted by AIDS, sought psychological and food assistance from the group, the grandmother has been receiving training to prepare her to take responsibility for her granddaughters. A psychologist from the group began to visit their home and talk to the grandmother. "I felt better prepared to look after them", says Antônia*, their 44 year old grandmother. Now, every Monday, they attend group therapy. The bus fare is paid by the NGO.

It is a standard practice of the group to seek out a member of the children's extended family, such as a grandparent, uncle/aunt, or sibling. Generally, the NGO chooses the family member indicated by the mother as being the person she trusts most. The idea is to strengthen ties of affection and foster bonds of understanding. "This is preventive work that we carry out in order to avoid the breach of family ties that all to often occurs when children are placed in a shelter", says Alaíde Elias da Silva, coordinator and founder of *Viva Rachid*, who is well aware of the reasons for avoiding institutionalization, since she herself lived in orphanages from the age of 4 to 14 years.

Viva Rachid

Rua dos Prazeres, 258,
Boa Vista, 50070-570,
Recife (PE)
Phone/Fax:
(55 81) 3221-6206
E-mail:
grupovivarachid@ig.com.br

*Names have been changed to protect people's identity.

HOW IT ALL STARTED

The compelling reason that led Alaíde to found the NGO was her son, Rachid, who in 1990 was diagnosed as having AIDS, contracted as a consequence of a blood transfusion. Throughout the period when the boy needed hospital care, mother and child experienced the barriers to access at health services that face those with AIDS, aggravated by

At the Viva Rachid premises, social services are offered with the aim of improving the quality of life of families and engaging them in processes of social inclusion

ignorance with respect to the disease on the part of health professionals, and the dearth of therapies available. In 1993, Rachid, age 3 years, died.

While she devoted herself to her child, Alaíde learned of the plight of other poor children with HIV/AIDS seeking treatment at the Instituto Materno Infantil, now called Instituto Materno Infantil Professor Fernando Figueira (IMIP). As a volunteer, she accompanied and comforted mothers of children treated at IMIP, which was to become a national reference center for the treatment of HIV/AIDS among mothers and children.

The experience thus gained helped her establish rapport with hospital staff, and to establish relations with the children and their families. Making parents aware of the importance of compliance with treatment, as the only means of maintaining control over the course of the disease, was one of the first priorities. And it was thus that *Grupo Viva Rachid* came into being.

The first activities carried out by *Viva Rachid*, which receives technical and financial support from UNICEF, focused upon fulfilling the essential needs and ensuring the survival of children with HIV, both within the hospital environment and in their own homes. Aside from ensuring that they do not go hungry, the group struggles to ensure that there are water filters in their homes, that they have mattresses and sheets on which to sleep, and school materials so that the children can attend school as an incentive for their personal development.

QUALITY OF LIFE

Currently, the work is carried out both through the day-hospital service provided by IMIP, and at the premises of *Grupo Viva Rachid*. At the hospital, the services of psychologists and occupational therapists are offered by the NGO, and support provided for families is an important component for complementing the work of doctors. From the time the diagnosis is confirmed, these professionals work with the family through individual or group activities.

At the *Viva Rachid* premises, social services are offered with the aim of improving the quality of life of families and engaging them in processes of social inclusion. These entail a variety of activities. There are demands for medication, cleaning materials and food, and restoration and building of homes. In some cases, support is sought from legal aid agencies, whereas other services are provided directly by the NGO.

According to Alaíde Silva, the situation of each family is assessed individually. "I have seen places where the children with HIV served by the group lived in subhuman conditions", she says.

The quality of life of Maria de Fátima*, a 38 year-old housewife and her daughter Ana*, 9 years, has improved considerably. She and her husband were both unemployed in 1998, when she discovered she was seropositive and had transmitted the virus to her daughter. At that time, the family lived in a one-room wooden shack with an earthen floor. There was only room for one single bed, and her husband slept on a piece of cardboard on the floor.

Maria de Fátima heard about *Viva Rachid* at IMIP, where she went looking for treatment for her daughter. Soon she was receiving the basic 'basket' of food and therapy. She only asked for help to rebuild her home when things became really unbearable. "One morning, I woke up and there were rats walking over us", she says. For the past four years, the family has lived in a house provided by the NGO.

This change in surroundings was beneficial. At her daughter's request, Maria de Fátima decided to have another child. She underwent all the phases of treatment to ensure that the virus would not be transmitted to her new baby. This boy, now almost 4 years old, does not have HIV.

Her husband now has a job as a truck driver, and the family no longer needs the 'basket' of food from the Group. Her ties to the NGO remain strong, however. Every Wednesday Maria de Fátima and her daughter go to *Viva Rachid* for therapy.

At the hospital, the services of psychologists and occupational therapists are offered by the NGO, and support to families is an important component for complementing the work of doctors

RESULTS

In 2004, a quantitative survey was carried out. It was found that in that year, per-capita family incomes of over half of the children served amounted to no more than 60 reais. Of the children receiving services, 65% were boys, and 55% were attending school or daycare. No means was found for measuring to what extent their lives were changed through contact with the NGO and, owing to financial limitations, no systematized impact evaluation of the project was carried out.

Though *Grupo Viva Rachid* receives funding from the Marc Foundation (France), and support

from UNICEF and from Government of Pernambuco, the institution nonetheless has great difficulty in making ends meet. All too often, important initiatives, such as periodic home visits, are at risk of being discontinued. The staff of *Viva Rachid* is small: aside from the coordinators, there are two psychologists, two occupational therapists, two social workers, a driver, and an administrative assistant. "We are not in a position to conduct systematic evaluations. It is a matter of priorities and resources. We must give priority to services for families", says Alaíde.

With respect to the impact of the project, it can be stated that, as a consequence of the distribution of food and dissemination of information on hygiene, basic sanitation, and general health care, people who receive services are now less prone to diarrhea and malnutrition. Thanks to these changes, and also to free distribution of the 'cocktail' of anti-retroviral drugs, the numbers of deaths of both children and parents have declined.

"People don't die of AIDS alone. They die of hunger and of sadness from living in misery and in inadequate conditions. Any person who has been through all this is much more vulnerable to the disease", explains the *Viva Rachid* coordinator. On the other hand, if family ties can be preserved, the children are emotionally much stronger.

Despite a lack of figures to corroborate the positive impact of the work of the NGO, the results speak for themselves. *Grupo Viva Rachid* was awarded the Betinho Children and Peace Prize in 1997 by UNICEF, and was acknowledged by Fundação Abrinq as one of the fifteen best social projects underway in Brazil. Replication of this successful experience in other parts of Brazil could stem the need for placement in shelters of children who have lost their parents to HIV/AIDS, thereby ensuring them their basic right to family life.

A threat to health

Child malnutrition rates have declined in Brazil in recent decades, nonetheless, the current situation warrants permanent attention in terms of food security and nutrition for children

The problem of child malnutrition is of alarming proportions throughout much of the world. Associated to poverty and inequality, and despite efforts carried out in recent decades, malnutrition is the cause of significant numbers of child deaths in the developing countries. Indeed, a report published in 2000 by the World Health Organization (WHO) states that 49% of the deaths of children below the age of 5 years in developing countries are related to malnutrition. Malnutrition also increases the risks of a variety of diseases that may affect children's growth and cognitive development, moreover, undernourished children are more likely to suffer from health complications when they reach adulthood. Thus, food security and nutritional safety are prime issues for the health of children.

In Brazil, no comprehensive and updated study exists on early-childhood malnutrition. The most recent survey on the theme was the National Demographic and Health Survey (PNDS), of 1996. When compared with two similar studies carried out in the 1970s and 1980s, the PNDS corroborates the historic decline of malnutrition in children below the age of 5 years (*Table 1*). The proportion of children with low body-weight for age, the principal indicator used in Brazil, which was 18.4% in 1974, dropped to 7% in 1989, and reached 5.7% in 1996. This last proportion is much lower than the figure estimated by WHO for Asia (32.8%)

Table 1

Child malnutrition in Brazil (1974-1996)

	1974	1989	1996
Low body-weight for age	18.4%	7.0%	5.7%
Low height for age (chronic malnutrition)	32.0%	15.4%	10.5%
Low body weight for height (acute malnutrition)	5.0%	2.0%	2.3%

Sources: National Family Spending Study (ENDEF) 1974/1975; National Health and Nutrition Survey (PNSN) 1989; National Demographic and Health Survey (PNDS) 1996.

Table 2

Proportion of children with low body-weight for age in areas covered by PACS and PSF (1999-2004)

	Children below the age of 1 year	Children between 1 and 2 years
1999	10.1%	19.8%
2000	8.2%	17.5%
2001	7.0%	14.6%
2002	6.1%	13.0%
2003	4.8%	10.1%
2004	3.6%	7.7%

Source: Primary Healthcare Information System (SIAB) Ministry of Health.

and for Africa (27.9%) during the same period, and also considerably lower than the figure for Latin America as a whole (8.3%). It is, nonetheless, still high when compared to rates in the developed countries, which are about 1%.

The decrease achieved between the 1970s and 1990s is also reflected by two other indicators used to measure child malnutrition: the proportion of children with low height for age, and with low body-weight for height. The ratio between height and age is an indicator of the child's nutritional history. It thus serves to identify cases of chronic malnutrition, and is an important datum for the planning of long- and medium-term policies. The ratio between weight and height, on the other hand, is an indicator of the current nutritional status of the child, and is thus useful for diagnosing cases of acute malnutrition, that require immediate intervention.

A more recent study, carried out by the Ministry of Health and the Institute for Applied Economic Research (IPEA), shows that in the first half of the present decade child malnutrition has continued to decline in Brazil. This study was based on figures provided by the Primary Healthcare Information System (SIAB), and was carried out by the information technology department of the Ministry of Health. The information relates to the population served by the Community Health Agents Program (PACS) and the Family Health Program (PSF). Coverage of these two programs encompasses roughly 40% of the Brazilian population and, from among this group, children below the age of 2 years were selected, since they are more susceptible to malnutrition. Between 1999 and 2004, the percentage of children with low-body weight for age dropped from 10.1% to 3.6% in the first year of life, and from 19.8% to 7.7% in the second year (*Table 2*).

The challenge of the Semi-arid region

In the region of Brazil with the worst poverty indicators child malnutrition is a serious problem in over one third of municipalities

The Semi-arid region is the area of Brazil in which the worst indices of child malnutrition are to be found. In this region, which comprises 86% of the area of the nine states of the Northeast, and parts of the north of the States of Minas Gerais and Espírito Santo, widespread poverty is reflected in the nutritional status of children.

Data from the Ministry of Health's Primary Healthcare Information System (SIAB), show that, in the first half of 2004, 8.3% of the children below the age of 2 years, served under the Community Health Agents Program (PACS) and the Family Health Program (PSF), had low body-weight to age ratios.

This rate is significantly higher than reported in other regions of Brazil. In the South, in the same period, for example, the proportion of children with low body-weight to age ratios was 2.3%.

SIAB data shows that, in 484 of the 1,444 municipalities of the Semi-arid region (34.3% of the total), the proportion of children below the age of 2 years with low body-weight to age ratios was above 10%, a situation classified as being of 'high vulnerability'.

A mapping exercise carried out by UNICEF in 2005 revealed that, in some of these municipalities, low body-weight to age ratios affect more than 25% of the children in this age group. This is the case in Olho D'Água (25.5%) in Paraíba; Águas Vermelhas (26.1%) in Minas Gerais; Oliveira dos Brejinhos (26.9%) in Bahia;

THE NECESSARY DIAGNOSIS

The decline in the number of cases of child malnutrition does not mean that the problem is under control in Brazil. Available statistics still raise concern, especially with respect to children with low body-weight for age, and with low height for age. As a signatory of the document entitled *A World Fit for Children* (2002), in which the United Nations set goals for children and adolescents to be achieved by 2015, Brazil has pledged to reduce malnutrition among children below the age of 5 years by at least two thirds, with special attention to children below the age of 2 years, and to reduce the incidence of low birth-weight by at least one third.

The Brazilian Government's Child Friendly President's Plan, launched in 2003 to meet the goals established in the United Nations' document, expresses the goal as: reducing the percentage of children with low body-weight for age (5.7% in 1996) to 3.7% by 2007; and reducing the incidence of low birth-weight from 7.7% to 5.7%. In order to achieve this, it is essential that a new national-level diagnosis of the problem be carried out, not only to enable monitoring of fulfillment of goals set by the government, but also to assist in setting targets for actions aimed at combating child malnutrition.

Table 3

Prevalence of child malnutrition by region (1996)

	Central-West	Northeast	North	Southeast	South
Low body weight for age	3.0%	8.3%	7.7%	4.8%	2.0%
Low height for age (chronic malnutrition)	8.2%	17.9%	16.2%	5.3%	5.1%
Low body weight for height (acute malnutrition)	2.9%	2.8%	1.2%	2.5%	0.9%

Source: PNDS, 1996.

The Ministry of Health secured an agreement with the Brazilian Institute for Geography and Statistics (IBGE) to include a module on the nutritional status of the population in its Family Budget Survey (POF 2002-2003). Data referent to children are due to be published in 2006. Also in 2006, the Ministry plans to conduct a new survey on the same lines as the PNDS.

One point that merits attention is the distribution of cases of child malnutrition in Brazil. In 1996, according to the PNDS, the problem was most

Miguel Alves (28.9%) in Piauí; Manari (29.4%) in Pernambuco; and Santo Amaro (29.4 %) in Maranhão.

In only 14.5% of the municipalities of the Semi-arid region are low body-weight to age ratios below 4%, the level considered satisfactory.

The need for interventions to improve this and other dismal social indicators that place the region's children in jeopardy led to the signing, in 2004, of the National Pact for a World Fit for Children and Adolescents in the Semi-arid Region, coordinated by UNICEF.

Under the Pact, the federal government, the governments of the eleven states that share the Semi-arid region, and various civil-society organizations have assumed a commitment to carry out actions targeted at improving the lives of the region's children.

One such initiative, launched in August 2005, by the Ministry for Social Development and Combating Hunger (MDS) in partnership with the Ministry of Health and fifteen universities, is a nutritional survey (Chamada Nutricional) on children up to the age of 5 years, designed to determine the scope of child malnutrition in the Semi-arid region, and orient public policies targeted at addressing the problem.

Also in 2005, the Pact sponsored expansion of the UNICEF Approved Municipality Seal to encompass the entire Semi-arid region. UNICEF launched this initiative with the aim of stimulating the adoption of municipal-level policies especially targeted at children.

Under this initiative, municipalities are monitored and assessed for compliance with three criteria: social impact; public-policy management; and social participation. In 2006, the second year of the initiative, 1,176 municipalities pledged to implement UNICEF's proposals.

By the end of 2006, those municipalities that have succeeded in improving their indicators will be awarded the Seal (for further information, see the text entitled Guarantee of Quality, at the end of this chapter).

In the Semi-arid region, the proportion of children below the age of 2 years that are undernourished is almost four times as great as in the South

serious in the Northeast and in the North of Brazil (*Table 3*). In the Semi-arid region, which encompasses municipalities of all of the states of the Northeast and of the north of the states of Minas Gerais and Espírito Santo, the proportion of children below the age of 2 years that are undernourished is almost four times as great as in the states of the South region *(see the text entitled The Challenge of the Semi-arid Region)*. Differences also reflect the location of the home. The PNDS revealed that the percentage of children with low body-weight for age in rural areas (9,2%) is twice as high as in urban areas (4.6%). No national-level data is available on the prevalence of child malnutrition broken down by race, though such data could have important implications for planning purposes. Between 2004 and 2005, for example, Brazilians were shocked by news reports of deaths caused by malnutrition among indigenous children in the states of Mato Grosso and Mato Grosso do Sul *(see the text entitled Indians at high risk)*.

HIDDEN HUNGER

There is another point that must be taken into consideration when assessing the nutritional status of children. Indicators such as weight, height, and age serve merely to measure protein-calorie malnutrition, which is the most significant form of nutritional deficiency. There are, however, other serious risks for children, such as: iron deficiency anemia, vitamin A, and iodine deficiency. A lack of such micronutri-

Indians at high risk

The deaths of children in the States of Mato Grosso do Sul and of Mato Grosso have drawn attention to the severity of the problem of child malnutrition in indigenous communities

In 2004 and 2005, considerable coverage was devoted in the Brazilian press to the deaths of indigenous children, caused by malnutrition, in the States of Mato Grosso do Sul and Mato Grosso. Most such deaths occurred among the Guarani-Kaiowás, whose reservation is in the municipality of Dourados (in Mato Grosso do Sul), and among the Xavante (in Mato Grosso). In the first four months of 2005 alone, 21 deaths of children below the age of 5 years were reported in Mato Grosso do Sul, and 6 in Mato Grosso. All these deaths were related to malnutrition. Thus, the public was alerted to the seriousness of the nutritional situation of indigenous children in Brazil, which had not been reflected in the most recent national surveys on child malnutrition.

A special congressional committee of the Chamber of Deputies, set up in 2005 to determine the causes of death of indigenous children in the two states, found that the reported cases were merely the most recent manifestations of a longstanding phenomenon. Between 2001 and 2002, the National Health Foundation (FUNASA) had reported 32 deaths of indigenous children to malnutrition in Mato Grosso do Sul. According to FUNASA, although between 2003 and 2004 child malnutrition rates among the indigenous communities of the state had declined from 15% to 12%, they nonetheless remained twice as high as the national rate. In geographic terms, this proves not to be an isolated phenomenon. Deaths of indigenous children caused by malnutrition have also been reported in other parts of Brazil, such as the northeast of Minas Gerais and the Javari valley in the State of Amazonas.

News of the alarming situation in Indian villages of Mato Grosso do Sul led to a series of emergency measures. Under one of the first of these FUNASA, in partnership with the Ministry of Social Development and Combating Hunger (MDS), the Ministry

ents is known as 'hidden hunger' because, although such deficiencies may constitute serious health problems, they generally pass unseen. Low iron levels may cause disorders that range from loss of appetite to retarded intellectual and psychomotor development. Vitamin A deficiency affects the eyes and my lead to total blindness. It also affects the immune system, and may greatly increase the risk of death from diarrhea and other diseases. Iodine deficiency may lead to retarded growth and mental development. It is the cause of cretinism, a disease that results in severe and irreversible mental retardation. Lack of iodine during pregnancy may result in miscarriages, mal-formation of the fetus, preterm deliveries, or children with severe mental retardation.

Other essential micronutrients for children are zinc and folic acid. Zinc is known to be effective in combating diarrhea, since it reduces the duration, intensity, and risk of recurrence of episodes. It is also effective for preventing other health problems, such as pneumonia, and contributes significantly toward the child's normal development. Folic acid, a vitamin of the B complex, performs an essential role in the formation of the baby while in the womb. A deficiency of this micronutrient in early pregnancy may result in malformation of the brain stem, the structure that gives rise to the child's brain and spinal column. Such malformations may result in serious congenital defects, such as anencephaly (failure of the brain to develop) and spinha bifida (a defect of the spinal column). In children, reduced growth and megaloblastic anemia are among the problems that may be caused by a lack of folic acid.

No systematic national-level survey has been

Deficiencies of such micronutrients as vitamin A, iron and iodine, also known as 'hidden hunger', may cause serious health problems

of Health, the Pan-American Health Organization (PAHO), and UNICEF, distributed megadoses of vitamin A to children below the age of 5 years.

To expand access to drinking water in the villages of the Dourados region, UNICEF in coordination with FUNASA, local municipal administrations, and indigenous leaders, distributed 9,000 ceramic water filters, along with 2.5% sodium hypochlorite solution, and training for families on how to use and maintain them. Thanks to concerted efforts on the part of FUNASA and other entities, not one child death was reported in August, September and October 2005, in the Dourados region. It is nonetheless imperative that this work be continued to avoid further outbreaks of child mortality.

Any more permanent solution to the problem will require consolidation of healthcare and child-nutrition policies. An important step was taken in 1999, when FUNASA began to deploy its Subsystem for Indigenous Healthcare Services, within the context of the Unified Health System (SUS). This subsystem comprises 34 Special Indigenous Health Districts (DSEIs), distributed throughout Brazil, to enable decentralized and continuous coverage for indigenous communities. The key component of this system are Indigenous Health Agents, indicated by the community and attached to health posts in each DSEI. Although the healthcare network and funding available for the DSEIs are still not adequate, the new structure nonetheless represents a step forward in terms of health policies for indigenous peoples.

There is, however, another factor that must be taken into account when attempting to reduce child malnutrition among Indian communities. For this segment of the population, two of the major causes of malnutrition (i.e., poverty and food insecurity) are directly linked to their not having sufficient land to maintain their lifestyles and produce crops. Communities that historically were self sufficient become vulnerable as their territory is reduced. Thus, land tenure issues are a fundamental consideration when seeking to improve the health and nutritional status of Indians.

The congressional commission that investigated deaths of indigenous children cited the insufficiency of the territory currently occupied by the Guarani-Kaiowás as one of the underlying causes of the problem. In Dourados, there are some 10,500 Indians living on an area of 3,500 hectares, capable of supporting no more than three hundred people.

conducted on micronutrient deficiencies. In general, the problem is only brought to the public's attention when dramatic consequences threaten the health of children. In the 1980s, an increase in the number of cases of xerophthalmia (drying of the cornea and conjunctivas), a disease caused by a lack of vitamin A. caused the Brazilian Government to distribute megadoses of vitamin A in the regions at highest risk. This problem has now been significantly reduced, and currently the major area of concern is iron deficiency. In the past fifteen years, various different projects, carried out at the local level, have drawn attention to the increasing prevalence of anemia affecting a significant proportion of Brazilian children.

Malnutrition and other nutritional deficiencies bear a close relation to poverty, the underlying cause of the problem

A survey entitled Magnitude, Spatial Distribution and Trends of Anemia in Preschool Children in Paraíba (2002)[1] demonstrated that, between 1982 and 1992, the prevalence of anemia among preschool children increased from 19.3% to 36.4%. Another study, entitled the Centennial Trend of Childhood Anemia in the City of São Paulo (2000)[2] , identified a similar trend among children below the age of 5 years in Brazil's largest city. Between 1984 and 1996, the prevalence of anemia rose from 35.6% to 46.9%. The most comprehensive data were collected under a national survey carried out by the Federal School of Medicine of the University of São Paulo (UNIFESP/EPM) which, between 1996 and 1999, assessed 8,000 children below the age of 3 years in public daycare centers in twenty state capital cities. Roughly half (49.8%) had anemia, and the worst situation was verified in Recife, where 80.7% of the children were anemic.

