II. Social ills

138. Although economic factors figure prominently among the causes of vulnerability, as explained in chapter I, many other factors often contribute to and reinforce economic disadvantage. Coping capacity is reduced, not only by a lack of financial assets and income, but also by limited access to health services and limited or no access to education. Health and education are therefore important contributors to and significant factors in determining earnings capacity and personal development.

The poor state of children's education and health

139. Health, education and social exposure are critical elements of a child's well-being. Furthermore, they are powerful determinants of a child's future, particularly of his/her development and behaviour during adolescence. It is therefore important to grasp the full significance of the vulnerabilities experienced by children because they can have a major influence on what happens to those children when they grow older and join the ranks of youth.

140. The education of children is a key factor in reducing the sources, manifestations and consequences of vulnerability, including poverty and child labour. Education is also a right, articulated in article 26 of the Universal Declaration of Human Rights, which recognizes the human value of education, and that education is indispensable in strengthening respect for human rights and fundamental freedoms. Thus, reducing vulnerabilities in one area is also related to reducing them in others: education is one of the key factors in reducing not only social and economic vulnerability, but also for reducing vulnerabilities related to human rights and to political and judicial systems.

141. Millions of children and youth under 18 worldwide are engaged in labour that hinders their education, development and future livelihoods. Many of them are engaged in the worst forms of child labour that cause irreversible physical and/or psychological damage, or that even threaten their lives, including forced and bonded labour, forced recruitment into armed conflict, prostitution and pornography, and other illicit activities. The International Labour Organization estimates that in 2000 an estimated 211 million children aged 5 to 14 were engaged in some form of economic activity.[25] Of those, 186 million[26] were engaged in child labour, including in its worst forms, to which the ILO member States, through agreed ILO conventions, have given priority for abolition. Of an estimated 141 million youth aged 15 to 17 engaged in economic activity, 59 million are engaged in child labour. When broken down by gender under the general classification of economic activity, girls and boys are involved equally up to the age of 14, while above that age the proportion of boys increases. For those engaged in what is considered to be child labour, boys' involvement is higher than that of girls for both the 5 to 14 and 15 to 17 age groups.[27]

142. Children who receive a primary education are already on the way to obtaining the tools and necessary foundation for reducing the potential for vulnerability as adults. Access to and completion of a primary education is the route to basic literacy and, of course, to a secondary education. Children of primary school age who do not go to school today are the young adult illiterates of tomorrow, whose life prospects, for employment and in general, are the bleakest of all. World leaders have recognized the importance of primary education by agreeing to the Millennium Development Goal targets on achievement of universal primary education and the elimination of gender disparity at all levels of education by 2015. Currently an estimated 113 million children of primary school age, of which 56 per cent are girls, are not enrolled

[25] According to the International Labour Organization, "economic activity" is a broad concept that encompasses most productive activities undertaken by children, whether for the market or not, paid or unpaid, for a few hours or full time, in a casual or regular basis, legal or illegal. It excludes schooling and chores undertaken in the child's own household. It is a statistical, but not a legal definition, and it is not the same as "child labour", referred to with regard to abolition.

[26] *A Future without Child Labour: Global Report under the Follow-up to the ILO Declaration on Fundamental Principles and Rights at Work*, Report of the Director-General to the International Labour Conference, ninetieth session, 2002 (Geneva, International Labour Office, 2002).

[27] Ibid.

Box 4
Assessing vulnerabilities: youth illiteracy

The lack of access to education constitutes one of the major dimensions of poverty and limits economic, social, cultural and political opportunities for poor people. Youth illiteracy remains alarmingly high in many regions, in particular among young women.

Regionally, the illiteracy rates for young women are the most severe in sub-Saharan Africa, where in many countries the proportion is over 40 per cent, and in some even over 70 per cent. Illiteracy rates for young men often exceed 30 per cent.

Source: UNESCO, Institute for Statistics, 2002.

in school.[28] Of those, 94 per cent are living in developing countries. Just over one third of the total are in sub-Saharan Africa, another one third in South and West Asia and 13 per cent in East Asia and the Pacific.

143. Not all children enrolled in primary school today will remain in school long enough to reach minimum levels of literacy and numeracy. Although illiteracy has decreased in all regions, during the period 1995 to 1999 in sub-Saharan Africa and South Asia, only 61 per cent of primary school entrants reached grade five, generally considered as the minimum required for basic literacy.[29] In many countries, children enrol in primary school at a late age. Educational systems that have high rates of enrolment in primary school at a higher age also tend to have high dropout rates prior to grade five. Leaving school before grade five and failing to attain minimum levels of literacy have a profound impact on the entry of children into adolescence and youth and on their subsequent ability to find decent employment. Although primary school enrolment has continuously increased over the past five decades, the number of illiterate young people has remained largely constant, mostly as a result of population growth.

144. In addition to the questions of increasing primary enrolment rates to achieve universal enrolment and retaining children in school through at least grade five, there is the question of educational quality. Millions of children are taught by committed but untrained and underpaid teachers in sometimes overcrowded, unhealthy and poorly equipped classrooms. In some countries, the high number of children repeating grades, whether resulting from attendance or performance problems, is a serious drain on the capacity of educational systems. In addition, some countries do not have enough primary school teachers, particularly the least developed countries, where classes with 100 pupils are common. It has also been argued that in sub-Saharan Africa, where women represent less than half of the teaching staff, a strategy for facilitating girls' access to education would be to increase the proportion of women teachers, which would help girls to improve their learning process and lead to an improvement in women's participation in all economic and social sectors. Children, particularly in rural areas, have to walk many kilometres before reaching a school, making them vulnerable to various kinds of abuse by peers and adults.

