

## MODULE ONE:

# The Social Context of Children in Especially Difficult Circumstances (CEDC)

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## SESSION ONE:

# Problems and Possible Actions

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### **Timing:**

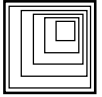
3 hours

### **Session learning objectives:**

- To define children in especially difficult circumstances (CEDC) and selected categories of CEDC;
- To identify, understand and analyse the situation of different categories of CEDC focusing on the immediate and root causes of their situation;
- To describe the process of moving to especially difficult circumstances and identify risk and protective factors at each stage;
- To identify and analyse the risks that selected categories of CEDC encounter in their situation and the implications to their physical and psychosocial health and development; and
- To describe the objectives of primary, secondary and tertiary programmes and strategies.

### **Session contents:**

- Definition of the terms CEDC (or children in need of special protection), other categories of especially difficult circumstances and health;
- Description and analysis of the life situation/social context of CEDC at different stages and factors that affect their physical and psychosocial health and well-being;
- Discussion of the children's care-seeking behaviour and availability of, and access to, health and social services; and
- Description of the levels of intervention and principles for effective interventions.



### **List of key terms:**

- CEDC
- CNSP
- Primary prevention
- Secondary prevention
- Tertiary prevention
- Rehabilitation
- Reintegration

### **Key questions to be asked:**

1. Who are CEDC?
2. What are the causal factors?
3. What are the intervening factors at each stage?
4. What are the health problems and how do the children cope with them?
5. What are the different levels of intervention and what are their objectives?
6. What programmes/strategies are appropriate at different levels?

### **Method of presentation:**

The facilitator will present the content and invite the participants to contribute information on their country contexts at different stages of the lecture. Participants should be encouraged to discuss and share examples based on their country contexts and experiences with the children they work with.

### **Workshop aids and equipment required:**

- PowerPoint presentation equipment/real object projector (not essential);
- Overhead projector;
- Transparencies and pens;
- Flip chart paper and markers.

### **References:**

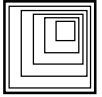
Resource materials provided in the participants' folder.



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**Note:** *This Module does not cover training on the Convention on the Rights of Child, as many good training guides exist already in this area. See the References section for a partial listing of available materials.*



## SESSION TWO:

# The ESCAP Project on Sexual Abuse and Sexual Exploitation of Children and Youth in the Greater Mekong Subregion (GMS): Research and Intervention Phases

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### **Timing:**

4.5 hours

### **Session learning objectives:**

- To identify needs assessment issues and concerns;
- To understand and be able to apply concepts of needs assessment; and
- To describe problems encountered in primary, secondary and tertiary prevention programmes and possible solutions.

### **Session contents:**

- Part 1: Needs assessment: how to identify the needs of CEDC and their families and how to use research approaches that view children as subjects; and
- Part 2: Interventions: the principles for effective interventions at the different levels that can be carried out at the street/work, centre and community levels.

### **List of key terms:**

- Needs assessment
- Action research



### **Key questions to be asked:**

1. What is happening to this community/family/child?
2. What are the characteristics of a good preventive and remedial programme?
3. How would you design a preventive and remedial programme for children in your care?

### **Method of presentation:**

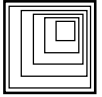
Concepts and principles of needs assessment effective interventions will be presented (first part). Participants will share their experiences and problems they have encountered in conducting needs assessment and developing interventions and brainstorm the solutions with input from the facilitator. Participants will also work in country groups to identify needs (second part) and develop minimum actions (third part) for selected groups of CEDC.

### **Workshop aids and equipment required:**

- PowerPoint presentation equipment/real object projector (not essential);
- Overhead projector;
- Transparencies and pens;
- Flip chart paper and markers.

### **References:**

Resource materials provided in the participants' folder.  
ESCAP subregional and national research reports (*see Reference list*).



# Background Document on The Social Context of Children in Especially Difficult Circumstances (CEDC): Problems and Possible Actions

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## 1. INTRODUCTION

Children are in especially difficult circumstances when their basic needs for food, shelter, education, medical care, or protection and security are not met.<sup>1</sup> Such children are at great risk of suffering malnutrition, disease and possibly death. Unless their own situation changes, their condition of gross disadvantage will extend to their own children who may suffer even greater misery and suffering.

Disruptive social change is the principal cause of the growing numbers of children in difficult circumstances in developing countries and Eastern European countries. Rapid urbanization associated with socio-economic, cultural and political transformation has resulted in numerous negative changes, disrupting the family and its traditional support system and weakening community organizations. Many parents looking for non-existent jobs in the city end up poorer, with their children condemned to living in overcrowded slums and squalid environments. Likewise, children seeking work in cities of neighbouring or far away countries to support themselves and their families are exposed to abuse and exploitation by their employers and the majority remain poor. They are made to work hard and for long hours and generally lack access to educational and health care services. They are susceptible to malnutrition and disease and their lifespan is short.

The problem of CEDC is not confined to cities. In rural areas of many developing countries there are children who are victims of abject poverty, frequent drought and famine. These children remain largely

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<sup>1</sup> These groups of children are usually referred to as “children in especially difficult circumstances” (CEDC), “children in need of special protection” (CNSP), “children in distress”, “children in crisis”, “children in exceptionally difficult conditions”, and so on. In this paper, CEDC is used since it is the most widely-used term internationally. These children are, for shorter or longer periods in their lives, exposed to intense, multiple risks to their physical and mental health. A common characteristic of CEDC is that they lack proper adult care and protection, and that they lead their lives outside society.



invisible and need to be further studied and addressed. They include children of landless squatters and unemployed parents (especially poor single female heads of households) as well as children of nomadic parents in drought-stricken areas and those of ethnic minority groups. Their condition and environment prevents them from realizing normal growth and achieving their full potential. They too are perpetually vulnerable to malnutrition, disease and death.

Besides the categories identified above, other groups of children in especially difficult circumstances include children who live and work on the streets, abandoned and neglected children, orphans, battered children, children with disabilities, child workers, children in armed conflicts, child mothers (including child brides) and their children, displaced and refugee children, children infected and affected by AIDS, children of imprisoned mothers, sexually abused children and sexually exploited children. All of these undergo various forms of deprivation, abuse or exploitation, and in most parts of the world, these categories of children are on the increase.

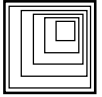
The Convention on the Rights of the Child, which is composed of 41 substantive articles, sets the standards for the rights of all children to survive, to develop, to be protected, and to participate fully in their family and society. These rights are all equally important and they must be seen in relation to each other in promoting a multi-disciplinary and cross-sectoral perspective.

The aim is to focus on the whole child, recognizing the interrelationship between different rights and needs. In the case of children who live and work on the streets, sexually abused and sexually exploited children, for example, one must address many interrelated issues and not merely issues of separation from parents, adoption and family reunification (articles 9, 10, 18, 20, 21 and 27) and protection from sexual abuse and exploitation (articles 34, 35 and 36).

Other issues that must be addressed to successfully combat the problems facing these children include:

- Protection from discrimination (article 2);
- Allocation of resources (article 4);
- Right to life (article 6);
- Rights to name, nationality and identity (articles 7 and 8);
- Provision of health education and care (articles 17 and 24)
- Protection from physical and mental violence (article 19);
- Rights of disabled children to care and reintegration (article 23);
- Protection from economic exploitation (articles 28, 29, 31 and 32);





- Right to recreational activities (article 31);
- Protection from drugs (article 33);
- Right to liberty (articles 37 and 40); and
- Rehabilitation (article 39).

Almost all countries of the world have ratified the Convention on the Rights of the Child and by so doing have committed themselves to improve the welfare of their children. Indeed, many of the countries have made progress in reducing infant and child mortality as well as extending primary education to children. These developments however, do not apply to the rapidly growing numbers of children in especially difficult circumstances in the world. These children are on the fringe of social and health services available to help children.

## **2. DESCRIPTION OF SELECTED CATEGORIES<sup>2</sup>**

### **2.1. Sexually abused children**

Sexual abuse of children<sup>3</sup> can be defined as contacts or interactions between a child and an older or more knowledgeable child or adult (stranger, sibling, or person in positions of authority, such as parent or caretaker) when the child is being used as an object for the older child or adult's sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure. The two forms of sexual abuse that are considered in this report are rape, which is defined as any sexual behaviour imposed on a child by a stranger, and incest, defined as any sexual behaviour imposed on a child by a member of either the immediate or extended family. The extended family includes people whom the child or family has known for a significant length of time and whom they trust, such as fathers, stepfathers, uncles, siblings and other family members, as well as friends, neighbours, teachers, doctors and members of religious

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<sup>2</sup> Only three categories of CEDC, namely sexually abused children, sexually exploited children and 'street children', are dealt with in this section. It is important to note that these groupings of children are not exclusive from one another. A child that lives and works on the streets may also be sexually abused, a child engaged in prostitution, a child mother, a refugee, a child with disabilities, etc.

<sup>3</sup> This definition is adapted by W. Kaime-Atterhog from: (a) W. Kaime-Atterhog, 1998. "Voices of sexually abused children who live on the streets of Nakuru, Kenya", unpublished report, Section for International Maternal and Child Health, Uppsala University, Sweden; (b) D. Finkelhor, 1994. "Current information on the scope and nature of child sexual abuse, *The Future of Children*, vol. 4 (2): 31-53; and (c) National Centre on Child Abuse and Neglect, 1980. *Sexual Abuse of Children – Selected Readings*, Office of Human Development Services, US Department of Health and Human Services, DHHS Publication No. 78-30161, pp. 1-6.

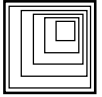


communities. Broadening the concept of incest beyond close blood relatives is very important. It helps underscore the special harm caused by any sexual activity between a person in a position of status, trust and authority, and a child in a position of dependency.

Sexual abuse can be physical, verbal or emotional, and includes:

- Physical sexual abuse: touching and fondling of the sexual parts of the child's body (genitals and anus) or touching the breasts of pubescent females; the child's touching the sexual parts of a partner's body; sexual kissing and embraces; penetration, which includes penile, digital and object penetration of the vagina, mouth or anus; masturbating a child or forcing the child to masturbate the perpetrator.
- Verbal sexual abuse: sexual language that is inappropriate for the age of the child, used by the perpetrator to generate sexual excitement, including making lewd comments about the child's body and making obscene phone calls.
- Emotional sexual abuse: use of a child by a parent or adult to fill inappropriate emotional needs, thereby forcing the child to fulfil the role of a spouse.
- Exhibitionism and voyeurism: having a child pose, undress or perform in a sexual fashion on film or in person (exhibitionism); and "peeping" into bathrooms or bedrooms to spy on a child (voyeurism); exposing children to adult sexual activity or pornographic movies and photographs.

Though the incidence of sexual abuse is lower than of physical and emotional abuse and neglect, this does not diminish its importance. It is generally accepted that statistical data on the reported cases of sexual abuse are significantly lower than the actual prevalence. Organizations that offer services to these children may have records of new cases that are reported to them. However, the data are largely documented in an unsystematic manner and reflect specific groups of victims. The police, for example, often only retain statistics on victims who could not settle their case with the abuser. The figures recorded by hospitals reflect the numbers of victims who suffer from severe physical or emotional problems and require treatment. Lastly, social welfare officers may only have statistics of young victims who need social welfare assistance. In many cases, young victims and their families, out of shame or fear of banishment, do not disclose or report the abuse. In cases where sexual abuse is exposed, it is often not recorded as an agreement is made between the victim's parents and the offender, often with the involvement of officials. Many authorities on the subject report that the pressure on victims of sexual abuse to remain silent or to retract their stories is heavy, and threats of violence are not uncommon.



Figures of reported sexual abuse of children and youth in many countries show that the majority of the victims come from poor families, a finding that has led authorities to associate sexual abuse of children with social disadvantage. However, it is most likely that this is the result of the manner of disclosure, and the extent of sexual abuse among the more advantaged may be effectively concealed. In addition, children of all ages, including infants, are at risk. Rates of the reported cases of sexual abuse of children and youth are higher among girls; however, childcare professionals report that increasing numbers of boys are also sexually abused. In the majority of cases, the main form of abuse is genital intercourse.

The rape of a child by a stranger is the rarest form of sexual abuse. Young people are most at risk from those living with them, related to them or acquainted with them, such as fathers, stepfathers, uncles, older siblings, boyfriends, neighbours and caretakers.

Some of the common health problems affecting children who have been sexually abused that have been identified by health care professionals in some Asian countries include: depression, withdrawal, fear, anxiety, vaginal discharge, painful genitalia and pregnancy. Some children also experience psychiatric problems, including running away from home and post-traumatic stress disorder.

There are few programmes in developing countries that address the issue of child sexual abuse. In developed countries, there has been a major thrust of child maltreatment prevention efforts in the last two decades. At the primary level of prevention, programmes have aimed at educating children of all ages about sexual abuse and its effects, providing them with a sense of empowerment and teaching them how to recognize a situation of potential abuse, to protect themselves and what to do if they experience actual or potential abuse. Many of these programmes are school-based and, although they may differ in the way they are presented, they appear to have certain common areas, namely: 1) learning touch distinctions (i.e. good touch/bad touch; green light touches/red light touches); 2) learning rules about touching; 3) learning children's rights and body boundaries; 4) learning about private parts; 5) learning skills for avoiding abuse, including saying 'no', screaming for help, running away; 6) knowing the difference between 'good secrets' and 'bad secrets'; 7) realizing the idea that sexual abuse is never the child's fault; and 8) knowing the need and ways to report abuse. The minimum requirements for a school-based prevention programme have been summarized as the 'four Rs', including training in remembering, recognizing, resisting and reporting. These forms of preventive programmes have been criticised for placing much of the responsibility for avoiding sexual abuse on children. Since many have not been evaluated, it is difficult to determine their effectiveness.



Secondary prevention programmes target children at high risk and encourage them to disclose attempted or on-going sexual abuse and intervening early. In developed countries school-based programmes have also served this objective. In addition, these programmes also focus on teachers and parents to inform them about appropriate ways of reacting to disclosures.