Micronutrient supplements

The Brazilian Government maintains policies for the distribution of iron and other micronutrient supplements. A Ministry of Health Order, of June 2004, requires that all wheat and corn (maize) flour produced in Brazil be enriched with iron and folic acid.

In May 2005, the National Iron Supplementation Program and the National Vitamin A Supplementation Program (Vitamina A Mais) were launched. The former entails shipping supplements to municipalities, for distribution to children from 6 to 18 months of age, and to expectant and nursing mothers up to the third month post delivery. The latter adopts a similar mechanism for the benefit of children below the age of 5 years, in the states of the Northeast, in the Jequitinhonha valley of Minas Gerais, and in the Ribeira valley of São Paulo. In 2005, these two programs aim to serve 5 million children.

With regard to iodine deficiency, the principal initiative for tackling this problem in Brazil is addition of iodine to table salt, a strategy that has been successfully adopted in several other countries. Iodization of salt, which has been used in areas of high risk since the 1950s has, since 1995, been compulsory throughout Brazil. The Ministry of Health estimates that, currently, 95% of the table salt consumed in Brazil is iodized.

In 2000, the ThyroMobil Project, an international iodine deficiency research initiative, with UNICEF support, assessed the status of children between the ages of 6 and 12 years in seventeen Brazilian municipalities located in high-risk areas. The prevalence of goiter, one of the main symptoms of iodine deficiency, was 1.4%, and thus far below the limit set by WHO, which is 5%.

Nonetheless, the survey found that in certain states, notably Maranhão, Mato Grosso and Tocantins, it was still possible to find table salt with insufficient iodine content. On the other hand, 47.4% of the samples contained iodine levels above the desired proportion (50 ppm), thus demonstrating a need to ensure better monitoring of salt iodation in Brazil.

1. Participants in the study included: Universidade Federal da Paraíba (UFPB), Universidade Federal de Pernambuco (UFPE), Universidade Estadual da Paraíba (UEPB) and the Pan American Health Organization (PAHO). The survey was published in *Revista de Saúde Pública*, 2002.

2. Participants in the study included: Departamento de Nutrição da Faculdade de Saúde Pública da Universidade de São Paulo (FSP/USP) and Núcleo de Pesquisas Epidemiológicas em Nutrição e Saúde (Nupens/USP). The survey was published in *Revista de Saúde Pública*, 2000.

PRECARIOUS NUTRITION

Malnutrition and nutritional deficiencies are closely linked to poverty. Insufficient or inadequate food, are primarily a manifestation of poverty and remain a fact of life for many families in Brazil. The main initiative of the Federal Government in its attempts to reverse this situation has been the Bolsa Família, a program which, in 2003, unified all the existing income transfer programs and set conditions for beneficiaries. Thus, in return for a cash benefit, beneficiaries of Bolsa Familia are expected to assume certain commitments.

By August 2005, 7.5 million 'poor' and 'extremely poor' families were receiving a monthly cash stipend under the program, especially in the Northeast and North regions, where child malnutrition is most prevalent. The Brazilian Government aims to reach a total of 11.2 million poor families by the end of 2006. There have not as yet been any evaluations as to the contribution of Bolsa Família to food security for children, however, in 2005, an initial field study was launched to gauge the impact of the program on the living conditions of families.

Aside from initiatives designed to expand the population's access to food, such as Bolsa Família, another line of action pursued by the Federal Government has been support for family agriculture. This is an important approach to combating child malnutrition, since the problem is overwhelmingly concentrated in rural areas. The National Program for Strengthening Family Agriculture (PRONAF), launched in 1995, grants credit and provides technical support for small farmers. In 2004, loan contracts were signed with 1.57 million people, and 5.6 billion reais in credit was granted.

Another strategy for assuaging nutritional deficiencies among the poorest of families, adopted by local governments and non-governmental organizations, has been the use of food supplements. The best known example of this approach is distribution of a 'multimixture' of flour consisting of foods that are readily available in each region, such as seeds, cereal germ, and eggshell. Distributed since 1985 by the Children's Pastorate, the multimixture has now been adopted by other organizations and has contributed significantly toward combating child malnutrition. More recently, however, this strategy has been brought into question and is being reassessed. Since 1994, the Children's Pastorate has exchanged the concept of a multimixture for one of fortified nutrition, emphasizing the value of all low-cost, locally-purchased, nutritive and tasty foods, such as mangoes, which provide an excellent source of vitamin A. Currently, multimixture is distributed to less than 10% of the families served by the Pastorate.

Exclusive breastfeeding in the first six months of life helps reduce the risk of child malnutrition, anemia, and other health problems

In order to improve the nutritional status of Brazil's children it is necessary to further increase breastfeeding rates. According to international recommendations, children should be exclusively breastfed up until the age of 6 months, and breastfeeding should continue up until 2 years or more. Exclusive breastfeeding during the first six months of life helps reduce the risk of child malnutrition, anemia, and other health problems. Although Brazil's Federal Government has maintained a National Breastfeeding Program since the 1980s, rates of exclusive breastfeeding up until the sixth month are still relatively low: only 9.7%, according to the latest national survey conducted by the Ministry of Health in 1999.

With a view to improving this situation, public awareness campaigns and other initiatives are often carried out. One strategy, launched by UNICEF and by WHO in 1990, is the Child Friendly Hospital Initiative, that seeks to engage healthcare institutions in efforts aimed at discouraging early weaning. Up until 2005, of the 4,500 hospitals that were potential candidates for accreditation under the program, 328 had received title of Child Friendly Hospital.

MALNUTRITION AND DISEASE

Aside from lack of food, another poverty-related factor associated with child malnutrition is exposure to infectious diseases. Malnutrition and recurrent infections are, in general, closely linked and part of a vicious cycle that places the lives of children in jeopardy. When a child contracts a disease such as diarrhea, the probability of its suffering from malnutrition rises significantly. The child's immune system then becomes more susceptible to the disease, setting off a cycle that may be difficult to break. Thus, combating malnutrition is highly dependent upon child healthcare, and involves factors that range from access to basic sanitation, to adequate guidance for families and hospital care.

The most significant programs sponsored by Brazil's Federal Government, through partnerships with municipal administrations, aimed at preventing diseases that lead to malnutrition, are the Community Health Agents Program (PACS) and the Family Health Program (PSF). Under the Family Health Program, teams comprising at least one doctor, one nurse, one nursing assistant, and five community health agents provide constant healthcare services for specific communities, guidance on disease prevention, and orientation on other health problems that do not require hospital internment. Launched in 1994, the program has been expanded gradually and, in May 2005, there were some 22,000 PSF teams at work, providing healthcare for some 72.4 million people.

> Malnutrition and recurrent infections are, in general, closely linked and part of a vicious cycle that places the lives of children in jeopardy

Another significant initiative for combating child malnutrition is carried out by the Children's Pastorate. This faith-based organization targets particularly poor areas, and is present in 70% of Brazil's municipalities, where it provides services for some 1.8 million children below the age of 6 years and over 80,000 expectant mothers. The Pastorate's Community Leaders are active in organizing the demand for healthcare services, in teaching families basic health and hygiene measures that can be adopted within the home, and referring those cases that require specialized treatment. Through their efforts, mothers learn to identify symptoms of pneumonia, and to treat diarrhea without resorting to hospital care. The Community Leaders also conduct regular monitoring of children's health, by means of such basic measures as monthly weighing, with a view to identifying the risk of malnutrition and applying interventions before the situation becomes more serious.

SERVICES FOR MALNOURISHED CHILDREN

All of the strategies discussed above are important for the prevention of child malnutrition, however, their effectiveness is challenged in cases where a child is already severely malnourished. In such cases, it is necessary to refer the child to an outpatients unit or hospital care. Only thus can the problem be treated and reversed so that it does not recur, thereby breaching the vicious cycle of malnutrition and recurrent disease. It is not easy to assess to what extent the health system and health professionals in Brazil are prepared to deal with such cases. One essential requisite for efficient treatment of such cases is multi-professional teamwork, involving a doctor, a nutritionist, and social workers, in order to tackle all the different aspects of the issue.

An alternative for treating cases of child malnutrition in hospitals entails the establishment of specialized care units. Centro de Recuperação e Educação Nutricional (CREN) in São Paulo, is the national reference center for such cases, and provides treatment for undernourished children, offering semi-borders and outpatient care, while also conducting community-based projects for children and their families. Similar approaches have been taken in experiences carried out in Fortaleza, Salvador, Eunápolis (BA), Limeira (SP), Pedras de Fogo (PB), and São Lourenço (MG).

Guarantee of quality

The UNICEF Approved Municipality Seal has contributed significantly toward reducing infant mortality, and increased the proportion of children who are vaccinated and that regularly attend daycare and preschools

Toim, Zé and Manu are mamulengos, large festive dolls, typical of the Semi-arid region, that come to life as part of a large-scale campaign to promote the health, education, protection, and participation of thousands of children and adolescents. They appeared in the first half of 2005 and have been working hard ever since. They have paraded in all the 1,176 municipalities of the Semi-arid region, to raise public awareness of the policies and actions needed to ensure fulfillment of the rights of local children and adolescents. They are constantly reminding people that everyone has a part to play in improving the living conditions of boys and girls, and calling upon the community to participate in a huge mobilization effort, for the benefit of the entire municipality.

The towns in which Toim, Zé and Manu have paraded are candidates for the UNICEF Approved Municipality Seal. This initiative, first launched in 1999 in Ceará, was expanded in 2005 to encompass the entire Semi-arid region. As candidates for the award, municipalities assume a commitment to strive to improve the quality of life of children and adolescents, and to achieve such concrete targets as reducing infant mortality, providing quality prenatal care for all expectant mothers, and adequate nutrition for all children below the age of 2 years. The municipality must comply with a total of nine social impact goals, fifteen management goals, and four social-participation goals, that are closely monitored by UNICEF.

Itabaiana, a town in the Semi-arid portion of the State of Sergipe, is one of the candidate municipalities. Among its greatest challenges is reducing child malnutrition rates since, according to data for 2003, 9% of local children up to the age of 2 years are undernourished (whereas the national average is 5.7%). When it applied as a candidate for the Seal, Itabaiana chose to join the mobilization and monitoring effort underway in municipalities of the region, and to implement policies and actions to ensure fulfillment of the rights of children and adolescents. In two years time, provided it achieves improvements in its social indicators, Itabaiana, like so many other towns in the region, will be eligible for the UNICEF Approved Municipality Seal.

COMBINED EFFORTS

Achieving these goals does not depend solely upon the efforts of public authorities, but also the entire municipal community. Success depends upon the combined efforts of the Attorney's Office (Ministério Público), the Children's Rights and Guardianship Councils, non-governmental organizations, schools, healthcare posts, families, and the children and adolescents themselves.

"Stimulating the participation of children, adolescents, their families, and of all the professionals directly involved with children's and youth issues,

Towns that are candidates for the UNICEF Approved Municipality Seal pledge to improve the quality of life of their children and adolescents

is our greatest challenge", says Maria Cândida Bispo de França, a municipal coordinator in Itabaiana. "Their participation in the process will greatly facilitate our efforts to earn the Seal."

Progress achieved in the struggle to improve social indicators for children and adolescents is announced in a simple and joyful manner. Thus, the entire community is able to accompany the achievements of the municipality, demand improvements, and collaborate in the attaining of goals. In order to fulfill the goals, municipalities need support from state governments, which are signatories of the National Pact to secure a World Fit for Children and Adolescents in the Semi-arid region. Under this Pact, the federal and state governments, and civil society organizations have pledged to implement measures to improve the living conditions of the region's children and adolescents.

The Semi-arid region is where Brazil's worst social indicators for children and adolescents are to be found. Over 8 million poor children and adolescents live with families whose per capita month-

ly incomes amount to no more than 150 reais (US$ 68). Over 4 million of these children live in houses not connected to safe water supply or to sewage mains. Each year, of every one thousand children born in the municipality, 65 die before completing their first year of life. The UNICEF Approved Municipality Seal is a contribution toward bringing about change in this scenario.

In Ceará, between 1999 and 2004, this initiative helped reduce infant mortality rates from 39, to 20 (per 1,000 live births), and to increase the proportion of children vaccinated from 63% to 95%. Since the project was launched, in 1999, eleven municipalities (Beberibe, Brejo Santos, Croatá, Horizonte, Icapuí, Itapiúna, Jucás, Maracanaú, Sobral, Tamboril and Tejussuoca) have been awarded the UNICEF Seal three times running (in 2000, 2002, and 2004).

Unequal Scenarios

Though Brazil has made progress in reducing the numbers of children born with HIV, providing services for those that lose their parents to the epidemic remains a huge and largely unmet challenge

AIDS affects the lives of Brazilian boys and girls in various ways. It may ravage their health, if they are born with HIV; or devastate their homes if their parents or family members are struck down by the disease.

It has been estimated that, in 2004, 217,000 women between the ages of 15 and 49 years contracted HIV, and many of them did not even know it. Thus, the risk that their children will be infected by HIV is enormous. When seropositive pregnant women are not diagnosed and treated in the prenatal period or do not receive medication when in labor, and if their babies are not adequately medicated upon delivery, such offspring are at high risk of infection by HIV. Furthermore, vertical transmission rates may be exacerbated through breastfeeding, an additional risk that increases each time the child is fed.

Since the onset of the AIDS epidemic in Brazil, in the early 1980s, 9,975 cases of the disease in children up to the age of 5 years have been reported. In the first half of the 1980s, roughly 70% of AIDS cases in this age group were a consequence of blood transfusions or of blood products, whereas almost 30% resulted from vertical transmission of HIV.

With improvements in the control of the quality of blood and blood products, by 1988, transmission by blood transfusions had declined significantly. In 1996, this form of transmission accounted for less than 1% of child cases. On the other hand, the number of children infected by vertical transmission increased, as a consequence of the spread of the AIDS epidemic among women. By the 1990's, vertical transmission was responsible for almost all the cases of the disease in this age group.

Considerable reductions in rates of infection of newborns have been achieved by means of measures for control of vertical transmission of

HIV, such as early diagnosis and anti-retroviral therapy for HIV-positive expectant mothers, immuno/chemo-prophylaxis with AZT at delivery for the mother and child, and a ban on breastfeeding. Studies have shown that such preventative measures may reduce the chances of HIV transmission, from roughly 25% to less than 1%.

Brazil has managed to reduce the vertical transmission rate for HIV, but unequally, in the five regions of the Country

Brazilian experience of the AIDS epidemic has been that the greatest proportion of AIDS deaths occur among people at the height of their reproductive capacity, i.e., between the ages of 25 and 49 years, and that this has a direct impact on the number of orphans. In 1999, the Ministry of Health estimated that there were some 30,000 orphans left motherless as a consequence of AIDS. This evidently leaves such boys and girls in a situation of great social vulnerability. In view of such numbers, it has become necessary to pursue interventions that mitigate the impact of HIV on orphans, and especially those infected by the virus.

NEAR ZERO

During the 1980s, cases of women with AIDS were less common than of men, and the proportion of children infected via vertical transmission did not seem very significant.

The increase in the number of AIDS cases resulting from vertical transmission has paralleled the number of women with the disease. Since 2000, however, the trend has developed differently among these two groups. The number of cases of young women with AIDS is still rising; but the number of children born with HIV has declined. In 2000, 214 cases of AIDS in babies below the age of 1 year were reported, whereas in 2003, there were only 86 reports. This implies that, after a period of steady increases, Brazil has now managed to reduce its rates of vertical transmission of the virus, but unequally, in each of the Country's five regions.

The principal explanation for this drop are actions targeted at maternal and child health deployed by the Brazilian Government. A study carried out in the State of São Paulo[1] , in 1997, estimated a vertical transmission rate of 16%. In 2002, according to a survey coordinated by the Brazilian Pediatrics Society[2] , the vertical transmission in Brazil was 3.7%.

A reduction in the proportion of children born

1. Beatriz Tess, *Breastfeeding, Genetic, Obstetric and Other Risk Factors Associated with Mother-to-Child Transmission of HIV-1 in São Paulo State, Brazil*, 1998.
2. Collaborative Multicentric Brazilian Protocol to Assess Mother to Child HIV Transmission Rates.

An attainable goal

Vertical transmission rates could be reduced to practically zero

Two factors could reduce the probabilities of a child's being born infected with HIV to less than 1%. The first of these is diagnosis of seropositive women prior to or during pregnancy; the second is use of prophylactic measures to avoid vertical transmission. When such procedures are not adopted, the risk of the child's contracting the virus are roughly 25%.

In order to achieve this reduction, firstly, it is necessary that complete and high-quality prenatal care and HIV testing be available for all women. As of that point, in the event of a positive test result, all possible measures must be taken to avoid transmission of the virus from mother to child.

Among the first of these procedures, in the 14th week of pregnancy, the HIV-positive expectant mother must be start-

infected with HIV is one of the goals of the United Nations' *A World Fit for Children*, that traces the actions needed to achieve the Millennium Development Goals (MDGs) for children and adolescents. The Child Friendly President's Plan, which contains the Brazilian Government's strategy for achieving the Millennium Goals as they relate to children and adolescents, pledges to reduce the rate of vertical transmission of AIDS to 2%.

Brazilian actions

In Brazil, since publication of Ministry of Health Order 874, in 1997, municipalities have been obliged to provide free HIV tests for all expectant mothers during prenatal care, and to offer treatment for those that test seropositive. Funding for such testing is now being transferred by the Federal Government, whereas procurement and distribution of anti-retroviral medication is in the hands of the Ministry of Health's National STD/AIDS Program. It is important to stress that such testing is a right of all expectant mothers, who ought to demand to be tested during prenatal care. It is thus incumbent upon health professionals not only to advise mothers as to the importance of being tested, but also to offer counseling upon delivering the result, regardless of whether it is positive or negative. It is necessary to provide guidance for both HIV-positive mothers and for those who are not infected, of measures to prevent infection by HIV and other sexually-transmitted diseases (STDs).

Expanding coverage of counseling services and testing of expectant mothers, and providing services specifically targeted at seropositive mothers and newborns, is the task of Projeto Nascer-Maternidades, launched by Ministry of Health Order 2.104, of November 19, 2002. Under this project, women who failed to undergo adequate prenatal care are tested for HIV at the time of delivery, which is regarded as the moment of highest risk of vertical transmission of HIV. The goals of the project are to identify seropositive mothers, by providing and conducting rapid testing at the time of delivery on any mother unsure of her serological status, and take prophylactic measures to impede vertical transmission.

Since the launching of Projeto Nascer-Maternidades, funding for the inputs necessary to ensure prevention of mother-to-child transmission (i.e., anti-retroviral therapy, rapid tests, lactation inhibitors, and milk formula) has been provided by the Federal Government. It remains, however, the responsibility of the states (including the Federal District) and of the municipalities to make the necessary operational arrangements to ensure deployment of the strategy. Children who have been exposed to the virus also receive anti-retroviral syrup and milk formula as a surrogate for breast milk during the first six months of life, with a view to avoiding transmission through breastfeeding. The Ministry of Health estimates that approximately 12,600 newborns are in need of the formula.

ed on a course of anti-retroviral therapy. She should be given injections of AZT during delivery, and her lactation should be inhibited. Use of medication reduces the mother's viral load and, thus, reduces the risk of transmitting HIV to her child.

It is also necessary to determine the form of delivery. Elective cesarean section, whereby the child is removed before the mother's water breaks, is the most recommended procedure when the viral load is high or unknown, since this way the child does not come into contact with any type of maternal secretion.

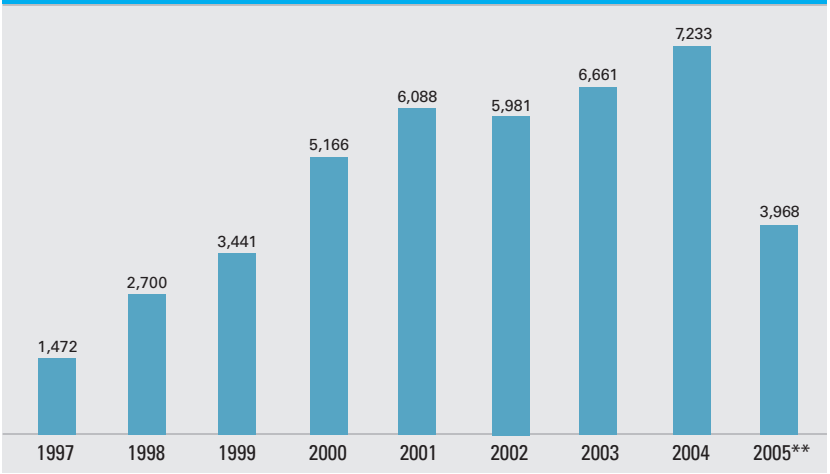
In the event that the mother was not tested for HIV during prenatal care, or when there is no information as to her serological status, it is important that a rapid HIV test be administered at the time of delivery, so that the necessary precautions can be taken.

A child that has been exposed should receive AZT syrup immediately after delivery, and throughout the first six weeks of life. The child should not be breastfed, and milk formula should replace maternal milk during the first six months of life.

If all these steps to ensure prevention of vertical transmission are taken, Brazil is likely to attain its goal of reducing this form of transmission to less than 1%, by 2007.

Graph 1

Number of HIV+ pregnant women receiving injected AZT in Brazil (1997 to July 2005*)



*Preliminary data from the National STD/AIDS Program.
**Goal achieved June 2005: an estimated 54.3% of infected mothers.

Table 1

Vertical HIV transmission rate (estimate 2002)

Brazil	7.0%
Central-West	6.0%
Northeast	11.0%
North	15.0%
Southeast	7.0%
South	6.0%

Source: Brazilian Pediatrics Society Study, 2002.

As a result of these actions promoted by the Ministry of Health, there has been an increase in the numbers of expectant mothers that have been diagnosed and have received prophylactic therapies to counter vertical transmission of HIV. Thus, each day, attainment of the Brazilian Government's goals of reducing transmission within the womb and during delivery, and eliminating transmission of the virus by breastfeeding, is becoming more likely.

In 1997, only 1,472 women infected with HIV had access to chemo-prophylaxis with AZT, which corresponded to 11.6% of the estimated total of pregnant HIV-positive women. In 2004, 7,233 seropositive women had access to this therapy, equivalent to 57.2% of the estimated total of seropositive mothers. The Ministry of Health has set the goal of attending to 100% of such women by the end of 2007, which corresponds to 12,644 infected mothers per year *(Graph 1)*.

THE EQUITY CHALLENGE

There are still some challenges that need to be faced in order for Brazil to fulfill its pledge to reduce vertical transmission of HIV. The inequality reflected in rates of vertical transmission in the various regions of Brazil *(Table 1)* is evidence of gaps in the coverage of the health system, which need to be filled if the goals are to be met.