145. Related to the issue of quality of education is the quality of pupils' health. There is evidence that children with poor health face greater learning challenges owing to illness, which causes absenteeism, and perhaps an inability to concentrate in classrooms. The implication is that they are likely to grow up to be poorly educated in addition to being in poor health. Such children can be expected to face problems later on, including the probability that they will have difficulty in finding decent-paying work and will therefore have lower earnings than their healthy counterparts. Therefore poor health in childhood can

[28] United Nations Educational, Scientific and Cultural Organization, *Education for all — Is the World on Track?*, EFA *Global Monitoring Report* (Paris, 2002).

[29] United Nations Children's Fund, *The State of the World's Children, 2003* (United Nations publication, E.03.XX.1), table 4.

have a significant impact on the child's educational attainment, which can in turn affect his or her future earning capacity as well as the ability to cope with future uncertainties.

146. Sources of vulnerability for children in terms of physical health and well-being begin before birth, as the health of an infant begins with the health of the mother. Poor maternal health and nutrition contribute to low birth weight in 20 million newborns each year — almost 20 per cent of all births.[30] Low birth-weight infants have a higher risk of dying before reaching their first birthday and are at greater risk for infection, malnutrition and long-term disabilities, including visual and hearing impairments, learning disabilities and mental retardation.

147. At least 30 to 40 per cent of infant deaths are the result of poor care during pregnancy and delivery. Those deaths could be avoided with improved maternal health, adequate nutrition and health care during pregnancy, and appropriate care during childbirth. The well-being of children is also linked to the literacy and education status of mothers: children of mothers with no education are more than twice as likely to die or be malnourished compared to children of mothers with a secondary or higher-level education.[31] Even though neonatal mortality has declined, the rates of decline have been much slower than those for infants and children below 5 years of age. Nevertheless, of the 8 million infants who die each year, possibly half die within the first month of life. That is largely a result of the slow progress achieved in maternal health.[32]

148. Malnutrition affects 150 million children under 5 years of age, or one third of all children below that age.[33] Although underweight prevalence declined from 32 per cent to 28 per cent in developing countries over the past decade, with the most progress in East Asia and the Pacific, worldwide about 183 million children weigh less than they should for their age; some 67 million children are "wasted", that is, below the weight they should be for their height; and 226 million are stunted. Children in some regions are particularly vulnerable: half of all children in South Asia are underweight, and in sub-Saharan Africa, where one of every three children is underweight, the nutritional status of children is worsening. Being underweight and wasting are only the most obvious forms of malnutrition; micronutrient deficiencies affect approximately 2 billion people worldwide, and 250 million pre-school children are clinically deficient in vitamin A, essential to the functioning of the immune system.[34]

149. Disease affects malnourished children, who have lowered resistance to infection and are more likely to die from such common childhood ailments as diarrhoeal diseases and respiratory infections. For those who survive, frequent illness saps their nutritional status, locking them into a vicious cycle of recurring sickness, faltering growth and diminished learning ability. Nearly 12 million children under five die each year in developing countries, mainly from preventable causes, and over half of those deaths are either directly or indirectly attributable to malnutrition. Although global deaths of children under 5 years of age have fallen from 20 million to 12 million annually over the last four decades, during the same period deaths of children under age 5 in sub-Saharan Africa almost doubled, from 2.3 to 4.5 million per year. Five major yet preventable diseases — pneumonia, diarrhoea, malaria, measles and HIV/AIDS — account for about half of all childhood deaths. Other preventable diseases relate to the lack of access to safe drinking water and inadequate sanitation. More than one billion people cannot obtain safe drinking water, and more than two billion people lack access to adequate sanitation.[35]

150. Ironically, while malnutrition continues to be endemic in parts of South Asia and Africa, obesity is

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[30] Safe Motherhood Inter-agency Group, *Safe Motherhood Fact Sheets*, available from http://www.safemotherhood.org/resources/publications.html

[31] UNICEF, *Progress since the World Summit for Children: A Statistical Review* (United Nations publication, Sales No. E.01.XX.20). Source data from over 35 Demographic and Health Surveys carried out between 1995 and 1999.

[32] World Health Organization, *Strategic Directions for Improving the Health and Development of Children and Adolescents* (WHO/FCH/CAH/02.21).

[33] "A world fit for children", final document of the special session on children, in *Official Records of the General Assembly, Twenty-seventh Special Session, Supplement No. 3* (A/S-27/19/Rev.1 and corrigenda), annex.

[34] Sustain, *Malnutrition Overview* (Washington, D.C., 2002), available from http://www.sustaintech.org/world.htm.

[35] "A world fit for children", final document of the special session on children, in *Official Records of the General Assembly, Twenty-seventh Special Session, Supplement No. 3* (A/S-27/19/Rev.1 and corrigenda), annex.

Box 5
Assessing vulnerabilities: malnutrition among children

Malnutrition among children, as measured by the proportion of children under the age of 5 who are underweight and underheight, is startling in many regions.

Malnutrition is most prevalent in the regions of sub-Saharan Africa, South Asia and East Asia and the Pacific, where in many countries over 40 per cent of the children are underweight or underheight.