In the line of tertiary prevention, there are various therapeutic services for victims which help them break the pattern of abuse, diminish its consequences on the child and other family members, protect the victim from future abuse and prevent them from becoming abusers.

Little research has been conducted to date on the sexual abuse of children and youth in developing countries and the little data that is available is fraught with serious methodological problems. Sexual abuse is an extremely sensitive issue and one that is not easily solved owing to a traditional reluctance to intervene directly with other people's family life.

## 2.2. Sexually exploited children

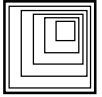
**Commercial sexual exploitation of children** is defined by the United Nations as the use of a child for sexual purposes in exchange for cash or in-kind favours between the customer, intermediary or agent and others who profit from the trade in children for these purposes (parent, family member, procurer, teacher, etc).

There are three forms of commercial sexual exploitation of children, which have already been defined by the United Nations: child prostitution, trafficking and sale of children across borders and within countries for sexual purposes and pornography.

**Child prostitution** is the act of engaging or offering the services of a child to a person to perform sexual acts for money or other consideration with that person or any other person.

**Trafficking and sale of children** across borders and within countries for sexual purposes is the transfer of a child from one party to another for whatever purpose in exchange for financial consideration or other rewards. Sexual trafficking is the profitable business of transporting children for commercial sexual purposes. It can be across borders or within countries, across state lines, from city to city, or from rural to urban centres.

**Child pornography** is visual or audio material, which uses children in a sexual context. It consists of the visual depiction of a child engaged in explicit sexual conduct, real or stimulated, or the lewd exhibition of the genitals intended for the sexual gratification of the user, and involves production, distribution and/or use of such material.



There is no accurate data on the number of children that are sexually exploited but available information from various studies carried out in different countries indicate that the problem exists and that it is growing in magnitude. The actual number of sexually exploited children is also difficult to determine with accuracy because many of the sex establishments engaging them are concealed. Children working in the commercial sex sector in many developing countries are known to lie about their true age and often have fake identity cards. In many countries, the commercial sexual exploitation of children takes the form of prostitution and trafficking within and across borders for the purposes of prostitution. Pornography is not reported to be a serious problem.

While all children, especially girls, are at risk of sexual exploitation, those living in poverty, those who have been abandoned or abused, children who live and work on the streets, domestic servants, the disabled, refugees and others affected by armed conflict are much more vulnerable. Sexually exploited children are often categorized on the basis of the structure within which they operate as this affects the degree of mobility and control over their lives, their earnings and their amenities. Children are often engaged in prostitution as street walkers, brothel prostitutes, bar and hotel waitresses or dancers, massage parlor attendants, theater or cinema ushers, temple prostitutes, school children, etc. While the majority of the children work independently, some work in establishments operated by adults. In many developing countries, the consumers of child sex are noted to be local men. While sex tourism does exist, observers note that it does not account for the vast majority of children brought into the sex trade because of local demand.

Commercial sexual exploitation endangers children's mental and physical health and impairs their development. The most common physical health problems are related to injury resulting from accidents and physical conditions in the working environment, long working hours, lack of sleep and substance use. The common symptoms of psychosocial disorders manifested by many of the children engaged in commercial sex are severe depression, guilt, powerlessness, deflated self-esteem and self love, escapism through dissociation, distorted perceptions of sex, inability to trust others, excessive emotional attachment, multiple phobias, loneliness, isolation, impaired ability to learn, poor memory and concentration span.

A number of actions have emerged at the national and local levels to prevent or combat the commercial sexual exploitation of children in developing countries. However, these activities remain limited and not well established at the community level. Primary prevention programmes focus on awareness creation regarding the causes, the exploiters and methods of recruitment, the effects on the children and appropriate ways of intervening. A handful of projects act as



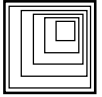
'community watchdogs' and intervene in communities to prevent children at risk from being recruited. Yet, other programmes focus on health outreach, rescue and provision of treatment and care to those already trapped in the commercial sex industry. Health outreach programmes focus on HIV/AIDS education, counselling, first aid and provision of food to those engaged in prostitution on the streets. Mobile medical units are not yet developed and most children's medical needs are cared for at conventional health centres. Children at residential rehabilitation centres often have easy access to health care services. Treatment and rehabilitation programmes are provided largely by NGOs in most countries. However, due to their small size and limited budget, the numbers of children reached with services is often a fraction of those needing care. In some cases, full rehabilitation can be hindered by the severity of the effects of commercial sex work. The other factor is extremely negative attitudes towards children in prostitution in many countries of the world.

Few systematic studies have been undertaken with a view to understanding the phenomenon and evolving strategies to prevent and combat sexual exploitation of children based on that knowledge. Moreover, caregivers have not received adequate training to enable them to address the needs of the victims of sexual exploitation and their families. This means that care is often provided on a trial and error basis.

### **2.3. 'Street children'**

The term 'street children' was introduced in the 1980s to refer to children who live or spend significant amount of time on the streets of urban areas to fend for themselves and/or their families through 'various occupations'. This also denotes children who are inadequately protected, supervised and cared for by responsible adults.

UNICEF makes a distinction between children *on* the streets and children *of* the streets. Children *of* the streets consists of boys and girls who see the street as their home. They may still have some family ties but seek shelter, food and a sense of family among their companions on the streets or they may have completely broken ties with their families and literally live on the streets. Often they have been abandoned by their parents, are orphans or runaways from neglectful or abusive families. Increasingly, this group includes children affected by war and AIDS orphans. The second group, children *on* the streets, includes those who still have family connections. They live at home, often in more than shacks, sometimes even attend school, but are sent to the streets by parents or go of their own accord to supplement the family income.



While concentrating on the children found on the streets, in his 1989 study in Rio de Janeiro, Brazil, Mark Lusk differentiated four main categories of the children:

- (a) Family-based street workers;
- (b) Independent street workers who have tenuous ties with their families and occasionally sleep on the streets;
- (c) Children who live on the streets and have no contact with their families (children of the streets); and
- (d) Children of street families (cited by Rizzini and others, 1994).

Apart from the abandoned or orphaned children who may become 'street children' immediately in their lives, the first two categories can also be gradual stages that one goes through to become a 'child of the streets'. Since they are already 'on the street', they should not be considered as potential 'street children'. The last category (d) seems to be where a second generation of 'street children' emerges from, as Onyango et al. (1991) concluded.

In the 1990s, some researchers have preferred to use the term 'working children' to refer to children who are generally found on the streets during the day, but who go home to sleep at night (children on the streets) and 'street children' to refer to those children to whom the street is their home (children of the streets). The term 'working children' is used since most of them have street jobs (Rizzini and others, 1994). In an attempt to avoid confusion, Rizzini and others (1994) clarified that this was not suggesting that 'street children' never work nor did all working children actually work.

Others such as Blanc et al. (1994) have argued that "real" 'street children' are those that live on their own on the streets and according to their definition, 'street children' are the roofless and rootless who live alone or with children like themselves.

From the available literature, it can be deduced that the definition of 'street children' is problematic and research has yet to unveil the various categories or sub-groups of children that fall under the general group of 'street children' in different cultural contexts. In this paper, the term 'street children' is not used as it is seen by the author as defining children by the circumstances that have negatively affected them instead of recognizing that they are victims of socially deficient structures and social policies. Moreover, labelling is disliked by the children themselves because it reinforces negative social attitudes towards them. The author prefers the use of the term children who live and work on the streets as this puts children first, before the circumstances that affect them. Thus, in this paper, the term children who live and work



on the streets is used to describe children who work on the streets during the day and return home at night as well as those to whom the street is home.

Depending on the definition used, estimates of the numbers of children involved range from 10 to 100 million. The majority of these children are believed to be in developing countries, with 40 million in Latin America, 23 to 30 million in Asia and 10 million in Africa. Accurate data on the number of children involved in specific countries is largely lacking. However, Blanc and others (1994) argue that the *real* 'street children', namely, those children to whom the street is their home, are of relatively small numbers and represent a manageable problem. They estimated that in larger cities where the phenomenon of children who live and work on the streets is common, the numbers of children who literally live on the streets generally range from 1,000 to at most 3,000.

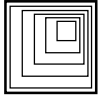
Street life has been taken as a domain of male children, who are believed to constitute 71 per cent to 91 per cent of all children who live and work on the streets, but the number of girls appears to be increasing.<sup>4</sup> In many countries, girls are reported to enter street life much later than boys. Girls are more likely to have worked as domestic servants and undergone various levels of abusive situations prior to turning to the streets. The street environment is particularly harsh for girls and many provide sexual favours to street boys for protection. The majority of the children who live and work on the streets fall in the 5 to 16 age-range and are expected to fend for themselves while others support their families as well.

Most children who live and work on the streets come from very poor parents who live in urban slum neighbourhoods, peri-urban areas, far away rural areas or they may also be living on the streets. Most of these parents are landless, unemployed or else engaged in unstable and unreliable income earning activities such as prostitution, unlicensed hawking, or brewing and selling of illegal alcohol. Not all studies, however, point to poverty as the main cause pushing children to the streets. In Uganda, for example, a survey carried out by a non-governmental organization revealed that most children who live and work on the streets had been abused by their step-mothers (Redd Barna, 1996). In Kenya, Wainaina (1997) also found that most of the children are on the street due to family related problems. He further argues that most of them come from a family background of physical,

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<sup>4</sup> It is important to mention from the very outset that most studies on children who live and work on the streets have focused on the 'visible' children on and of the streets, namely boys. Despite this clear gender imbalance in the data collected, the term children who live and work on the streets continues to be used in much of the available literature, and indeed in this report, as referring to both girls and boys.





emotional and/or sexual abuse. Although these findings point to family dysfunction and disintegration as the major reasons why children end up on the streets, it should be noted that most of these family problems are aggravated by poverty.

Day-to-day survival is the primary objective for most of the children who live and work on the streets and almost all their activities in the streets are in one way or another considered illegal particularly by law enforcers (Van Beers, 1996). From an analysis done on studies of children who live and work on the streets in Kenya, Nigeria and Zimbabwe, Ojwang (1996) identified the following specific activities of children in the streets: (a) spending long hours in the streets begging for money, food and other things; (b) selling small-scale merchandise in the streets to pedestrians and motorists; (c) directing motor vehicles into and out of parking in return for a tip; (d) watching over vehicles against interference or theft in return for a tip; (e) loitering along the streets for purposes of prostitution; (f) selling drugs and other illicit goods in the streets; and (g) engaging in petty crime such as picking pockets, snatching necklaces and handbags in the streets. The list is no way exhaustive since children who live and work on the streets will engage in any activity that would help them to earn a living. Other activities that children who live and work on the streets are known to undertake are touting, collecting papers or scavenging from garbage dumps or bins, shoe shining and acting as guides for blind beggars. The few studies that have been carried out on street girls show that their activities are limited to begging and prostitution.

Children who live and work on the streets are especially vulnerable to mental disorders and disease because life on the streets is unprotected and involves greater exposure to impairment of attachment, unsanitary living and working environments, drug abuse, prostitution (with high exposure to sexually transmitted diseases and HIV/AIDS), infectious diseases, malnutrition, accidents and, more recently, violence. They have limited access to health care services than other urban dwellers and their diseases go untended until they become severe. Consequently, mortality is high among them.

Much of the work in developing countries has focused primarily on preventing children from ending up on the streets and rehabilitation of those who leave the streets. Children who are still living with their families will often turn to community or neighbourhood health facilities when ill, while children who have left street life and are undergoing rehabilitation are provided with basic welfare services including food, shelter, health care, counseling, functional literacy and vocational training within or outside the rehabilitation centres. There are relatively few programmes that address the health problems of those children that literary live on the streets. In some countries, street educators provide



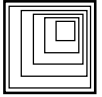
first aid to these 'hard-to-reach' children and refer serious cases to hospitals and health centres. But in general, these children lack access to health education and professional care and when they get sick they remain that way or seek care when the conditions become serious. It is important that efforts to improve the lives of children who live and work on the streets also take into account their health needs while they are still on the streets.

The lives of these children exemplifies the resilience, creativity, independence and survival drive of children living in difficult circumstances. This freedom and independence also means that children who live and work on the streets are difficult to be reached by traditional support programmes. They view health and social services as unfriendly, threatening and unhelpful. Many of the children aspire to obtain education, jobs, reunite with families and establish their own families and homes. The programmes that have had a great degree of success in working with children who live and work on the streets, are those that aim at strengthening their ability to cope and a sense of their own value as well as providing services in the areas of education, vocational training, housing and health care. These programmes first make contact with these children living and working on the streets through drop-in centers where children are provided with, for example, food, clothing, shower facilities and health care. A relationship of trust may be established during these contacts giving children the courage to talk about their problems. Children themselves decide when they are ready to leave the streets and begin a new life.

Research on children who live and work on the streets has focused on runaways and street life, victimization, legal considerations and attempts at rehabilitation. Research on health aspects, particularly of children who become pregnant through their street activities, and care of the newborn children is lacking. Similarly, data on the health seeking behavior of these children is not available. Programmes and research, so far, have primarily focused on urban areas, where the problem is most visible, and children in small towns and rural areas remain unreached. Without data, it is impossible to formulate and plan realistic and well-targeted policies and interventions.

### **3. STRATEGIES FOR PREVENTION**

Child sexual abuse, sexual exploitation, problems of children who live and work on the streets, children with disabilities, refugees and displaced children, child mothers and so on are community health problems and, thus, prevention efforts must be initiated at the local level. Before presenting the strategies for prevention at the primary, secondary and tertiary levels it is necessary to first define the term 'health'.



