Reclaiming Childhood

Theresa Betancourt studies the world’s most neglected and traumatized youths.

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At the train station in Jaipur, India, a ragtag group of boys and men squat on the tracks, hunched over piles of empty water bottles. A load of these bottles, picked up after they are discarded on train cars, might earn a collector 100 rupees ($2) at day’s end when they are traded in for recycling—or, more likely, refilling by a street vendor who will claim they are factory-sealed.

During downtime between trains, the boys and men pass around a rag soaked in Liquid Paper, getting high on the fumes. When a train rumbles into the station, they start to move.

The smallest of them, Badal, is also the fastest. He runs alongside the train, keeping pace so that before it has fully come to a halt, he has grabbed a handrail and hoisted himself into the car. As passengers gather belongings and make their way to the exits, he dodges and weaves among them, scooping bottles from the floor and dropping them into the plastic bag slung over his back.

Badal is eight years old. Worldliness lines his face, in stark contrast to his young features. He collects bottles not because he would rather do this than go to school, but because it buys food for his family. At the end of the day, he will sleep on the sidewalk under a railroad bridge with his mother and siblings.

It is easy to see Badal as a pitiful and needy figure—but Theresa Betancourt, S.D. ’03, associate professor of child health and human rights at the Harvard School of Public Health (HSPH), suggests that a different viewpoint would lead to more effective strategies for helping disadvantaged children. Betancourt seeks a wholesale shift in the language used by aid organizations and the philanthropic community, so that Badal might be seen as a resourceful figure, acting in ways that are understandable given his family’s limited prospects for economic success and education, and his own emotional and developmental needs. Collecting bottles, hanging out with older men, taking drugs to blunt emotional pain: viewing these as survival strategies acknowledges that all humans have the same needs. Instead of merely bandaging poverty’s symptoms (“These people act in ways we can’t understand, therefore we’ll never change their behavior”), Betancourt focuses on poverty’s causes (“These people are just like you and me, and will make healthier choices if presented with a better set of alternatives”).

As the director of the Program on Children and Global Adversity at Harvard’s François-Xavier Bagnoud (FXB) Center for Health and Human Rights, Betancourt studies the effectiveness of interventions that aim to help children from Asia and Africa to Boston. She works with former child soldiers, AIDS orphans, refugees, and children growing up on construction sites, as well as those in the Jaipur train station. The common thread is documenting survival strategies: studying how some children and families manage to channel their resourcefulness in a positive direction, and considering how to open up those salubrious paths to more people.

Her work takes aim at some of the biggest structural problems in international aid. Some nongovernmental organizations (NGOs) do great work, but can’t scale it up for wider impact; others continue programs that haven’t been proven to work. Some major donors demand evidence of efficacy, but that evidence doesn’t yet exist; others fund programs without it. International aid follows a crisis but dries up soon after, ignoring the enduring fallout, or focuses chiefly on infrastructure projects (roads and bridges) or physiological needs (alleviating hunger and preventing malaria) when mental-health and social services might be just as important in en-
abling a country’s next generation to succeed economically.

Betancourt operates one country at a time, one community at a time, and ultimately, one person at a time: one of her guiding principles is tailoring therapies by identifying the specific needs of her study populations, and of smaller groups within them. But through her research, her scholarly articles, and the relationships she builds, she seeks to demonstrate models for governments, NGOs, funding organizations, and communities to work together in coordinated ways that ultimately improve children’s lives.

ISHWAR CAN’T SAY exactly how old he is—he thinks about 18. He’s also not sure how old he was when he ran away from home—10 or 12, he says. His mother died when he was one and a half. She was cooking lunch one day and her sari caught fire; she burned to death before his eyes.

Ishwar’s father remarried. The boy and his stepmother often bickered. Eventually, Ishwar’s father told him, “Since you can’t get along, it’s better that you go.”

The boy hopped a train not knowing where it was going, and ended up living on the station platform in Jaipur, selling soap and performing menial tasks for a bit of money. He became addicted to correction fluid, headache balm, and eventually heroin.