Source: FAO, *State of Food Insecurity in the World, 2002* (Rome, 2002), and World Bank, *World Development Indicators, 2003* (Washington, D.C., 2003).

becoming a major health problem, not only in developed countries but increasingly in many developing countries as well. The number of obese children continues to grow, and chances that an overweight child will suffer lifelong weight problems are high. According to the World Health Organization (WHO), developing countries are seeing rapid increases in body mass indexes, a height/weight formula used to measure overweight and obesity, particularly among the young. WHO also estimates that worldwide some one billion people can be considered overweight, with 300 million people clinically obese.[36] The share of young people (children and youth) in the totals is unknown, but the long-term consequences for public health systems can be extensive and structural. In developing countries, there is the likelihood of new demands and an increased strain on public health services, as health-care systems will need to deal with both tropical and preventable diseases as well as with obesity-related illnesses, such as diabetes and cardiovascular disease, which typically require high-cost treatment.

151. One disease not clinically related to malnutrition or poor nutrition, but very much related to poverty, is HIV/AIDS. Roughly 16 per cent of all new HIV infections in 2001 were among children. About 800,000 infants were infected with HIV, mainly through mother-to-child transmission, in 2002. Largely as a result of the high infection rates among pregnant women in Africa, it appears that children are currently the fastest-growing age group among HIV infections: the total of 800,000 infections in 2002 contributed to a current total of 3 million infected children (table). Currently, some 1.8 million pregnant women are infected with HIV/AIDS, 1.5 million of whom are in sub-Saharan Africa. Mother-to-child transmission of the virus through pregnancy, labour, delivery or breastfeeding is responsible for over 90 per cent of the HIV infections in infants and children under the age of 15. HIV/AIDS has begun to undermine the years of steady progress in child survival. In the worst affected areas, the under-five mortality rate is expected to increase by over 100 per cent.[37]

[36] World Health Organization, *World Health Report, 2002: Reducing Risks, Promoting Healthy Life* (Geneva, 2002). See also Seth Mydans, "Clustering in cities, Asians are becoming obese", *New York Times* (13 March 2003).

[37] Joint United Nations Programme on HIV/AIDS, *Epidemic Update* (December, 2002); and World Health Organization, *World Health Report, 2002: Reducing Risks, Promoting Healthy Life* (Geneva, 2002).

Table
Children, youth and HIV/AIDS in 2002

(Millions)	*Have been infected with HIV/AIDS*	*Currently living with HIV/AIDS*	*Newly infected in 2002*	*Died from HIV/AIDS in 2002*
Adults	62	42.0	5.0	3.1
Youth (15-24)	22	12.0	2.4	1.5
Children	4-5	3.0	0.8	0.6

Source: UNAIDS, *Epidemic Update* (December, 2002); and Vivian Lopez, "HIV/AIDS and young people — a review of the state of the epidemic and its impact on world youth", paper presented at the Expert Group Meeting on Global Priorities for Youth, Helsinki, 6-10 October 2002. Figures in italics are estimates.

152. A second devastating effect of the HIV/AIDS pandemic on children is the emergence of a new group of children who are AIDS orphans. More than 11 million children currently under 15 have lost one or both parents to AIDS. That number is forecast to more than double by 2010. Before the onset of AIDS, about 2 per cent of all children in developing countries were orphans. By the end of 2002, in the 10 worst affected countries of Africa, more than 15 per cent of the children had become orphans.

153. The social and economic impacts of AIDS threaten the well-being and security of millions of children worldwide. As parents and other family members become ill, children take on greater responsibility for income generation, food production and care of family members. They face decreased access to adequate nutrition, basic health care, housing and clothing. Fewer families can afford to send their children to school, with young girls at particular risk of being denied an education first. Isolated from emotional connections with the family, some turn to risky sexual behaviour. While most of these children were born free of HIV, they become highly vulnerable to infection themselves.[38]

154. Health and education-related vulnerabilities experienced during childhood continue to have a strong bearing on adolescent development. Equally important is the fact that those vulnerabilities may also have implications for adolescents in terms of both their behaviour, particularly risk-taking and antisocial behaviours, and their perception of social reality.

Youth drug abuse and juvenile delinquency

155. Two significant sources and manifestations of social vulnerability and risk for youth are drug abuse and juvenile delinquency. Drug abuse is a source of vulnerability, in that it can lead to undesirable and negative consequences, such as early termination of education, unemployment or even HIV/AIDS from the use of unsterilized needles. However, it also is a consequence of vulnerability. Youth with emotionally unsupportive or troubled and unstable families or who feel unhappy and without hope as a result of their socio-economic status or perceived futures may turn to drugs to relieve stress and escape their current situation. Similarly, juvenile delinquency is a source of vulnerability and risk, particularly when it is related to the possibility of continuing on to serious criminal activity in adulthood, as well as a consequence of young people taking action as a response to other emotional and/or socio-economic vulnerabilities.

156. No comprehensive international comparative data are available on drug use by young people. Youth drug use in developing countries remains particularly elusive. However, according to the data that are available, alcohol, tobacco and cannabis are the substances most commonly used by young people

[38] United States Agency for International Development, UNICEF and UNAIDS, "Impacts on children, families, and communities", in *Children on the Brink, 2002: A Joint Report on Orphan Estimates and Program Strategies* (Washington, D.C., TvT Associates/The Synergy Project, 2002) available from http://www.unicef.org/publications/pub_children_on_the_brink_en.pdf.

around the world.[39] The first drugs used are usually tobacco and alcohol and, in some communities, inhalants. The greatest use of substances is generally found in the last two years of high school, continuing into early adulthood in most countries. In almost all regions, boys are more likely to use all substances than girls and are more likely to use them in risky ways. Rates of alcohol and tobacco use by students in Europe appear to be the highest in the world, while students in North America and Australia appear to have the highest rates of illicit drug use.