### 3.1. Definition of the term 'health'

The World Health Organisation (WHO) defines health as “... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This definition has received strong criticism for various reasons. It is believed to be a static definition that does not allow for development or change in an individual's state of health. Furthermore, Köhler and Jakobsson (1987) argue that the WHO definition of 1946 is inhuman and unfair in that it does not allow, for example, handicapped people to be considered healthy. They further note that the definition is also utopian, since hardly anyone can attain an absolute state of physical, mental and social well-being; and the definition says that social maladjustment is synonymous with ill-health and therefore should be treated medically, for example, with psychiatric care. Their final objection is that the definition makes the health services seem capable of solving every human problem, whether it is a sore throat, grief, loneliness or unemployment. According to Köhler and Jakobsson, this entails bringing medicine into every facet of life, and may lead to a 'health imperialism', which frightens many. Köhler and Jakobsson observe that many people prefer a dynamic health concept which is associated with the individual's own situation and implies that the person is able to cope with the demands which life makes. Despite this strong opposition, the WHO definition of health continues to be widely used, as its critics have not been able to find another all-encompassing definition. For lack of another comprehensive definition, the WHO definition of health is used in this report.

It is important to remember that although health is frequently equated in the minds of most people with physical well-being or the absence of physical disease, the WHO concept of health is far wider than that and includes two other dimensions that are often forgotten, mental and social well-being. Mental well-being, or stability within the mind, allows a person to be at ease within herself or himself and to cope with the changing world in which we live. Many people consider spirituality and emotional well-being including self-esteem, family attachment, feelings of love, and acceptance as important or even essential ingredients in this concept of mental well-being. The social dimension of health, on the other hand, includes knowledge and capacities that are needed to live successfully within a social context such as literacy, numeracy, vocational education, a sense of group identity and ability to cooperate with others. All these three dimensions of health are interlinked and influence each other.

The term 'health' also applies to the environment in which people live. Destruction and pollution of the environment results in contamination of food, water and air, which have a negative bearing on the health of the persons that inhabit that environment.



### 3.2. Prevention strategies

NGOs and religious groups have spearheaded activities related to CEDC in most developing countries. They have been very successful in assisting the poor, supporting informal schools, assisting poor children in formal schools, improving shelter facilities, expanding child health and nutritional services (including feeding programmes), promoting skills development and credit facilities for income-generating activities, constructing and maintaining children's homes and educating disabled and other disadvantaged children. However, due to their limited capacity, they are unable to initiate such activities on a wide scale and include a comprehensive set of services. Competition for limited funds also makes it difficult for them to cooperate among themselves.<sup>5</sup>

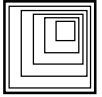
The governments, through children's departments, also manage a limited number of programmes, which include approved schools, feeding programmes, children's homes, borstal institutions, juvenile remand homes, bursary schemes, rehabilitation and vocational training and skills development programmes. In many countries, government programmes are seen to have had less success compared to those implemented by NGOs. Many poor people, particularly women and CEDC remain unaware of the existence of government schemes and programmes.<sup>6</sup> As a result some NGOs and women's groups have taken the initiative to inform the public of government resources available under various programmes.

Despite a relative profusion of programmes, the number of children in especially difficult circumstances continues to increase at such an alarming rate that existing efforts provide merely a token response to the problem. Ultimately, the goals of children's programmes should aim at promoting a safe and healthy environment in which all children can grow without fear of becoming a child in especially difficult circumstances (primary prevention); identifying vulnerable groups of children and preventing them from being forced into difficult circumstances (secondary prevention); and providing support and treatment to those who are already in difficult circumstances in order to reduce harm (tertiary prevention). In many developing countries, most programmes specifically addressing CEDC focus on tertiary prevention. Programmes for primary and secondary prevention must necessarily deal with larger

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<sup>5</sup> The fight against AIDS has changed this to some extent and many NGOs have realized the need to cooperate if they are to meet the various needs of those seeking care.

<sup>6</sup> Many CEDC may be aware of these programmes and may even have enrolled in a number of them at one time. However, they may view them as threatening and staff members insensitive and unhelpful.



underlying social, cultural and economic problems, which are usually viewed in the context of general economic and social development programmes. The basic services approach is particularly effective for primary and secondary prevention, and should be an integral part of comprehensive CEDC programmes. Although the mix of programme objectives and strategies will vary from country to country, underneath are some general strategies for prevention and service improvement that are relevant for most developing countries.

### ***3.3.1. Strategies for primary and secondary prevention***

Primary and secondary preventive measures must address underlying problems such as basic needs, family instability, socio-economic inequity, communal conflicts, environmental degradation, and poverty.<sup>7</sup> However, within the broad framework of overall socio-economic development that is needed, there are specific strategies and actions that most directly affect the situation of children. Education and child services are important, as are measures that enhance the welfare and stability of families with children. Strengthening legal measures and raising public awareness of children's rights creates an environment for protection of the most vulnerable children.

#### *Supportive legal framework and policies*

Only the government has the mandate and capacity to create and alter laws and policies and provide overall coordination of national programmes. It is crucial that the government establishes a supportive legal framework and policies to facilitate the work for children at all levels.

#### *Promotion of universal basic education*

Children who continue in school until completion of a basic education at age 14 or 15 are much less likely to be lured into exploitative work or situations where they are abused, at least while regularly attending school. They also have the school social network to fall back on if difficulties do arise. Therefore expanding education facilities and

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<sup>7</sup> It has been argued that since poverty is a structural problem, the major responsibility for its resolution lies with government agencies. However, many people view NGOs as having had considerable success in improving the living standards of the poor. The experience of organizations working with the poor reveals that once the poor understand their conditions, they no longer consider mere economic improvement sufficient. NGOs, therefore, may not help people to escape from poverty but they do remove some of the worst forms, enabling people to focus better on the next stage of the struggle to improve their lives.



extending free and compulsory education to all children between 6 and 15 years of age is an extremely effective strategy for prevention of the most exploitative types of child labor and much of the problem of children who live and work on the streets. Advocacy for universal basic education is needed, both to expand resources and personnel in the education sector, and to get the support of parents in this effort.

Other aspects of education that need attention are: excessively uniform curricula, inflexible schedules, location of schools mainly in better off areas, and the high cost of education. All of these discourage participation by less privileged groups, and lead to a high drop-out rate. It is particularly important for less developed countries to recognize the inevitability of some work for most children. Therefore, schooling should be available which allows children to continue working, but still have an opportunity to study and a curriculum that is interesting and practical in relation to life and work. The Underprivileged Children's Educational Programme in Bangladesh is an example of such a programme.

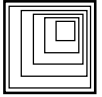
#### *Community-based child and youth services*

Proper nutrition, mother and child health care and early childhood mental stimulation are also fundamental primary and secondary preventive measures. Programmes addressing these problems prevent or reduce disability, enable children in otherwise deprived conditions to overcome their situation, to compete effectively in school, work or sports, and, most importantly, develop a higher self esteem. Programmes of this type help to break the inter-generational transmission of poverty and ignorance, which underlies much of the exploitation and abuse of children.

A good system of primary health care, home-based day care in poor areas, and pre-schools, can go far in preventing problems for disadvantaged children later on. Community-based study halls, sports facilities and youth centres keep young people off the streets and are also effective long-term preventive measures. Urban and area basic services programmes in many developing countries have already demonstrated that such services can be provided within the combined means of the government, NGOs and poor communities, if a basic services strategy is used.

#### *Increasing family stability*

Family stability cannot be tackled directly, but it can be indirectly influenced, through education, raising public awareness, and counseling and support of families at risk. Interventions in this area require a thorough and sensitive qualitative analysis of all aspects of the family in



local cultural contexts. Even within the same country there may be many variations that need to be taken into consideration in trying to promote family stability. Here again, community-based strategies are most likely to be effective. Nearly every community has traditional advisers or counselors on cultural and family matters. It would be wise to begin by supporting such traditional systems, unless they are clearly detrimental to the children. Even in such cases, the training and reorientation of traditional elders and cultural leaders at the community level is likely to be more effective, and less expensive, than attempting to develop corps of professional family counselors. Several countries have incorporated family life education in both the formal and informal education curriculum. While considerable progress has been made, much remains to be done. Most developed countries also have been negligent in promoting and protecting family stability, and only recently several have begun to give this more attention. This is clearly an area where countries at all levels of development have much to learn from each other.

In some respects, the strength of family traditions in most Asian and African cultures has cushioned the shock of rapid industrialization and urbanization and declining economic growth respectively. On the other hand, the extended family in Africa, which serves as the social security system, is on the decline. In Asia, the near total autonomy of families in rearing of children has suppressed exposure of intra-family child abuse and prevented public intervention.

### *Children as a “Zone of Peace”*

Every effort must be made to prevent children from becoming victims and combatants in armed conflicts. In the 1980s, the idea was advanced that children should be considered as a “Zone of Peace”.<sup>8</sup> This means that armed conflicts should not use children as combatants, target children for attacks or terrorism, or intentionally interrupt or destroy facilities and services for children. This concept has been effectively used to temporarily suspend hostilities to permit immunization campaigns, and to bring international pressure to bear on all sides in armed conflicts. However, it has done little to reduce the numbers of abandoned and refugee children and the psychological trauma that are the inevitable result of armed conflict. Only the prevention of armed conflict itself can eliminate these problems.

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<sup>8</sup> This concept was first formulated in 1983 by Nils Thedin of Sweden in a proposal to UNICEF. It has since then been used in El Salvador in 1985 to vaccinate 250,000 children during three days of intensive work, in Uganda in 1986, in Lebanon in 1987, in Afghanistan from 1988 to 1989 and in Sudan from 1989 to 1995.



### ***3.3.2. Strategies for tertiary prevention***

A key element in tertiary prevention is the availability and accessibility of counselling, treatment and rehabilitation services for physical, mental and social problems. Treatment and rehabilitation can focus on the individual, family or community and can be carried out in an institutional setting or on an outreach basis. Services that treat children are largely in the health and social sectors and have a great variation.

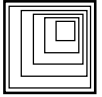
#### *Non-institutionalized care as a first step*

Traditionally, governments and religious organizations have established welfare homes providing complete residential care and schooling for various categories of CEDC. Critics have argued that this strategy is costly and the resources available limited. As a result of lack of resources, such institutions seldom have adequate professional staff, and are often poorly equipped, furnished and maintained. Residential care institutions have also been accused of seeking to perpetuate themselves and expand their operations as much as possible. Therefore, they may not be diligent in trying to reunite children with their families, especially if it is difficult to find parents or they need counselling and support in order to properly care for the child. Such institutions are also seen to tend to regiment children and not allow them to leave the institution, and, in the worst cases, they can become a kind of prison for children. Even the better public institutions, it is believed, do not have enough personnel or flexibility to provide individualized guidance and care for children.

Services for children in difficult circumstances need not be provided in a fully controlled residential institution. Examples of non-institutional services exist in many Asian and Latin American countries, but they are usually small NGO projects or local community initiatives. Drop-in centres for children who live and work on the streets in the Philippines, mobile crèches for children of women construction workers in India, mobile health clinics in Brazil, the Underprivileged Children's Education Programme in Bangladesh and Nepal, youth centers providing hot meals, a place for bathing and temporary accommodation in Thailand, feeding programmes for refugee families in Angola are a few examples of non-institutionalized services that can be provided.

The advantage of such non-institutionalized services are that they are cheaper and permit children the freedom to continue with work and maintain contact with families, friends and other support networks in their own community. This also permits children to make their own decisions and choose their own way of life, seeking guidance and help when they feel they need it. Because such limited services are cheaper, they can be extended to a much larger group of children, or this can free resources for other CEDC programmes.





The main objective of the non-institutionalized programmes mentioned above is to reach many children with services, including employment alternatives, but give them the opportunity to decide when they are ready to leave their current lifestyle. It should be borne in mind, however, that there are children for whom institutional care is necessary, at least for an initial period to prepare them physically, socially, emotionally and psychologically to be (re)integrated into society. The approach that is selected depends on the careful examination of the child and his or her family and community.

*Health outreach as an example of non-institutionalized care*

Ill health is the natural product of life on the streets, in refugee camps or in prostitution. Unfortunately, the pressures imposed by street, work, and brothel or bar life make health a very low priority. By and large, many CEDC do not use mainstream services or come later when help is more difficult. The discriminatory treatment of health care providers, who do not see these children as being entitled to use their services, serves to further alienate them from the health care system. Their experience is often a negative one, and word of mouth keeps them and other children away. As a result, health care for these children ends up being poor and fragmented. Furthermore, the provision of information, education and communication to CEDC in general is rarely linked with the health services locally available. Health services, therefore, need to be accessible to these children who may be living outside of mainstream society to promote health, and especially to intercept problems at an early stage for human, health and economic reasons.

Outreach work – locating services where the hidden population can be found – is necessary in order to engage the children and link them to health services while providing them with education and raising their expectations. In much of the world today, many CEDC lack specific information about how to make use of existing services. They often do not know what is available, where it is, how to use it, what will happen when they get there, what it will cost, whether it is confidential, private or painful, what will follow and, perhaps most important, whether they will be welcome. Underneath are some of the few areas where health promotional activities may benefit these children.

*Health surveillance:* Opportunistic screening for conditions such as chronic bronchitis, dental caries, poor hearing, poor visual acuity, indigestion, feet and skin problems as well as vaginal tract infections are likely to reveal problems that can be prevented or treated at an early stage. This is likely to improve the quality of life of these children.

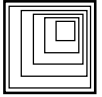


*Immunization:* It is important to ensure that CEDC (and their offsprings) are up to date with their immunizations, in particular tetanus.

*Enhancing knowledge:* CEDC in many countries are not provided with adequate knowledge about their own development, especially in regard to sexuality. They need appropriate knowledge about growth and changes in puberty. Children living on the streets, children with disabilities, refugee and displaced children and others need to know how to protect themselves from sexual abuse and sexual exploitation and how to prevent pregnancy, STDs and HIV/AIDS. They should be counselled about safer sexual practices and condoms made available to those that are sexually active. Information on how to protect themselves against illness and injury including the consequences of tobacco, drugs and alcohol should also be communicated to them. It is also important for the educators and counsellors to discuss issues such as rest, nutrition (in particular food hygiene and safety), personal hygiene and personal safety with the children. It is well recognised that information, education and communication (IEC) and counselling can lead to a change in behaviour, transforming both the beneficiaries of such services as well as the service providers.