He became a regular at the drop-in center run by FXB International, Betancourt’s partner organization in Jaipur. The center’s director, Lata Singh, noticed that Ishwar was among the more responsible of the children, looking out for the younger ones. She saw that he was intelligent and sensitive, and that he yearned for a different life, so she gave him a job making daily runs to pick up meals donated by a nearby hotel and performing other tasks around the center.

Ishwar got clean and even went home briefly, but was soon back in Jaipur, living with the other runaways who had become his family. Singh hopes to help him get a job driving an auto-rickshaw or working at a Hindi-language call center, but first he will need treatment for medical and psychological problems caused by his drug use.

By some measures, Ishwar’s is a success story—but it also indicates how fragile that success can be, and how difficult to make the transition to a different life after years on the street. Most of the children who come to the drop-in center spend their days begging, selling soap, or collecting bottles, like Ishwar and Badal. Singh has learned that escorting the truant children to school, or even pressuring them to go, doesn’t work. They just end up not coming back to the center, and thus not benefiting from its services: food, clothing, tutoring, and attention from caring adults.

The center’s collaboration with Betancourt is new—the parties are just beginning to discuss how they might work together—but they hope their work might help reveal what factors helped Ishwar fare better than his peers, in that he holds down a steady job and still has a sense of hope for the future. Ultimately, the findings would be used to identify effective ways
to help younger children like Badal move toward productive, happy, and healthy lives, against dire odds.

One of Betancourt’s earliest research projects was in Sierra Leone, working with youths who served as child soldiers in the country’s decade-long civil war. These children were taken from their homes by rebel groups and ordered to commit violent acts. Some were forced to take drugs to deaden their inhibition to killing; some were forced to kill or maim their own relatives.

After the war ended in 2002, they went home, aided by NGOs that provided counseling and helped them get back to their families. Reintegration was not easy: neighbors, and sometimes even their own families, distrusted them. People wondered whether they were irreparably damaged and condemned to a violent future.

Betancourt began studying a group of more than 500 former child soldiers and other war-affected youth (such as those who suffered deaths in the family) just after the war’s end. Here, as in Jaipur, she wanted to understand why some children have reintegrated successfully while others have had a harder time. “In our sample,” she notes, “we have a young man who’s in jail because he killed his girlfriend in a fit of rage, and we have a young woman who’s finished medical school.” Part of the explanation, of course, lies in personal qualities: intelligence, determination. But external factors—family and community, differing wartime experiences—also influence their trajectories. Betancourt has sought to clarify the various factors to determine how best to help youths recover from the trauma of war.

In her quest to bring greater awareness to children’s needs, Betancourt recognized the power of a straightforward construct that is easily summed up and remembered. She looked to the success of the GOBI model, developed by UNICEF in the early 1980s for improving maternal and child health: growth monitoring (to identify malnourished children and supplement their diet), oral rehydration (a cheap, simple way to balance the electrolytes of a child suffering from diarrhea in order to prevent death—developed by senior lecturer on international health Richard Cash and colleagues), breastfeeding (to help strengthen children’s immune systems), and immunization. The campaign led to significant declines in infant and child mortality in many places, but as Betancourt and colleagues wrote in a journal article, “Promoting the health and development of children requires more than just keeping them alive.”

Betancourt devised her own model, SAFE, to reflect the notion that children have rights beyond mere survival: safety and freedom from harm; access to basic physiological needs such as food, shelter, and medical care; family or connection to other attachment figures; and education and economic security. This framework has already been used by other researchers in Haiti and Lesotho, as well as in her own projects in India, Sierra Leone, Rwanda, northern Uganda, and with a Somali Bantu refugee population in Boston (see “Far from Home,” page 38).

SAFE isn’t just a scorecard, Betancourt specifies: “It’s about interrelatedness.” Insecurity in any of these four domains threatens security in the others. “Kids need attachment figures,” she says. “If they’re not finding it from their immediate family, they’re going to find it somewhere”—as with the Jaipur runaways who act as each other’s family. Children without solid attachment figures are at risk of being recruited into child labor or sex work, or conscripted as child soldiers, so strong is their need for an adult who takes an interest in them; but should they take one of these paths, they’re missing out on education, and their very safety is at risk.