157. Urban youth tend to use substances to a greater extent than those in rural areas. Similarly, countries in social and political transition, such as those in Central and Eastern Europe, may have an environment that contributes to increased use of substances by young people. Tobacco and alcohol consumption has also been promoted through aggressive marketing campaigns reaching ever-increasing numbers of people worldwide despite efforts in some countries, including harsh health warnings, to curb marketing aimed at younger populations.

158. Young people use substances for many of the same reasons adults do, such as to relieve stress and heighten enjoyment, yet there are other reasons that are specifically related to adolescent development. Young people are at a stage in life where they desire and need to demonstrate independence from parental and societal authority, and take risks and satisfy their curiosity about new experiences while often being exposed to negative peer pressure. Many experiment with drugs; some go further and adopt risk-taking behaviours, such as drug and alcohol abuse, habitual use of tobacco or delinquency.

159. Although substance-use decisions also involve perceptions of risk by the individual, it has long been established that young people tend to ignore the long-term risks associated with substance use. Young people also tend to minimize the risks posed by their own substance use, with young men tending to do so more than young women. Young people almost everywhere generally tend to use substances to a greater extent and in riskier ways than older people.

160. Social vulnerability and exclusion have a direct influence on the risks of youth using and abusing drugs. Recent studies examining substance use patterns distinguish between mainstream youth and youth living in difficult circumstances with fewer opportunities and less support, including young people living in developing countries as well as those living out of the mainstream and experiencing social exclusion in developed countries. Substance use by those young people, often referred to as the "especially vulnerable", tends to be aimed more at relieving difficult circumstances, including physical or emotional pain, and at coping with such things as neglect, violence, physical or sexual abuse, homelessness and war, or with difficult economic circumstances, such as longer working hours and unemployment. In contrast, mainstream youth are more likely to use substances to enhance pleasure and as part of their leisure activities and culture. While there may be some overlap between the two, the issues and challenges can be quite different. Substance use and abuse by young people living in difficult circumstances strongly illustrates how drug abuse is also a consequence of social vulnerability.

161. Juvenile delinquency is another source and consequence of youth social vulnerability and risk and is often highly correlated with drugs and drug abuse. Juvenile delinquency encompasses a multitude of different violations of legal and social norms, ranging from minor offences to severe crimes committed by minors. Some types of juvenile delinquency are considered to be part of the process of maturation and growth and disappear as young people make the transition to adulthood. Many socially responsible adults committed some kind of petty offence during their adolescence. Arrests rates, mainly for petty offences, are typically highest among 15 to 19 year-olds.[40] However, at the other extreme, other juveniles create stable criminal groups with a corresponding subculture and begin to engage in the same activities as adult criminal groups.

162. The available data show that delinquency and crime are gender-specific, with males being more

[39] Unless otherwise indicated, data presented on drug use are from Gary Roberts, "Youth and drugs", paper presented at the Expert Group Meeting on Global Priorities for Youth, Helsinki, October 2002.

[40] Michael L. Benson, *Crime and the Life Course: An Introduction* (Los Angeles, California, Roxbury Publishing Company, 2002).

vulnerable and at risk than females.[41] The crime rates of male juvenile and male young adult offenders recorded by the police are more than double those of females. Young males are convicted six or seven times more often than young females. The number of male juvenile suspects per 100,000 per age group is more than six times the number of females, and in the case of young offenders it is even 12.5 times as many. Many possible reasons for those differences exist, including less social tolerance of behavioural deviations by girls than by boys, stronger family control over girls than over boys, and social and historical differences between the sexes with respect to violence, such that young men may use violence as a means to construct gender identity.

163. Juvenile crime has become a worldwide problem. During the 1990s, a majority of the regions of the world suffered from a rise in youth crime. Countries in transition have been particularly affected; since 1995, juvenile crime in a number of countries in transition has increased by more than 30 per cent. Juvenile crime levels in developed countries remain high, both by historical standards and in comparison to other countries. Delinquency is also a problem in developing countries, where juvenile delinquency and extreme juvenile problems occur at levels higher than in other countries, particularly in relation to street children, who have ruptured ties with their families and engage in various survival activities on the street.

164. Data from many countries also show that delinquency is largely a group phenomenon, for two thirds to three fourths of all juvenile offences are committed in groups. Group delinquency, in which the young people belonging to a particular group form and share a joint assumed identity, exhibits the characteristics of a subcultural group. The most extreme examples of this, and the most likely participants in group delinquent activities, are territorial gangs. According to statistical evidence, juvenile gangs commit three times more crimes than young people who are not gang members. Studies reveal that the most frequent offences committed by the gangs are fighting, street extortion and school violence; however, the appearance of juvenile street gangs is almost always also accompanied by drug trafficking. Children and adolescents are more likely to be victims of juvenile crimes than other social groups: in general, the victims of juvenile crimes usually belong to the same age group as the perpetrators.

165. While economic factors, including high unemployment and poverty, may strongly influence youth delinquency, they are not always pivotal, and other social factors, such as cultural norms and values, family cohesion, peer-group influence and a supportive social environment also play a role. For example, in western societies, disinvestment of social capital in poor urban neighbourhoods may very well explain the increased occurrence of crimes by young people.[42] Urbanization may also play a role — urbanized societies have higher registered juvenile crime rates in comparison with countries with a strong rural lifestyle. One explanation is that urbanized societies may have less social control and social cohesion, whereas societies that are more rural are able to rely to a greater extent on family and community control to deal with antisocial behaviour.