*Enhancing life skills:* CEDC need to develop their capacity to communicate and make plans and decisions. This will entail teaching children ways of communicating, expressing their feelings and working with others. It is equally important for educators to also teach children practical skills like first aid as well as thinking of ways of how to solve problems. Good attitudes are very closely linked to life skills and thus educators should teach the children the skill of listening to other people as a sign of showing respect. Good attitudes, however, are not only required of CEDC. Educators too must learn how to listen to the children as a sign of showing respect. Giving children an opportunity to talk about their emotions without fear of being censured gives them the self-esteem to know their feelings do matter.

For CEDC to be able to protect their health, a friendly environment in which information, counselling and other services are provided in a confidential manner by people whom they trust and who are empathetic to their needs is necessary. Peer education and counselling are two ways of assisting these children to participate, contribute and assume responsibility while obtaining the information they need. In some countries, peers are used as effective outreach as they are more likely not to reprimand the children for their questions. To do this well, however, requires a partnership with adult care providers, initially, to help obtain and provide sound information from reliable sources, and for support to the children providing such help, since they may be faced with situations, which require more than straightforward information.



Peer counselling is harder to achieve, since it requires special training in counselling and psychological skills, adequate knowledge of the needs of specific groups of CEDC, ways to meet these needs and how to know when to refer to others. This requires training, supervision and above all, continuing support, since it can be a stressful and very demanding task. Health care providers would also benefit from training on how to reach CEDC and how to meet their special needs.

### *Direct services through NGOs and governments*

CEDC require individualized attention to determine the exact nature of their problems, and what family or other ties they may still have which should be taken into consideration. They frequently have psychological problems and each child needs to be dealt with on a case-by-case basis. Government agencies are, by their very nature, bureaucratic structures for providing standardized and routine services. Therefore, it is not surprising that NGOs are often more effective in providing the individualized services that these children need. NGOs do however have a number of problems and weaknesses. Usually they have limited and very unstable funding since they depend on voluntary contributions. They naturally try to select those types of children and situations with high visibility and high appeal for fund raising. This may often cause excessive concentrations of services in urban areas and for some types of children and leave other children and small towns and rural areas with little support. Because of the large number, small size and varying methods and quality of NGOs, the governments are often reluctant to channel resources through them without excessive controls.

Considering these factors, the optimum system would be to rely more on NGOs for direct services to children, but within a framework of governmental regulation and sustained financial support. Several countries have evolved systems of this nature, which seem to work relatively well with social welfare councils for children or children's committees being the link between the government and NGOs. The government can also play a strong role in direct service provision channeling funds for services to NGOs, by regulating and registering NGOs, and by facilitating coordination among government service agencies and NGOs. In Zimbabwe, where the government and NGOs work closely in addressing CEDC issues, NGOs are encouraged and supported to develop and initiate programmes but they are required to hand over these projects to the government once they are well established and stable (personal communication, 1999 CEDC Course participant). There is likely to be a continuous source of tension between governments and NGOs, but it is a healthy tension, if the government remains primarily a facilitator.



### *Linking CEDC and community services*

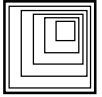
Linkages between CEDC services and existing community organizations and service systems helps to mobilize community resources, helps coordinate implementation and assures that they are well adapted to local conditions. In many countries CEDC and basic services programmes, focusing mainly on primary health care, education, housing, justice, and income-generating skills, have been linked from the outset. Indeed, CEDC programmes have largely grown out of efforts to serve the most deprived children who live and work on the streets in urban basic service programmes. In some countries the reverse has happened. Tracing the families of children who live and work on the streets has led to the identification of particular communities where basic service programmes were introduced as preventive measures.

### *Using community volunteers and non-professionals*

Although professional social workers, psychologists and administrators are needed in CEDC programmes, there are not enough professionals nor money to pay them. Indeed, the most effective workers with CEDC are those people who have faced such difficulties themselves and overcome them. Former children who live and work on the streets are the best street educators; former refugees are more sensitive to the psychological trauma suffered by refugee children; and respected neighbors and community leaders may be the most effective and accepted counselors for a family with abused or neglected children. Many volunteers and non-professionals can be supported at the same cost as one professional. Professionals should be used strategically in training, supervision, and handling referrals of the most difficult cases. In this way, the quality of programmes can be maintained, while a much larger number of children can be served by dedicated volunteers and non-professional staff.

## **4. CONCLUSIONS**

The year 1990 witnessed some extraordinary events at the global level concerning the rights of the child. The United Nations Convention on the Rights of the Child came into force in 1990. In September of the same year, a record number of Heads of State met at the World Summit for Children to pledge their commitment to children by adopting the World Declaration on the Survival, Protection and Development of Children and a Plan of Action for its implementation. Presently, almost all countries of the world have ratified the Convention. Moreover, many countries now have national programmes of action to implement the Summit goals.



Some countries have made progress in reducing the mortality rate of children aged below five years, but social problems facing the surviving children have increased tremendously. Poverty is mentioned consistently as a cause, with the socio-economic needs, particularly in developing countries, compelling children to engage in exploitative work to support themselves and their families. In addition to these socio-economic needs is an increasing pattern of family breakdown, as a result of migration from rural to urban areas and from one country to another. As parents are pressured to meet the demands of modern life, children may find themselves neglected or abused. They may become “runaways, throwaways or walkaways”, because the safety net traditionally accorded by the family unit no longer offers them security (Muntarhorn, 1992).

Inadequate housing arrangements in slum neighborhoods, where families have only one room and thus children and parents share sleeping quarters, may also contribute to driving children “of age” to the streets. Poverty is also closely related to disability, as many conditions affecting children in developing countries are easily prevented by proper health care and nutrition. Civil war has taken its toll on the world’s children and leaves the surviving children, disabled, malnourished, orphaned and scarred for life.

If major changes are to be effected in the lives of the world’s children living in the conditions described in this report, then, words must be matched by deeds at the local levels. This calls for realistic laws and policies, but these are of no consequence if they are not enforced. For example, most countries have laws on child labour, child abuse and protection of children in difficulties already in place, which are sufficient to permit substantial improvements in the situation, but enforcement is lacking. Therefore, ratifying the Convention will do little, unless these rights are publicly known and laws are enforced to provide protection and services to these children. These children, their families and communities deserve special attention, protection and assistance as part of national efforts and international cooperation. Muntarhorn (1992) sums this well: *“It is not only the law that counts, but the whole development process. It is not only policies that count but also implementation, evaluation and concomitant budgets. It is not only education that counts but also earnings. It is not only the governmental sector that counts but also the non-governmental sector, particularly in the call for popular participation. It is not only federal programmes that count but also municipal and local action. It is not only national initiatives that count but also international commitment, with the child and the family as the center of human development.”*



# Background Document on The Mekong Project on Sexual Abuse and Sexual Exploitation of Children and Youth: Research and Intervention Phases

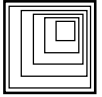
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## 1. INTRODUCTION

The ESCAP project entitled “Strengthening national HRD capabilities through training of social service and health personnel to combat sexual abuse and sexual exploitation of children and youth in the Greater Mekong Subregion” was formulated in direct response to the concern expressed by ESCAP member governments at the Asia-Pacific Meeting on Human Resources Development for Youth, held in Beijing in October 1996.<sup>9</sup> The Beijing Statement on Human Resources Development for Youth in Asia and Pacific, adopted by that Meeting, puts forward a proposal for action on the elimination of sexual abuse and exploitation of youth. In particular, it highlights the lack of information on the situation of sexual abuse and exploitation of young people, the inadequate health and social services available for victims and potential victims of sexual exploitation and abuse, and the general lack of training among social service and health providers. The on-going ESCAP programme seeks to address these gaps, with its overall objective being to strengthen the human resources development (HRD) capabilities of social service and health personnel to assist young victims and potential victims of sexual abuse and sexual exploitation to: (1) be reintegrated in communities and families; (2) avail themselves of relevant health and social services; and (3) develop skills for alternative means of livelihood. The project is supported by the Swedish International Development Cooperation Agency (Sida) and partially by the United Nations Population Fund (UNFPA), the United Nations Drug Control Programme (UNDCP) and the Joint United Nations Programme on HIV/AIDS (UNAIDS). It is being implemented in close collaboration with the Section for International Maternal and Child Health (IMCH) at Uppsala University.

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<sup>9</sup> ESCAP’s regional programme also includes a parallel project in South Asia and the Philippines, with funding from the Governments of Japan and Australia. This background document (Module One), however, refers only to those activities undertaken in the Greater Mekong Subregion.



The activities of this four-year programme commenced in 1998. In the first phase, ESCAP invited the governments of all the six countries to nominate a focal point for the project. For some of the governments, the existence of child sexual abuse and sexual exploitation had not even been openly accepted. Thus, some governments were initially reluctant to nominate any government counterpart, for to do so would be to admit that such problems did exist in their own country. Though it is true that certain organizations, particularly NGOs, had been working in these areas for many years, it was felt that governmental recognition and acceptance from the beginning and throughout all subsequent phases of the project activities would enable policy changes to be made and thus facilitate the greatest impact to the beneficiaries – the victims and/or potential victims of sexual abuse and sexual exploitation. In fact, some of the governments that were contacted were initially reluctant to appoint any government focal point for the project precisely because of the sensitive nature of the project topics.

The next step in the first year of the project was to conduct qualitative research to establish the health needs of the victims and the type of services available to them in the six participating countries, namely, Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam. The resulting national research reports form the basis for the development of interventions in the second and third years of the project. In addition, collaborative linkages and networking among government agencies, research institutes and NGOs working to combat sexual abuse and sexual exploitation of children and youth in the subregion were established. In the same year, a film entitled "No is Not Enough" was produced and screened at the Second Asia-Pacific Intergovernmental Meeting on Human Resources Development for Youth, held in Bangkok in June 1998, to sensitize policy makers about the needs and problems of this group of children with a view to supporting policies and programmes to improve access to relevant health and social services. Other activities for this year included the production of a directory of organizations providing social and health services to sexually abused and sexually exploited children in the subregion.

The second phase of the project activities, in the second year, were initiated at national HRD workshops on sexual abuse and sexual exploitation among youth, which were held in all six participating countries. The workshops, attended by up to 60 health and social service care providers from concerned government ministries and NGOs, as well as United Nations agencies, were organized jointly by ESCAP and each of the national focal points. The objectives of the workshops were threefold: (1) to share the findings and recommendations of the qualitative research; (2) to identify the training needs of health and social service providers; and (3) to develop a pilot project to



follow up on some recommendations of the research. The training needs assessments have been used in the development of curriculum and training materials to enhance the capacity of social service and health professionals to deal with sexually abused and sexually exploited children and youth. In addition, community-level pilot projects were implemented from mid-1999 to mid-2000 to follow up the recommendations of the research as well as to raise awareness among community members of the health implications of sexual abuse and sexual exploitation for children.

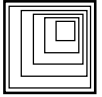
The next phase of the project, from mid-2000 to December 2001, focused on the conduct of the subregional *ESCAP HRD Course on Medical and Psychosocial Services for Sexually Abused and Sexually Exploited Children and Youth* to assess the applicability of the course curriculum developed during the second year. The curriculum and training materials, which will be translated into national languages, will provide input for the training of other social services and health personnel, and allow for project sustainability and improved services to sexually abused and sexually exploited children and youth. As follow-up to the course, country teams implemented pilot projects over a period of eight months, which aimed to improve the access of sexually abused and sexually exploited children and youth to relevant health and social services, as well as educational and training opportunities. In addition, the pilot projects increased awareness among institutions, both governmental and non-governmental, of the need to prevent sexual abuse and sexual exploitation of children and youth. The conduct of the *ESCAP Course* produced a pool of competent social service and health personnel whose improved performance will lead to better service delivery. This pool of qualified personnel could in turn train other service providers at the community level.

## 2. THE RESEARCH PROCESS

The following section provides definitions of terms used in the project as well as a synthesis of the situation relating to child and youth sexual abuse and sexual exploitation in the six participating countries. The subregional synthesis is based on the national reports of Cambodia, Yunnan Province (China), Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam. National research teams composed of government agencies and NGOs and/or academic institutions have carried out the national research and written the reports, with assistance from ESCAP. The research had the following **objectives**:

- (1) To collect and analyze existing information on the country context, sexual abuse (rape and incest) and sexual exploitation (trafficking, pornography and prostitution);





- (2) To identify the common health (medical, psychological and social) problems and needs of sexually abused and sexually exploited children; and
- (3) To explore the range of services available to sexually abused and sexually exploited children and the capacity and potential of the different agencies in providing such services.

It is necessary from the very onset to provide **definitions** of some terms that were used in the research. To define a child, the research used article 1 of the Convention on the Rights of the Child, which defines a child as, “every human being below the age of 18 years, unless, under the law applicable to the child, majority is attained earlier”. According to the national laws of the participating countries there are numerous age brackets and definitions of what constitutes a child and his/her rights and responsibilities as a citizen. In many of the countries, children are considered to be those citizens aged less than 16 years old. However, for the purpose of the ESCAP research project, a person under the age of 18 years is considered a child. This definition of a child overlaps with the United Nations definition of “youth”, which covers the age range of 15 to 24 years.

**Sexual abuse of children**<sup>10</sup> can be defined as contacts or interactions between a child and an older or more knowledgeable child or adult (stranger, sibling, or person in positions of authority, such as parent or caretaker) when the child is being used as an object for the older child or adult’s sexual needs. These contacts or interactions are carried out against the child using force, trickery, bribes, threats or pressure. The two forms of sexual abuse that were considered in this study are rape, which is defined as any sexual behaviour imposed on a child by a stranger, and incest, defined as any sexual behaviour imposed on a child by a member of either the immediate or extended family. The extended family includes people whom the child or family has known for a significant length of time and whom they trust, such as fathers, stepfathers, uncles, siblings and other family members, as well as friends, neighbours, teachers, doctors and members of religious communities. Broadening the concept of incest beyond close blood relatives is very important. It helps underscore the special harm caused by any sexual activity between a person in a position of status, trust and authority, and a child in a position of dependency.