In Brazil, access to prenatal care is practically universal: 96% of women underwent at least one prenatal visit in 2004, according to the National STD/AIDS Program. However, 51% do not attend the ideal number of visits, i.e., over six, according to the Ministry of Health. In 2004, 63% of expectant mothers underwent HIV testing and were aware of the result prior to delivery. Such coverage is unequally distributed throughout the Country *(Graph 2)*. In the North and Northeast, for example, less than half of the mothers were subjected to HIV testing. It is no coincidence that, in these regions, children born to HIV-positive mothers are more vulnerable to vertical transmission.

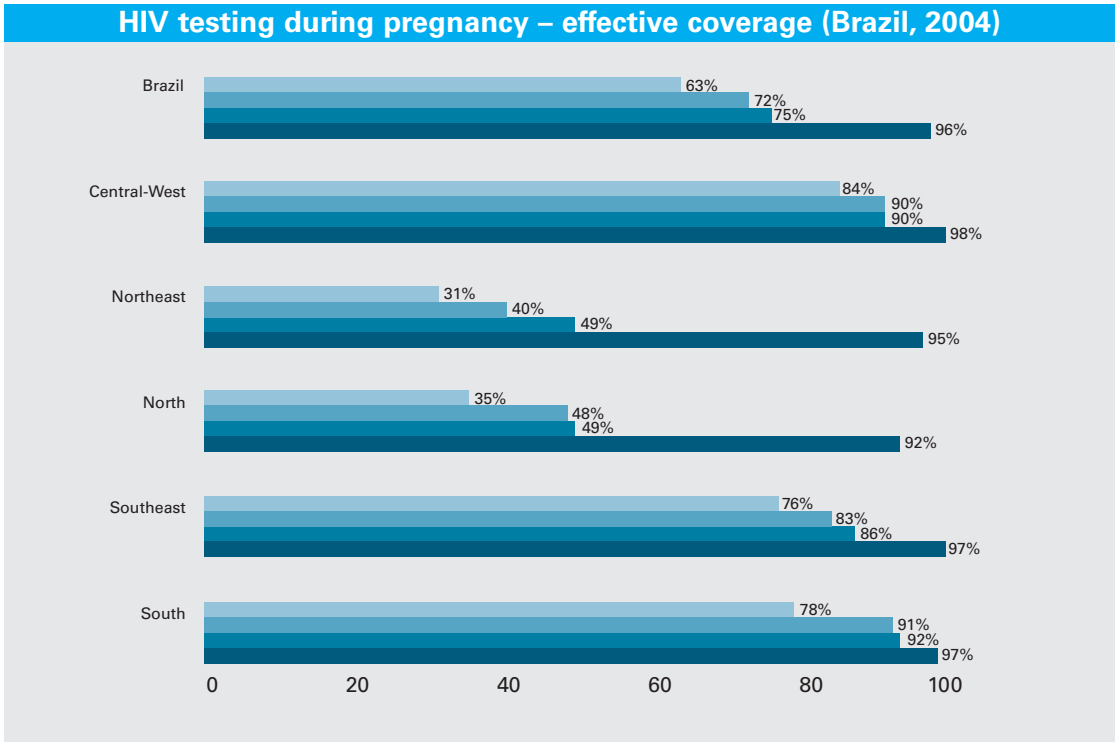
Children of seropositive women with low schooling levels also appear to be more likely to be born with the virus. Data from the National STD/AIDS Program (for 2004) show that mothers with lower schooling levels are less likely to receive guidance at the health services with respect to testing, when compared to more educated women. Furthermore, even when they receive counseling, a major percentage of women with low schooling levels refuse to take the test: more than twice as many as those with secondary or university education *(Graph 3)*.

Children in small towns in all regions would also appear to be more vulnerable to HIV. In municipalities with less than 50,000 population, proportionally fewer tests are carried out on pregnant mothers than in larger towns.

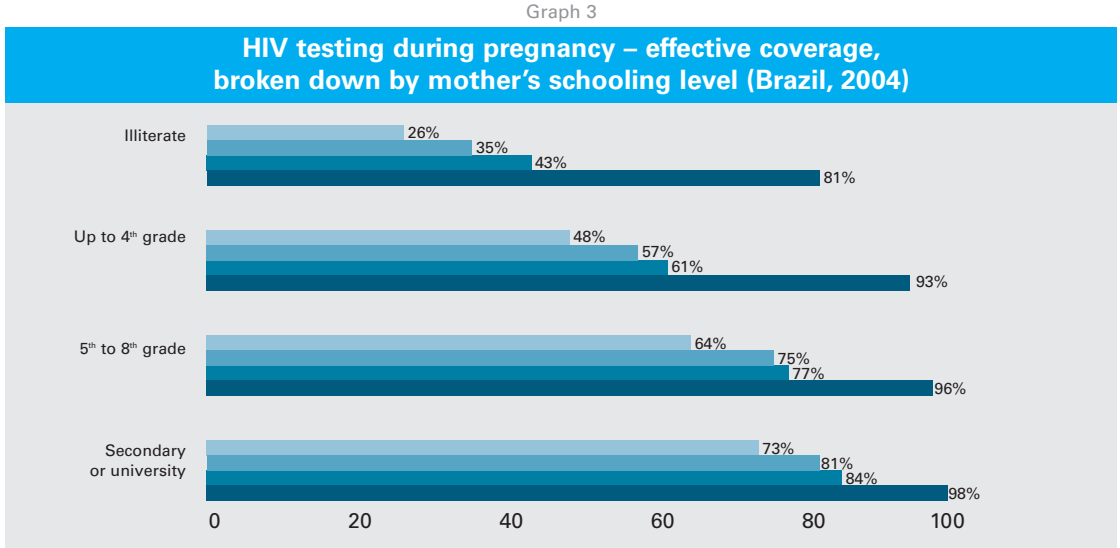
The prenatal care system itself contributes toward this situation. When a pregnant woman attends her first prenatal care visit, she undergoes as series of tests, including a test for HIV (if she consents) and the result is available by the time of her next visit.

Differently to countries of Western Europe and the United States, Brazil has no national guidelines for following up pregnant women who test positive for HIV. Introduction of such a system would enable health professionals to trace pregnant women who test positive, so as to

Graph 2



Graph 3



Knew the result of their serological test prior to delivery
Serological test for HIV requested and the mother agreed
Serological test for HIV requested
At least one prenatal care visit

Source: National STD/AIDS Program.

inform them of their serological status and initiate treatment with a view to preventing vertical transmission.

Some municipalities, such as Campinas, Sorocaba and Santos (in the State of São Paulo) and certain health services in the City of São Paulo, are already taking this approach.

Racial vulnerability

Racial inequality, reflected by the number of prenatal visits, also demonstrates the inequity surrounding the issue of HIV. A far larger proportion of black women undergo less than six prenatal care sessions than of white women. In 2000, according to the

Ministry of Health, 66% of black women attended no more than six prenatal care sessions; whereas for white women, the proportion was 45.2%. Furthermore, figures on reported cases of AIDS would appear to show that the number of new cases among non-black women has stabilized, whereas among black women it is continuing to rise.

Being black, it would seem, tends to increase a woman's vulnerability. Rates of condom use for black girls, for example, are almost 50% lower than for non-black girls. Whereas 42% of non-black girls protect themselves with condoms, among black girls only 28% do, according to a survey carried out in 1999 by the Ministry of Health and the Brazilian Center for Analysis and Planning (CEBRAP)[3]. Another survey, carried out in 2003 by the Ministry of Health together with IBOPE (a polling institute), found that price was the main reason why black women and men report lower rates of condom use[4] .

Late diagnosis is another problem among black women. A survey carried out in the city of São Paulo [5], with 1,068 women (542 black and 526 non-black) receiving services at three reference centers, found that they become aware of their serological status only when a child, husband, or they themselves become ill. Among the women interviewed, the blacks were the ones that received the least pre- and post-testing counseling, orientation with regard to their clinical status, or anti-retroviral treatment for their new-born children.

The evidence indicates that actions under the health system tend to treat black and non-black women in an unequal manner, and thus exacerbate the vulnerability of the black population. Specific policies urgently need to be instituted to address the needs of this segment of the population. It is, for this reason, necessary that surveys provide information broken down specifically to produce data

3. Comportamento Sexual da População Brasileira e Percepções do HIV/Aids. Série Avaliação, nº 4, Brasília: 2000.
4. Pesquisa Nacional com a População Sexualmente Ativa, 2003.
5. Fernanda Lopes, *Mulheres Negras e Não-Negras Vivendo com HIV/AIDS no Estado de São Paulo: um Estudo sobre suas Vulnerabilidades.* Doctoral thesis presented at Faculdade de Saúde Pública da Universidade de São Paulo, 2003.

United in the struggle against AIDS!

This is the title of a global campaign, launched by UNICEF in October 2005, with the aim of mobilizing all sectors of society in the fight against HIV/AIDS in children and adolescents

In October 2005, UNICEF launched a global campaign calling upon governments, civil society, international agencies, companies and the general public, to face up to the problem of HIV/AIDS in children and adolescents. The full title of the campaign was: "United with children and adolescents. United to vanquish AIDS!". The main goals of this campaign were to increase public awareness of the problem, raise the profile of programs for the prevention of vertical transmission, offer protection and services for children and adolescents affected by HIV/AIDS, and provide treatment for those who are infected.

Throughout the world, the actions under this campaign were expressed as the four Ps:

- Prevention of vertical transmission.
- Pediatric care.
- Protection, services and support for children affected by HIV.
- Prevention, information, skills and services.

In Brazil, aside from including an additional P, for Participation of adolescents, the campaign will initially seek to foster prevention among millions of adolescents attending public schools. Other aims of the campaign are: training for community health agents, strengthening programs and services to make them more receptive to adolescents; support for groups of young people affected by HIV; and encouragement for the formation of other similar programs.

UNICEF will provide funding to supply some 50,000 rapid HIV tests for pregnant women in the Semi-arid region, and support for the International Cooperation Project (ICP) (see the text entitled International applications), and over a dozen initiatives targeted at children affected by HIV/AIDS with the aim of ensuring their inclusion in schools and in the community, while at the same time strengthening their families.

on black women, and that health professionals be made more aware of racial issues. In August 2005, the National STD/AIDS Program launched a Strategic Affirmative Action Program for the Black Population and AIDS, with the aim of investigating where and how differences of access to information, prevention practices, and healthcare services occur, as a function of color/ethnicity.

Intervention on the front line

In Brazil, the most vulnerable populations (low-income communities, people with low schooling levels, and blacks) now have an important point of entrance to the health system: the Family Health Program (PSF). Multi-professional health teams provide primary healthcare services for the population and guidance on health issues. Community health agents visit and monitor families, thereby bringing 100 million people into contact with systems for the prevention, diagnosis, and treatment of diseases.

This system provides an excellent framework for preventing HIV and providing guidance for pregnant women on HIV testing and detection of the virus. The National STD/AIDS Program has developed guidelines for carrying out preventative actions, providing services through the primary healthcare network, and carried out various forms of training with PSF teams on the prevention and treatment of STDs and AIDS. Initiatives carried out in certain Brazilian municipalities have demonstrated the potential of this partnership. In the City of São Paulo, for example, an agreement between the Municipal Secretariat of Health and the Family Health Association (an NGO), broaches the issue of HIV/AIDS under its reproductive health and primary healthcare coverage. Technical staff have received training that has enabled them to attend to 100,000 women and girls.

In Belo Horizonte, in 2000, the municipal secretariats of health and of education jointly launched a program entitled BH de Mãos Dadas contra a AIDS. Their proposal entails continuous peer-to-peer education, adolescents discussing prevention with other adolescents, and women receiving information from other women. This work was carried out through the Primary Healthcare Units (UBS), and within homes. Multiplying agents from low-income communities, selected by community health agents, received training from members of the PSF teams. In 2005, 155 technical staff members and community health agents received training on how to promote prevention of HIV/AIDS and provide guidance to people who have contracted AIDS but are clinically stable. In this manner, the intervals between visits to the specialized services may be longer and, moreover, those with more serious manifestations of the disease have a better opportunity to receive individual attention.

These examples demonstrate the potential that such professionals, when properly trained, have for disseminating information and mobilizing support. They provide an important contribution toward ensuring that segments of the population that were historically excluded from access to healthcare services, are treated as equals alongside other groups, in terms of the progress made in facing up to vertical transmission in Brazil.

PROSPECTS FOR THE FUTURE

Aside from the consequences of contracting HIV infection, a child's early development may be affected by the AIDS epidemic in other ways. According to a study published in 2004, entitled The Situation of AIDS Orphans in Porto Alegre/RS: Factors relating to Institutionalization[6] , at the time of the death of one or of both parents to AIDS, 66% of the orphans in Porto Alegre (capital of Rio Grande do Sul) were less than 9 years old. This survey also revealed that seropositive children tend to lose their parents even earlier than those whose mothers were diagnosed as having the disease and managed to prevent vertical transmission.

As a consequence of the progress that Brazil has achieved in reducing vertical transmission

6. Marlene Doring, *Situação dos Órfãos em Decorrência da Aids em Porto Alegre/RS e Fatores Associados à Institucionalização*. Doctoral thesis presented at Faculdade de Saúde Pública da Universidade de São Paulo, 2004.

through early diagnosis and anti-retroviral therapy during pregnancy, most of the children that lose their parents to AIDS do not have HIV. In Porto Alegre, only 10% of the orphans of parents who had died of AIDS were HIV positive.

The study reports that early death of either of the parents has serious implications for surviving family members, since it tends to exacerbate poverty. Moreover, such deaths jeopardize the child's emotional well being and security, and may hamper his/her mental development and health.

HIV/AIDS may thus deprive a child of the right to a well-structured family and community life, since loss of one or of both parents increases the probability of his/her being placed in institutional care. In some cases, even when ties to the surviving parent are maintained, the child's right to full development has been curtailed.

According to the Report on the Global AIDS Epidemic, published by the United Nations Joint Programme on AIDS (UnAIDS) in 2004, when deprived of the protective family environment, children who lose their parents to AIDS are more exposed to a variety of risks, including: failure or drop-out from school, exploitation as child labor, abuse, violence and sexual exploitation; and lack of access to healthcare; furthermore, their lives tend to be marred by stigma and prejudice.

WOMEN'S AND CHILDREN'S RIGHTS

- Right to knowledge of methods for preventing HIV infection in order to protect themselves and others.
- Right to know their serological status, with the guarantee of adequate and ethical counseling.
- Right to integral services and to treatment, including pediatric care.
- Right of access to services for the prevention of mother-to-child transmission of HIV and of syphilis.

Source: UNICEF.

Brazilian panorama

Nobody knows how many children in Brazil are in this situation. A report entitled Children on the Brink 2002[7] estimated that some 127,000 Brazilian boys and girls had lost one or both parents. Few studies have investigated the issue of who these children are and how they live. From the results of local surveys, however, it is possible to draw the broad outlines of the problem.

A survey entitled Learning about Realities facing AIDS Orphans, carried out by Associação Santista de Pesquisa, Prevenção e Educação em STD/AIDS, in Santos in the State of São Paulo, published in 2004, estimated that there were 521 AIDS orphans in that town. An in-depth study examined the situation of 33 children living with extended-family members, and reported that they tended to have learning disabilities. Moreover, the families complained of financial problems, since their average monthly per-capita incomes amounted to no more than 1.5 minimum wages. The caregivers (grandparents, aunts, sisters, and members of adoptive families) feel incapable of fulfilling the needs of children and providing them with adequate education, especially in view of the stigma of HIV.

These same difficulties were also reported in the aforementioned Situation of AIDS Orphans in Porto Alegre/RS: Factors relating to Institutionalization, which assessed the situation of 853 children who had lost one or both parents to AIDS in Porto Alegre. Not even the legal status of many of these children was in order, and almost half of them were living with families that had no legal authority to keep them.

The survey demonstrated that the school performance of children who have lost parents to AIDS is likely to be negatively affected and, based upon reports from their relatives, in 4.2% of cases, the stigma of HIV (manifested by snide remarks, off-color jokes, and gossip imbued with prejudice) led them to abandon school. Two thirds of these children were in grades that did not correspond to their age, and half of them had repeated a grade at least once. This is merely an indication of the damage that the stigma of HIV has upon education, and it is probable that such harm is even greater than these statistics reveal.

In Porto Alegre, 5% of the children who have lost their parents to HIV are in institutional care. Those that are seropositive are more likely to be placed in institutions than those that are not. Half of the AIDS orphans infected with HIV in Porto Alegre are in shelters. Of those that are not infected with the virus, only 4.9% are in such institutions.

Boys and girls whose mothers are non-white, and those that have lost their mothers, (regardless of whether the father is alive or not) are also more at risk of ending up in institutions.

7. UNICEF, United States Agency for International Development (USAID) and the Joint United Nations Programme on HIV/Aids (UNAIDS).

Institutions

No specific guidelines exist to provide for children who lose their parents to AIDS and do not remain with extended family. The State has no institutions responsible for providing support to extended families, neither are any alternatives to institutionalization offered for this specific segment of the public. Thus, only two possibilities remain: either the child is sent to a conventional shelter; or is taken to a support home, maintained by a civil-society organization. UNICEF advocates that the rights of all children to family life ought to be guaranteed, in compliance with the Statute of the Child and Adolescent.

Public policies are needed to rise to the challenge of building inter-sectoral policies that fulfill demands arising from AIDS and poverty, especially for children whose lives are affected, or who have contracted HIV/AIDS and are living in shelters. In this respect, it is important to establish links and interfaces with other public policies, so as to come up with efficient strategic approaches toward reducing the impacts of the AIDS epidemic on social security and welfare policy. Thus, the National STD/AIDS Program has adopted certain actions targeted at promoting social inclusion of persons living with HIV/AIDS.

In acknowledgement of the importance and contribution of Support Houses in the work of promoting the social inclusion of such children, adolescents and adults, the National STD/AIDS Program is seeking mechanisms that contribute toward the sustainability of actions carried out by these civil-society organizations.

To address the needs of adults sheltered in Support Houses, Ministry of Health Order 1.824, of 2004, sets procedures for the accreditation of civil-society organizations in Brazil's states and municipalities. Partnerships established in accordance with these guidelines entitle institutions to receive transfers of governmental funding as contributions toward the maintenance of Support Houses. These guidelines also foresee the establishment of links between civil-society organizations and state and municipal STD/AIDS coordination units, with a view to determining the number of places required, the division of responsibilities between state and

International applications

Brazil is transferring technologies for HIV/AIDS treatment and care to countries in Latin America, Africa, and Asia

Since 2002, the Ministry of Health's National STD/AIDS Program has been sharing Brazil's experience in combating and preventing HIV/AIDS through its International Cooperation Project (PCI). The goal of this project is to transfer technologies, developed in Brazil for providing services and treatment for HIV/AIDS patients, to other countries of Latin America and Africa. Under the project treatment, consisting of anti-retroviral drugs produced in Brazilian governmental laboratories, has been provided to one hundred AIDS patients.

In 2005, the project was expanded, and now encompasses the donation of the seven drugs produced by governmental laboratories in sufficient quantity to serve all the seropositive patients in the seven countries that participate in the project: Guiné-Bissau, São Tomé & Príncipe, Cabo Verde, East Timor, Paraguay, Bolivia and Nicaragua. A total of 5 million reais is to be channeled to the project by UNICEF and its partners. Furthermore, the Project will offer technical-training opportunities for health professionals.

The seven countries have pledged to distribute the drugs at no charge, to provide medication for the treatment of opportunistic diseases, and to procure second-generation drugs, in the event of therapy failure.

The project will also address prevention of vertical transmission. UNICEF will be providing 1.1 million rapid test kits for the diagnosis of HIV in pregnant women. This is important because, in Guiné-Bissau for example, 6% of pregnant women test positive for HIV. In Brazil, it has been estimated that 0.41% of pregnant women have the virus.

municipal authorities, and ensuring the quality of services provided at Support Houses.

Support Houses were set up at the onset of the epidemic to provide shelter and care for poor seropositive persons, be they adults or children.

Public policies are needed to rise to the challenge of building inter-sectoral policies that fulfill demands arising from AIDS and poverty

They emerged as a community-based response to the challenges posed by AIDS. Over the past twenty years, their numbers have multiplied, and currently there are 140 Support Houses with some 1,800 beds, that provide services for children and adolescents. Brazil's Federal Government, through the National STD/AIDS Program, has provided support for such civil-society initiatives. In line with current decentralizing policies for the treatment of STDs and AIDS, state and municipal administrations have also taken measures to share the burden of maintaining Support Houses for children and adolescents whose lives have been stricken by AIDS. In 2005, funding amounting to 1 million reais was earmarked for projects carried out by civil society organizations. When assessing requests for funding submitted by such entities, questions as to what efforts they make to preserve family and community ties are considered. To date, 28 projects for Support Houses have been approved in Brazil's 5 regions.

The National STD/AIDS Program defines Support Houses as institutions that provide healthcare and beds for seropositive individuals. The segment of this target population and methodologies employed are essentially matters for the Support Houses themselves to decide. This means that they must choose, for example, if they are going to provide shelter for seronegative AIDS orphans, if they are going to cater only for seropositive children, or if they accept siblings with different serological status. Rather than providing shelter for children affected by AIDS, some institutions have opted to provide support in terms of psychosocial and family welfare services, as a means of stimulating preservation of family ties *(see the text entitled An Alternative to Shelters)*.

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Restoration of family ties

In the light of increasing post-infection survival, and in line with accepted children's rights principles, most specialists agree that the proper role for Support Houses and governmental policies is to foster family ties and restore children as swiftly as possible to their family environments, rather than providing long-term shelter.

This is in line with the general guidelines proposed by international agencies for policies targeted at children who have lost their parents to AIDS. At the World AIDS Day Forum, in December 2003, five key strategies were proposed to ensure the fulfillment of goals set forth in such international documents as *A World Fit for Children*:

- Strengthen the capacity of families to protect and care for orphans and other vulnerable children, by prolonging the lives of their parents and providing economic, psychosocial, and other types of assistance.
- Mobilize communities and support responses arising from communities, aimed at providing immediate and long-term support to the most vulnerable homes.
- Ensure access for orphans and other vulnerable children to basic services, including education, sanitation, and birth registry.
- Ensure that governments protect the most vulnerable children by means of adequate welfare policies and legislative measures, and guarantee funding flows for communities.
- Promote awareness at all levels, by means of activities designed to promote social mobilization, with the aim of fostering family and community ties for children affected by HIV/AIDS.