166. The role of families and family life is clearly important: young people living in so-called dysfunctional families, characterized by conflict, inadequate parental control, weak ties with other members of the extended family and community, and premature autonomy, are closely associated with delinquency. As with drug use, children and young people in disadvantaged families with fewer opportunities for legitimate employment and who face either the risks or reality of social exclusion are overrepresented among juvenile offenders. If, in addition to living in a dysfunctional and disadvantaged family, a youth is also of an ethnic minority or from a migrant family, the level of vulnerability to delinquency can be even higher.

167. Other factors that can have an influence are the media, such as television violence and its popularization of violent heroes, low educational attainment, social exclusion, peer group pressure, the adoption of delinquent images and a delinquent identity by adolescents, and also the prospect of financial award from delinquent behaviour. For example, selling drugs is associated with financial reward, particularly in communities where there are few other, or otherwise

[41] Unless otherwise indicated, data on juvenile delinquency are from Alexander Salagaev, "Juvenile delinquency", paper presented at the Expert Group Meeting on Global Priorities for Youth, Helsinki, October 2002.

[42] See, for example, Benson, op. cit., chap. III, for an overview of John Hagan's theory of criminal capital and disinvestment.

low-paying, economic opportunities. However, the drug "business" is also associated with increases in the rate of violent and aggravated crimes, including by young people, thus leading to a perverse relationship in which drug abuse and juvenile delinquency are mutually reinforcing.

Health-related vulnerability of older persons' health

168. A major source of vulnerability for older persons is a lack of access to appropriate health care. Over the past two decades, changes in economic thinking and approaches have brought about a restructuring of social welfare policies, particularly in health care. In many countries, economic reforms have resulted in the diffusion of responsibility for the provision of health-care services and in the removal of health subsidies, which has increased the demands on household income. Many of the changes have had a wide impact on older persons in terms of affordability and access, particularly if discriminatory health-care rationing based on age is instituted. Whereas medical advances have extended lives and reduced disability, inequalities in longevity and health disparities within and between countries have widened. For a vast majority of people, including older persons, ill health is related to poverty, and health-care improvement in a country is related to its political economy and overall strategies of development.

169. Many factors affect the health of individuals as they get older and become exposed to increasing risk of illness and disability. Lifetime exposure to poverty means that many people reach old age already in chronic ill health, showing signs of poverty and disease before their sixtieth birthday. Chronic illnesses, including heart disease, cancer and mental disorders, are fast becoming the world's leading causes of death and disability. Non-communicable diseases now account for 59 per cent of all deaths globally, which means that developing countries have a double burden of disease: rapid growth of non-communicable diseases at the same time that they are struggling with malnutrition and infectious diseases such as HIV/AIDS, malaria and tuberculosis. Chronic diseases, which increase dramatically at the older ages, are significant and costly causes of disability. It is especially true for older women who, because of greater longevity, have higher incidences of impairment and disability, but whose vulnerability to disability is also generated by gender inequalities over the life course and a lack of understanding of their physical, mental-health and post-menopausal needs.

170. Older ethnic minorities tend to suffer greater discrimination and disadvantage at every level, including health. Whereas the health profile of those groups is comparable to the majority older population at the lowest socio-economic strata, their constant existence on the margins points to greater and more acute vulnerability. Further, in spite of having a poorer health profile, older minorities are frequently found to be isolated from mainstream health and social care services. A number of reasons can be cited for their situation: lack of awareness of services, resulting in part from ineffective dissemination of information and outreach by mainstream organizations; language barriers, including illiteracy; user fees and issues of transport; and problems of perception and mistrust between service providers and the older persons. The issue of perception is of particular importance and can impact all the other issues. Older minorities feel that providers do not allocate culturally appropriate care that may address dietary, religious and linguistic differences. In addition, when outreach attempts are made, they are often based on stereotypical assumptions about the minority group.[43]

171. Until recently the prevalence of HIV/AIDS among and its effects on older persons had been largely ignored owing to the unavailability of data, which excludes the effect of the pandemic on the older population in many parts of the world, including sub-Saharan Africa, where the decimation of the population from AIDS is most severe. In Western Europe, nearly 10 per cent of the new infections declared between January 1997 and June 2000 were among persons over 50. In the United States of America, 10 per cent of all reported cases occur among people over 50, and over half are of African-American and Hispanic origin, indicating greater risks among minority groups. Many of the older infected persons may have had the virus for years before being tested, at which time the infection may be in its most advanced stages. Further,

[43] "Minority ethnic elder care: a synopsis of country profiles" (Leeds, United Kingdom, Policy Research Institute on Ageing and Ethnicity [PRIAE], 2002), prepared under the three-year Minority Ethnic-Elder Care research programme, a European Commission Fifth Framework Programme.

age accelerates the progress of HIV to AIDS, and age-related conditions, such as osteoporosis, increase the risk of severe complications.[44]

172. The consequences of HIV/AIDS extend far beyond the disease itself. As mentioned above, AIDS has resulted in growing numbers of orphans around the world. Older persons, mostly women, are not only taking on the care of children who have been orphaned by the disease, but are also suffering the magnitude and complexity of the consequences: orphaned children are more likely to have poorer nutrition, be underweight, drop out of school, and face depression and psychological problems. If they do not have a grandparent to care for them, they are more likely to live on the streets, be exploited because they are forced to work or sell their bodies as their only asset.[45] The burden of caring for the children is extraordinary, especially when it is put in the context of local environments that are already ravaged by conflict, famine, displacement and conditions of extreme poverty. Furthermore, many older persons who take on such new responsibilities are already in mourning and deprived of the support from their adult children that they had expected in their old age. Their own resources are seriously depleted at the same time that they are called on to help others possibly worse off than they.