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<sup>10</sup> Adapted by W. Kaime-Atterhog from: (a) W. Kaime-Atterhog, “Voices of sexually abused children who live on the streets of Nakuru, Kenya”, unpublished report, Section for International Maternal and Child Health, Uppsala University, Sweden (1998); (b) D. Finkelhor, “Current information on the scope and nature of child sexual abuse, *The future of Children*, vol. 4 (2): 31-53 (1994); and (c) National Centre on Child Abuse and Neglect, *Sexual Abuse of Children – Selected Readings*, Office of Human Development Services, US Department of Health and Human Services, DHHS Publication No. 78-30161 (1980), pp. 1-6.



Sexual abuse can be physical, verbal or emotional, and includes:

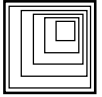
- Physical sexual abuse: touching and fondling of the sexual portions of the child's body (genitals and anus) or touching the breasts of pubescent females, or the child's touching the sexual portions of a partner's body; sexual kissing and embraces; penetration, which includes penile, digital and object penetration of the vagina, mouth or anus; masturbating a child or forcing the child to masturbate the perpetrator.
- Verbal sexual abuse: sexual language that is inappropriate for the age of the child, used by the perpetrator to generate sexual excitement, including making lewd comments about the child's body and making obscene phone calls.
- Emotional sexual abuse: use of a child by a parent or adult to fill inappropriate emotional needs, thereby forcing the child to fulfil the role of a spouse.
- Exhibitionism and voyeurism: having a child pose, undress or perform in a sexual fashion on film or in person (exhibitionism); and "peeping" into bathrooms or bedrooms to spy on a child (voyeurism); exposing children to adult sexual activity or pornographic movies and photographs.

**Commercial sexual exploitation of children** is defined by the United Nations as the use of a child for sexual purposes in exchange for cash or in-kind favours between the customer, intermediary or agent and others who profit from the trade in children for these purposes (parent, family member, procurer, teacher etc).

There are three forms of commercial sexual exploitation of children, which have already been defined by the United Nations: child prostitution, trafficking and sale of children across borders and within countries for sexual purposes and pornography.

**Child prostitution** is the act of engaging or offering the services of a child to a person to perform sexual acts for money or other consideration with that person or any other person.

**Trafficking and sale of children** across borders and within countries for sexual purposes is the transfer of a child from one party to another for whatever purpose in exchange for financial consideration or other rewards. Sexual trafficking is the profitable business of transporting children for commercial sexual purposes. It can be across borders or within countries, across state lines, from city to city, or from rural to urban centres.



**Child pornography** is visual or audio material, which uses children in a sexual context. It consists of the visual depiction of a child engaged in explicit sexual conduct, real or stimulated, or the lewd exhibition of the genitals intended for the sexual gratification of the user, and involves production, distribution and/or use of such material.

The starting point for the research was that commercial sexual exploitation and sexual abuse of children and youth are a violation of the rights of young people, with far-reaching consequences for their health and well-being. The basic premise is enshrined within the Convention on the Rights of the Child which, in articles 19, 34 and 35, requires States Parties to protect children from abuse and neglect, sexual exploitation and sale, trafficking and abduction. Article 33 states that States Parties shall take all appropriate measures, including social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances. This problem is closely linked to the health of children in prostitution and those living and working on the streets.

The Convention also addresses issues related to the provision and quality of health services. In article 24, children have the right “to the enjoyment of the highest attainable standard of health”. In addition, article 3 states that the best interests of the child shall be a primary consideration in all actions concerning children, and it emphasizes the responsibility of States Parties to have a good standard of health care: “States Parties shall ensure that the institutions, services and facilities responsible for the care and protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision”. The text in article 39 is clear regarding the factors that are crucial for effective rehabilitation programmes for sexually exploited and sexually abused children: “States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters health, self-respect and dignity of the child”.

### **3. METHODOLOGY**

The project design was based on an interactive process whereby the children and social service and health-care providers were informants of the research. Given the nature of the data to be collected and the subjects, the researchers used qualitative research approaches. The project began with an initial planning phase when the research



methodology was developed, teams were identified and trained in research methods. This was followed by an exploratory phase, in which primary data on the background and locations of the children, their health problems and their care-seeking behaviour in all six countries were collected and analysed by the research teams. Information was also collected on the nature of the services available to sexually abused and sexually exploited children and the capabilities of the staff to provide care.<sup>11</sup>

These planning and exploratory phases enabled the research team to be familiar with and initiate discussions with children, communities and service providers. The information on the agencies and their programmes was vital for establishing potential collaborators in the field and the gaps in their current programmes. Interventions on awareness-raising at the community level were designed based on the findings of the research. The pilot projects were developed at national HRD workshops held in each of the participating countries for social and health-care providers, and are currently being implemented by the national coordinating organizations in each of the six countries. Apart from developing the pilot projects, the workshop participants also discussed the research findings and analysed their training needs. Specific interventions for the effective delivery of care to the victims and potential victims of sexual abuse and sexual exploitation were designed by the national coordinating organizations during the ESCAP subregional course for 30 social service and health-care providers from the subregion, which was held in September 2000. The follow-up projects were implemented over an eight-month period following the course, and thereafter evaluated at a national seminar in each of the six countries. The next section covers the planning and exploratory phases of the project.

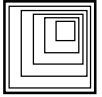
### **3.1. Planning Phase**

#### ***3.1.1. Adaptation of the research methodology***

Researchers working with children in exceptionally difficult circumstances have noted that surveys and quantitative research approaches often fail to generate valid data. This research, therefore, utilized a qualitative research methodology that has been developed by the expert on the subject, Wanjiku Kaime-Atterhog, and used among children in prostitution in Thailand and street children in Kenya. A key aspect of this method is the understanding that children and care providers are knowledgeable of their own “world” and researchers can only really

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<sup>11</sup> The interview guide is contained in annex 1 of this background document.



understand these “worlds” by listening to and learning from their respondents. Furthermore, any interventions for these two target groups aimed at improving their situation must be based on such an understanding if it is to have any meaningful impact on their lives.

In order to provide guidance to the country research teams, a detailed set of methodology notes was produced, as well as a research protocol. A broadly qualitative and participative approach was set out in which the following were the main methods used:

- Review of documentary and archival information, including reports, evaluations, registers, videos etc.;
- Observation of programme activities, adopting participant observation techniques where appropriate;
- Informal discussions with a wide variety of people encountered during visits of observation; and
- Semi-structured interviews with sexually abused and sexually exploited children and youth, programme managers, medical staff, social staff, teachers etc.

### ***3.1.2. Selection and training of the national research teams***

Owing to the sensitivity of the topics under investigation and the sustainability of the project, it was proposed that local staff members from the national coordinating organizations conduct the research. Many government officers, however, are responsible for developing and implementing policies and programmes on sexual abuse and sexual exploitation of children and youth in their respective countries, often without an understanding of the real problems and needs of the target groups. This therefore involved identifying appropriate persons from the national coordinating organizations that had some previous experience in participative research or were working with young people and had an interest in research.

In two countries, China and Thailand, the national coordinating bodies lacked the staff to carry out the research and, together with ESCAP, identified local academic institutions to serve as the national research focal points. In Myanmar, the government officers worked alongside staff from the psychology department and did not entirely hand over the research activities to an academic institution. These national research teams were then trained on sampling and data collection methods and techniques by ESCAP, but it is to the credit of the national research teams that the research generated a large amount of rich data.

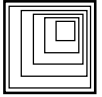


The researchers came from a wide range of different academic and professional backgrounds, which undoubtedly enriched the material that they generated. Research sites were also selected during the research methods training sessions based on the following criteria: the selected provinces should have rural and urban centres known to have a large number of children engaged in prostitution and sexually abused children; and the selected provinces should be those that serve as areas of origin, transit and destination for children who are trafficked within or outside the country for purposes of prostitution. The research teams then decided on the specific districts that they would target for the study.

More specifically, the research teams were trained in sampling methods and techniques to establish trust and friendship with the children and care providers. Because of the difficulties involved in identifying sexually abused and sexually exploited children and service providers, the researchers were familiarized with the snowball sampling method. This method begins the interview process with a few interviewees and then relies on them to expand the contacts. In order to avoid bias in identifying the target groups to be interviewed, the researchers were asked to consult other sources of information in the community. Various methods were explored in the training workshops to access children at highly concealed places of work such as brothels. These included such methods as collaboration with health workers in the area who were already involved in care provision to the target group, and police officers, or posing as clients or pimps.

Research teams employing such undercover techniques were requested always to reveal their true identity and purpose to the children and obtain their consent before conducting the interviews. Unfortunately, some country teams did not reveal their identity or objectives of the research to the children they interviewed in brothels. Adequate sample size, utilizing the snowball method, is obtained when the data from the samples consistently repeat themselves and reveal definite patterns of information. The data that are obtained from such a sample are reliable in explaining behavioural patterns.

To establish trust, the research teams were asked to begin with observational and informal interviews selecting a topic of interest and one easy to discuss before moving to in-depth interviews. Once a relationship was developed, the researchers used a semi-structured interview procedure to guide their discussions, relying heavily on the spontaneous generation of questions as they emerge naturally from the free-flowing discussion between them and the respondent. Moreover, they were asked to make use of the immediate surroundings to increase the relevancy, concreteness and immediacy of interview questions and responses. The research teams were also encouraged to help children,



especially those who might have appeared to be traumatized by talking about their abusive and exploitative experiences, whenever they could, including providing basic counselling, or referring them to counsellors. However, there were few cases in which the researchers intervened in order to assist the children. One example is of a girl interviewed in Khammouane Province in Lao People's Democratic Republic, who had been working in a local pub for two weeks. She had not been sexually exploited but she was homesick and wanted to go back to live with her parents a long way from town. She had no money or knowledge about how to return because she had been accompanied by relatives who had left her at the pub to earn money. The researchers thought she was at high risk of being sexually exploited and so they sent her home on a bus.

Owing to the sensitivity of the information to be collected from the children and service providers, and the importance of keeping the interviewing environment as natural as possible, the research teams were requested not to use a tape recorder at the beginning, but to do so at a later stage, once trust had been established. Regrettably, some national research teams used concealed tape recorders without the consent of the children.

The training also focused on methods of recording and analysing data obtained from observations and interviews.

The national research teams from the six participating countries comprised the following persons.

In **Cambodia**, ESCAP selected the Cambodian Centre for the Protection of Children's Rights (CCPCR) to serve as the research focal point. The research team in Cambodia consisted of three staff members of CCPCR in Phnom Penh. The research team targeted nine provinces for the study, Koh Kong, Sihanoukville, Siem Riap, Kompong Chhnang, Phnom Penh, Kompong Cham, Poipet, Battambang and Svay Rieng. On average, the researchers spent 5 to 10 days at each research site and the data collection phase ran from April to June 1999.

In **China**, the All-China Youth Federation was chosen by ESCAP as the focal point for this project. The Yunnan Academy of Social Sciences was then designated as the research focal point. The fieldwork was conducted in Kunming, Quijing, Xishuangbanna and Hekou. The research team comprised six staff members of the Academy who split into two groups to collect the data. The research was conducted from October to December 1998, with staff spending one to two weeks in each research site.



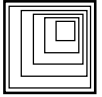
In the **Lao People's Democratic Republic**, the Department of Social Welfare under the Ministry of Labour and Social Welfare served as the national focal point for this project. The Deputy Director of the Social Welfare Department was the coordinator of the project. The research team consisted of staff of the Department of Social Welfare from the Ministry and Vientiane Municipality and from the Lao People's Revolutionary Youth Union. The fieldwork was carried out from June to July 1998 and the researchers spent 15 days in each province.

The Department of Social Welfare served as the national focal point for this project in **Myanmar**. A professor of the Psychology Department, Yangon University, coordinated the research. The research team members comprised people from the Psychology Department of Yangon University, the Department of Social Welfare and the Rehabilitation Centre for Ex-Drug Addicts. Two research teams carried out fieldwork simultaneously owing to unavoidable delays in the conduct of the study. The first team, Team A, was assigned to conduct fieldwork in Muse, which is situated on the Myanmar-China border, and Yangon. The second team, Team B, was assigned to conduct the study in Hpa-an and Mawlamyine, which are situated in the southern part of the country.

In **Thailand**, the National Commission on Women's Affairs initially served as the national focal point for this project. (The focal point was changed to the National Youth Bureau in mid-1999). The research focal point was Chulalongkorn University and a child psychiatrist at the University served as the research coordinator. The research team members comprised staff of the University, child psychiatrists from Vajira and Ramathibodhi hospitals, and a nurse and volunteer from the Centre for the Protection of Children's Rights Bangkok. The data were collected from the provinces of Chiang Mai, Chiang Rai, Nakhon Ratchasima, Udon Thani, Khon Kaen, Nakhon Pathom, Bangkok, Rayong, Chonburi, Songkhla, Phuket and Trang from October 1997 to May 1998.

The Department of Social Evils Prevention served as the national focal point for the project in **Viet Nam**. The Department organized a research group including eight of its own specialists and researchers from the Institute of Labor Science and Social Affairs and the Centre for Human and Labor Resources (both under Ministry of Labour, Invalids and Social Affairs). In order to complete the project in three months and within the proposed budget, the team was divided into two groups. Team A worked in Hanoi and Lang Son provinces and Team B in Danang, Khanh Hoa, Ho Chi Minh City and Can Tho.





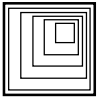
## **3.2. Exploratory Phase**

### ***3.2.1. Preparation for fieldwork***

The research teams in all six countries began by locating and reviewing available documents, including medical and police records, and studies conducted by international organizations and governmental institutions on sexually abused and sexually exploited children. The data were reviewed and summarized to provide an overview of the areas where sexual abuse and sexual exploitation were prevalent, and the organizations that worked with the victims and potential victims in the respective countries. The research team members also held discussions with care providers in organizations providing services to sexually abused and sexually exploited children to obtain information on the research sites and interviewees.