The only action foreseen under the Child Friendly President's Plan, in relation to boys and girls that have lost their parents to AIDS, however, is the earmarking of funds for addressing the specific healthcare needs of seropositive orphans.

It is only after having carried out an adequate diagnosis of the issues facing children and adolescents affected by HIV/AIDS that it becomes possible to draw up public policies to mitigate their plight. This is one of the lessons learned from international experience. In Brazil, the lack of specific actions targeted at addressing the needs of AIDS orphans is a consequence of a failure to carry out a deep and comprehensive diagnosis of the situation.

Access and quality: the great challenges

Though the potential of early-childhood education to stimulate child development has been clearly demonstrated, in Brazil, less than half of boys and girls up to the age of 6 years attend daycare or preschools. Furthermore, the quality of education and care provided for this age group often leaves much to be desired

One decade ago, daycare centers and preschools, hitherto considered a matter for social welfare policy, were officially acknowledged as a child's right and regarded as an integral component of basic (primary) education. The National Education Guidelines Law (LDBEN) of 1996, required adjustments and changes at institutions that provide early-childhood education services, in order to prepare them to serve as educational (rather than simply care-giving) institutions, and bring them into compliance with certain basic quality standards.

The law divided early-childhood education into daycare (for children up to the age of 3 years) and preschools (from 4 to 6 years). According to the Synthesis of Social Indicators for 2004, published by the Brazilian Institute for Geography and Statistics (IBGE), referent to 2003, only 11.7% of children up to the age of 3 years attended daycare centers. Data provided by the Ministry of Education's Anísio Teixeira National Institute for Educational Studies and Research (INEP) relating to 2004, crossed with Census (IBGE-2000) figures, 55.1% of children between the ages of 4 and 6 years attended preschools.

According to the Synthesis of Social Indicators, of the poorest 20% of the population, only 28.9% of boys and girls up to the age of 6 years attend any type of school. Among the richest 20%, over half of the children in this age group attend school.

Historical inequality

Such inequality has its roots in the history of early-childhood education in Brazil. Initially, daycare centers emerged independently of the education system. They catered for children up to the age of 6 years whose parents go out to work and had no one to leave the children with. In parallel to this,

Table 1

Number of daycare centers and preschools in Brazil

Daycare centers					
Total	Central-West	Northeast	North	Southeast	South
30,266	1,675	8,611	1,117	13,408	5,455
Preschools					
Total	Central-West	Northeast	North	Southeast	South
10,650	4,958	47,951	9,116	25,580	14,045

Source: INEP, Statistical Synopses of the School Census 2004. Preliminary data.

since 1975, an official preschool system has begun to emerge. Since the public school system was not able to fulfill demand for early-childhood education services, poor families were often obliged to send their children to daycare centers operating under the social-welfare system, which generally have little to offer by way of infrastructure or pedagogical stimulus, or even adequate childcare services. Meanwhile, the middle class and the rich have always resorted to private schools[1].

Preliminary data provided by the Primary Education Statistical Synopsis (INEP 2004), show that almost half of Brazil's daycare centers are private whereas, of the total of preschools, 25.8% are privately owned. It should be observed, however, that many daycare centers and preschools, and especially those run as philanthropic or community-based institutions, receive funding under agreements with governmental bodies.

There are a total of 101,650 preschools, and 30,266 daycare centers in Brazil, according to INEP. A major portion (47.1%) of preschools are concentrated in the Northeast region, whereas the largest portion (44.3%) of daycare centers are in the Southeast: (*Table 1*).

Obstacles to diversity

There are no significant gender differences in terms of access to early childhood education. The Census (IBGE 2000) shows that girls are slightly better represented: 9.5% of girls, vs. 9.4% of boys in the up to 3 years age group; and 61.9%, vs. 60.5% in the 4 to 6 year age group.

When the figures are broken down by ethnicity, indigenous children are the least likely to attend daycare or preschools. According to the census, only 3.9% of indigenous children up to the age of 3 years attend school. Children of asian origin are the best represented group, and 15.2% of boys and girls of asian descent attend school). Discrepancies between school enrolment rates for white (10.3%), black (9.5%) and brown children (8.3%) are less startling[2] . When examining these data, it is important to bear in mind factors inherent to the culture of each of these groups. The desirability of early-childhood education for indigenous children needs to be discussed within their own communities, taking their traditions into account.

Whereas in urban areas 40% of children up to the age of 6 years attend schools, in rural areas this proportion drops to 27%. Preliminary data from the Statistical Synopsis of Primary Education (2004) show that the number of daycare centers in rural areas is insufficient. There are 4,165 such facilities, distributed throughout 5.560 municipalities.

Children with disabilities in this age group are also significantly less likely to receive early-childhood education services although, by law, they are entitled to attend regular schooling. Of the total number of such children (109.596) in daycare and preschools in 2004, 78.2% attended special schools. Though such specialized institutions play an important role, most of them are primarily focused on health aspects and fail to conduct activities that stimulate development of social skills. Such skills are an important part of regular schooling and, ideally, these two aspects should complement each other.

Long-term benefits

In the past two decades, studies conducted by specialists in a wide variety of fields have emphasized the importance of integral services for early childhood, since promoting cognitive development during this phase of life has decisive impacts on children's future prospects.

The first years of childhood are a period of bur-

1. Antônio Carlos Gomes da Costa, O desafio da educação infantil, in *Cidadania Antes dos Sete Anos*, Brasília, Andi/UNICEF/Editora Cortez, 2003.
2. Data published in a study entitled Custo Aluno Qualidade, conducted by Campanha Nacional pelo Direito à Educação, 2005.

geoning awareness, when the brain needs stimuli in order to build and strengthen mental, cognitive and emotional structures. It is in the first 6 years of life that 90% of the brain's synapses are formed. Early childhood is a period in which the so-called 'windows of opportunity' occur, when children, neurologically, are most apt to develop a variety of skills.

By 4 years of age, children have developed half of the mental potential that they will have as adults[3]. Their potential vocabulary, for example, is determined by words they have acquired up until the age of 3 years. The neurological bases for the development of mathematical and logical skills are formed before children reach the age of 4 years. Emotional stability is strongly influenced the way in which the brain develops during the first two years of life.

By the age of 6 years, the broad outlines of self-esteem, the sense of morality, responsibility, empathy, social relationships, and other fundamental aspects of the child's personality have been formed. Thus, aside from stimulating the acquisition of specific skills, early-childhood education expands the child's potential for social interaction, and promotes development of autonomous individuals.

Children who live alongside children relate to the world differently to children accustomed to living exclusively in the company of adults. Interaction with people in their own age group enables them to play a series of different roles. They learn to refuse, share, and accept; indeed, they learn what it feels like to be part of a group.

A better future

Aside from promoting their integral development, access to daycare centers and preschools for children from low-income families brings other social benefits. James Heckman, an American winner of the Nobel Prize for Economics (2000), having analyzed various international studies, concluded that early-childhood education and better quality services for children within the home ensure better lives for them as adults[4]. "The main component of poverty, and I am sure that this must be even more true in Brazil, is differences in family environments and their influence on educational performance ", he says.[5]

Aside from promoting their integral development, access to daycare centers and preschools for children from low-income families brings other social benefits

One such study (Perry Preschool Study) monitored the lives of American black low-income boys and girls, from early-childhood education to the age of 40 years. Researchers divided the children into two groups: one that had attended early-childhood education establishments, and the other that had had no access to daycare or preschools. Once the participants reached the age of 40, it was found that the first group contained a higher proportion of persons who had concluded secondary schooling. Furthermore, members of the second group tended to have held better jobs and to earn higher wages. According to the study, the chances of teenage pregnancy are lower among girls that have participated in early-childhood education programs. Also, boys that have attended daycare or preschools are less likely to commit crimes.

Financial impact

In Brazil also there is evidence to support the argument that access to early-childhood education for children of low-income families has a positive impact upon family income, especially among the poorest families. A study entitled Trabalho e Responsabilidades Familiares: Um Estudo sobre o Brasil[6] showed that, in Brazilian

3. World Bank, Boosting Poor Children's Chances: Early Development Services for Poor Children, 1999.
4. James Heckman and Flavio Cunha, Credit Constraints, Family Constraints and Optimal Policies to Reduce Inequality and Promote Productivity. Study presented at the International Meeting of Early-Childhood Education, held at Centro de Políticas Sociais da Fundação Getúlio Vargas (FGV). Available at: http://www.fgv.br/ibre/cps/. Access November 21, 2005
5. "Pré-Escola Combate Pobreza e Desigualdade, Diz Nobel", Agência Estado, November 16, 2005.
6. Bila Sorj, Trabalho e Responsabilidades Familiares: Um Estudo sobre o Brasil, Relatório Final (Contracted by ILO), Rio de Janeiro, Universidade Federal do Rio de Janeiro (UFRJ), 2004.

households whose children attend daycare centers and preschools, per capita incomes are roughly 50% higher than in those whose children are not engaged in early childhood education. In the former households, mother's wages are 55% higher than in the latter.

Investments in early-childhood education are important in that they expand access and help ensure the quality of services provided for children

According to this study, daycare is an efficient mechanism for conciliating the demands of family and a job. Aside from enabling women (and especially poor mothers) to work, it helps them hold down better jobs. Expanding the supply of early-childhood education is one of the top priorities of the National Policies for Women Plan, drawn up in 2004 by the Presidency of the Republic's Special Secretariat of Policies for Women (SPM).

Indirect stimulus

Another study, commissioned by the World Bank[7], showed that attendance in early-childhood education also has an influence on the final schooling levels achieved by Brazilians. Two years of preschool lead to an average increase of one additional year of schooling. Furthermore, a child that has attended early-childhood education is less likely to repeat grades or to be in a class inappropriate for his/her age. The study also concluded that wages earned as an adult may be increased by between 2% to 6%, as a consequence of having attended a year of preschool.

A study by the Institute for Applied Economic Research (IPEA) suggests that a person from a low-income family that attended two years of early childhood education, upon reaching adulthood is likely to earn 18% more than he/she otherwise would.

Since they result in such positive developments for the future, investments in early-childhood education can be perceived as the most effective means of promoting gender equity, reducing crime, and of combating poverty and social exclusion.

ACCESS AND QUALITY

Brazil pledged to invest in early-childhood education when it ratified the United Nations' effort to achieve A World Fit for Children, in 2002. This report lays out the actions needed to fulfill the United Nation's Millennium Development Goals (MDGs) for children and adolescents.

In keeping with its international commitments, the Brazilian Federal Government announced the Child Friendly President's Plan, signed by President Luiz Inácio Lula da Silva upon taking office, which set the goal of improving and expanding access to early childhood education. This goal implies expanding services for boys and girls up to the age of 6 years at daycare centers and preschools, so that they reach 65% of all children in this age group by 2007.

The goal set by Brazil's National Education Plan (PNE), announced in 2001, is that by 2011 half of all boys and girls up to the age of 3 years should attend daycare; and that 80% of those between the ages of 4 and 6 years should attend preschools. In recent years, considerable advances have been made in this area. Between 2000 and 2003, the number of boys and girls attending schools increased by 8%, according to IBGE. On the other hand, a survey entitled Cost per Student and Quality (CAQ), carried out by the National Campaign for the Right to Education, shows that, in order for Brazil to fulfill the goals, there will have to be a 474% increase in the number of places available at daycare centers, and a 63% increase in the number of preschool places available.

The funding problem

Public spending on daycare needs to increase 1,088% by 2011, from 898 million reais to 10.7 billion reais, according to a study carried out by the

7. World Bank, Desenvolvimento da Primeira-Infância: Foco sobre os Impactos da Pré-Escola, Brasília, 2002.

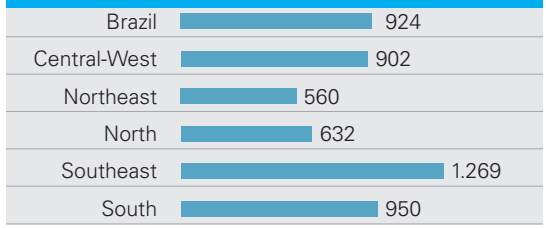
Ministry of Education and published in 2004, in an article in the *Folha de S.Paulo* newspaper[8].

The Basic Guidelines for National Education Law (LDBEN) establishes that the states and Federal Union are responsible for setting guidelines for early childhood education, and for providing financial support to municipalities. It is however the municipalities that must establish and manage early-childhood education systems. All this notwithstanding, the setting up of daycare centers and preschools has not been among the top priorities of most municipal education managers.

The Fund for Maintenance and Development of Primary Schooling and Enhancing the Status of Teachers (FUNDEF) set up in 1998, made strides in expanding access to primary schooling, however, at the cost of cuts in overall investment in early childhood education. The law requires that, of the 25% of state and municipal taxes compulsorily earmarked for education, 60% should be targeted exclusively at primary schooling. This implies that primary schooling is entitled to 15% of total tax revenues. One negative result of such compulsory spending formulas is that states and municipalities seek to offset revenue losses by reducing their investments in daycare centers and preschools[9].

Graph 1

Annual spending per student on public early-childhood education services, in reais (1999)



Source: Student Cost and Quality Study (CAQ), National Campaign for the Right to Education, 2005. Calculations based on data from INEP and IBGE.

A new fund

With a view to correcting such distortions, the Chamber of Deputies (lower house of the National Congress) is currently deliberating a proposed Fund for the Maintenance and Development of Basic Education and Enhancing the Status of Education Professionals (FUNDEB). The proposal will guarantee transfers of federal, state, and municipal funding not only for primary schooling, but also for early-childhood education and secondary schooling. Though still under discussion, this proposal foresees no subsidies for daycare.

The reason for this, according to the sponsors of the Bill, is that 20% of FUNDEB is to be funded by tax revenues of the states (and of the Federal District), whereas Federal Government resources will be provided only when annual per-student spending fails to reach a pre-established level. Since, according to the law, early-childhood education is the responsibility of the municipalities, the Bill's sponsors fear that the states and Federal Treasury would have to come up with a vast volume of funding, in order to provide for early-childhood schooling systems that ought to be the responsibility of the municipalities.

> Investments in early-childhood education can be perceived as an option in favor of gender equity and of combating poverty and social exclusion

The reaction of civil society has been to demand that educational facilities for boys and girls up to the age of 3 years be included under FUNDEB. In October 2005, a special committee of the Chamber of Deputies was set up with the aim of discussing this issue and presenting alternative approaches. At the end of November, the Federal Government announced disbursement of more funding for FUNDEB. Civil society observers, however, claim that the sums approved are insufficient to enable incorporation of daycare centers under the bill, and that the 200 million reais earmarked for the fund are short by about 83%. The congressional committee is in favor of including daycare and, if their recommendation is approved, the Bill will have to be voted, first in the Chamber of

8. Menor é melhor, Caderno Sinapse, *Folha de S.Paulo*, pp. 8-12, 27 jan. 2004.
9. Rita de Cássia Coelho and Ângela Rabelo Barreto, *Financiamento da Educação Infantil*, Brasília, Unesco, 2004.

Table 2

Schooling levels of early-childhood education teachers

	Daycare	Preschool
Had not concluded primary schooling	2.21%	0.52%
Primary schooling	5.04%	1.84%
Secondary schooling	68.94%	62.58%
University degree	23.81%	35.06%

Source: INEP, Primary Education Statistical Synopsis 2004. Preliminary results.

Deputies and then in the Senate, prior to being sanctioned by the President of the Republic.

Funding difficulties

Another difficulty is that federal funding transfers for municipal and non-profit private daycare centers and preschools are still distributed through the social-welfare system, and thus vulnerable to spending cuts and management difficulties. The federal authorities are aware of the problem and, in 2005, the Ministry for Development Social and Combating Hunger (MDS) and the Ministry of Education established an inter-ministerial committee to address the issue of unifying the sources of funding.

The Federal Government has made efforts to bring daycare and preschools within the scope of its investments in education. Since 1994, funding has been earmarked for procurement of teaching materials and, since 2002, early-childhood education establishments have been eligible for funding under the school meals program. Previously, only primary schools had been eligible for such transfers.

Quality guarantees

Investments in early-childhood education are important not only because they expand access to educational opportunities, but also because they improve the quality of educational services provided for children. Brazil has not as yet set minimum standards for daycare centers and preschools and, in November 2005, the Ministry of Education was still working on the text of a document entitled Quality Parameters for Early Childhood Education, with the aim of providing guidelines for daycare centers and preschools.

A consensus is, however, developing with respect to some of the criteria that should underpin guidelines for fostering full development of children up to the age of 6 years, the qualifications required of professionals engaged in providing early-childhood education services, the relevance of pedagogical planning, operating conditions, class sizes, and the need to maintain close links with families.

The Student Cost and Quality Study (CAQ), carried out under the auspices of the National Campaign for the Right to Education, concluded that the sums spent on early-childhood education in Brazil are insufficient to ensure minimum quality standards. In 1999, average annual disbursements amounted to 924 reais per student (Graph 1). The distribution of such spending varies from one region to another. In the Northeast, for example, annual spending per stu-

Table 3

Physical installations and furnishings at daycare centers

		Brazil	Central-West	Northeast	North	Southeast	South
Physical installations	Infirmary	**8.6%**	7.2%	4.0%	5.3%	3.9%	6.1%
	Diaper changing room	**23.5%**	19.2%	3.0%	4.3%	33.2%	39.4%
	Breastfeeding room	**15.2%**	15.9%	3.1%	3.7%	21.7%	22.4%
Appropriate furnishings	Highchairs (for feeding children)	**25.2%**	16.9%	9.3%	13.8%	34.5%	35.1%
	Playpen	**14.9%**	14.4%	2.2%	3.2%	24.0%	18.4%
	Walkers	**8.2%**	7.9%	1.5%	2.4%	12.2%	11.5%

Source: INEP, Early-Childhood Education Census 2000.

Table 4

Equipment and services at public institutions

	Daycare	Preschool
Electric power	98.0%	99.0%
Internet	19.0%	9.0%
Playground	45.0%	54.0%
Adequate toilet fixtures	43.0%	57.0%

Source: National Campaign for the Right to Education, CAQ study, 2005.
Calculated on the basis of INEP data for 2001 and 2002.

dent amounts to 560 reais; whereas in the Southeast, it amounts to 1,269 reais. Such disparities are reflected both by problems of access and of the quality of early-childhood education services provided.

Quality standards

Systems for ensuring the quality of early-childhood education are not centralized. Aside from providing financial support for municipal school systems, the Ministry of Education is also responsible for setting basic guidelines to help them in the selection of basic local criteria and standards for early childhood education. In pursuit of the later objective, in 1998, the Ministry prepared a document entitled Support for Accreditation and Control of Early-Childhood Education Institutions, with a view to providing guidance for daycare centers during the transition from the social-welfare to the education system. Among the suggestions it raises are: that municipalities set criteria with regard to the physical installations required to provide services for children in this age group; that appropriate teaching materials be provided; and that the pedagogical framework be focused on the child as the subject of the educational process.

The role of the National Education Council is to transform the guidelines set by the Ministry into standards that effectively regulate the day-to-day activities of these institutions; whereas municipal and state education councils are responsible for adapting these standards to reflect local realities.

Teacher training

Some advances have been achieved in the past ten years with regard to standards for early childhood education. Teacher training and pedagogical practices are a case in point. Formerly, it was generally accepted that anyone could take care of children at a daycare center or preschool. In 1999, the National Education Council issued the National Curriculum Guidelines for Early Childhood Education, which determined that a teaching certificate, and preferably a university degree, were the minimum training requirements for teachers at early-childhood education establishments.

Of the 75,275 daycare teachers registered with INEP in 2004, 2.21% had not even concluded primary schooling, and only 23.81% had a university degree. Among preschool teachers, the situation was slightly better: only 0.52% of the 293,699 teachers had not concluded their primary schooling (Table 2).

PROINFANTIL, a program being carried out by the Ministry of Education in partnership with the states and municipalities, seeks to enhance the

Table 5

Teaching materials used at daycare centers

	Brazil	Central-West	Northeast	North	Southeast	South
Toys	**84.1%**	90.3%	64.1%	76.5%	92.8%	95.6%
Educational games	**73.7%**	77.3%	53.7%	65.1%	82.5%	85.8%
Arts materials	**61.7%**	66.0%	40.1%	45.8%	71.5%	75.7%
Text books	**36.7%**	36.5%	25.1%	30.5%	41.2%	46.1%
Reading books	**58.1%**	63.3%	37.2%	33.3%	65.7%	76.7%
Primers	**8.4%**	10.5%	14.2%	16.0%	4.9%	4.7%
Physical education materials	**39.8%**	41.7%	9.5%	18.7%	51.4%	64.5%
Pencils and notebooks	**58.9%**	52.2%	74.7%	66.8%	52.1%	49.6%
Scrap materials	**82.6%**	82.4%	73.0%	77.0%	86.4%	90.2%

Source: INEP, Early-Childhood Education Census 2000.

Table 6

Teaching materials used in preschools

	Brazil	Central-West	Northeast	North	Southeast	South
Toys	**61.4%**	74.5%	37.1%	40.4%	88.7%	92.3%
Educational games	**75.2%**	80.8%	61.6%	55.6%	91.4%	94.8%
Arts materials	**55.7%**	69.7%	33.6%	41.0%	79.0%	83.4%
Text books	**53.8%**	61.7%	49.0%	60.1%	57.4%	56.1%
Reading books	**63.7%**	78.7%	46.3%	38.2%	82.8%	89.8%
Primers	**43.0%**	50.7%	59.9%	64.6%	22.3%	15.2%
Physical education materials	**40.3%**	57.3%	11.1%	25.1%	66.1%	84.4%
Pencils and notebooks	**93.0%**	93.8%	93.6%	94.6%	91.8%	91.8%
Scrap materials	**82.3%**	87.8%	71.5%	76.1%	93.4%	95.9%

Source: INEP, Early-Childhood Education Census 2000.

qualifications of teachers engaged in early childhood education, by offering them the opportunity to conclude their secondary schooling or higher education. In 2005, pilot projects were launched in the States of Goiás, Rio Grande do Sul, Rondônia, Ceará, and Sergipe and, in 2006, the program is to be extended to encompass all of Brazil's states. Courses offered include presential activities and distance learning over a two-year period.

Weak framework

Brazil's National Education Plan (PNE 2001) foresees establishment of guidelines and minimum standards for installations at early-childhood education institutions, with emphasis on spatial requirements, safety, drinking water, facilities, and furnishings. The Ministry of Education expects to have these standards and recommendations ready for publication before the end of 2005, but they are intended to serve only as guidelines.