173. In a recent case study on the effect of HIV/AIDS on older persons, findings suggested that the loss of remittances and other economic support, the lack of food and clothing, the high cost of medical fees during illness, and the inability to pay school fees for orphans affected the ability of older persons to provide care. Older persons were under serious physical and emotional stress, and cases of physical violence, stigma and abuse resulting from witchcraft accusations were prevalent. Moreover, older persons infected with the disease experienced limited access to health services owing to the high cost of care, transport difficulties, the stigma of the disease and the attitudes of health workers.[46]

174. At a wider level, AIDS is causing life expectancy to decline. In Southern Africa alone it has fallen from over 60 years to under 50, and it is expected to fall further. Moreover, the movement of HIV/AIDS eastward into Asia, combined with the rapid growth of death rates from tuberculosis and malaria, will result in a continued reduction of life expectancy and an increase in the vulnerability of and burden on older persons, with far-reaching health, economic and psychosocial impacts.

Migrant health and social protection

175. Three elements can be identified as the source of health-related vulnerability among migrants. First, there is evidence that their health risks are compounded by discrimination and restricted access to health information, health promotion, health services and health insurance. Second, migrants as a group disproportionally suffer from high exposure to occupational and environmental hazards. Third, migrants are at greater risk because some of their specific health needs are ignored or not well understood and therefore are not adequately addressed.

176. Migrant health is an area of intense debate. Concerns with pre-existing and untreated conditions such as infectious and communicable diseases have long been a priority for health authorities, since migrants pose potential sanitary threats to host populations. A few years ago, considerable public and media attention was devoted to the association between migrants and HIV/AIDS. The focus has now switched to the health threat posed by undocumented migrants. There is also speculation on whether a significant number of migrants may be motivated by the health-care entitlements in host countries that provide them with treatment not available or affordable in their country of origin. It is argued that the provision of health care to migrants puts additional financial stress on already overstretched and underperforming public health systems. In addition, the use of a health condition in court as a ground to challenge expulsion orders in several countries has caused further uneasiness on the part of public authorities. It has also undermined the case for a legally binding recognition of health as a human right. So far, although migrants

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[44] UNAIDS and World Health Organization, "HIV/AIDS and older people", in *Building a Society for All Ages, Second World Assembly on Ageing, Madrid, Spain, 8-12 April 2002* (DPI/2264), available from http://www.un.org/ageing/prkit/hivaids.htm.

[45] Alan Whiteside, "Future imperfect: the AIDS epidemic in the twenty-first century", inaugural lecture, University of Natal, Durban, South Africa, 5 December 2002.

[46] World Health Organization, *Impact of AIDS on Older People in Africa: Zimbabwe Case Study* (WHO/NMH/NPH/ALC/02.12).

have argued that expulsion should not be enforced when there are serious, including life-threatening, health conditions and a need for medical treatments that might not be available in the migrant's country of origin, all courts have rebutted their claims.

177. Migrant health poses a triple challenge by raising fundamental questions of social equity, public health and human rights. Unfortunately, the current controversial context makes it difficult to reduce their health-related vulnerability despite ample evidence of their plight. For example, in Europe, occupational accident rates are, on average, twice as high for migrant workers than for native workers. In both developed and developing countries, many migrant agricultural workers display pathologies related to exposure to toxic pesticides. The large majority of those migrants do not have medical coverage or access to health services.

178. Work carried out by the World Health Organization and the World Bank on mental health has found that immigrants and refugees are among the groups that are disproportionately affected. Although knowledge of the mental health of migrant populations remains fairly limited, there is enough evidence to suggest that severe psychological stress due to uprooting, disruption of family life and a hostile social environment is common. Unfortunately, a large number of migrants have no or little access to mental health care, either because they are excluded from existing service arrangements or because there is no provision for mental health care, a situation that prevails in more than 40 per cent of countries.

179. Trafficking and smuggling expose migrants to additional health hazards, including dangerous travel conditions, violence and abuse, and unsafe working environments. Those who are trafficked for work in the sex industry face increased risks of sexually transmitted diseases. At the same time, the fear of deportation and the absence of medical insurance make them unlikely to seek medical care.

180. Migrants who live in societies that have extensive social protections systems do benefit from them. However, owing to existing institutional arrangements and piecemeal adaptation to the changing nature of migration flows, the social protection of migrants and their access to social programmes are fragmented, partial and inadequate. The inadequacy of coverage also reflects a lack of concern for the social needs of migrants. Nevertheless, the availability of welfare benefits to migrants has given rise to a heated debate between those who support the right of migrants to comprehensive social benefits and those for whom the debate on immigration policy centres on the trade-off between the economic benefits of immigration and social redistribution.

181. At a basic level, migrants' entitlement to social protection depends on whether they live in a country where welfare benefits are provided primarily as a result of being employed and having contributed to the social insurance system — such as in the labour-importing countries of Western Europe — or in a country where benefits are granted on the basis of residence — such as the traditional countries of immigration (Australia, Canada, New Zealand and the United States), the Scandinavian countries or the United Kingdom of Great Britain and Northern Ireland. In labour-importing countries, social benefits depend largely on the migrant's specific status — for example, primary visa holder, dependant or refugee — and time requirements. As welfare provisions are often contained in bilateral treaties, the migrant's country of origin also matters.