In Viet Nam, for example, the Department of Social Evils Prevention wrote to the provincial branches of the Ministry of Labour, Invalids and Social Affairs in all the six research sites requesting information on sexually abused and sexually exploited children and youth and available services. In Thailand, where the national research team comprised medical professionals, information was sought from hospitals and other health-care facilities, including the Division of Venereal Diseases Control. The Centre for the Protection of Children's Rights, where one of the team members worked as a volunteer, was also visited. The team in Myanmar held preparatory meetings to review the objectives of the research, identify research sites, distribute and discuss the interview guides and to develop a detailed programme for the two teams. In the Lao People's Democratic Republic, the research teams compiled their own lists of questions based on the interview guides. In order to conduct a research project in the Lao People's Democratic Republic, government cooperation is necessary at all levels. Thus, the next step was to obtain permission from the Minister of Labour and Social Welfare. After the permission had been obtained the researchers divided themselves into two research teams. In China, the Yunnan Academy of Social Sciences interviewed all the different departments concerned, such as public security and health, before conducting the fieldwork. Owing to the sensitive nature of the issues, they integrated in-depth interviews with the questionnaires. In addition, group discussions were held.

The last step before primary data collection was the translation of all the interview guides into the six local languages.



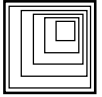
### ***3.2.2. Community entry phase: establishing a presence***

At the provincial level, researchers made initial contact with social welfare offices, police and some NGOs to brief them on the project and its purpose as well as to collect general information on the situation of sexually abused and sexually exploited children in the province.

In Cambodia, the research teams contacted the Commissar of the provincial and municipal police headquarters to ensure some level of security for the team members should it be required. In addition, researchers met with relevant sections of the Ministry of Social Action and Veteran Affairs, district police inspectors and some NGOs in the province, which were working with sexually abused and sexually exploited children, in order to obtain more information about the problem. In the Lao People's Democratic Republic, the provincial officers introduced the researchers to officials at the provincial governing office. There they met with representatives of the Lao Youth Union, the Lao Women's Union and the police to obtain information on the situation of the children concerned at each research site. After the provincial-level meetings, researchers were accompanied by officers from the Ministry of Labour and Social Welfare and introduced to district-level police officials who were able to provide area-specific information regarding location and methods for contacting such children. In China, the researchers interviewed government departments at each research site. In Viet Nam, the researchers worked with the provincial branches of the Ministry of Labour, Invalids and Social Affairs, and the Committee for the Care and Protection of Children in each province. The research team also requested the assistance of officials from the Viet Nam Women's Union and the police in the field.

### ***3.2.3. Identification and selection of target groups***

Sexually abused and sexually exploited children and youth are sensitive issues in all countries and areas of the subregion and the researchers used several methods to locate them as well as their caregivers. In Cambodia, for example, the researchers spent time surveying the brothel areas prior to selecting their entry strategy and tried to target both open and closed brothels for their interviews in each province. The male researchers posed as clients, while the female researchers posed as pimps or brothel owners. In some instances, the researcher also disguised herself as a man in order to enter closed brothels. In this way, they were able to identify and interview 65 children, including 55 girls and 10 boys. More time would have been required for the researcher to build up trust with the boys and to gather their full stories.



In the Lao People's Democratic Republic, as another example, the researchers identified sexually exploited children from police files as well as from the children's friends. The local police officers also tipped them about entertainment establishments where children were known to be engaged in prostitution, and even accompanied them to those entertainment places. The researchers initially made enquiries with the establishment owners and the friends and relatives of sexually abused children about the location and backgrounds of the children. Using this approach, they were able to identify and interview 43 girls who were sexually exploited. Although researchers identified children who had been sexually abused from police records, they decided it was inappropriate to interview them as the situations seemed to have been resolved and they did not want to upset the children by asking them to recount their stories. The researchers also interviewed doctors in two clinics and two hospitals, a secondary school teacher, representatives of the Lao Women's Union and the Lao Youth Union, and a pharmacist.

#### **3.2.4. Methods of data collection**

Data were collected through observation, in-depth interviews and group discussions. Techniques to establish trust and friendship with the children were emphasized during all of the interviews in the participating countries. In **Cambodia**, the three researchers differed in their approach. One researcher tried to take the children he interviewed away from the others, either by taking the girl into her room or by leading her away from the brothel. He took the time to explain the purpose of the study to the girls whom he interviewed and he built up the girl's trust in him through conversation. Another researcher always interviewed the girl in open areas within the brothel while simultaneously engaging in other activities that the girls enjoyed, including playing cards, singing, watching television and eating. He felt that conducting the interview in that informal way made the girl feel at ease. In addition, a female researcher spoke about her own life or pretended that she knew the girl's parents in order to secure the trust of the children. Two of the researchers never revealed their true identity as they felt they lacked the time needed to explain the objectives of the study to the girls. Furthermore, they feared that the girls would reveal their identity to the brothel owner, which might have endangered them. Most of the interviews lasted from half an hour to two hours. In some cases, when more information was required, the researchers returned to the brothel for a second interview. All researchers taped interviews using small concealed cassette recorders, and following the interviews recorded information and observations on paper.

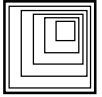


The research teams from **Yunnan Province (China)** conducted in-depth interviews and had the children fill out questionnaires. In addition, group discussions were held. The researchers used tape recorders and transcribed the interviews later. Working with the local women's federations, they were able to locate the girls for interviewing, and conduct on-the-spot investigations. The researchers also spent much time observing the environment before the interview, to better acquaint themselves with the girls' situation. It was often necessary to provide detailed assurances to the children that they would be treated with respect in the interviews and that the researchers would not expose them and damage their reputation.

In Savannakhet and Khammouane provinces in **the Lao People's Democratic Republic**, the girls felt more comfortable speaking to a woman researcher. Interviews were usually conducted with individual children but in some places it was necessary to meet with two or three children. For some interviews, conducted in Khammouane and Savannakhet, researchers brought the children together in a larger group of five or six children for a meal and an informal discussion. After the meal, the researcher interviewed the children separately. During the interviews, she asked questions while another researcher took notes. In Vientiane Municipality and Champasack Province, the two male team members posed as clients in order to collect data from the sexually exploited children. They did this after they realized from the first few interviews that the children were reluctant to talk to them. The researchers suspected that the children might have thought they were police officers who wanted to arrest them, or the girls might have felt uncomfortable talking with men about their situation. In these cases, it was necessary to interview the children first, and write down their answers later.

The research teams from **Myanmar** conducted the interviews in quiet places with no interruptions. They used tape recorders, with the children's permission, to record interviews that lasted for one hour to three hours. The researchers also kept a daily diary, including verbal and expressive material from each child.

In **Thailand**, where most of the research team members were psychiatrists, a psychiatric assessment was conducted together with the semi-structured interview of each child. Brief, focused counselling was provided to children when required and relevant. Observation of health-care facilities, correction homes and centres that were visited was also carried out. When possible, group discussions were conducted with children, care providers and local people in order to obtain a more thorough understanding of their feelings, attitudes and opinions on sexual abuse and sexual exploitation.



The researchers in **Viet Nam** made the children comfortable by having a local staff member who was acquainted with the families hold informal conversation. The research team members were introduced as social officers and not researchers. Once the families were relaxed, the researchers would slowly begin their interviews, beginning with general information. Members of the research team worked in pairs, with one person asking the questions and the other taking down notes. They also recorded the interviews, although this was not always with consent from the children. They felt that the families appeared comfortable with the team because they were in the company of officers known to them.

### **3.2.5. *Methods of data analysis***

The teams used tables based on the interview questions to facilitate data entry. In those countries where tape recorders were used, the teams first transcribed the data and then coded them, examining common patterns of behaviour as well as variations. Both question and content analysis methods were used to summarize and describe the data from each province in the participating countries. The provincial data were then analysed and synthesized to present a qualitative country assessment of the services and health needs of sexually abused and sexually exploited children in each country. The reports from Cambodia, Viet Nam and Thailand were first written in the local languages and then translated into English by the team members. The Yunnan Province (China), the Lao People's Democratic Republic and Myanmar reports were written in English. The ESCAP team, working together with the research teams, produced more complete and thorough reports.

### **3.2.6. *Problems encountered***

The researchers encountered common problems in their study. They all felt that they lacked sufficient time both to establish trust with sexually abused and sexually exploited children and to conduct in-depth interviews. Many of the researchers did not conduct interviews in the provinces with health-care providers, social workers and teachers owing to limited time and resources. They did, however, interview managers of organizations providing services to the target group.

In **Cambodia**, the presence of armed guards and brothel owners in some cases hampered the interview process, as the girls were afraid to speak out. Some researchers did not enter these brothels, themselves fearing the guards. The research team also felt that they had lost some interview information owing to the secretive procedure followed, which did not allow for the manual recording of information at the time of the interview.



In **China**, the issues of sexual abuse and sexual exploitation are very sensitive. It was thus necessary for the researchers to visit service providers once or twice to explain in detail the purpose of the project prior to conducting the interviews. In addition, as prostitution is illegal in China, it was difficult for the children to admit that they were involved in illegal activities. This made it difficult for the researchers to identify and approach the girls. To deal with these problems, the researchers spent a considerable amount of time observing the girls before approaching them, and treated them with a respectful attitude.

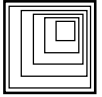
The teams in **the Lao People's Democratic Republic** had problems finding sexually exploited children, as they are highly mobile. In several instances, when the researchers went to find the children who had been referred to them by the child's friend, a police officer, or another key informant, they were sometimes told that the girl had moved on to another pub or restaurant located in a different province or district. At times, the pub owners would not co-operate with the researchers or the police who accompanied them because they were afraid of being arrested or they were annoyed that the researchers were taking too much of the girl's time from customers who were spending money at the pub. To deal with this problem, the researchers bought drinks and food while they were conducting interviews or making observations. Researchers suspected that the children might have been lying about or did not know their ages. This may have been because prostitution is illegal.

For the male researchers it was often difficult to ask the girls about their sexual health. Thus, the researchers would spend time drinking soda or beer with the girls in order to put them at their ease. Further, when asking about condom usage, if the researchers were posing as customers, the girls might not have told the researchers about their true condom use behaviour. This could be because they would be more likely to tell a prospective customer what they would want to hear about previous condom usage rather than divulge their actual behaviour.

In **Myanmar**, many of the brothels where girls were known to be working were located across the borders and the researchers had no access to them.

As the researchers had extensive networks in the field, and employed local health professionals known to the children, no problems were encountered in **Thailand**.

Sexual abuse cases were especially difficult to identify and interview in many of the countries. In **Viet Nam**, most of the sexually abused children identified from police records came from families which had not



received satisfactory compensation or those threatened by the sex offenders. Thus, the sample of sexually abused children represented a specific group of children. For children involved in prostitution, the researchers felt that the data collected were not precise, as the children were not consistent on a number of points. However, the researchers tried to control this by rephrasing the questions. Researchers also found that giving children toys, candy and various gifts helped in gaining their trust and acquiring more accurate information.

## **4. RESEARCH FINDINGS**

### **4.1. The Magnitude of Sexual Abuse and Sexual Exploitation of Children**

There are no accurate data on the number of cases of sexually exploited and abused children and youth per year and the proportion of young people already affected in specific countries, but indications are that these are growing problems in all six countries.

Little research has been conducted to date on the sexual abuse of children and youth in the Greater Mekong Subregion. It is a sensitive issue and one that is not easily solved owing to a traditional reluctance to intervene directly with other people's family life. In many cases, young victims and their families, out of shame or fear of banishment, do not disclose the crime. In cases where sexual abuse is exposed, it is often not recorded as an agreement is made between the victim's parents and the offender, often with the involvement of officials. Many authorities on the subject report that the pressure on victims of sexual abuse to remain silent or to retract their stories is heavy, and threats of violence are not uncommon. Organizations that offer services to these children may have records of new cases that are reported to them. However, the data are largely documented in an unsystematic manner and reflect specific groups of victims. The police, for example, often only retain statistics on victims who could not settle their case with the abuser. The figures recorded by hospitals reflect the numbers of victims who suffer from severe physical or emotional problems and require treatment. Lastly, social welfare officers may only have statistics of young victims who need social welfare assistance. Thus, the actual number of sexual abuse cases is well in excess of the documented total.

Although the data available on sexual abuse and sexual exploitation of children and youth from service organizations are not comprehensive, they do show that a serious problem exists and that it is growing in magnitude.



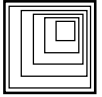
The actual number of sexually exploited young people is also difficult to determine with accuracy because many of the sex establishments engaging children are concealed. Children working in the commercial sex sector in many of the countries of the subregion are known to lie about their true age and often have fake identity cards. Some estimates on the number of sexually exploited children in Cambodia and Thailand have been provided by organizations working with these children and are a major factor causing divisions between government authorities and NGOs in these countries. In Cambodia, a survey conducted by Human Rights Vigilance among 6,110 sex workers in Phnom Penh and 11 provinces showed that 31 per cent of the interviewed sex workers were children aged 12 to 17 years. The greatest number of sexually exploited children were found in Phnom Penh and Battambang provinces, where they made up a third of the total. Proportionally, Takeo and Kompong Chhnang surpassed the other provinces, where sexually abused children made up 47.4 and 36.6 per cent of the totals respectively.

In Thailand, NGO figures of children involved in prostitution are as high as 800,000 while government figures put the number at 15,000. Government statistics on children in prostitution are percentages of the adult commercial sex workers. Figures on the latter are based primarily on information from venereal disease (VD) clinics or open commercial sex establishments, and thus those commercial sex workers who do not visit these clinics and those hidden away in closed commercial sex establishments, including many children in prostitution, are not included. Some health officers who treat sexually exploited children do not report the true figures from their surveys on child prostitutes as this may result in conflict with the police owing to the government policy to eradicate child prostitution. The provinces with the highest numbers of commercial sex workers are Bangkok Metropolis and the central region, followed by Chonburi (Pattaya), Songkhla (Hat Yai District), Phuket and Chiang Mai.