The Early-childhood education Census, a special survey carried out in 2000 by INEP, showed that a great many of Brazil's daycare centers do not offer the basic requisites for children's well being. For example, only 23.5% of Brazilian daycare centers have special facilities for changing diapers.

Budgetary delays

Though a major portion of the funding earmarked for policies targeted at children and adolescents is effectively disbursed, budget spending constraints hamper planning and execution

Of the 16.6 million reais allocated in the budget for the Early-childhood Education Development Program, by October 10, 2005, only 14.45% had been effectively disbursed. The aim of the program is to procure equipment and provide support for municipal initiatives, including the refurbishing of daycare and preschools facilities and the distribution of teaching materials.

Such disbursement delays occur owing to the Federal Government's fiscal policy of containing all spending until primary-surplus targets have been met. In practice, this tends to mean that major portions of disbursements are effected only in the last quarter of the year.

Although most of the funding is effectively executed, this practice greatly hampers implementation and planning of homogeneous policies for children and adolescents.

This leads to paradoxes. In the first nine months of the year, there is little prospect of receiving any funding. In the last quarter, the Program must execute the greatest possible number of actions. Indeed even if, at the beginning of the fiscal year, unspent funding is left over from the previous year, such funds can be used only to cover expenses incurred prior to December 31. This practice lends itself to one-off and poorly coordinat-

Once again, regional disparities are striking, and in the Northeast, only 3% of them have such facilities (*Table 3*).

The diagnostic analysis carried out under the CAQ study identified some failings with respect to quality. In 2001 and 2002, only 43% of public daycare centers and 57% of preschools had toilet fixtures for small children, and only half of them had playgrounds (*Table 4*).

Pedagogical aspects

In early-childhood education, learning takes place through play and interaction, and activities that enable the child to explore the world and develop independence. To this end, aside from having areas with plenty of space, appropriate teaching materials such as games, toys, books and magazines, should be readily available.

Data from the Early-Childhood Education Census (2000) show that a great many such establishments do not use such materials (*Tables 5 and 6*). Once again, regional disparities are significant: for example, in Brazil as a whole, 73.7% of daycare centers use educational games. In the Northeast region, however, this proportion drops to 53.7%, whereas in the South, educational games are in use at 85.8% of daycare centers.

From theory into practice

In terms of legislation and guidelines for early childhood education, Brazil has made significant strides in recent years. More difficult is ensuring compliance with the law. Generally speaking, little supervisory activity takes place, and no sanctions are applied to municipalities that fail to abide by decisions of the National Education Council or guidelines set by the Ministry of Education.

Aside from setting standards and putting them into effect, municipalities and (sometimes) states are also responsible for inspecting schools and ensuring compliance, though many municipalities simply do not have the structure.

Profile of the best municipalities

One of the first steps necessary to foster early childhood education is the conduct of local diagnostic analyses. Few systematic studies of this type have been conducted. A survey carried out in 2001 by Fundação ABRINQ pelos Direitos da Cirança e do Adolescente in 668

ed actions, and weakens the structure of the Program as a whole.

Budget spending constraints also undermine other important areas affecting children and adolescents. By October 2005, transfers effected by the Federal Government had amounted to only 30.6% of the total earmarked for eight social areas. Because of the mandatory allocations for education enshrined in Brazil's Federal Constitution, primary and secondary schooling were among the least affected areas, and 75% of the funding for these areas had been executed. On the other hand, transfers authorized by law for investment in early childhood education were severely curtailed by budget spending constraints.

Only 44.47% of the funding allocation for continuous teacher training for daycare centers and preschools was disbursed in 2003. Indeed, this is one of three areas within the sphere of action of the Ministry of Education (MEC) that was most affected by budget spending constraints, according to data provided by the Institute for Socioeconomic Studies (INESC).

With a view to pressuring the Government to disburse funding budgeted for children, INESC, UNICEF and Fundação Abrinq have established a project for monitoring execution of the budget, entitled Keeping an Eye on the Children's Budget (De Olho no Orçamento Criança). This project developed a methodology whereby various groups from civil society undertake to monitor performance of governmental programs and actions targeted toward children and adolescents, and a report, with the same title, was issued in 2005. This publication examines mechanisms of the budget process, provides information on how individuals and groups can participate in preparation of the budget, and encourages the public to demand accountability from municipal authorities. (www.orcamentocrianca.org.br).

municipalities that participate in the Child Friendly Mayor program, found that one of the principal problems facing municipal administrations engaged in ensuring fulfillment of the rights of children was simply the lack of places in early childhood education.

In 2002, analyses were carried out on programs specifically targeted at providing integral protection for children and adolescents. It was found that 12% of the initiatives promoted by municipalities were specifically targeted at daycare centers and preschools. Each program was assessed by a group of specialists, who rated seventeen indicators, with scores ranging from 1 to 3.

On the positive side, the overall average scores were encouraging. Among the 8 items that rated over 2 were: coherence; combating the root causes of the problem; and alignment with the doctrine of integral protection. Among the aspects considered weakest, the most pressing were: lack of diagnostic analyses, surveys and research; lack of integration with Municipal Guardianship and Children's Rights Councils; and poor rapport among institutions that provide early-childhood education services and families.

Complementary roles

Strengthening such interaction is one of the prime objectives of the National Early-Childhood Education Policy, issued in 2005. In no way

Development with respect for cultures and identities

The aim of Projeto Nyamê is to foster social inclusion while ensuring the rights of afro-descendent children and adolescents in quilombola communities in the state of Maranhão

When Maria de Fátima de Sousa was 2 years old, she was shy, would not talk to anyone, and wouldn't socialize. That was before she began to hear stories of her grandparents, great-grandparents, and great-great-grandparents, of how their people had crossed the seas in very crowded ships, and how they had had to struggle for freedom in the new world. In 2002, Fatima began to participate in Projeto Nyamê, an initiative that aims to promote social inclusion by focusing on ensuring the rights of afro-descendant children and adolescents living in former quilombos [communities founded by former slaves] in the State of Maranhão.

Among Brazil's states, Maranhão has the third largest black population, and the sixth lowest Child Development Index (CDI): 0.54. Under Projeto Nyamê, actions were carried out in eleven quilombola communities in rural areas of the municipalities of Codó and Itapecuru-Mirim (respectively 350 and 120 kilometers from the state capital), to reach 880 families living in conditions of extreme poverty.

Maria de Fátima, now 5 years old, was one of these children. "Now she sings and dances to black music, and keeps asking to go to school", says her mother, Patrícia Sousa, joyfully. She has witnessed how her daughter and some thirty other children from the community, have come to learn the history of their people, by means of cognitive and social stimuli.

Focused activities

Play is essentially the activity whereby children construct their self image, strengthen their cultural identity and achieve integral development. It is for this reason that Projeto Nyamê has created Play Houses, as spaces where children can engage in activities that strengthen healthy child development.

Local women receive training in how to deal with boys and girls up to 6 years of age. With the help of a stipend of 100 reais per month, a 'mother' and a teenage girl (known as brinquedistas) work on developing the children's self esteem, creativity, autonomy, and cultural identity. To do this, they use various materials, including black dolls, toys made from natural materials such as straw, and afro-Brazilian music and dance.

Most quilombola communities in Maranhão tend to be neglected by public policies, and to lack basic infrastructure, and education, health, sanitation, electric power, and telephone services. Despite these deficien-

should daycare and preschool services be regarded as a replacement for family-based care, since the function of early-childhood education is both different and complementary to the role played by families.

Involvement of parents in the education of their under-6 year old children ought to be underpinned by the joys of education and the sharing of responsibilities. The family should have the right to participate in the choice of daycare centers or preschools, and in the formulation and implantation of pedagogical frameworks, by means of 'democratic management' of early-childhood education establishments. With a view to ensuring quality, it is important that family members take an active part in meetings held to define priorities for pedagogical activities, materials, and human resources.

Unless significant levels of investment are targeted specifically at reducing inequity, quality improvements may simply fail to reach those boys and girls that are most vulnerable, thereby exacerbating the vicious cycle of social exclusion.

cies, the brinquedistas manage to disseminate the local culture. "Even when we had no electricity or sound system, we sang and taught songs, and we drew what the kids did not see on television," says mother and brinquedista Gleiciana Márcia dos Santos.

The result of this perseverance has been burgeoning cultural awareness. "It is great to hear the children asking to be told the history of the community. It keeps the culture alive," says Gleiciana with pride. Moreover, although the Play House and toy library have not as yet been recognized as a daycare center or preschool, while playing with the toys, the children learn the letters of the alphabet, numbers and colors. "This results in development not only for the children, but also for the community as a whole," she says.

These Play Houses are also a place where children can remain in safety while their parents work in the fields, fish, or gather and break palm nuts. Most of the adult population of the communities encompassed by the Project is illiterate, and lives in straw houses with earthen floors.

Integration

Projeto Nyamê has also made it possible to strengthen family and community competencies and promote better childcare practices. Mothers, fathers, grandparents, and community leaders have attended lectures and debates on childcare themes, always taking issues relating to the local culture into account.

As a consequence of these exercises in awareness building, various municipal administrations have been working together, and the population has benefited. Villages have been connected to the electric-power network, school buildings made with bricks, wells drilled, and water tanks installed. There are now teachers, as well as community health agents chosen within the community.

Under the project, each community is treated as an independent entity with its own identity, and cooperation and reciprocity are regarded as practices that ensure survival. Another notable factor has been the mobilization of quilombola leaders, who perceive children and families as the key to maintaining continuity and fostering the local culture.

Strengthening of partnerships to develop the project entailed delicate political negotiations, with the aim of strengthening ties among community leaders and the public authorities. The role of the Association of Black Rural Quilombola Communities (ACONERUQ) and of the Foundation for Children and Adolescents (FUNAC) were of fundamental importance in this process. However, since 2004, financial constraints have led to the closing of the Play Houses in the Codó and Itapecuru-Mirim communities.

Notwithstanding these obstacles, in 2006, Play Houses and initiatives relating to health, education, culture and leisure, carried out under Projeto Nyamê, are to be extended to another five quilombola villages in the municipality of Alcântara, 60 kilometers from São Luís. Furthermore, in 2005, the Project's methodology won funding awards under the second round of the Petrobras' Fome Zero [Zero Hunger] program.

Integrated services

Integral development stimulus enhances citizenship of children with cerebral palsy

Surmounting obstacles posed by misconceptions about children with cerebral palsy, and fostering their inclusion into society, are challenges assumed by the Center for Children with Cerebral Palsy (NACPC). Since 2001, the NACPC Center, in Salvador Bahia, has provided free services for children with cerebral palsy and their families, most of whom are poor. To help them face up to the problem, health professionals, teachers, social workers, and family members meet to join forces in a variety of activities aimed at providing stimulus and promoting integral development and social inclusion for these boys and girls, and offering educational opportunities.

Cerebral palsy is caused by lack of oxygen in the brain, either during pregnancy, at delivery, or during the period of neuromotor development. As a consequence, the child may experience difficulties that range from an almost imperceptible gait defect, to total incapacity for speech or movement. "Whatever the case, a child with cerebral palsy experiences difficulties in motor development, but cognitive and affective processes are not paralyzed", says physician Daniela Matsuda, Director of the clinic at the NACPC Center. Thus, if the child receives stimulus, chances of developing all capacities and adapting to life in society are much enhanced.

It based upon this principle that the NACPC offers not only health-related activities, but also physiotherapy, speech therapy, music therapy, and occupational therapy. The 250 children and adolescents who frequent the Center also three times a week attend a "Transition School" where they receive preparation to move on to regular schools. "It makes no sense to promote psychomotor development while leaving them encased in cocoons", says Daniela.

At the Transition School, which is maintained under a partnership with the Secretariat of Education, boys and girls with cerebral palsy participate in activities similar to those in regular schools. They have classes in Portuguese and mathematics, field trips and after-class activities, while the school maintains the flexibility to cater for the specific needs of each child.

So far, seventy children have passed on to the regular school system. Six-year-old Matheus Barbosa is one of them. Since June 2005, he has attended early-childhood education classes at a municipal school. Owing to compromised motor function, he needs constant attention from his 29 year-old mother, Luciana Santos Barbosa, who still has to feed him. "It is wonderful to see how well he is adapting", she says. His classmates play with him, push his wheelchair when they go for walks. "Children adjust easily to differences", says his mother.

"Often, education professionals doubt their own capacity to deal with cerebral palsy", says Valdeci Pereira, the Center's pedagogical coordinator. This is why NACPC also provides support to regular schools, through seminars and systematic visits. Also, children that have been placed in regular schooling continue to attend classes at least once a week at the Transitional School, where they receive coaching.

Care for the children's health is closely linked

to actions in the education area. Doctors, physiotherapists, speech therapists, and other health professionals monitor the work of the teachers at the Transitional School. These health professionals periodically visit classrooms, so as to check the children's posture, use of language, and motor difficulties. They also visit regular schools attended by the 70 boys and girls with cerebral palsy who have passed through the Center.

PARTICIPATION OF THE FAMILY

The child's family also has an important role to play in the process. While their children are receiving individual attention or when they are in the classroom, family members learn to recognize problems and how best to deal with them, and receive orientation on children's rights and family competencies. They also learn to have faith in the abilities of their children, thereby demystifying cerebral palsy. This is the central aim of a project, known as Conta, Reconta: Ação e Multiplicação, carried out by the NACPC in partnership with UNICEF.

By means of role play and story telling activities, this Project places the caregivers of these boys and girls in contact with issues relating to their integral development and social inclusion. "Through such stories, children expand their experience of various situations, and this helps them make real-life connections", explains the pedagogical coordinator. Such activities stimulate interaction between families and children, and groups of family members make classroom presentations for the children.

Housewife Silvanira Rodrigues, 58 years old, has learned the power of such interaction. She has provided care for 6-year-old Cléverson, her grandson, since he was 7 months old. She says the boy's mother abandoned the family, and the father, after hearing that the boy had cerebral palsy, lost all interest in him. She tells how, after becoming involved with the Project, she began to have a better understanding of these issues. "As my behavior in relation to him improved, I learned how best to take care of him", she says.

Coming into contact with other children in the same situation was also important for Silvanira. She recalls how, upon receiving the diagnosis of cerebral palsy, she was devastated and afraid. "After having seen other children with the same condition, and learned of the work the Center carries out with them, I perceived that there was no reason to treat him any differently from other boys or girls of his age", she says.

Encouraging such interaction is one of the aims of the Project. The intention is that family members should become multipliers, and pass on everything that they have learned, in a light and playful manner. Thus, Conta, Reconta: Ação e Multiplicação is an extension of an initiative launched by UNICEF in 2003, Projeto Afagar, that seeks to provide support and guidance for families of children with disabilities. The idea is to provide training for the people who work most closely with children with cerebral palsy, with a view to making them multiplying agents in their daily lives. Through them, it is possible to spread information on the rights of children with disabilities, and even help reduce the prejudice that surrounds them.

In order to foster such multiplying effects, mothers and caregivers are awarded certificates as multiplying agents. In Silvanira's case, this encouragement was all she needed to spread the word wherever she goes in Salvador. With respect to her grandson, she says: "People don't understand cerebral palsy. They feel sorry for the child. They look upon him as if he had a disease. I want to tell them that that is not how it is. I am very proud of my grandson."

The idea is to provide training for people that work closely with children with cerebral palsy, and make them multiplying agents in their daily lives.

Deprived of citizenship

Birth registration, the most basic acknowledgment of a child's citizenship rights, necessary for access to public services and benefits, is still denied to over one fifth of newborns in Brazil

Awareness of the scope of the problem of children without birth registration in Brazil has increased since the 1990s, when debates and awareness-building campaigns were first launched to combat underreporting of births. Estimates based on 2003 data, published by the Brazilian Institute for Geography and Statistics (IBGE) indicate that, each year, almost 750,000 Brazilian children (over one fifth of newborns) reach their first birthday without having received the document that records their name and the names of their parents. Such children are denied their fundamental right to a name, birth registration, and a birth certificate. The Convention on the Rights of the Child of 1989, states that all children ought to be duly registered immediately after birth.

If a child is unregistered, it simply does not exist as far as the State is concerned, and is not eligible for services and benefits provided for by law. As the basic requisite for any person to be acknowledged as a citizen, birth registration is required, for example, for the obtaining of a birth certificate, and thereafter a plethora of other documents, effecting enrolment at school, eligibility for governmental benefits, and access to Social Security. Birth registration is also an essential requisite for public policy planning.

The huge numbers of unregistered children pose an obstacle to researchers that seek to portray the true situation of children in Brazil, and for the planning of actions and programs targeted at serving the needs of children and youths. Faulty birth registration data also hampers efforts to quantify trafficking in children and child labor, since difficulties of proving the legal existence of each child make it harder to address such issues.

Ensuring birth registration for all newborn children is one of the goals of *A World Fit for Children*, the United Nations document issued in 2002 to underscore measures necessary for fulfillment of the Millennium Development Goals (MDGs) for children and adolescents. In 2003, in Brazil, the

Child Friendly President's Plan, prepared to facilitate fulfillment of the MDGs, pledged to pursue the goal of universal birth registration, by means of promoting a national birth-registration drive.

REDUCING UNDERREPORTING

Public concern for the expansion of coverage of Brazil's birth registration system has been rising since the 1990s. In 1997, with the enactment of Law 9.534, birth registration and issuing of a free first birth certificate became the right of all citizens, rather than only of those that plead poverty, as foreseen in the Constitution. Though unquestionably a major advance, the law did not (as had been expected) result in a major reduction in the levels of underreporting of births, i.e., numbers of children not registered in their first year of life or in the first quarter of the following year.

From 1993 to 2003, according to IBGE estimates, underreporting levels remained between 20% and 30% *(Table 1)*. During this period there were variations from one year to another, but no lasting reduction to indicate consistent progress in reducing underreporting. The lowest levels were reported in 1999, when the Ministry of Health, in close coordination with other governmental and non-governmental bodies, conducted a successful campaign to encourage birth registration. The results, however, proved fleeting and, by 2001, once the effects of the campaign had passed, underreporting levels climbed back to over 25%.

Table 1

Estimated underreporting of births in Brazil*	
1993	26.9%
1994	25.2%
1995	28.6%
1996	27.4%
1997	29.4%
1998	26.5%
1999	20.9%
2000	22.7%
2001	25.6%
2002	24.4%
2003	21.6%

Sources: IBGE, Birth Registration Statistics1991-2002 and Birth Registration Statistics 2003. * Percentage in relation to the total of live births

Another much larger-scale initiative targeted at reducing underreporting of births in Brazil was launched in October 2003. The National Birth Registration Mobilization drive, which brought together the efforts of 62 entities at the federal level and committees from each of Brazil's 27 states, was coordinated by the Under-Secretariat for Human Rights of the General Secretariat of the Presidency of the Republic. Three different areas were targeted:

- **Awareness-building** – since 2003, events have been held to commemorate National Birth Registration Mobilization Day, and Rural Birth-Registration Mobilization Day. Also, campaigns to promote birth registration have been carried out in partnership with the Social Service for Industry (SESI) and the Globo Television network, within the scope of Ação Global.
- **National Level** – In May 2004, a meeting was held with 112 representatives of the entities that participate in the National Birth-Registration Mobilization Drive, at which a National Plan for Birth Registration was drawn up, setting priorities to be met in the struggle to eradicate underreporting of births in Brazil. This meeting culminated in the signing of a national pact for implementation of the Plan.
- **Articulation among government programs and actions** – Partnerships were formed with ministries and public bodies to enable staff members to assume the role of permanent advocates for the cause of universal birth registration. Coordinators of the mobilization drive produced primers, targeted at community health agents, literacy teachers, and monitors of the Zero Hunger (Fome Zero) Program, encouraging them in their efforts to promote birth registration.

Initial results of this mobilization drive are reflected in the Estimates of Underreporting of Births, published by IBGE as of 2004.

UNEQUAL COVERAGE

One of the challenges for reducing underreporting in Brazil is difficulties of access to

areas where the problem is most accentuated. A survey carried out by the Ministry of Health under the National Birth-Registration Mobilization Drive, illustrates regional disparities in the coverage of the birth-registration system (Table 2). The survey took into account only statistics on births reported by the healthcare system, and does not include children born at home. Thus, the national total differs from the IBGE estimate, which is a projection of all live births in Brazil.

The results, though they do not furnish precise figures on levels of underreporting in Brazilian states, nonetheless provide a clear indication that underreporting is concentrated principally in states of the North and Northeast regions.

Aside from disparities between states and regions, there are also often significant variations in the levels of underreporting among municipalities of a single state. A survey conducted by the Ministry of Health in 2002, that encompassed 78 municipalities in all regions of Brazil, revealed underreporting levels of over 80%.

In the States of Amazonas, Pará, Tocantins, Maranhão, Alagoas, Rio Grande do Sul and Mato Grosso, there are small municipalities in which fewer than 2% of the children born in 2002 were registered in that same year. Even within municipalities, significant disparities in birth-registration levels can be observed. Rural, indigenous, and quilombola (former-slave) communities are more likely to have higher percentages of unreported births (see the text entitled Difficulties faced by indigenous groups).

Table 2

Birth registration coverage in relation to births reported by the healthcare system (2002)

State	Birth registration coverage	Underreporting
Brazil	**83.3%**	**16.7%**
Central-West		
Distrito Federal	91.9%	8.1%
Goiás	85.5%	14.5%
Mato Grosso	78.7%	21.3%
Mato Grosso do Sul	87.1%	12.9%
Northeast		
Alagoas	66.9%	33.1%
Bahia	88.9%	11.1%
Ceará	75.2%	24.8%
Maranhão	62.0%	38.0%
Paraíba	84.2%	15.8%
Pernambuco	73.8%	26..2%
Piauí	65.6%	34.4%
Rio Grande do Norte	75.7%	24.3%
Sergipe	73.7%	26.3%
North		
Acre	71.7%	28.3%
Amapá	67.5%	32.5%
Amazonas	60.0%	40.0%
Pará	60.1%	39.9%
Rondônia	83.9%	16.1%
Roraima	59.6%	40.4%
Tocantins	63.1%	36.9%
Southeast		
Espírito Santo	89.0%	11.0%
Minas Gerais	96.1%	3.9%
Rio de Janeiro	87.8%	12.2%
São Paulo	95.0%	5.0%
South		
Paraná	92.7%	7.3%
Rio Grande do Sul	90.0%	10.0%
Santa Catarina	95.0%	5.0%

Sources: Ministry of Health, Information System on Live Births (Sinasc) 2002, and IBGE - Birth Registration Statistics 2002.