Betancourt notes that in many plac-
es where governments fall short and international aid has dried up—such as Sierra Leone—NGOs pick up the slack, but are not as effective as they could be. “They see one need and they work to meet that need,” she says. “They see that kids are hungry, and they offer food. They see that kids need healthcare, so they open a free clinic. But nobody pays attention to how these different needs are interrelated or how organizations with different types of expertise might work together to bring the same child greater benefit.”

In each setting, SAFE becomes a lens for understanding children’s needs and moving toward meeting them. In Sierra Leone, for instance, Betancourt’s team interviewed children and families about wartime and postwar experiences: How supportive were family members after children returned home? Did domestic factors (abuse in the home, death of a parent) hamper recovery? How supportive was the community? The researchers documented cases of mental-health problems such as depression and anxiety. They evaluated youths’ confidence, their facility with “prosocial behavior” such as making friends and helping others, and their levels of aggression and hostility.

By revealing different groups’ specific needs, these analytical methods provide data for customized interventions. For instance, youths who demonstrate anger problems and continued deficits in prosocial behavior might receive something beyond the routine package of reintegration services. In villages where stigma lingers, NGOs might hold community workshops designed to probe and unseat this stigma, which compounds mental-health challenges and inhibits healing. Betancourt’s team is currently testing the “Youth Readiness Intervention,” a group therapy they designed for the most persistently troubled war-affected youth in post-conflict Sierra Leone. The therapy aims to improve these youths’ skills at relating to others, understanding how their experiences might affect their relationships, managing their anger, and coping with difficult emotions.

With local adaptation, Betancourt’s methods can be applied worldwide. One recent survey estimates that 300,000 children are currently serving in government forces or armed rebel or militia groups. Just since 2001, child soldiers have been conscripted for conflicts in Angola, Burundi, the Central African Republic, Chad, Ivory Coast, the Democratic Republic of Congo, Guinea, Liberia, Somalia, and northern Uganda, as well as Sierra Leone and Rwanda.

Since Rwanda’s 1994 genocide (in which up to one million people died, compared to 50,000 in Sierra Leone’s civil war), the country has emphasized communal healing. But the HIV epidemic, combined with an already-high number of orphans from the genocide, has led to an extraordinary number of child-headed households. Here, Betancourt works with children affected by HIV—not necessarily infected, but with a family member who is HIV-positive or has died of AIDS.

Broadly speaking, HIV-affected children in Rwanda face many of the same issues as former child soldiers in Sierra Leone: anxiety, depression, conduct problems in school. If they are siblings’ caretakers, their future prospects are often diminished because they have left school to work. Their health may be in danger, too: adolescent girls might engage in sex for money and run the risk of contracting HIV themselves. The genocide’s aftermath—the loss of a parent or other family member, witnessing violence,
Like former child soldiers in Sierra Leone, HIV-affected Rwandan children face anxiety, depression, endangered health, and diminished prospects. or lingering bitterness among neighbors—can compound HIV’s emotional strain on families.

Betancourt’s work in Rwanda exemplifies the “mixed-methods” research in which she specializes, blending the qualitative and quantitative. In an initial round of interviews with adults in the communities chosen for the study, the researchers kept their questions open-ended, simply asking what problems children faced. Analyzing the themes that emerged, they settled on five broad phenomena that capture the emotional impact of coping with HIV in the family. In the next round of interviews, they asked what qualities help children and families cope; in a third round, they sought more detail about each quality.

Naturally, these concepts did not map neatly to Western conceptions of mental health, or even to English translations of Kinyarwanda terms. Children said to have kwihangana (perseverance) played with others instead of isolating themselves and engaged in prayer, in addition to working hard in spite of personal problems and resisting becoming discouraged. Kurera neza (good parenting) included the concept of parenting “for the country.”

These painstaking research practices are necessary, Betancourt says, if findings are to be culturally sensitive: “We need to know how people here think about child mental-health problems. If we show up in Rwanda, interested in child mental health, and we try to start with Western words and concepts—if we go with the interpreter to a village and say, ‘Tell me about child mental-health problems’—there’s a good chance the interpreter is going to say, ‘She’s interested in learning about madness in children.’” So taboo is that topic, she says, “you might as well be finished right there.”