## **4.2. Causes of Sexual Exploitation of Children**

No studies have been carried out on the factors that make children vulnerable to sexual abuse in the subregion. However, some studies exist, mainly in Cambodia, Thailand and Viet Nam, on the factors that influence the entry of children into commercial sex. In Cambodia, the social and economic crisis has created a large supply of young, undereducated and unaware girls, who seek employment to assist their families financially. Owing to the high demand for sex services in the country, young girls are forced or volunteer to sell their virginity for a high price and then continue to work as prostitutes. Boys who live on the street in urban centres have also been sexually exploited by paedophiles in recent years, but they are in far less demand than girls.





With the rapid spread of HIV/AIDS throughout the region in the past decade, young girls have been in high demand in sex establishments as many believe that virgins are virus-free and, in the case of old men, that virgins can restore a man's virility.

In Thailand, poverty, community acceptance of the profession, low educational level and lack of skills among children, severe family problems, history of sexual abuse, materialism, and acquaintance with a commercial sex worker are contributing factors. The economic benefit accruing from prostitution has always enticed young people in Thailand. The Thailand study found that each time a prostitute goes out with her customer, she earns at least 500 baht for her sexual services. If she stays overnight with him, she makes B1,500, and the guide who brought the customer to her receives B200 to B300 commission. Salaries in other fields that require minimal education offer far lower wages. The highest minimum wage level in Thailand is currently B162 per day. Many commercial sex workers hope to save money from their work in order to return home to start a family and invest in a small business such as a grocery store or a beauty salon. A recent study on boy prostitutes in Bangkok found that most boys enter prostitution between the ages of 12 and 18 years for monetary reasons, and in some cases, for the sexual experience. These boys live in groups and are often substance abusers of drugs and cigarettes. Sexually, they are known to be promiscuous.

In Viet Nam, cases of girl prostitutes are normally those of girls born in peasant families. Sometimes, a child will see prostitution as an easier way to earn money because it is higher paying than most other available jobs, and will enter the business of prostitution voluntarily. Because of the new market economy and the rapid economic and social changes in Viet Nam, it has been difficult for the state to stay current and in control of all the latest changes, including the business of trafficking and the prostitution of children and child sexual abuse.

### **4.3. Health Effects of Sexual Abuse and Sexual Exploitation**

Commercial sexual exploitation and sexual abuse of children and youth result in several physical and psychosocial problems. The limited information available on the health aspects is concentrated on the direct effects of sexual experiences. However, equally important is information on the circumstances leading to the exploitation and abuse and the long-term and intergenerational effects. The direct effects of sexual exploitation and sexual abuse include injury resulting from accidents and physical abuse, pregnancy and STDs, as well as affective, personality and organic mental disorders. Medical doctors working



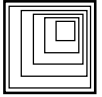
in university hospitals in Thailand, where the majority of sexually abused cases in the country are referred for treatment, report that depression, withdrawal, fear and anxiety are the most common psychological reactions in the victims. Physical signs include vaginal discharge, painful genitalia and pregnancy, while some children have psychiatric problems, including running away from home, post-traumatic stress disorder and withdrawal.

Conditions in the workplace, working hours and the nature of the tasks involved and their consequences are the most obvious characteristics affecting children's physical health and development. The conditions under which children in prostitution live and work in many of the countries of the subregion are reportedly unhealthy and exploitative. In the 1994 survey by the Cambodia Women's Development Association conducted in Cambodia among 399 women and girl prostitutes, 13 per cent of the respondents, when asked about their problems, replied that they "live like animals". Other reports show that these sex workers must be available to serve clients 24 hours a day, whether they are in good or poor health (GAATW 1997). Receiving an average of 5 to 10 customers a day, children in prostitution are extremely vulnerable to STDs. Some common forms found in the countries of the subregion include gonorrhoea, syphilis, herpes simplex, urinary tract infections and polyps.

In Cambodia, Human Rights Vigilance reported that the physical health problems of the children in prostitution it surveyed in 1995 included skin irritations, discharges, warts and STDs. The organization sees HIV/AIDS as the biggest health threat to sex workers. Most sexually exploited children have never been educated about, or discussed, sex and do not know their own bodies. In many cases, they have no control over the behaviour of their clients. Moreover, many visit the pharmacy near the brothel for treatment of the disease as, for many of them, mobility is restricted and the cost of visiting a doctor is too high. Some simply have no access to medical care (GAATW, 1997). Girls will only visit a doctor when they are really ill, which in the end increases the expense as their health condition has deteriorated.

#### **4.4. Legislation and Available Social and Health Services**

Sexual abuse and sexual exploitation of children are considered crimes under the penal laws of all countries in the subregion and offenders are liable to imprisonment or a fine. Furthermore, all the countries are signatories to the Convention on the Rights of the Child and the majority have national committees on the rights of the child that facilitate the implementation of the laws and provisions of the Convention. With the legislative measures in place, the challenge for countries of the



subregion appears to be with law enforcement. In many of the countries, however, these laws are relatively new and methods of law enforcement and judiciary procedures are still being developed. With few exceptions, the police and military in countries of the subregion do not implement laws that protect children from sexual crimes. Instead, in several cases they are actually engaged in the sexual abuse and sexual exploitation of children and youth. According to the UNICEF *The Trafficking and Prostitution of Children in Cambodia: A Situation Report*, there is little doubt that law enforcement officials are involved in practically every stage of the trafficking process (UNICEF 1995). Several locally powerful police and military personnel are known to be involved in both abduction rackets and the protection of establishments which offer the services of child prostitutes. Secondary data from the subregion also point to the fact that many officials and community members, including children, are not aware of these new laws or of the rights of children.

Many organizations are working to end the sexual exploitation and sexual abuse of children and youth in the countries of the subregion as well as to care for the victims of these crimes. The current research project on the health needs and services available to sexually abused and sexually exploited children and youth forms a contribution to these common goals. The few programmes that are in place in the countries of the subregion focus on sexually exploited children. Child rights groups and religious groups have raised fundamental questions regarding the causes, the exploiters and methods of recruitment, the effects on the children and appropriate interventions. They have intervened in communities to prevent more children from being recruited, and they have rescued and cared for those already trapped in the commercial sex industry. This focus has largely been translated into preventive and rehabilitation programmes that are often implemented on a trial and error basis.

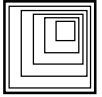
## **5. RECOMMENDATIONS**

The recommendations that follow are based on the findings from the research that was conducted in the six participating countries and from feedback received from the national HRD workshops for social and health care providers held upon the completion of the research. The workshops were intended both to disseminate the results from the research and to elicit input for formulating additional recommendations and developing the training curriculum and pilot projects. The recommendations are grouped under three levels of prevention: primary, secondary and tertiary. Specific recommendations are also made with regard to training and future research. More detailed country recommendations are also contained.



Interventions at **the primary level of prevention** suggest programmes that will promote a safe and healthy environment in which all children and youth can grow without fear of sexual abuse and sexual exploitation. The main features of primary prevention include specific policies and laws, basic health, education and housing services, and the provision of information and education through a variety of channels. Policies and legislation can have a powerful impact on the conditions that promote healthy development in young people. It is important that such policies and laws be integrated, taking into account the many different sectors that affect the healthy development of children. The strength of basic health, education and housing services and the amount of appropriate attention they can give to children depend in large measure on national priorities as expressed through policies and legislation. The public, including children and youth, can be informed of issues related to sexual abuse and sexual exploitation of children and youth by means of one-way channels of communication, such as radio, television, live entertainment, newspapers, magazines, books, comics, cartoons, videos, films, cassettes, records, posters or pamphlets, or through two-way communication – in person, by telephone, or through an exchange of written messages. Interactive communication is especially powerful, since it permits people to ask questions and explore issues of special individual significance, ensuring that the information has a greater degree of personal relevance. Education not only provides information for children and youth but also nurtures intellectual as well as social and moral development. Education should not only include guidance on maturation, sexuality and relationships but also aim at enabling children to manage their own healthy destiny. The two major vehicles for such education are the school system, which often provides formal training in sexual health education, and the family, the primary source of knowledge and habit formation for everyone. Other people who can play a significant role in providing education to children and youth are health workers, leaders of youth organizations, religious leaders, modern heroes of sport and entertainment and so on. For education to be a success, educators must be both knowledgeable and skilled at communicating with the public and the young, in particular. This means being able to listen sensitively and without condemning the individual.

The interventions at the **secondary level of prevention** are meant to identify vulnerable groups of children and reduce the risk of sexual abuse and sexual exploitation. Research, including that undertaken by ESCAP, has shown that some children and youth are more vulnerable than others to sexual abuse and sexual exploitation because of their individual, family or social circumstances. Programmes at this level of prevention therefore are typically grass-roots-oriented, relying on key institutions such as the family, school, church, village council, health



centre, social or youth club, women's group, and so on, for initial identification and action. However, because many schools and communities are without an effective screening service, self-reporting and identification by family or community groups long after the sexual abuse and/or sexual exploitation has taken place is more common. Secondary prevention will only be effective if young people in need are reached early enough with sex education and life skills training to increase their resilience. In many countries in the subregion, children often do not know where to turn or what help can be provided. It is a major challenge to make services and service providers more accessible to the young. If public information on sexual abuse and sexual exploitation is readily available, in and out of school, and accurate, it is more likely that children will seek care when they need it. For this to work well in the long term, it requires a two-way process in which the local institutions identify and contact the children at risk of sexual abuse and sexual exploitation and, at the same time, the child is willing to trust, confide in and seek out those who can help him or her. People with the ability to listen well, who feel and show respect for the individual child, are more likely to attract children seeking help, whether they are in a professional setting or not.

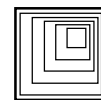
**Tertiary prevention** aims to reduce harm or further damage to child victims of sexual abuse or sexual exploitation. The main focus is on compensatory services for those in fluid situations, treatment and (re)habilitation. A key element in tertiary prevention is the availability and accessibility of counselling, treatment and rehabilitation services for physical, mental and social problems. Treatment and rehabilitation can focus on the individual, family or community and can be carried out in an institutional setting or on an outreach basis. The approach that is selected depends on the careful examination of the child and his or her family and community. Complications can be prevented or cured much more easily if the child and his or her immediate family understand the problem and if those who provide the care are aware of the special needs and perceptions of sexually abused and sexually exploited children and their families. Services that treat such children and youth are largely in the health and social welfare sectors and have great variation. They are predominantly aimed at physical and social problems and, to a lesser extent, at problems of mental health. The few services available in the health and social sectors appear to be curative and stigmatizing respectively. Providing care early to prevent more chronic conditions is highly cost-effective. Furthermore, rehabilitation needs to be directed at the whole individual so that he or she is able to develop physically, psychologically and socially to the fullest extent possible. This requires good cooperation between the sectors, particularly between health, education and social services, and the involvement of community and non-governmental organizations.



The efforts must be directed not only at the young person, but also at those who have contact with him or her, and this calls for retraining and awareness-training for health and social service personnel so that they are better equipped to help the child integrate into his or her natural setting. When a prolonged stay in a hospital or rehabilitation institution is necessary, efforts must be made to maintain a normal environment as far as possible, including, for example, continued schooling, association with peers, recreation, and daily chores compatible with age and recovery, so as to help psychosocial and physical development and pave the way for a return to normality.

The Human Resources Development Section of ESCAP is aware of the challenges that the participating six countries of the subregion now face to turn their recommendations into action. It is also aware of the fact that governments in the respective countries must initiate such action. In its effort to further strengthen the capacity of government agencies and NGOs responsible for programmes targeting sexually abused and sexually exploited children and youth in the subregion, ESCAP has implemented the following activities.

- (a) Established a web site, which is available to countries in the Greater Mekong Subregion. The web site provides detailed information about the current situation of sexual abuse and sexual exploitation of children and youth in the countries of the subregion, legislation to protect children from sexual abuse and sexual exploitation, information on complementary activities under way in the context of the subregion and their relationship to other regional and international initiatives. It also includes a directory of organizations in countries of the subregion engaged in programmes to prevent or combat sexual abuse and sexual exploitation of children. The national coordinating organizations collaborating with ESCAP in this project will continue to serve as focal points for each participating country and will be responsible for providing information to the web site. Moreover, a video depicting the situation of sexually abused and sexually exploited children in the subregion has been developed and distributed to the participating countries to create more awareness of the phenomenon.
- (b) Conducted a subregional course in September 2000 to provide training that will help social and health-care professionals in the subregion to deal with the needs and problems of sexually abused and sexually exploited children. The course will also address caregivers' needs and how to deal with them, as well as equip them with a child-centred approach in carrying out needs assessments, planning programmes, implementing, monitoring and evaluating programmes for sexually abused and sexually exploited children.



The above-mentioned activities that are being implemented by ESCAP will invariably strengthen exchange and collaboration within countries of the subregion to prevent sexual abuse and sexual exploitation of children and youth and facilitate the repatriation and reintegration of young people who have been trafficked within and across borders. It could also form the basis for exchange visits, joint research and investigation on both preventive and remedial approaches.

Finally, ESCAP is aware that the shortage or ineffective allocation of funds is one of the main obstacles to the delivery of services to sexually abused and sexually exploited children and youth. To this end, ESCAP will continue to work with governments and NGOs to stress the importance of the provision of health and social services to victims of sexual abuse and sexual exploitation. ESCAP will also work in partnership with governments and NGOs to implement follow-up projects targeting sexually abused and sexually exploited children and youth, and the conduct of national training courses on service provision.

The following recommendations are especially pertinent to government and non-governmental programmes in the six countries of the subregion participating in this research project. The following abbreviations are used in the recommendations: primary prevention (PP), secondary prevention (SP), tertiary prevention (TP), research (R), and training (T).

## **A. CAMBODIA**

### **Recommendations from the research**

- (1) The quality and delivery of basic health and education services need to be improved in order that all citizens, particularly children, can access them, including those who live in rural areas (PP).
- (2) Existing laws to protect children from sexual abuse and sexual exploitation should be enforced by the police and other government officers in a smooth, open and coordinated manner. Sexually exploited children should be treated as victims and not criminals (PP).
- (3) Awareness-raising activities on the implications and consequences of sexual abuse and sexual exploitation of children should be conducted in high-risk communities. Networks, which exist to eliminate the sexual exploitation of children, should be strengthened (SP).
- (4) The activities in recommendation No. 3 should be combined with vocational training courses, revolving funds and employment to enable children as well as their parents to learn skills and have alternative sources of income (SP).