FAMILY AWARENESS

Throughout Brazil, a general lack of information is one of the principal causes of underreporting of births. A large proportion of the population seems unaware that, without birth registration, a child can not obtain documents, use public services, or receive government benefits. People are generally also unaware of how to go about registering a child. A great many women fail to apply for registration simply because the child's paternity has not been acknowledged, despite the fact that, by law, they can register a child in their own name, or supply the name of the alleged father at the registry office.

Many families are also unaware that, by law, registration is free of charge. For all these reasons, it is important that efforts to stimulate universal birth registration involve activities for informing

families of their rights, by means of awareness-building campaigns and registration drives.

Awareness building initiatives can not, however, be merely one-off activities. As the experience of the Ministry of Health's 1999 campaign has shown, if such activities are not continuous, though their short-term effects may be significant, they are unlikely to be long lasting. The achievement of the latest National Birth-Registration Mobilization Drive, launched in 2003, is that it combined high-profile events, such as National Birth-Registration Mobilization Day, with permanent efforts to provide information for families, by means of the staff of governmental services and programs.

Also important for ensuring lasting outcomes has been the engagement of state and municipal authorities in efforts to raise popular awareness of the importance of birth registration. Especially in those areas where underreporting of births is most prevalent, the efforts of local authorities need to be added to those of the national government. In certain areas of Brazil successful experiences have been reported, as in the municipality of Santa Quitéria, in Maranhão, which has managed to reduce underreporting of births to zero (see the text entitled Birth registration: a right of the child and of the family). In various other locations, partnerships between such players as the Municipal administration, the State Attorney's Office [Ministério Público] and non-governmental organizations, have resulted in campaigns to stimulate birth registration.

PROBLEMS OF ACCESS

For significant portions of the poor population, problems of access to a registry office or notary service make it difficult to register their children. All too often, the parents fail to go to the registry office, simply because they can not afford the cost of transport. In 2002, Ministry of Health Order 938, instituted financial incentives for hospitals and maternity services affiliated to the Unified Health Service (SUS) that offer birth registration services. This simple measure has proven an effective means of reducing underreporting of births, since it makes it easy to register newborn children before they are discharged from hospital.

Aside from this Ministry of Health incentive, engagement of public authorities at the state and municipal levels has proven important for improving birth-registration rates in Brazil. Sixteen of Brazil's

Difficulties faced by indigenous groups

Registration issued by FUNAI does not solve problems of indigenous communities

The problem of underreporting of births takes on even greater complexity among indigenous communities. Indigenous families may opt to take out a document known as Administrative Registry Birth of an Indian (RANI) issued by the National Indian Foundation (FUNAI) thereby saving them the trouble and expense of traveling to a registry office. This document (RANI) should, in theory, be valid as birth registration. There have been cases, however, in which public bodies refuse to acknowledge the validity of the RANI as birth registration. In such events, Indian families are obliged to seek out a notary office, which often entails a long journey.

Even in places where validity of the RANI is not challenged, distance may prove a great obstacle to birth registration. Not always are RANI certificates issued at the nearest FUNAI post to the village. The fact that registry services are centralized at the FUNAI's regional offices, rather than at local support services, adds to the difficulty of access of Indigenous peoples to birth registration. Efforts are currently underway within FUNAI to provide birth registration services at the village level, but staffing shortages make this difficult to deliver. The result is that many families end up simply not registering their children owing to the vast distances they would have to travel, especially in the Amazon region where communities tend to live in remote locations.

Lack of information is another problem that exacerbates underreporting among indigenous communities, especially since they are normally less susceptible to awareness building campaigns targeted at

27 states have reached agreements with local public notary offices to install birth-registration posts at maternity hospitals, and efforts are currently underway to expand the number of maternity services that offer on-site birth registration. In Campo Grande (Mato Grosso do Sul), Municipal Ordinance 4.285 of June 2005, instituted birth registration services at maternity homes in the municipality. This law authorizes the municipal administration to sign agreements with public notary offices for the installation of birth-registration posts at all maternity homes in the city of Campo Grande. The hospitals are responsible for providing appropriate installations, and for informing families of the service and of the importance of registering their children, whereas the notary offices provide the staff.

Another strategy for promoting birth registration has been the establishment of mobile registration posts that travel to poor or remote communities offering birth-registration services to the local population. With a view to instituting this service, the National Association of Registrars of Natural Persons (ARPEN Brasil), at the 12th National Congress of Registrars of Natural Persons, held in October 2004, announced the launching of the 1st National Mobile Birth Registration Campaign. The first mobile birth-registration units went into service in Maceió (Alagoas) in December of the same year. Despite this welcome initiative on the part of ARPEN Brasil, there have been few experiences of this type. However, the coordination unit of the National Birth-Registration Mobilization Drive plans too intensify efforts to expand coverage of birth registration services, in partnership with ARPEN and with the Association of Notaries and Registrars of Brazil (ANOREG).

In the State of Maranhão, since 1998, there has been an official program to provide birth registration and other services through mobile registration posts that visit remote municipalities. This program, known as Viva Cidadão, is a result of a partnership between the State Government and the Court Oversight Commission [Corregedoria Geral de Justiça]. The program has 13 mobile registry offices, mounted on trucks and on a railroad wagon that runs on the Companhia Vale do Rio Doce railroad line, and two fixed registry posts at maternity hospitals. This makes it possible to provide birth-registration services for families in small towns and remote rural communities, where the highest rates of underreporting occur. Since the Viva Cidadão program was launched (up until July 2005) over 170,000 births have been registered at its 15 registry posts.

the Brazilian population as a whole. There are also cultural barriers since, among indigenous peoples, the birth of a child is not regarded as an event that needs to be legitimized by a paper or document. Notions of citizenship are different, since the majority of the parents were not registered at birth either, and fail to understand the importance of registering their newborn children.

Though no official estimates of underreporting of births among indigenous communities are available, a combination of all the abovementioned factors lead such communities to top the ranking of children that have not been registered within the first year of life. To resolve this problem, aside from greater efforts on the part of the government, it will be necessary to interest organizations of indigenous leaders in the question of providing birth registration for their young.

In the Alto Rio Negro region, in 2001, the Federation of Indigenous Organizations of the Rio Negro (FOIRN) launched a successful initiative aimed at promoting birth registration and citizenship among local communities. This project, known as Balcão da Cidadania, was funded by the Under-Secretariat for Human Rights of the General Secretariat of the Presidency of the Republic, and received support from Instituto Socioambiental (ISA) and from UNICEF.

Using a boat belonging to a local education program, the project team visited villages in the region to register the local inhabitants and issue identity documents. Prior to each journey, appeals for mobilization were broadcast on the local radio, with a view to preparing the villagers and helping them understand the importance of birth registration and of identification documents.

In part, the importance of this initiative was its educational value, in that it contributes toward changing attitudes that are likely to result in lower rates of underreporting. Furthermore, the immediate results achieved were quite significant. In the three stages of the program, carried out in 2001, 2002 and 2003, 3,346 people were registered, in this vast region that encompasses 750 villages and an indigenous population of 35,000.

WEAKNESSES OF THE SYSTEM

Many improvements in the system still need to be effected in order to achieve universal birth registration in Brazil. Many failings compromise the uniformity, mobility and efficiency of the system. Sustainability of the system is one of the key issues since, although free birth registration has been guaranteed by law since 1997, notary offices are private institutions and rely on charges for the services they perform. To address this issue, Federal Law 10.169, of 2000, ordered the states (and the Federal District) to create mechanisms to compensate notary offices for the provision of birth-registration services that they are obliged to provide at no charge. In practice, this implies the establishment of a state fund to underwrite the costs of birth registration.

Though the law went into force in 2002, the situation has not yet been normalized. A survey conducted by ANOREG and ARPEN in 2005, shows that in most states these funds exist, but are insolvent. By 2005, the States of Amapá, Goiás, Pará, Roraima and Sergipe had not taken any steps to compensate notary offices. In a few states, most notably São Paulo, the first to establish such a fund, the system works well. The São Paulo fund was set up in 1998, when federal law instituted free birth registration, and prior to enactment of the requirement that all States establish forms compensating notaries for the service.

One of the difficulties for resolving the situation throughout Brazil is the provision of Law 10.169, article 8, sole paragraph, that determines that such compensation shall not result in expense for the public authorities. Thus, such funds have to be drawn from revenues generated by the notary offices, and since these are already required to contribute toward the Special Fund for Modernization and Enhancement of the Judicial Branch, they are reluctant to assume new liabilities. This impasse has yet to be resolved, if the funds for underwriting the costs of birth registration are to be effective.

Aside from the problem of sustainability, the birth registration system suffers from serious structural weaknesses. Many notary offices still use archaic systems that greatly hamper their efficiency, and accessibility for the public. The ANOREG/ARPEN survey pointed out that the levels of information-technology use vary considerably in different parts of Brazil. Whereas in São Paulo, Santa Catarina, Paraíba and the Federal District, 100% of the notary offices rely on computerized systems, in states of the North and Northeast regions, less than 50% of them do. Striking disparities are also in evidence between notary offices in state capital cities, and those in small towns of the interior, the latter generally being poorly equipped and unprepared to cope with the increased demand for free birth registration services.

Strengthening and revitalization

All these issues were of foremost concern when the National Plan for Birth Registration was drawn up, during preparations for the National Birth-Registration Mobilization Drive. The Plan foresees that, after having conducted a diagnostic analysis in each state, a program for strengthening and revitalization of the birth registration system be instituted. It proposes that joint efforts be carried out by federal bodies to modernize the operations of notary offices, especially those in the interior. It also proposes measures for ensuring compliance in all of Brazil's 27 states with legal requirements for the establishment of funds to compensate notary offices.

Though implementation of the National Plan is essential if lasting and consistent progress is to be achieved in expanding birth registration coverage, the question of where the necessary funding is to come from remains unresolved. The Management Committee of the Child Friendly President's Plan, in a report issued in 2004, acknowledged that the greatest difficulty for achieving goals relating to birth registration was "the lack of financial resources to carry out actions for implementation of the national plan, given that mobilization for this activity currently lies outside the scope of budget planning".

If funding is not forthcoming, it is likely that actions identified as necessary by the various players involved in drafting the National Birth-Registration Mobilization Drive will remain unfulfilled.

Birth registration: a right of the child and of the family

From Maranhão, an exemplary experience for the rest of Brazil.

Santa Quitéria is the first municipality to eradicate underreporting of births

Since 2001, the UNICEF office in São Luís, in partnership with the State Courts and State Government, has provided support for a project entitled Birth Registration: a Right of the Child and of the Family, with the aim of reducing the numbers of children with no birth certificate or birth registration in the State of Maranhão.

According to census data, Maranhão was the Brazilian state with the highest level of underreporting of births: 62% (IBGE 1996). Since a major portion of the population lives in rural areas, measures to address the problem have required considerable strategic planning and the participation of a great variety of players. The first step was to carry out a diagnostic analysis of underreporting of births at the municipal level, comparing data from the Census (IBGE), the Information System on Live Births (SINASC), the Primary Healthcare Information System (SIAB), and the records of notary offices and the Judicial Oversight Commission [Corregedoria de Justiça].

Among the strategies adopted were: active searches for unregistered children in the records of municipal health secretariats, maternity hospitals, and notary offices; citizenship drives; the setting up of birth-registration posts at maternity homes; articulation with the Children's Rights Councils and Guardianship Councils; inclusion of the theme in educational initiatives carried out in conjunction with the local Viva Cidadão program, through a partnership with the Judicial Oversight Commission, with media coverage of the theme, and the holding of regional mobilization seminars.

Maranhão, a State that formerly had the highest levels of underreporting of births, has reversed this situation, and now has an exemplary successful experience to share with other states in Brazil. The most recent census data (IBGE 2002) shows that underreporting of births has dropped to 38.2%. Furthermore, Santa Quitéria is the first Brazilian municipality to attain the Federal Government's goal of eradicating underreporting of births.

SANTA QUITÉRIA, AN EXAMPLE OF CITIZENSHIP

Upon delivery of a report to the Under-Secretariat for Human Rights of the General Secretariat of the Presidency of the Republic, in June 2005, Santa Quitéria, a small municipality in the Semi-arid region of the State of Maranhão, was acknowledged as the first municipality in Brazil to have eradicated underreporting of births. The campaign, launched in November 2003 and concluded on May 31, 2005, reached 2,500 persons, including children, youths, adults and the elderly, in 82 communities. Active participation of the local population and of the network of partners were among the factors responsible for the success of the campaign.

As a strategy for responding to the various sit-

During the campaign to eradicate underreporting of births in Santa Quitéria, alterations were made to the documents of over five hundred people

uations identified, the local Courts and Attorney's Office [Ministério Público] provided support for the establishment of a Forum for the Rights of Children and Adolescents, in which 45 municipal organizations, community and faith-based groups, associations and trades unions participated. Popular assemblies, meetings and citizenship drives were held, with field trips to rural communities for the staff of court and extra-judicial services. Birth registration was not the only challenge addressed; also on the agenda was the need to promote citizenship, and to reestablish family, community, and affective ties.

"Birth registration is a passport to citizenship", says Nahyma Abas, prosecutor for the Santa Quitéria court district. She reports that, as a consequence of the mobilization drive, requests for services rose by almost 90%, with petitions for food aid, paternity suits, and adoptions. According to Justice Luís Jorge Silva Moreno, a veritable awakening has taken place in the demand for judicial services within the municipality.

On the occasion of the founding of the Forum for the Rights of Children and Adolescents, the Courts and the Attorney's Office located a family in which neither of the parents (cowboy and farmhand José Carlos da Silva, and his wife Rosa Vieira) nor any of their six children (ages ranging from 3 months to 13 years) had been registered or possessed a birth certificate. This family became the symbol of the campaign, though other similarly dramatic cases were found.

"For many families the Forum was a great reunion. Siblings that had not seen each other for years, families that had been uprooted, stories of neglect, abandonment and death", recalls Justice Luís Jorge Moreno.

According to Justice Luís Jorge Moreno, most of the people registered were over 12 years old. Many people between the ages of 70 and 80 years had never had a birth certificate. The oldest person to be registered was 92 years old. "The campaign to eradicate underreporting is restoring citizenship and self-esteem, along with the history, sense of community and self-respect", he says.

During the campaign, alterations were made to the documents of over five hundred people (birth and marriage certificates with incorrect birth dates, names, or professional data). In one family of ten, nine members had documents with discrepancies or incomplete data, or which provided only the person's name and birth date.

To stimulate public participation, 110 volunteers, community leaders, and members of the Children's Pastorate, received training as monitors of citizen-

ship rights. Another mobilization activity, that brought together representatives of seventy villages (a total of 1,200 people) was the 1st Meeting of Communities, held in December 2004. At this meeting it was decided that priority should be given to strengthening the human rights agenda, through a pact for the eradication of underreporting of births in the first half of 2005, and the struggle to ensure fulfillment of other rights, such as access to electric power and public telephone services, and land tenure. Alongside these actions, community health agents joined the search to identify individuals without birth certificates in the municipality.

Judge Luís Jorge Moreno considers that this 'front line' approach, in which the Courts, the Attorney's Office, and the Center for Defense and Promotion of Citizenship Rights were the principal players, was crucial to the success of the initiative. Currently, the main concerns, both of the judge and of the prosecutor of the Santa Quitéria court district, are how to ensure that all births continue to be registered in the municipality, and replication of the experience in other towns in Maranhão.

Among the approaches for ensuring that all births continue to be registered, the judge prescribes:

- Surveillance and inspection of notary offices.
- Actions by the Attorney's Office, that has held meetings with community health agents and signed an agreement with the Municipal Secretariat of Health. The agents have pledged to inform parents of the importance of registering their children, and notifying the Attorney's Office of cases of unreported births, so that the appropriate legal measures can be taken (cautioning of the parents, clarification of their rights as parents, etc.).
- Struggle for the implantation of Guardianship Councils, the bodies responsible for ensuring fulfillment of the rights of children and adolescents.
- Visits to communities, to promote the process of citizenship training.
- Broadcasting of information by local radio stations on the right to birth registration.
- Scheduling of community weddings, twice a year. During the current campaign 860 community wedding were celebrated.
- Printing of "certificates" to be delivered by the Under-Secretariat for Human Rights at each home in Santa Quitéria, as part of the process for promoting citizenship training and awareness building. The idea is to instill public awareness and assimilation of the importance of their collective achievement.

With a view to replicating this experience in other towns in Maranhão, the judge and the prosecutor of the Santa Quitéria court district have assumed a commitment to meet with their colleagues in other towns to enlist their support for the campaign, and to meet with representatives of the National Council for Food and Nutritional Security (CONSEA), the State Secretariat for Justice and Citizenship, civil society organizations, and local representatives of the Executive Branch and Legislatures.

According to Justice Luís Jorge Moreno, the strategy used in Santa Quitéria (involving diagnostic analyses, installation of a Forum for Eradication of Underreporting, meetings with local communities, and the scheduling of visits for mobile birth-registration services) could be replicated in at least seven other municipalities: Anapurus, Barreirinhas, Buriti, Icatu, Milagres, Nina Rodrigues and Vargem Grande. "Santa Quitéria is an example of what can be done to change realities and make things happen", says Prosecutor Nahyma Abas.

Strengthening families in order to strengthen children

A survey carried out by UNICEF reveals the importance of investing in families so as to foster the development of their under-6 year old children and ensure fulfillment of their rights

Ensuring full development and protection for children in their first six years of life depends not only upon the efforts of governments and social organizations. The essential role of families is clearly stated in article 227 of Brazil's Federal Constitution: "it is the duty of the family, society, and the State to ensure children's rights".

Parents and those responsible for children are the players most actively involved in providing the care that children need, and it is important that their competencies be strengthened so as to enable them better to fulfill their role in providing care for their children up until the age of six years.

It is for this reason that UNICEF underscores the importance of family competencies, meaning a set of knowledge, practices, and skills necessary for promoting survival, development, protection, and participation of children. Though families generally possess such competencies, in many cases they need strengthening.

The scope of family competencies encompasses adequate preparation for birth, psychosocial stimuli for the child, fostering cognitive development, the capacity to identify signs of disease and take the necessary measures, and actions to promote peace and prevent violence. In Brazil, a variety of governmental and non-governmental initiatives aim to promote such competencies. Three initiatives with ample coverage are the Family Health Program (PSF); the Community Health Agents Program (PACS), that function as partnerships between the Federal Government and municipal administrations; and work carried out by the Children's Pastorate, a faith-based social-services organization linked to the National Conference of Bishops of Brazil (CNBB). These entities work in direct contact with families in poor communities and provide child-care guidance for parents.

In the first half of 2005, there were 196,009 community health agents working in 5.110 munic-

ipalities, whereas the Family Health Program had some 22,000 health teams working throughout Brazil. These teams comprise one doctor, a nurse, a nursing assistant, and five community health agents. At the same period, there were some 140,000 community leaders of the Children's Pastorate at work throughout the country.

A UNICEF survey of communities in eight municipalities revealed weak family competencies, and consequently weak fulfillment of children's rights

Through partnerships with the Family Health Program, the Community Health Agents Program, the Children's Pastorate, and others, UNICEF has developed a Strategy for Strengthening Brazilian Families, the aim of which is to contribute toward enhancement of family competencies *(see the text entitled Qualification of Families)*. Within the scope of this initiative, in 2004, a comprehensive survey was carried out of communities in eight municipalities where the strategy was to be put into effect. Although care must be taken not to make sweeping generalizations, the data from this survey provides a snapshot of the status of family competencies in poor communities living in very different circumstances. The survey was carried out in the following locations:

- The outskirts of Belém, Pará.
- The indigenous village of Te´yi Kue, in Caarapó, Mato Grosso do Sul.
- Cabo de Santo Agostinho, an outlying area of the Recife metropolitan region, in Pernambuco.
- Itapecuru-Mirim, a quilombola [former slave] community, in Maranhão.
- Juazeiro, a medium-size municipality in the Semi-arid area of Bahia.
- The outskirts of Pelotas, a medium-size municipality in Rio Grande do Sul.
- Urban and rural areas of Salvaterra, a small municipality in Pará.
- The urban district of Tauá, a small municipality in the Semi-arid area of Ceará.

In each municipality, 250 families with children below the age of 6 years were interviewed (with the exception of Itapecuru-Mirim, where the community proved not to have that many families). The indicators assessed showed that, although significant differences exist between these communities, all of them had weaknesses in the area of family competencies and, consequently, in the fulfillment of children's rights.

DELIVERY CARE

The UNICEF survey assessed competencies related to care that ought to be taken prior to the birth of a child. The quality of prenatal care, so necessary for detecting risks during the course of pregnancy and preventing subsequent problems for the baby, varies considerably from one location to another. Whereas in Pelotas three quarters of expectant mothers attended no less than six prenatal-care sessions (the minimum number recommended by the Ministry of Health), at the quilombola community of Itapecuru-Mirim 40% of expectant mothers had not attended any prenatal-care sessions (*Table 1*). The survey also found that women are poorly prepared to demand their rights to high-quality prenatal care. When asked what they would do if they were not satisfied with the services provided, few mothers appeared to

Table 1

Number of prenatal care sessions attended

	Belém	Caarapó	Cabo de Santo Agostinho	Itapecuru-Mirim	Juazeiro	Pelotas	Salvaterra	Tauá
None	6.0%	32.4%	5.1%	40.0%	0.9%	0	6.8%	5.7%
1 or 2 sessions	4.3%	15.1%	1.3%	25.0%	2.7%	1.7%	3.4%	4.0%
3 or 6 sessions	33.7%	23.7%	22.6%	30.0%	38.9%	22.1%	60.5%	46.7%
7 or more sessions	56.0%	28.8%	71.0%	5.0%	57.5%	76.2%	29.3%	43.6%

Source: UNICEF.

Table 2

Participation of fathers in prenatal care								
	Belém	Caarapó	Cabo de Santo Agostinho	Itapecuru-Mirim	Juazeiro	Pelotas	Salvaterra	Tauá
Did not attend the session	77.0%	84.2%	76.5%	69.2%	55.9%	72.0%	82.7%	70.3%
Went to the health post	9.1%	7.9%	6.1%	30.8%	16.9%	11.3%	5.8%	19.4%
Attended the session	13.9%	7.9%	17.4%	0%	27.1%	16.7%	11.5%	10.4%

Source: UNICEF.

be aware that they could complain to the Municipal Health Council or to the municipal administration.

During pregnancy it is important that women receive anti-tetanus injections to ward off neonatal tetanus, which poses a serious hazard for babies. This disease results from contamination by instruments used to cut the umbilical cord. More than half of the women interviewed at Caarapó and at the Itapecuru-Mirim quilombola community were not adequately vaccinated.