182. In most cases, migrants do not qualify for welfare benefits — beside health care — during their first year of residence. However, in a few countries, denial of social benefits may last longer, up to several years. Claiming social benefits may jeopardize a migrant's rights and that of his or her family to remain in the host country if he or she does not meet time requirements. Most importantly, residency requirements deny many migrants social benefits when joined by their families, namely at a time of great need.

183. In many countries, in particular in federal States, responsibility for social assistance programmes has been devolved to subnational authorities, increasing the complexity and the diversity of situations faced by migrants. Such differences make the availability of social provisions to migrants unequal both within and between host countries.

184. While health care is available to all migrants, including undocumented migrants on an emergency basis, the scope and quality of health services to which they have access vary greatly. However, there is evidence that migrants may sometimes be reluctant to assert their rights and do not avail themselves of the health services they are entitled to, for reasons ranging

from a lack of information to cultural gaps and various forms of discrimination. For unemployment benefits, social assistance and public housing, eligibility criteria are much more restrictive and often apply only to long-term residents. In a significant number of countries, non-nationals are excluded from certain benefits.

185. The non-portability of retirement benefits is increasingly attracting attention as an issue of equity. Despite many signed bilateral agreements, a large number of migrants, in particular from developing countries, fall outside those agreements and cannot receive pension benefits if they decide to leave the host country. The issue of the non-portability of benefits has gained additional momentum following the surge in the international recruitment and mobility of skilled workers.

186. The social protection of migrants is a question that lies at the core of the migration debate. It has been contended that the open welfare state offers a strong motivation for people with a low level of human capital to migrate. Whether there is an economic case or not, the controversy over the social protection of migrants is one of the issues that feeds anti-immigrant feelings.

Inadequate accessibility: a disability perspective

187. Every child is unique and has a fundamental right to education. However, in developing countries only a small minority of disabled children are in school, falling below 10 per cent in Asia and the Pacific.[47] When denied the basic right of education, disabled people become severely restricted in terms of their economic, social and political opportunities as well as the prospects for their personal development. Without an education it is more difficult to secure a job, particularly one that pays a decent wage, participate actively and fully in the community and have a meaningful voice in policy making, especially with regard to issues that directly concern the affected population.

188. Children and youth with disabilities face a host of barriers to education, starting with an inaccessible school environment. In most cases, the lack of proper teacher training and appropriate teaching materials and methods makes it unlikely that their special needs will be addressed in a timely fashion. Negative attitudes and exclusionary policies and practices towards children with disabilities as well as a lack of support systems for teachers further undermine the schooling options of children with disabilities. The problem is particularly severe in rural areas, as special education schools are located mainly in urban areas.

189. Given the dynamics of disability and health, access to adequate health-care services is essential for the promotion of independent living for the disabled. Health services play a critical role in the prevention, diagnosis and treatment of illnesses and conditions that can cause physical, psychological and intellectual impairments. However, for the majority of persons with disabilities living in developing countries, as well as for a significant minority living in industrialized countries, poverty precludes access to those vital services, either because health-care facilities and practitioners are not sufficiently available or because there are not enough funds to purchase needed medications and devices. Not only are there too few orthopaedic surgeons, the number of medical rehabilitation centres to help people adapt to disabling conditions is insufficient to meet the demand, and many more appliances such as orthotics, prostheses, hearing aids and wheelchairs are needed to improve daily functioning.

190. Independent living implies integrating the disabled into the general community, rather than placing them in exclusionary institutions or relegating them into "colonies" of disabled. Community-based rehabilitation programmes, which are in the process of becoming fairly well established in industrialized countries but remain rare in developing countries, tend to be part and parcel of independent living strategies. The intention of the programmes is to lower the costs and increase the effectiveness of disability services by replacing more costly, segregated, medically based institutional approaches with more cost-effective and responsive approaches intended to empower and support disabled persons and their families.[48]

[47] United Nations, Economic and Social Commission for Asia and the Pacific, *Asian and Pacific Decade of Disabled Persons*, 1993-2002, available from http://www.unescap.org/Decade.

[48] Robert L. Metts, "Disability issues, trends and recommendations for the World Bank", Social Protection Discussion Paper No. 0007 (Washington, D.C., World Bank, 2000).

191. The potential for enhancing the possibility of persons with disabilities to carry on independent lives within the community rests on the adoption of inclusive technologies and universal design in buildings, public facilities, communications systems and housing. Inclusive technical devices, such as wheelchairs, crutches, sign language translation, Braille machines, adaptive keyboards, and audio cassettes can significantly improve mobility and communication for the disabled. Likewise, adopting the principles of universal design can greatly facilitate the physical accessibility of schools, training centres, workshops, offices, public buildings and residences.[49] If those accommodations are made, disabled people will have greater ease of access to education, employment and social, political and cultural opportunities, all of which can improve their well-being and that of the communities in which they live.

Threats to the well-being of indigenous peoples

192. The overall well-being of indigenous peoples is threatened in a number of different ways. One major source of vulnerability is the risk of disintegration of the social structure that is crucial to their survival. Other sources of vulnerability, many of which are directly related to their social structure, include health problems; a lack of education and a lack of access to education; migration; armed conflict; loss of lands; and violence, exploitation and abuse.

193. The health of indigenous peoples is closely related to their lands. The appropriation of ancestral lands, environmental degradation and dwindling natural resources compromise agricultural livelihoods, the supply of food specific to their diets and the sources of their traditional medicines. Furthermore, indigenous peoples have been exposed to diseases that were once those of "outsiders"; the incidence of such illnesses as AIDS and cancer from radioactive pollutants, against which traditional medicine is not effective, has been on the rise among indigenous peoples.