In Rwanda, as elsewhere, Betancourt didn’t stop at documenting the problem: results from several rounds of interviews informed a response. Rather than start from scratch, her team adapted a well-tested, effective therapy that she believed could translate readily for use in Rwanda. Developed at Harvard by Monks professor of child psychiatry William Beardslee, the “Family Talk” intervention is designed to mitigate the effect of a parent’s depression on a child. With HIV, as with depression, the child might not understand the parent’s illness; parents want to know what they can do to minimize the illness’s impact on their children; and families might need help learning how to communicate openly about the illness.

Betancourt’s “Family Strengthening Intervention” incorporates education about HIV (addressing common misconceptions) and training in parenting skills tailored to Rwandan culture and views. Recognizing the limited capacity of the country’s medical and public-health sectors, the intervention trains families to rely on their own resources, rather than depend on sessions with a counselor. Facilitators lead families in discussing the future and in identifying family strengths, to help them move beyond a negative focus defined solely by HIV. This intervention is currently being tested with 20 families; if the mental-health outcomes are favorable, it will be tested with 80 more.

By the time this wider study produces results next year, it will have been six years since the Rwanda project began. These endeavors require patience: without evaluation, an intervention’s impact will never be known—nor does it follow that because a therapy works in one setting, it will have the same effects everywhere. “The big development funders spend large quantities of money on programs that may not have a strong evidence base,” Betancourt says, “and then you have the National Institutes of Health very carefully, systematically building an evidence base—but the two of them are not communicating.” With the right evidence, these two groups might begin to speak a common language.

Betancourt became interested in public health after receiving her bachelor’s degree in psychology (with a minor in international studies) from Linfield College in McMinnville, Oregon.
Far From Home

Bantu tribal people were brought to Somalia from other African countries as slaves in the nineteenth century. After emancipation, with few options for formal employment, this minority group adopted a subsistence lifestyle, settling in remote river valleys without schools or access to healthcare. The group, which constituted at least 5 percent (and by some estimates, much more) of Somalia’s population, didn’t have even one representative in the national government. When the civil war began in 1991, Somali Bantu communities were defenseless as armed groups from both sides of the conflict started coming to their communities, raping, pillaging, and killing under the pretense that the villagers had helped the other side.

Tens of thousands of Somali Bantus ended up in refugee camps in Kenya. Returning to Somalia, where they suffered from discrimination and where outbreaks of violence persisted (and still do), was not a good option. By the time the United States agreed to accept 13,000 Somali Bantu refugees for resettlement, most of them had been living in the camps for more than a decade.

In 2006, Theresa Betancourt and colleagues at the Boston Medical Center (BMC) received a request for help from the public schools in Lynn, Massachusetts, home to a Somali Bantu refugee community. The refugee children were having behavioral problems, and the school system was having trouble communicating with their parents. They sought out the BMC team, who were known for their expertise in working with African populations and war refugees.

Betancourt and her colleagues engaged teachers and administrators in Lynn to help them understand not only the cultural differences involved (refugee parents weren’t accustomed, for example, to speaking directly to teachers about their children’s education) but also the challenges specific to the Somali Bantu experience (such as parents’ lack of literacy, and mental-health issues stemming from exposure to violence, being uprooted, and then living in camps for years). The goal was collaborative, rather than antagonistic, relationships with the parents.

Later, Betancourt saw an opportunity to try locally an intervention similar to those she'd developed for use in Sierra Leone and Rwanda. Aweis Hussein, a Somali Bantu teacher's aide and interpreter whom Betancourt knew from her work in the Lynn public schools, had helped found Shanbaro, an organization for the Boston-area Somali Bantu refugee community. Working with Hussein and other community leaders, Betancourt conducted interviews to assess both children's needs and any factors that seemed to mitigate the effects of the adversity they experienced as refugees; she hopes to design and test a family-strengthening intervention adapted to the Somali Bantu culture and needs. In the meantime, graduate student Stephanie Loo has already won funding to lead a Somali Bantu girls' empowerment group and Betancourt's interviews have resulted in a community needs assessment that can be used to apply for further grant aid. Rita Falzarano, development coordinator for the nonprofit Chelsea Collaborative, an umbrella organization that includes Shanbaro, notes another benefit: Hussein and four other Somali Bantu community members worked side by side with Harvard researchers, receiving training in social-science research methods to help carry out the study.