Another risk factor identified during the survey was consumption of tobacco and alcoholic beverages during pregnancy. The highest levels were reported in Pelotas, where 43% of pregnant women smoked and 35% consumed alcoholic drinks, whereas at Itapecuru-Mirim, the proportions were 45% and 50%, respectively.

Participation of fathers in prenatal care

The participation of fathers in prenatal care, an early indication of their involvement in childcare, was low in all of the communities surveyed (*Table 2*). The proportion of fathers who did not attend any prenatal care sessions ranged from 55.9%, in Juazeiro, to 84.2% at Caarapó Indian village. It was also noted that rarely do the men that accompany an expectant mother to the health post attend the session. Among the families interviewed at the Itapecuru-Mirim quilombola community, not one of the fathers attended any of the prenatal care sessions.

At the time of delivery, a remarkably low proportion of women were accompanied by a family member. In Belém, only 11.6% of them were accompanied; in Pelotas, 13.7%. The presence of a family member is more common only in those localities where babies are delivered at home. In Itapecuru-Mirim, where home deliveries occurred among 61.9% of families, a family member was present at 76.2% of deliveries. The presence of a family member alongside the mother is an important factor for reducing anxiety and ensuring better delivery assistance. When this survey was conducted, most of the maternity wards affiliated to the Unified Health System (SUS) did not allow companions to attend the birth. Progress was achieved with the enactment of Law 11.108, of April 2005, that obliges health services affiliated to SUS to permit the presence of a companion during labor, delivery, and immediately postpartum.

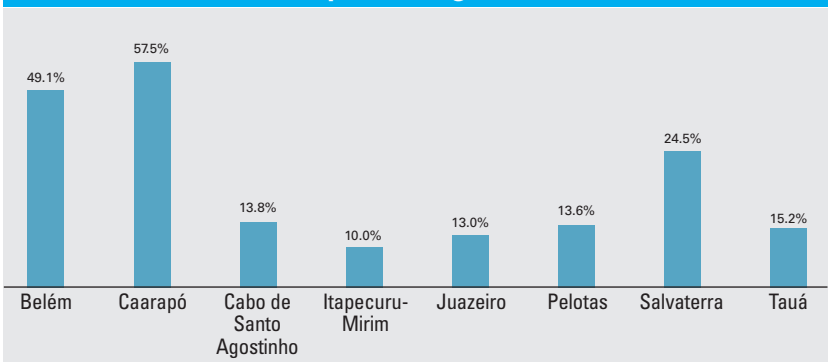
The international recommendation is that children should be exclusively breastfed up until the 6th month, and that breastfeeding should continue at least until the child is 2 years old

WHOLESOME FOOD

Another set of important competencies relates to care with the child's nutrition, beginning with breastfeeding. The international recommendation is that children should be exclusively breastfed up until the 6th month, and that breastfeeding should continue at least until the child is 2 years old. In Brazil, this recommendation is seldom fulfilled. The survey found that average duration of exclusive breastfeeding varied, from 1.9 months in Cabo de Santo Agostinho and Tauá, to 6.2 months at the Caarapó indigenous community. The proportion of children fed exclusively on breast milk up until the age of 6 months was below 20% in five

Graph 1

Proportion children that are exclusively breastfed up to the age of 6 months



Source: UNICEF.

of the eight municipalities in the study *(Graph 1)*. It is also extremely unusual for children to be breastfed up until the age of 2 years. Only in Caarapó did average breastfeeding periods continue up to the age of 2 years. In Cabo de Santo Agostinho, Tauá, and Pelotas, breastfeeding lasted on average less than one year.

The diet of older children is insufficiently balanced in most communities. The most commonly consumed food is rice

In order for breastfeeding periods to be extended in line with the recommendation, it is important that mothers receive guidance and that measures be taken to facilitate breastfeeding. It is important that mothers be instructed to breastfeed their babies within the first half hour of life. The survey shows that this rarely occurs in the communities studied. Whereas in Caarapó and Salvaterra over 90% of mothers breastfed their babies immediately after delivery, on the other hand, in Pelotas, Tauá and Juazeiro, less than 80% did.

Quality diet

The interviews revealed that the diet of older children is insufficiently balanced in most communities *(Table 3)*. The most commonly consumed foods are rice, followed by beans and meat. Fruits, vegetables and greens are consumed to a much lesser degree. The situation that most causes concern is at the Itapecuru-Mirim quilombola community where, in the 24 hours prior to the interviews, only 10% of the children had eaten fruit, 20% had eaten vegetables or greens, 15% had drunk milk, and none had eaten eggs. The families in Pelotas were the ones that offered the most balanced diet to their children.

The survey also assessed the degree to which children were receiving vitamin A, iron, and iodine supplements, that are so necessary to ensure that children's health is not undermined by micronutrient deficiencies. Four of these municipalities (Cabo de Santo Agostinho, Itapecuru-Mirim, Juazeiro and Tauá) are encompassed by the Federal Government's National Vitamin A Supplementation Program that focuses its attention upon the regions at highest risk. In Cabo de Santo Agostinho and Tauá, over 95% of the children over the age of 6 months had received vitamin A supplement. In Juazeiro and at the Itapecuru-Mirim quilombola community, fewer

Table 3

Foods consumed by children up to the age of 6 years in the 24 hours directly prior to the interviews

	Belém	Caarapó	Cabo de Santo Agostinho	Itapecuru-Mirim	Juazeiro	Pelotas	Salvaterra	Tauá
Milk	52.2%	27.4%	57.3%	15.0%	52.4%	78.4%	46.3%	79.8%
Fruit	50.0%	27.3%	52.7%	10.0%	42.5%	67.8%	64.9%	35.4%
Vegetables	27.6%	51.7%	25.3%	20.0%	33.6%	50.0%	18.1%	20.2%
Rice	61.8%	91.8%	76.4%	80.0%	71.4%	85.3%	59.7%	87.9%
Eggs	25.2%	21.0%	29.3%	0%	15.7%	23.6%	28.8%	23.6%
Meat	65.0%	54.8%	74.6%	55.0%	63.5%	71.9%	62%	54.9%
Beans	58.1%	85.3%	76.9%	35.0%	70.9%	84.0%	68.4%	68.7%

Source: UNICEF.

than 85% of the children had received this supplement. The situation at Itapecuru-Mirim raises concern, since the diet was found to be particularly poor in foods containing vitamin A (milk, fruits, vegetables, greens and eggs).

Iron supplementation, used to control anemia, a disease that is highly prevalent in Brazil, is tackled by the Federal Government, through the Community Health Agents Program (PACS) and the Family Health Program (PSF). The results of the survey suggest that such efforts are failing to meet their objective, since children living in areas covered by these programs had not received doses of iron sulfate in the three months prior to the interviews. The proportion of children that had received supplements of iron sulfate during the period covered by the interviews ranged from 12.5% in Itapecuru-Mirim, to 62.6% in Caarapó Indian village.

Iodine supplementation, effected by means of iodized salt, has proven more effective. In the homes where researchers were able to verify the provenance of table salt used, it invariably contained iodine. The highest incidences of the use of non-iodized salt were found at Cabo de Santo Agostinho (5.2%) and Tauá (4.8%).

WARDING OFF DISEASE

Providing for the health of children depends to a great extent upon family competencies in such areas as disease prevention, identification of symptoms and referral for treatment when necessary. An essential instrument for monitoring children's health is the Child's Card [Cartão da Criança], on which information relating to the child's growth, development, and vaccinations received is noted. In the municipalities surveyed, over 95% of the families interviewed claimed that they had the card. The exception was Juazeiro, where this proportion dropped to 94.4%. In Pelotas, the percentage was 99.2%.

The levels of concern with respect to vaccination of children varies from one community to another but, generally speaking, the percentages of children who had received all the vaccinations appropriate to their age were very low *(Graph 2)*. At Caarapó Indian village, the proportion was below 50%; and in three other localities (Salvaterra, Cabo de Santo Agostinho and Pelotas) less than 75% of the children had received all the prescribed vaccinations. As vaccinations follow a compulsory calendar and are provided free throughout Brazil, the main factor needed to keep children's vaccination cards up to date is effort on the part of their parents.

Levels of concern with respect to vaccination of children varies from one community to another but, generally speaking, the percentages of children who had received all the appropriate vaccinations were low

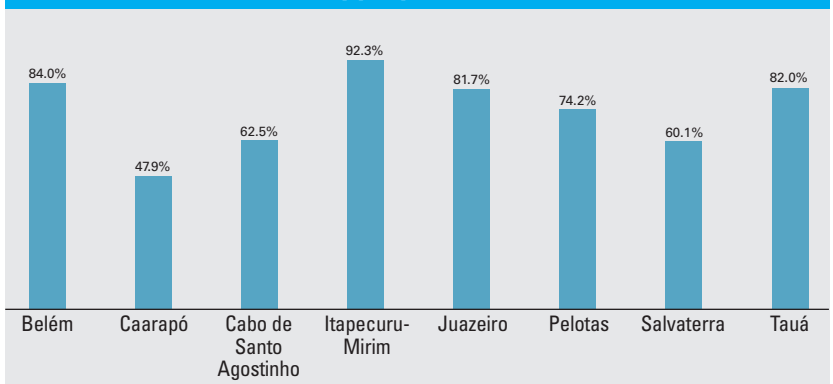
The best vaccination coverage levels were found in Itapecuru-Mirim quilombola community, where 92.3% of children had received all the basic vaccinations appropriate for their age. This high level can be attributed to actions carried out by the Children's Pastorate. Each month, the Pastorate's community leaders weigh all the children, and check that their vaccinations are up to date.

Hygiene

Hygiene precautions as basic preventive measures, were well understood in all the com-

Graph 2

Proportion of children up to the age of 6 years who had received all appropriate basic vaccinations



Source: UNICEF.

Table 4

Signs of disease that should lead families to seek emergency medical services

	Belém	Caarapó	Cabo de Santo Agostinho	Itapecuru-Mirim	Juazeiro	Pelotas	Salvaterra	Tauá
Very yellow skin	97.2%	82.9%	94.3%	80.0%	94.5%	93.0%	93.1%	94.0%
Cough and high fever	98.8%	89.9%	98.3%	90.5%	97.6%	98.8%	100.0%	98.0%
Difficulty breathing	99.6%	86.9%	93.1%	80.9%	100.0%	99.4%	100.0%	96.4%
Rapid and noisy breathing	96.8%	91.5%	90.6%	81.0%	96.1%	95.2%	96.3%	94.0%
Sunken eyes, intense thirst, extreme lethargy	97.6%	86.5%	94.7%	76.2%	98.4%	98.7%	99.4%	95.1%
Blood in the feces	98.2%	84.3%	97.5%	95.0%	99.2%	98.2%	97.5%	94.4%
Blueness of feet, hands, and lips	99.2%	85.9%	97.6%	71.4%	96.9%	98.1%	100%	93.5%

Source: UNICEF.

munities surveyed. In almost all of the families, the person responsible for the child washed hands, after using the toilet, before cooking, and (to a slightly lower extent) before feeding the baby.

The survey found that a great number of children do not receive exclusive attention of family members

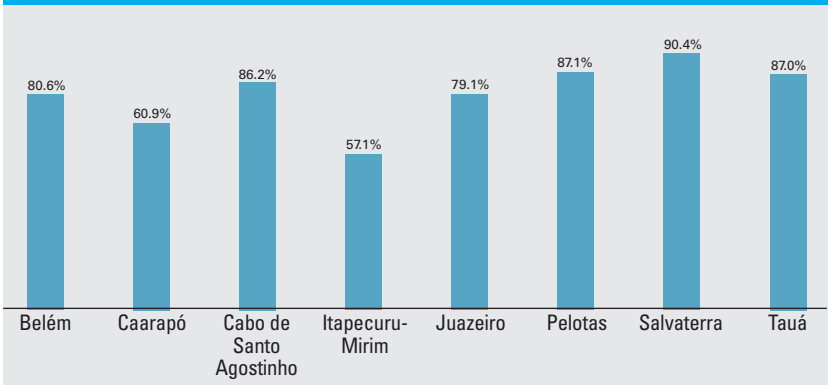
Among the children too, the habit of washing hands before eating is fairly common. Observers found that it varied, from 90.5% in Juazeiro, to 97.2% at Caarapó Indian village. The proportion of children who wash their hands after using the toilet varied, from 91% at the Itapecuru-Mirim quilombola community, to 96.8% in Salvaterra.

Within the scope of the survey, it was found that most parents and caregivers know how to identify signs of disease that require urgent medical attention, though there are exceptions *(Table 4)*. In Caarapó and Itapecuru-Mirim, over 10% of those interviewed failed to mention such important symptoms as sunken eyes, intense thirst, and extreme fatigue, blueness of the feet, hands and lips, yellow skin, and difficulty breathing.

Failure to notice such symptoms poses a serious risk to the child. Since both these communities are in rural areas, located far from the nearest health services, it is of fundamental importance that the family take the initiative in seeking the services of a doctor as quickly as possible when a child shows the first signs of any disease, so as to avoid worsening of the problem before medical attention can be received.

Graph 3

Proportion of families in which someone devotes exclusive attention (playing, reading or talking directly and exclusively) to children on a daily basis



Source: UNICEF.

ENCOURAGEMENT AND ORIENTATION

Families have a key role to play in the cognitive and emotional development of their children. Children need attention, stimuli, and a propitious environment in which to develop. The survey found that great numbers of children do not receive exclusive attention from family members. One of the questions asked during interviews was whether someone in the family ever played, read, or talked exclusively and directly with the child. In 42.9% of the families at Itapecuru-Mirim quilombola community; 39.1% of families at Caarapó Indian village; and 20.9% of the families in Juazeiro, the answer was no *(Graph 3)*.

Table 5

Attitude of the caregiver when a child below the age of 6 years misbehaves

	Belém	Caarapó	Cabo de Santo Agostinho	Itapecuru-Mirim	Juazeiro	Pelotas	Salvaterra	Tauá
Say "don't" and explain why	94.8%	68.9%	82.7%	90.5%	90.5%	83.2%	87.3%	89.6%
Make threats	46.2%	38.6%	53.6%	61.9%	48.8%	49.0%	58.6%	52.3%
Smack the child	80.2%	48.5%	81.9%	85.7%	76.0%	74.3%	80.3%	74.0%
Beat the child	55.0%	49.2%	57.5%	85.7%	52.0%	38.4%	59.3%	41.6%

Source: UNICEF.

Having an opportunity to play with other children is also important for child development, and is part of day-to-day life of a somewhat larger proportion of the children, ranging from 78.2% in Pelotas, to 95.2% in Itapecuru-Mirim.

Providing stimulus for children within the home environment is especially important, given that the survey revealed that little demand for daycare and (in some of the 8 communities surveyed) for preschools. The proportion of children up to 3 years old attending daycare was 8.4% in Pelotas, 9.6% in Juazeiro, and 11.8% in Salvaterra, whereas the largest proportion reported was 25% in the Itapecuru-Mirim quilombola community. In the 4-to-6 year age group, preschool attendance rates were only 27.3% at Itapecuru-Mirim; 32.3% at Caarapó Indian village; and 34.3% in Pelotas, despite the fact that all children at this age ought to attend preschools. In the other communities surveyed, the proportions were much higher (over 70%), and in Tauá 92.5% of the children in this age group attended preschool.

There are very few books, magazines and toys in the homes in all eight localities, though this varies from one to another. Over 40% of families living in urban communities have no children's books, and the situation is far worse in rural areas. In Itapecuru-Mirim, only 9.5% of families own a children's book. Though the proportion of children that have some contact with magazines or newspapers is somewhat larger, in rural communities especially it remains very low (less than 15% in Caarapó and Itapecuru-Mirim).

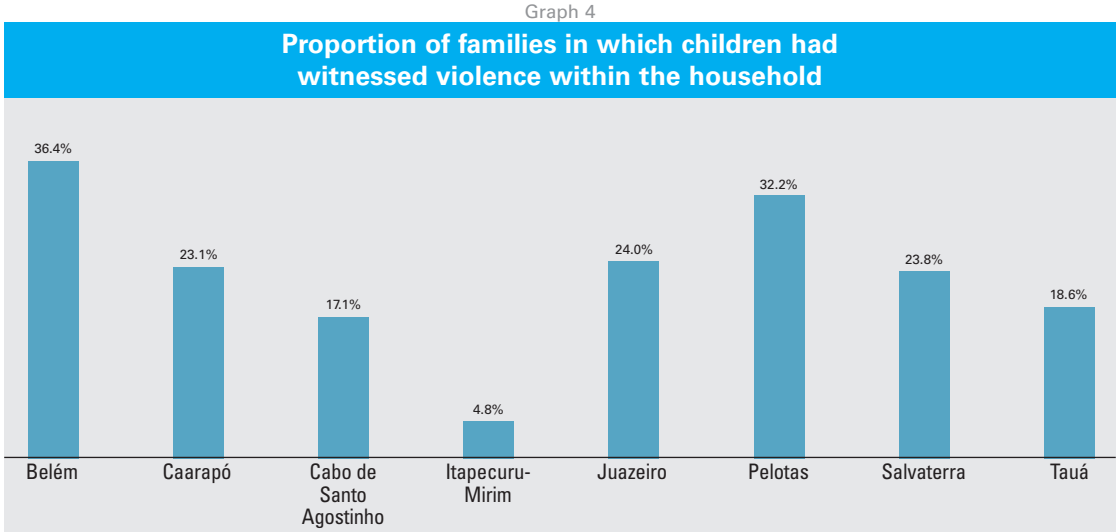
Moreover, the survey found that families have very few toys: the average number per child varies from 3.2 in the Itapecuru-Mirim quilombola community, to 5.8, in Pelotas. The most common toys are balls and dolls. Few homes offer any of the other toys that are so important for stimulating child development. Fit-together toys, or those that children can assemble, for example, are available to less than half the children. The establishment of toy libraries was one of the proposals suggested for increasing children's access to toys and expanding ties among groups of children in the communities that participated in the survey.

Another function of parents and caregivers is guiding the behavior of children, which includes correct management of situations when a child does something wrong. In such cases, it is important that issues be resolved without violence, by telling the child not to behave in said manner, and explaining why.

Very few books, magazines and toys were found in homes in all eight localities, though this varies from one to another

Although most of the interviewees claim that they do indeed talk to a child that needs reprehending, many of them also resort to violence, make threats, smack, or beat the child *(Table 5)*. In Tauá, Pelotas, and Juazeiro, roughly 75% of parents or caregivers smack children when they misbehave, and this proportion rises to over 80% in Belém, Salvaterra, Cabo de Santo Agostinho, and Itapecuru-Mirim. In general, roughly 90% of the interviewees reported that they use some form of physical or verbal violence when reprehending a child.

Graph 4



Source: UNICEF.

PROTECTED CHILDREN

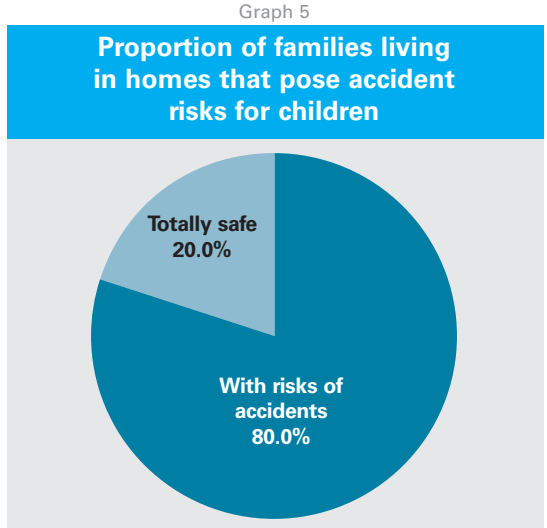
Competencies associated to child protection were also assessed during the survey. One of these relates to the degree of priority allotted to children in the family budget. In order for the child's needs to be fulfilled, it is necessary that the caregiver (generally the mother) should have control of the household budget, and be in a position to decide what is to be purchased for the child, and how much should be spent. In the communities surveyed, this is the case in approximately three-quarters of families. Lower proportions were detected in Cabo de Santo Agostinho (70.6%), Belém (67.6%), and Juazeiro (63.3%). In families where the mother or caregiver has no discretion over spending for children, this role generally lies with the father.

Bringing up children in an environment without violence or risk of accidents is another often-neglected but necessary measure for their protection. In Belém and Pelotas, over 30% of the children have witnessed violence and fights within the home *(Graph 4)*. Of the eight localities surveyed, this proportion was lower than 10% only in Itapecuru-Mirim (4.8%).

Precautions taken to prevent accidents are inadequate in all of the communities surveyed. For example, over half of the children below the age of 1 year sleep in the same bed as their parents, and only 20% of the families live in homes that are totally safe for children *(Graph 5)*. Since accidents lead to a significant number of deaths in Brazil, this point is one that merits attention and initiatives to guide families.

Bringing up children in an environment without violence or risk of accidents is another often-neglected but necessary measure for their protection

Graph 5



Source: UNICEF.

Qualification of families

UNICEF strategies offer guidance for community health agents, leaders of the Children's Pastorate, daycare and preschools teachers in the promotion of family competencies

Kit for *Strengthening Brazilian Families,* UNICEF 2004

Strengthening family competencies is one of the main focuses of UNICEF's work in Brazil. In pursuit of its aims on behalf of Brazilian children below the age of 6 years, UNICEF has launched its Strategy for Strengthening Brazilian Families, based on the premise that the family is the most important agent for providing care for children below the age of 6 years.

The principal tool in this initiative is the Kit for *Strengthening Brazilian Families*, launched in 2004, comprising five albums on essential childcare, from pregnancy to 6 years of age. The material was developed to be used by staff of the Community Health Agents Program (PACs), the Family Health Program (PSF), community leaders of the Children's Pastorate, daycare and preschools teachers, and especially by families. By 2005, the program had reached some 2 million families.

One characteristic of these Kits is that they present essential information for families in a simple and straightforward manner. When defining the design and format of the albums, UNICEF was assisted by community health agents and various institutions devoted to serving children below the age of 6 years. With simple and objective texts, accompanied by illustrations, the albums examine a range of issues, from themes encompassed by the work of the community health agents, such as prenatal care, breastfeeding and disease prevention, to questions of psychosocial and cognitive development, protecting children from violence, and the importance of the father's participation in the child's upbringing. All of these topics are covered from a children's rights standpoint.

These materials have been well received by professionals who use them in their work, and also by families. "In all my career as a community health agent, I have never received anything so valuable as this kit," says Francisco Roldão, of Juazeiro do Norte, Ceará. "The instructional material enriches our professional lives. Using it, we are able to hold workshops, meetings and lectures that previously we could not do," adds community health agent Zilene Alves, of Nova Russas, Ceará.