194. In the area of education, indigenous peoples face discrimination in two spheres. First, they often lack access to educational facilities. Second, educational curricula seldom take into account the special characteristics of indigenous peoples. Thus, indigenous children often drop out of school, while those that do continue often face discrimination in gaining access to institutions of higher education.[50] Furthermore, compared to boys, indigenous girls are less likely to attend school, and fewer indigenous children attend school as compared with other children. As a result, the lowest literacy rates are often observed among indigenous women.

195. The opening of indigenous territories has led to the migration of indigenous youth to urban centres, leaving older members of the community in traditional settlements or at relocation sites. Urban migration erodes the intergenerational support that has sustained indigenous peoples over many years and severs ties to traditional territories. Older indigenous peoples, left on their own in less desirable physical environments, become victims of abuse and maltreatment, hunger and suicide.[51] The departure of the younger members results in higher dependency ratios within indigenous communities and, unless reversed, eventually leads to the extinction of those communities. There outmigration of indigenous women seeking work in other countries as domestic helpers has also increased.[52] While their remittances help indigenous communities financially, lasting outmigration also leads to the further breakdown of families and social values.

196. Increased military actions to combat drug cartels and armed insurgency, as well as the presence of

[49] See "Disability and poverty reduction strategies: how to ensure that access of persons with disabilities to decent and productive work is part of the PRSP process", discussion paper, InFocus Programme on Skills, Knowledge and Employability (Geneva, International Labour Organization, Disability Programme, 2002), para. 36.

[50] Chandra Roy, "Racial discrimination against indigenous peoples: a global perspective", *Indigenous Affairs*, No. 1 (2001).

[51] "Human rights of indigenous peoples: indigenous peoples and their relationship to land", final working paper prepared by the Special Rapporteur to the Commission on Human Rights (E/CN.4/Sub.2/2000/25).

[52] Victoria Tauli-Corpuz, *The Resistance of the Indigenous Peoples of Asia against Racism and Racial Discrimination* (Baguio City, Philippines, Indigenous Peoples' International Centre for Policy Research and Education, n.d.), available from http://www.tebtebba.org/tebtebba_files/ipr/racism.htm (accessed 4 November 2002).

paramilitary forces, have hastened the social disintegration of indigenous peoples' communities and have forced thousands of them off their lands, converting them into refugees.[53] The problem becomes even more difficult for indigenous communities located along the borders of several nation States where police protection is not effective.

197. Other conflicts exist between indigenous peoples and members of modern society coexisting on adjacent lands, stemming from differences in their concepts of land rights. Violent means have sometimes been used to evict indigenous peoples from their lands. Other human rights violations against indigenous peoples include assassinations, forced disappearances, compulsory relocation and destruction of villages and communities.[54] Missionary work of followers of institutionalized religions and the subsequent conversions of some members of indigenous communities have also led to conflicts within those communities and the rejection by some members of their indigenous cultures.

198. Another source of vulnerability is exploitation and abuse. Displaced women possessing only farming skills become easy prey to prostitution rings. In areas where land has been expropriated for logging, indigenous women may be forced into prostitution only to be left behind when the logging operations are completed.

199. Oppression and alienation from their own traditions has had serious sociocultural, psychological and emotional effects on indigenous peoples. This is manifested in a very high incidence of domestic abuse and violence, alcoholism and suicide in indigenous peoples' households, particularly in urban settings. "Over-policing" has also resulted in the overrepresentation of indigenous peoples in custody, with high levels of youth institutionalized and detained.[55] A high incidence of mental health problems has also been observed among indigenous children taken from their families and placed as servants in non-indigenous homes.

200. The sources of vulnerability and problems mentioned above are exacerbated by indigenous peoples' isolation. They usually live in remote areas where access to health, education, housing and refugee services is limited. Indigenous peoples often have limited resources to protect themselves from violence or to punish perpetrators when formal justice and criminal justice systems are located in faraway urban areas.

Conclusion

201. Traditionally, the public sector provides basic social services, including education, health care and social assistance and social protection to ensure equal access and protect the basic needs of individuals, families and communities. Those services form an integral part of the capacity to cope with the effect of social risks. Unfortunately, fewer and fewer resources are available for such purposes in the current environment of public sector retrenchment in both developed and developing countries. As a result, there is a general trend towards reductions in public provisions while alternative methods of delivering basic services have fallen short of expectations in terms of universal access. The situation has further weakened coping capacity, especially among disadvantaged and vulnerable populations.

202. The disintegration of social infrastructure in the areas of education, health care and administration/governance, and the weakening of social institutions have put large segments of the population at risk for disease, lawlessness and ignorance, all of which contribute to increasing vulnerability.

203. Furthermore, the demographic transition brings with it such social concerns as older persons' health, which is becoming an issue for more people in more countries as population ageing occurs. All the while, precious resources are spent fighting expensive (both in money and human lives) wars instead of addressing social ills and the special needs of large segments of the population in some of the world's poorest countries. For some, they are trapped in a vicious cycle: poverty and unmet social challenges — violent conflict — deepening social division and poverty.

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[53] "Briefing notes", *World News*, 6 February 2001.

[54] "Indigenous issues: human rights and indigenous issues", report of the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous peoples (E/CN.4/2002/97).

[55] Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report, 1997* (Sydney, Australian Human Rights and Equal Opportunity Commission, 1997), available from http://www.humanrights.gov.au. Path: publications.

204. The challenges posed by the social ills analysed in the present chapter are great for both national Governments and the international community. Commitment and cooperation are needed at the national and international levels to address those issues.