With most so-called research partnerships, says Falzarano, researchers gather the data they need “and that is the last you hear from them.” The partnership with Betancourt “is a true partnership,” she says: “It benefits the community as well as the researcher.”

Working as a school mental-health specialist in Oregon, she became determined to get to the root of her young clients’ troubles. “It’s a public-health adage,” she says. “You see people drowning in a river and you’re pulling them out and saving them, but then eventually you say—wait a minute, let’s go upstream and find out why they’re falling in.”

But the seeds were planted earlier, during her childhood in Bethel, Alaska, then a city of 3,000 accessible only by air and water, with a majority-Yup’ik population. There were no paved roads. Betancourt’s home had no plumbing; the family showed up at the high school or the fire station (her father was the fire chief). Stray dogs roamed the streets. Still, she says, “I thought it was great. We were outside all the time, playing with our friends and building things out of snow, ice skating, playing hockey.”

She believes this early experience instilled respect for other cultures—and prepared her to work in the developing world. “When I work in Africa, and there’s no plumbing, and there are no paved roads, and there are stray dogs in the streets, it feels like home to me.”

As a girl, she observed the problems that resulted when a people accustomed to living off the land rapidly adopted a different way of life: high crime rates, rampant alcoholism, child neglect. Even then, she recalls, “the question of resilience always came back to me. These kids weren’t just on a deterministic path. If people in the community stepped in, or if kids got an opportunity, even a child from a terrible background managed to make it out OK.”

In 1998, Betancourt entered a doctoral program at HSPH; an interest in refugee issues also led her to spend time abroad working for the United Nations (in 1999) and consulting for the International Rescue Committee (from 2002 to the present). Again she observed resilience among children—in Albania, Russia, and Ethiopia, where she helped design education programs for further grant aid. Rita Falzarano, development coordinator for the nonprofit Chelsea Collaborative, an umbrella organization that includes Shanbaro, notes another benefit: Hussein and four other Somali Bantu community members worked side by side with Harvard researchers, receiving training in social-science research methods to help carry out the study.

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Zahara Haji (foreground) and Amina Abdulahi, research assistants in Betancourt’s project with the Somali Bantu refugee community in Boston, during a presentation at Chelsea City Hall

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cation programs for use in refugee camps. Her eventual dissertation explored the role social support played in the mental health of youths displaced by the conflict in Chechnya.

She cites the influence on her work of two Harvard Medical School researchers: Margarita Alegria, who has questioned the cultural validity of applying commonly used mental-health assessment and services models to minority populations, and Felton Earls, whose long-term study of Chicago youths examined the consequences of violence, tracking a broad range of measures: physical health, social connection, educational and vocational achievement. Remembering these lessons, Betancourt has resisted the temptations to apply Western models elsewhere without adapting them and to stop at the sort of cross-sectional study (one-time data collection, with no follow-up) that dominates research in the developing world. In countries that lack basic infrastructure and government data collection, the challenge of keeping track of study subjects year after year becomes even harder. But, she says, “How can we ever look at resilience if we keep looking at a single snapshot in time?” She has now been following the same children from Sierra Leone for more than a decade; a newly obtained grant will allow her to follow them as they start their own families—the first multigenerational study of the impact of war in Africa.

Betancourt believes her “long-term relationships” in the countries where she works help her navigate foreign cultures as people begin to trust her and her team members. Ties with partner organizations, such as FXB in Jaipur and Partners In Health in Rwanda, are also crucial. Though her India projects are new, she intends them to be equally enduring. “Once I commit to a place,” she says, “I tend to stay committed for a long time.”

Office buildings and residential towers under construction are a hallmark of Indian cities today. In fact, these sites are homes already: next to each unfinished skyscraper, low-ceilinged, ramshackle lean-tos of corrugated tin make up a workers’ village. India has an estimated 40 million migrant construction workers; most of them have families in tow.

Children who live on construction sites typically do not attend school. They may not speak the local language of instruction, and may also be several years behind because of frequent moves or a lack of schooling in their native villages. Families do not usually stay on one construction site more than a few months: when laborers who specialize in pouring foundations are finished, they move to a new project, replaced by those who will erect the building, then by stone masons—and so on. What’s more, enrolling children in school means taking time away from work. Even locating the nearest school in an unfamiliar area can be daunting.