Fathers and mothers have also found the kits useful sources of information. "If I had known what is in this album, I would not have had eight children, and I would have known the importance of playing and talking to them", says Ornete da Conceição, who lives in João Pessoa.

The idea now is to conduct a survey in all the municipalities where the Kit for *Strengthening Brazilian Families* is used, to measure its impact on the knowledge of community health agents, leaders of the Children's Pastorate, and daycare and preschool teachers.

In the wake of this initiative to strengthen family competencies, in 2005 UNICEF embarked upon a project aimed at strengthening the competencies of municipalities with regard to children below the age of 6 years. To this end, a book has been published, entitled *The Municipality and Children below the Age of 6 Years*, which discusses the roles of various different municipal players, starting with the mayor, town-council members, judges and prosecutors, tradesmen, health professionals, teachers, council members, radiobroadcasters and journalists, etc. The book will be distributed, free of charge, in all of Brazil's municipalities to the principal social players involved with issues relating to children.

The Municipality and Children below the Age of 6 Years, UNICEF 2005

Radio programs discuss citizenship

With UNICEF support, two projects in the interior of Ceará are using radio to debate themes relating to Guardianship Councils, and family and municipal competencies

According to educator Paulo Freire, "communication is dialogue – and people only learn by communicating". This view is substantiated by the conversations between families that participate in a project called Communicating Knowledge, Fulfilling Dreams: Radio Strengthening Family Competencies [Comunicando Saberes, Realizando Sonhos]. This project, being carried out in five municipalities in the interior of Ceará, entails the holding of two meetings in each municipality, one in a rural area and one in an urban area, in what amounts to ten rounds of conversations.

Launched in 2002, the project has sought to enlist radiobroadcasters in the interior of Ceará in the strengthening of family and municipal competencies. With UNICEF support, Catavento Comunicação e Educação Ambiental, an NGO, provides training for radiobroadcasters, produces and distributes a weekly program called Conversa em Familia, and broadcasts spots on family and municipal competencies from sixty radio stations in the interior of the State.

Perereca, defender of children's and adolescents' rights, is a character from a radio program that aims to strengthen *Guardianship Councils* in the Semi-Arid region

People recount their experiences and discuss childcare and family relationships, and voice their doubts and difficulties. These conversations bring together mothers and fathers, and explore themes of interest to the group. At a meeting in the municipality of Palhano, 48-year-old Pedro Miguel do Nascimento, took his eldest daughter (of 25), his son-in-law and granddaughter (4 years old), and his second wife, and two younger daughters (7 and 3 years old). On this particular day, topics of conversation focused on two themes: the importance of children's knowing their father's workplace, so as to understand the value of the things they have in the home; and the importance of parents' giving more fruits and vegetables to children so that they develop healthy eating habits.

At such meetings, stories told by one person are instructive to others. For housewife Francimar da Silva Souza (31 years old), from Lagoa da Telha in the municipality of Palhano, the radio program has made it easier to discuss family relations, and shown how fathers and mothers can contribute toward the emotional development of their children. Francimar was unable to breastfeed her first daughter, because she discovered she had cancer immediately after delivery. The child died of dehydration. She, having overcome the disease, knows the importance of breastmilk for the health and well being of the child. Experiences, such as those told by Pedro Miguel and Francimar are to be used in a video and in vignettes about family competencies. The material is to be released in January 2006.

The Comunicando Saberes, Realizando Sonhos project also publishes a mural news bulletin called Sintonia Infância, to communicate with the Network of Child Friendly Broadcasters, also set up in 2002. This network comprises over one hundred radiobroadcasters throughout Ceará, who have made space in their programming for the discussion of issues relating to the rights of children and adolescents. "It is through this network that we debate, interact and improve our work", says 38 year-old Deri Martins, radio announcer of Rádio Jornal de Canindé. The focus is upon quality information, respecting regional differen-

ces, but without loosing sight of the children for whom the network was originally set up. "The network is important not only because it brings together radiobroadcasters and has a program that talks about families, but also because it helps listeners with the upbringing of their children," says 40 year-old Júlio Lopes, broadcaster of the Difusora Vale do Acaraú radio station.

Aside form the mural news bulletin, every month, radiobroadcasters that comprise the network receive a copy of the UNICEF Approved Municipality Seal Bulletin, which reports what municipalities are doing to improve the lives of children.

QUALITY INFORMATION

Radio is one of the most important means for spreading information in towns of Ceará, and was the media selected by the NGO Catavento to propagate its Bom Conselho a Gente Faz project. Since July 2004, the project has received UNICEF support, with the aim of strengthening Guardianship Councils. The project centers on twenty educational programs and radio spots, prepared on the basis of questionnaires mailed to councilors in the thirty participating municipalities. Based upon the responses to these, interviews, questions raised, and opinions offered by current councilors, the project team concluded that there are many misconceptions as to the role of Guardianship Councils, and that doubts are common not only among the general public, but even among councilors serving a second term of office.

After having conducted an evaluation of the situation of Guardianship Councils, work began on a program entitled Councils for the Future. The initial diagnostic analysis made it possible to describe the context in which councilors operate, and to provide the information necessary to support and strengthen their work.

In the coming year the Bom Conselho a Gente Faz project will seek to consolidate relationships between radiobroadcasters and councilors; mobilize communities to acknowledge the role of Guardianship Councils in protecting the rights of children and adolescents; and continue disseminating information that is useful for their work. By November 2005, the programs were reaching 47 municipalities in Ceará, and being distributed by UNICEF to seventy participants of the Child Friendly Radiobroadcasters Network.

"The Conversa em Família and Councils for the Future programs are important, since the provide access to information on themes relating to children and adolescents, and are a form of democratic communication", says 29-year old Valmir Gomes, a councilor from Palhano. In his opinion, the programs help keep councilors in touch with radiobroadcasters and the community. "Since these two programs arrived in Palhano, the population has sought the councils more frequently", he says.

Children and youths of Palhano love Perereca, a character from the Councils for the Future radio program, who has contributed toward the success of the Bom Conselho a Gente Faz project. When superhero Perereca visited a school and radio station in the municipality for the first time, he was welcomed by children who had only ever heard him over the radio, amid much mirth.

'In the guise of' an ordinary citizen, Perereca arrived by bus on a sunny November morning, without revealing his super powers. In a small room, the change took place: a green costume, sandals, local leather cowboy hat, cape, mask, and with the Statute of the Child and Adolescent in his pocket. With much good humor, the superhero of the Semi-arid region and defender of children's rights, revealed his true identity.

The recently-launched National Pact for a World Fit for Children and Adolescents in the Semi-arid Region acknowledges that immediate special measures are needed to address the needs of children in this region. Developing projects aimed at strengthening Guardianship Councils, and fostering a perception of the importance of families for the well being of children, are among the strategies for reducing migration from rural areas and combating the belief that it is impossible to ensure dignified living conditions in the Semi-arid region.

Aside from these two projects, UNICEF is also providing training for radiobroadcasters in seven states, by means of a Primer on Radio for Children and Child Development for Radiobroadcasters, prepared in collaboration with Rádio Extra Comunicação, of the State of Ceará. This initiative is underway in 102 municipalities and reaches 491 radiobroadcasters.

The challenges of participation and of universal rights

For the cause of children's rights in Brazil to advance, it is necessary that governments, businesses, and civil society assume a portion of responsibility and make their contribution

All of Brazilian society needs to be engaged in the task of ensuring children top priority. Unquestionably, the public authorities at the three levels (federal, state and municipal) have an important role to play, nevertheless, government alone can not be expected to provide all the necessary solutions. Only when all the main social players attain a degree of awareness and engage in concerted action will it be possible to surmount the difficulties posed by this theme.

Defining strategies for overcoming difficulties has been a dominant theme in debates between society and formulators of public policies throughout the world. At the General Assembly of the United Nations, in 2002, Heads of State and of Government resolved to reaffirm and expand their commitment to the agenda set at the World Summit for Children (1990). It was thus that the document entitled *A World Fit for Children* came to guide actions and establish goals for addressing the problems of children, in line with a proposal for articulated action on the part of all of society.

A World Fit for Children stresses that, in order to address the difficulties faced by children, it is necessary to engage in discussion of all related aspects, including the struggle for a more equitable and democratic society. The text reads: "We stress our commitment to create a world fit for children, in which sustainable human development, taking into account the best interests of the child, is founded on principles of democracy, equality, non-discrimination, peace and social justice and the universality, indivisibility, interdependence and interrelatedness of all human rights, including the right to development". The conceptual bases for this are also to be found in the United Nations Millennium Declaration, a historic document approved at the Millennium Summit, which reflects the concerns of 147 Heads of State and

of Government, and of the 191 countries represented at the meeting (*summarized highlights of these two documents accompany this text).*

As a signatory of *A World Fit for Children*, Brazil has assumed a commitment to make efforts to improve its indicators with respect to children.

In order for Brazil to improve its indicators with respect to children, it is important that each social group understand its particular share of responsibilities

Under the Child Friendly President's Plan, Brazil pledged to improve and expand early-childhood education, and set the goal of providing educational services for 65% of all children up to the age of 6 years by 2007 *(for more information, see the chapter on Access and quality: the great challenges).* Brazil has also pledged to reduce, by at least one third, malnutrition among children below the age of 5 years *(for further details, see the chapter entitled Threat to health).* For infant mortality, the goal is to reach 2015 with an infant mortality rate no greater than 16 per 1,000 *(for more information, see the chapter entitled Children still vulnerable).*

Article 227 of Brazil's Federal Constitution states that; "…it is the duty of the family, society and the State to ensure children and adolescents, with absolute priority, the right to life, health, nourishment, education, leisure, professional training, culture, dignity, respect, freedom, and family and community life." Nonetheless, fulfillment of the "absolute priority" provided for in this clause remains a huge challenge. In order for Brazilian society to make real progress in relation to the goals established and to attend at the same time to specific demands from its communities, it is important that each social group understand its portion of responsibility and the contribution it must make.

It is the responsibility of governments to define and execute comprehensive and consistent public policies and to make efforts to provide the necessary funding for projects. The private sector also has an important role to play,

A World Fit for Children

Principles and goals

1. Put children first: in all actions related to children, the best interests of the child shall be a primary consideration.

2. Eradicate poverty: investment in children and the realization of their rights are among the most effective ways to eradicate poverty. Immediate action must be taken to eliminate the worst forms of child labor.

3. Leave no child behind: all forms of discrimination affecting children must end.

4. Care for every child: children must get the best possible start in life. Their survival, protection, growth and development in good health and with proper nutrition is the essential foundation of human development.

5. Educate every child: all girls and boys must have access to and complete primary education that is free, compulsory and of good quality. Gender disparities must be eliminated.

6. Protect children from harm and exploitation: children must be protected against any acts of violence, abuse, exploitation and discrimination, as well as all forms of terrorism and hostage-taking.

7. Protect children from war: children must be protected from the horrors of armed conflict.

8. Combat HIV/AIDS: children and their families must be protected from the devastating impact of HIV/AIDS.

9. Listen to children and ensure their participation: we must respect their right to express themselves and to participate in all matters affecting them, in accordance with their age and maturity.

10. Protect the Earth for children; we must safeguard our natural environment, with its diversity of life, its beauty and its resources, all of which enhance the quality of life, for present and future generations.

Source: United Nations, 2002. Abridged version.

in adopting social and corporate responsibility programs that aim to improve the living conditions and sustainability of communities and, consequently, of their children. Non-governmental organizations, professional associations, social movements and other institutions have a double role. In certain circumstances, they are directly on the front line, putting into practice concrete measures for the defense and guarantee of children's rights. But it is also incumbent upon them to field complaints and inspect the actions of the government, so as to ensure that their standpoints and needs are fulfilled.

BUDGETARY PRIORITY FOR CHILDREN

If insufficient funding is allocated for public policies targeted at children, and if the resources earmarked are not effectively disbursed, no amount of planning will produce concrete results.

Concern for children's rights ought to be present during the processes of budgetary formulation and execution, at the three levels of government. In order to comply with the provisions that award 'absolute priority' to children in both the Federal Constitution and the Statute of the Child and Adolescent, it is necessary that funding be allocated for policies targeted at their fulfillment.

During the process of drafting budgetary legislation, it is essential that both the Executive and Legislative Branches seek to hear the views of society. Only thus will they be able to define clear priorities and align their efforts to those of non-governmental organizations, thereby optimizing the distribution of resources. Organizations that work with children have important contributions to make in the drafting of the budget.

One of the main problems referent to the public budget has been spending constraints. All too often, the government simply withholds disbursements of funding allocated under the budget. Also, there is a tendency for funding to be disbursed only in the last quarter of the year, thereby posing great obstacles for planned execution of policies.

Early-childhood education is one of the areas that faces serious funding problems. Creation of the Fund for Maintenance and Development of Primary Schooling and Enhancement of the Status of Teachers (FUNDEF) in 1998, had the indirect consequence of reducing investment in early-childhood education. This occurred because the FUNDEF law determined that, of the 25% of tax revenues that states and municipalities are constitutionally mandated to spend on education, 60% should be earmarked for primary schooling. With a view to correcting this distortion, a new law currently under review at the Chamber of Deputies, known as the Fund for Maintenance and Development of Primary Schooling and Enhancement of the Status of

If insufficient resources are earmarked for children, no amount of planning will produce concrete results

Millennium Development Goals

1. Eradicate extreme poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.
4. Reduce child mortality.
5. Improve maternal health.
6. Combat HIV and AIDS, malaria and other diseases.
7. Ensure environmental sustainability.
8. Develop a global partnership for development.

Source: United Nations General Assembly, September 8, 2000.

Education Professionals (FUNDEB), will seek to ensure that federal, state and municipal funding encompasses the needs not only of primary schooling, but also of early-childhood education and secondary schooling.

With a view to monitoring allocation of funding for children in the public budget, in 1995 UNICEF established an instrument for administrative and social control, known as the Children's Budget, using a methodology developed by the Institute for Applied Economic Research (IPEA), with a view to setting parameters for measuring the performance of public managers and enabling monitoring on the part of civil society.

MORE PUBLIC PARTICIPATION

During the course of recent decades, Brazil has undergone significant institutional changes. Many of these have related to greater awareness of children's rights, as recognized and awarded priority under the Federal Constitution (1988) and the Statute of the Child and Adolescent (1990).

New institutions, such as Children's Rights Councils (at the federal, state, and municipal levels), Guardianship Councils, and sector-specific councils (such as the Councils for Social Welfare, Education, and Health) were introduced in a context of restoration of democracy. Such bodies ensure transparency and public participation in public policy making, either by providing a space for direct participation (such as selection of representatives for Children's Rights Councils), or by serving as an intermediary in attending to the needs of the population and provision of corresponding public services (as in the case of Guardianship Councils).

Though these councils are essential components of an institutional structure set up to defend children's rights, it is now necessary to ensure that they are effectively functioning in all municipalities and in all the states of Brazil. According to the Federal Government's Information System on Children and Adolescents (SIPIA) in July 2005 (out of a total of 5,560 municipalities) 4,260 had Guardianship Councils, and 4,561 had Children's Rights Councils. However, even where such councils have been established, challenges remain, owing to a lack of adequate facilities and flaws in their functioning.

Articulation on public-policy issues among the various different councils and Executive Branch institutions is important to ensure that all questions relating to children's rights are fully addressed. On the other hand, fostering the necessary conditions for child development is not solely the responsibility of governments and social organizations. The family also has an essential role to play, and thus needs to receive capacity building in order to fulfill this function. Strengthening family competencies has thus become one of UNICEF's main priorities *(for more information, see the chapter on Strengthening families so as to strengthen children).* Furthermore, children and adolescents also ought to have a voice in discussions and in the definition of public policies.

Fostering the necessary conditions for child development is not solely the responsibility of governments and social organizations. The family also has an essential role to play

IMPORTANCE OF PRIVATE-SECTOR PARTICIPATION

Businesspeople should also participate directly in early childhood development. By managing companies in accordance with the best practices for corporate and social responsibility, they can contribute to improving living conditions of employees and, consequently, of their children. By complying with environmental standards, they also help foster sustainable development and avoid leaving liabilities for future generations. Furthermore, businesses can sponsor projects and social initiatives, and participate in

the planning and funding of projects targeted at improving the lives of children.

Alongside other segments of society, businesses are responsible for setting the conditions that ensure all children dignity and health. Socially-responsible companies listen to the interests and aspirations of the various players (shareholders, employees, service providers, suppliers, consumers, the general community, government, and environmental authorities) and allow their views to be reflected in corporate planning activities.

Concern for corporate social responsibility ought also to encompass respect for children's rights. Businesspeople need to be personally committed, and prepared to engage their companies in the process of changing society, and especially the situation of children.

In 2000, the United Nations founded the Global Pact, comprising a set of principles and goals aimed at bringing corporate practices and policies into line with basic principles of human rights, international labor laws, and UN environmental standards. Worldwide over 2,000 business leaders, including more than 100 from Brazil, have expressed interest in participating in the Global Pact.

There are various ways in which businesses can become involved. For example, they may choose to donate products, sponsor campaigns, support philanthropic causes or projects targeted at children. The Brazilian Government acknowledges the importance of the engagement of the business sector in policies designed to promote the well-being of children, and stimulates such participation through the granting of tax incentives: companies have a 1% corporate income-tax rebate to cover donations to Municipal Children's Rights Funds (individual tax payers can also make donations).

Such funds, managed by Municipal Children's Rights Councils, are responsible for selecting and indicating the projects to be supported. Any company that makes regular contributions to a fund receives regular reports from the Council containing documentary information on how the money was spent. Thus, aside from making a concrete contribution toward programs that foster the well-being of children, the company can monitor the results, thus stimulating continuity, participation, and co-responsibility in the conduct of public policies.

The challenge consists of expanding corporate donations and fostering the exercise of corporate social responsibility

Thus the challenge consists of expanding corporate donations to these funds, and fostering the exercise of corporate social responsibility. The general public can participate, by expressing support for the principles of corporate responsibility to business leaders, by exercising the power of consumers and giving preference to the products of companies committed to social responsibility, and by supporting the efforts of specialized institutions such as Instituto Ethos and Instituto Akatu.

The lives of Sateré-Mawé indigenous children

Gathering information on the situation of children in indigenous communities in Brazil poses great challenges. A diagnostic analysis among the Sateré-Mawé people, in the Amazon region, aims to guide the formulation of public policies to address the needs of this population

The Sateré-Mawé people are today mostly engaged in the production of guaraná. A major portion of this production is for Brazilian domestic consumption, but some of it is exported to France. The income thus generated, however, is scarcely sufficient to ensure dignified livelihoods, or nutrition and health for indigenous children and adolescents. In the first half of 2002, with UNICEF support, work began on a Participative Socio-demographic Diagnostic Study of the Sateré-Mawé Population[1].

The major portion of this population lives in the State of Amazonas, on the Andirá-Marau and Koatá Laranjal Indigenous Areas, in the Middle Amazon region. Many Sateré-Mawés live in urban portions of the municipalities of Maués, Parintins, Barreirinha, and Nova Olinda do Norte, near the Amazonas/Pará state boundary. The overall aim of the study has been to gather data upon which to base the planning of projects, programs and policies for children and adolescents, and foster sustainable development among the indigenous communities.

Only in 2005 was the study concluded, with the publication of a final diagnostic report. The study which, from its inception relied heavily on participation of indigenous leaders, teachers, community health agents, and young Sateré-Mawé students, produced much information on a hitherto undocumented way of life. It encompassed a total of 8,500 self-proclaimed members of the Sateré-Mawé people, and visited 1,759 households, in 91 communities, and in urban areas of the aforementioned municipalities.

The diagnostic study revealed that fertility rates among the Sateré-Mawé population are high: on average, each woman has around eight children. Cases of girls of 13 years old who were already mothers, and of 49 year-old women who were still bearing children, were encountered.

Migration also proved to be a strong factor among the Sateré-Mawés. Over half of those living in the indigenous areas had moved home at least once. With respect to religious beliefs, the vast majority of the Sateré-Mawé were found to have adopted non-indigenous faiths: 65% declared themselves Roman Catholic, but many frequent protestant denominations (including Baptist, Adventist churches, or the Assembly of God).

1. The diagnostic study was carried out through a partnership between the Indigenous Policy Foundation of the State of Amazonas (Fepi-AM), Fundação Joaquim Nabuco, the Coordination of Indigenous Organizations of Brazilian Amazônia (Coiab), the Secretariat of Education of the State of Amazonas, the United Nations Population Fund, the National Indian Foundation (FUNAI), the National Health Foundation (FUNASA) and the Federal University of Amazonas (UFAM).

POOR SERVICES

The status of public health and education services revealed by survey raised considerable concern, and an immediate response from UNICEF. In the indigenous areas, only 34% of children below the age of 1 year have been duly registered. Only 60.3% of women received such essential prenatal care measures as blood-pressure monitoring, and 45.2% could not recall if they had ever been weighed. Such simple procedures are the key to early diagnosis of such complaints as eclampsia, a clinical condition that places the lives of both the mother and the child in jeopardy. Furthermore, even among those women who had attended prenatal care sessions in the year prior to the survey, 28.4% reported that they had not been subjected to any tests.

The study also revealed that the proportion of children that conclude the first four years of primary schooling is extremely low (87%). In the indigenous areas, 148 children between the ages of 7 and 14 years had never been to school. It was also found that there simply are no schools offering the second 4-year cycle (5th to 8th grade) of primary schooling, let alone secondary schooling. Evidently, much has yet to be done to ensure compliance with constitutional provisions that mandate education services for indigenous citizens.

THREATENED WITH EXTINCTION

The diagnostic study also revealed in which communities the Sateré-Mawé language is vanishing. On average, 95.9% of those living in indigenous areas still have full command of and regularly speak their native language. On the other hand, among communities on the Ariaú River, 60% of individuals had lost the ability to speak the language, and in the Uaicurapá region, 26% spoke only Portuguese. Based upon this data, the Ministry of Education, and state and municipal secretariats of education, will be able to formulate targeted initiatives to strengthen the Sateré-Mawé language, to ensure that it does not become extinct.

Data on economic activity among the Sateré-Mawé people reveal that fishing is no longer a viable source of livelihood, and that hunting has also declined in importance. These factors portend significant changes to the economy in the indigenous areas, and have direct repercussions on the diet and health of indigenous children.

Teams of researchers, comprised entirely of Sateré-Mawé men and women, spent months traveling among the communities, gathering data and information for the diagnostic study on their people. Among the positive results of this initiative has been UNICEF's decision to support similarly-designed studies in other indigenous areas.