Mobile Crèches, a Delhi-based NGO with which Betancourt is collaborating, assists parents with enrollment and daily transportation to school for their children. It operates daycare centers on construction sites, offering tutoring, meals, clothing, and medical care, and even negotiating breastfeeding breaks for female construction workers.

At a site in Gurgaon, half a dozen 20-story buildings rise into the fog. Here, in the birthplace of the overseas call center and the first hub of customer-service outsourcing to India, Mobile Crèches operates a center serving 60 children—only a fraction of those living here. (Multiple construction companies commonly work on the same site; understandably, the companies that pay for crèches allow only their...
own employees’ children to attend.) The other children spend their days cooking, procuring water, or caring for younger siblings. They play unsupervised amid heavy machinery and piles of rusty rebar, with background noise of clanking metal and buzzing generators.

The crèche, tucked away in a metal-fenced courtyard, is a cheerful oasis in this landscape of gray and brown. In an open-air classroom on the terrace, the older children are at work on an assignment to write an illustrated story using the Hindi words for clouds, stars, and fair. Inside, the three-to-five-year-olds sing along with a boombox, eagerly miming the motions to a song about hygiene: combing hair, brushing teeth, washing hands. A schedule for the under-three group, posted on the wall, includes time blocks for playing with toys, tickling, and hugs.

More broadly than the concrete services it offers—food, education, healthcare—Mobile Crèches aims to provide “a place where children reclaim their childhood.” This focus on child development beyond physiological needs drew Betancourt’s interest. A student (Ashkon Shaahinfar, M.P.H. ’11, now a clinical fellow in pediatrics at Massachusetts General Hospital) proposed using the SAFE framework to examine the NGO’s work as his thesis project; he and Betancourt wrote the first articles explaining how SAFE applies here and conducted interviews with government officials, NGO workers, academics, and parents to study the impact of growing up on a construction site.

Betancourt’s team is working to create a “SAFE Child Impact Assessment,” modeled after environmental impact assessments—a sort of “report card” that might be used to tally just how child-friendly a company is. She says she has had “very interesting conversations” with India’s Ministry of Women and Children about drafting legislation to require such assessments before new projects break ground. She wonders, “Under the rubric of corporate social responsibility, could we make this like going green, so it’s a good thing, an exciting thing, to be child-friendly?”

Beyond operating 36 childcare centers, Mobile Crèches is an advocacy organization. Betancourt is equally excited to be engaged on this front: the need is so vast that it would be virtually impossible for one organization to serve the entire target population. A construction worker might earn 150 rupees ($3) a day—not much more than Badal makes collecting bottles in the Jaipur train station. Minimum-wage laws exist, but “the law is flouted everywhere,” says Mobile Crèches executive director Mridula Bajaj. Any construction site with a certain number of female workers of reproductive age is required by law to have a crèche, but few do.

Mobile Crèches pressures the government to enforce laws and raises awareness about unenforced laws that affect families and children. “They don’t know that they can advocate for their children to have the right to education,” says Betancourt. “They don’t know that India has an integrated child development scheme where their zero-to-three-year-olds should be able to go to an early childhood center. They don’t know that India has ratified the UN Convention on the Rights of the Child, and all that it stipulates.”

That convention, which she calls “the gold standard,” entitles children to healthcare, education, security in food and housing, and protection from all forms of violence and exploitation—yet in many of the countries that have signed and ratified the convention, the majority of children lack at least one of these. “Time and time again,” says Betancourt, “we fail to do just the very basic things.”

She would like to see a world where children not only survive, but thrive. In India, she wants children’s rights to be part of the conversation. In Sierra Leone and Rwanda, she seeks to make the case that children still need help long after crisis aid has dried up. Such measures, she points out, affect not just individual children, but entire nations, as they could mean the difference between a generation that finds gainful employment and one mired in psychological problems. “We have lovely laws on the books,” she says. “But to just sign them and not uphold them is a very crass exercise.”

Former associate editor Elizabeth Gudrais ’01 now lives in Madison, Wisconsin. Her reporting in India was supported by an anonymous donation for international news coverage.