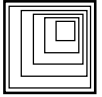


- (5) More centres should be established to provide shelter, medical care, counselling and skills training for sexually abused and sexually exploited children, particularly in those provinces in which these services do not currently exist and in those with high concentrations of children in prostitution (TP).
- (6) Innovative outreach services are needed to address the physical and psychological health needs of sexually exploited children (TP).
- (7) Sexually exploited children who are kept against their will in brothels should be released (TP).
- (8) Awareness-raising activities should be conducted to reduce societal discrimination against sexually abused and sexually exploited children (TP).
- (9) Law enforcers should be trained to change their attitudes and behaviour regarding sexually abused and sexually exploited children. Brothel owners should receive training in the prevention of STDs, including HIV/AIDS. Caregivers who work with sexually abused and sexually exploited children, and with vulnerable children in general, lack the skills required to provide them with appropriate psychological care. These staff members need to be trained to be able to identify the psychological needs of sexually abused and sexually exploited children, who are often traumatized children, as well as the skills to address those needs (T).
- (10) Both qualitative and quantitative studies should be conducted on the sexual abuse of children in Cambodia, as there is a lack of research in this field thus far. Children with disabilities should be included in the focus of the study (R).

**Additional recommendations from the national HRD workshop held at Phnom Penh from 2 to 4 June 1999**

- (11) Education and public awareness should be heightened with regard to HIV/AIDS (PP).
- (12) Collaboration between government organizations and NGOs working to assist sexually abused and sexually exploited children should be strengthened (SP).
- (13) A referral system, including medical care centres, counselling and psychosocial services, and skilled psychologists should be established to handle cases of sexually abused and sexually exploited children (TP).
- (14) Substance abuse problems among sexually exploited children should be addressed (TP).





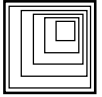
## **B. YUNNAN PROVINCE (CHINA)**

### **Recommendations from the research**

- (1) Sex education should be included in the school curriculum, and public awareness of sexual issues, particularly sexual health, should be increased (PP).
- (2) Existing laws and regulations should be reinforced and fully implemented, while new legislation needs to be put in place to ensure the protection of the rights and interests of women, children and youth, particularly with regard to curbing the commercial sex trade, trafficking in women and children, pornography and other forms of sexual exploitation (PP).
- (3) Steps must be taken to promote sexual equality in both the social and the legal aspects (PP).
- (4) Knowledge of STDs and AIDS must be disseminated through various channels, in order to raise public awareness of these diseases. In particular, this information must be made available to those involved in the commercial sex trade, who are more difficult to access because of the covert nature of their work (SP).
- (5) Measures should be taken to help women, children and youth who have been involved in the commercial sex trade, or who are victims of sexual abuse, to increase their levels of self-esteem. Negative social attitudes towards these groups must also be addressed. Social workers and family members can also be trained to provide advice on relevant laws, as well as on sexual matters, in order to reach those women, children and youth who have not had access to government programmes (SP).
- (6) Community-based work must to be conducted as a means of assisting sexually exploited and sexually abused youth and children, and to prevent others from being involved (TP).
- (7) When designing community-based action, measures must be taken and implemented in relation to the situation prevailing in each area. For example, a profile of women's and children's social and economic development can be drawn up in an area where there is a considerable amount of trafficking in women, and comprehensive development projects based on these findings can be established. These development projects should incorporate programmes to enhance the protection of the rights and interests of women and children, programmes of education for female children, and promotion of fertility and health (TP).



- (8) Training programmes should be developed aimed at raising awareness of AIDS and STDs, and their prevention (TP).
- (9) More education is required on the legal and personal rights of women, in order to provide more women with knowledge of how laws can be used in circumstances where their personal rights have been violated, or are under threat. Legal assistance, psychological counselling and information on health must be provided for sexually abused women and children, to ensure that their personal rights will not be violated again (TP).
- (10) Community-based organizations should develop their capacity to prevent the trafficking of women and children (TP).
- (11) Close attention must be paid to saving and helping the most vulnerable groups of women, and to providing assistance, medical treatment, legal aid and psychological counselling to women, children and youth who have been rescued from situations of abuse and/or exploitation (TP).
- (12) Training courses to develop women's vocational skills must be provided, in order to equip them with the means to achieve a stable livelihood (TP).
- (13) Training courses should be provided for family members and social workers in communities with a high incidence of entry into the commercial sex trade. The trainees should be asked to raise awareness about legal matters, sexuality and health, as well as provide ideological counselling for those children and youth who have been involved, or are at risk of involvement, in commercial sex work (TP).
- (14) Information on sexual issues and sexual health should be made available in communities where cases of sexual abuse are common, in order to reduce the number of cases of sexual abuse (TP).
- (15) The sexually exploited and sexually abused children need assistance in reintegrating into their home communities and families to minimize personal trauma as much as possible, as well as developing life goals and resuming normal lives (TP).
- (16) The youth and children who are reluctant to return to their former careers after their release from the detention centre, or refuse to continue to engage in the pornographic trades should be given practical assistance in the areas of employment, study, training, marriage, housing and family relations, so that they will not be forced to go back to, or become trapped in, commercial sex work (T).



- (17) Girl prostitutes who go on with their careers should also be advised on how to protect themselves, so as to reduce the risk of contracting STDs; for those girl prostitutes who have been detained, the training programmes should incorporate sexual education, health education, training in technical skills, and education on legal issues (T).
- (18) More attention needs to be paid to the provision of psychological counselling for these groups (T).
- (19) Family education and marriage adjustment training should be conducted among the parents or husbands of these girl prostitutes so that they can enter a favourable family environment after their release from the detention centre (T).
- (20) The sexually exploited and sexually abused children need training courses which provide knowledge of hygiene and health, particularly basic knowledge of the spread and prevention of STDs and HIV/AIDS (T).

## **C. LAO PEOPLE'S DEMOCRATIC REPUBLIC**

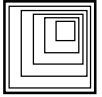
- (1) Existing laws relating to sexual abuse and sexual exploitation should be reviewed and improved to protect children more adequately, and public awareness should be raised among the general public on these laws. Additional laws to protect children should also be formulated, including those that prohibit children from entering entertainment establishments (PP).
- (2) Children, at high risk of sexual exploitation should be trained in appropriate vocations. Particular attention should be paid to juvenile delinquents, drop-outs and other marginalized children (SP).
- (3) The working conditions of factories, including garment factories, should be improved (SP).
- (4) A sex education curriculum should be developed and taught in schools with a specific component on sexual abuse and sexual exploitation (SP).
- (5) Parents should be actively involved in raising their children and decreasing their vulnerability to sexual abuse and sexual exploitation (SP).
- (6) Organizations should be established to provide services to sexually abused and sexually exploited children, including counselling, rehabilitation and medical services. Existing government health facilities should be upgraded to offer such services. These services should be accessible to sexually abused and sexually exploited children (TP).



- (7) Existing and potential care providers should be trained, in order to address the health needs of sexually abused and sexually exploited children effectively. Possible topics for training could include statistics collection techniques; counselling children on how to protect themselves; knowledge about medical, psychological and social health issues; treatment; and implementation of appropriate vocational education programmes for youth (TP).
- (8) Outreach programmes should be implemented to raise awareness among sexually exploited children on health issues, covering STDs, including HIV/AIDS; the dangers of substance abuse; and proper treatment from medical personnel, including gynaecologists (TP).
- (9) Sexually exploited children should receive vocational training and they should be assisted in the search for alternative forms of employment (TP).
- (10) Further research should be conducted on the physical and psychosocial needs of sexually exploited children as well as their specific health service needs, particularly in the provinces not covered by the study, such as those in the northern part of the country. Further studies should also target children of the many ethnic groups other than the Lao Loum. Sexually abused children and their health needs should also be researched. The research could be conducted with the collaboration of the Ministry of Labour and Social Welfare, the Ministry of Health and the Ministry of Interior. Half of the researchers should be women, as this research showed that sexually exploited children trusted women more than men (R).

**Additional recommendations from the national HRD workshop held at Vientiane from 4 to 6 May 1999**

- (11) Basic health care and medical services in the country, including clinics, hospitals, pharmacies and traditional health care, should be improved, particularly in areas outside the Vientiane municipality. Some of these services should be established in all villages and districts (PP).
- (12) Child development centres and consultation centres should be established throughout the country (PP).
- (13) Public information campaigns on the health effects of substance abuse should be launched (PP).
- (14) Family members and members of the community of the sexually abused and sexually exploited children should be informed on how to assist them, as well as on the services available for such children, once they are developed (PP).



## D. MYANMAR

- (1) Strict enforcement of the laws that exist to protect sexually abused and sexually exploited children should be strengthened through the joint efforts of governmental and non-governmental organizations. Some laws should be further elaborated in line with the Convention on the Rights of the Child (PP).
- (2) The quality and accessibility of educational and health-care services in Myanmar should be improved, particularly in rural and remote areas (PP).
- (3) Public awareness should be heightened concerning the Convention and its implications, particularly among children (PP).
- (4) The delivery of health education should be enhanced, particularly at the village level, so that positive behavioural changes occur in addition to increased knowledge of health topics, such as personal hygiene, nutrition, reproductive health and HIV/AIDS (PP).
- (5) Families should be strengthened through increased economic and social service support, particularly those in high-risk communities (SP).
- (6) Rehabilitation centres for sexually abused and sexually exploited children should be established throughout the country. Existing health services for these children should be widely publicized (TP).
- (7) The number of health-care facilities, including hospitals, clinics and public health care centres, should be increased and made accessible to sexually abused and sexually exploited children (TP).
- (8) Awareness and understanding of the health risks of unsafe sexual relations and substance abuse should be promoted among sexually exploited children, their customers and the owners of sexual establishments, particularly in relation to the transmission of HIV/AIDS and STDs (TP).

### **Additional recommendations from the national HRD workshop held at Yangon from 7 to 9 April 1999**

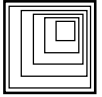
- (9) Recreational facilities for children, including playgrounds, should be built (SP).
- (10) Children in high-risk communities should be provided with the resources and training needed to earn sufficient income (SP).
- (11) Sexual abuse should be discussed (SP).
- (12) Foster parent programmes should be expanded for sexually abused and sexually exploited children (SP).



- (13) In addition to the need for establishing rehabilitation centres for sexually abused and sexually exploited children, existing institutional services and community-based services need to be improved (TP).
- (14) The number of health facilities that conduct HIV/AIDS testing should be increased, and existing services should be strengthened (TP).
- (15) The quantitative and qualitative data collection skills of social workers should be developed in order to facilitate research on sexually abused and sexually exploited children (R).

## **E. THAILAND**

- (1) The Prevention and Suppression of Prostitution Act, BE 2539 (1996), should be enforced (PP).
- (2) The law regarding the closing hours of entertainment establishments and those which bar the entry of children to them should be enforced (PP).
- (3) The number of entertainment establishments should be reduced and the remaining ones should be contained in one area (PP).
- (4) Support for children at high risk of sexual abuse and sexual exploitation should be provided so that they can continue their education. This should be combined with appropriate vocational training between Grades 6 and 9 (SP).
- (5) Recommendation (4) should be coupled with support for the children's parents in the form of income-generation activities for poor families (SP).
- (6) Special care should be provided to street children, including the provision of accommodation and food. The Homes should be open, allowing children to seek assistance but also giving them the freedom to stay or leave (SP).
- (7) Members of the community, especially parents should be informed about the frequency at which sexual abuse and sexual exploitation occurs; they should try to ensure that their baby-sitters are not sexual abusers. Parents and other community members should be made aware of the physical and psychosocial impact of sexual abuse. They should be able to detect the need for rehabilitation in order to help their children and they should know whom to contact regarding cases of sexual abuse and sexual exploitation (SP).
- (8) Parents and communities should be educated regarding the exploitation and health risks involved with prostitution, including HIV/AIDS (SP).



- (9) Sports centres should be established and children should be encouraged to spend their free time playing. The centres should be equipped with adequate facilities and equipment (SP).
- (10) Teachers should be trained in how to handle cases of sexual abuse and sexual exploitation and should be informed of the services available to treat sexually abused and sexually exploited children in the country (SP).
- (11) More centres and homes providing services for sexually abused and sexually exploited children, particularly in the area of rehabilitation, should be established in the country (TP).
- (12) Caregivers who work with sexually abused and sexually exploited children should receive further training in how to treat the psychosocial problems of such cases (TP).
- (13) Services for sexually abused and sexually exploited children should be improved, especially with regard to rehabilitation (TP).
- (14) Male sexually abused and sexually exploited children should be targeted for physical and psychosocial care (TP).
- (15) Follow-up programmes should be implemented for sexually abused and sexually exploited children who have been discharged from centres, homes and hospitals (TP).
- (16) Rehabilitation programmes should be developed and implemented for sexual offenders (TP).
- (17) The reporting of cases of sexual abuse should be improved (TP).
- (18) The legal process for sexually abused children should be improved and shortened in length (TP).
- (19) An active network should be established in all large cities and towns to assist with cases of sexual abuse. The work of organizations that serve sexually abused and sexually exploited children should be advertised so that community members are aware of their work (TP).

## **F. VIET NAM**

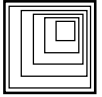
- (1) The Government should formulate a specific and comprehensive national policy to prevent and combat sexual abuse and sexual exploitation of children. Such a policy should also be translated into concrete programmes (PP).
- (2) To better meet the needs of sexually abused and sexually exploited children, public education and advocacy programmes about relevant laws, the rights of children, sexual abuse and sexual exploitation



should be developed to encourage children and families to report instances of sexual abuse and exploitation. Such education campaigns and advocacy programmes should also be implemented in remote and border areas and, where applicable, information, education and communication material should be developed in the languages of minority ethnic groups. Furthermore, campaign messages should be developed for the different information channels to ensure that a wide range of the population is reached (PP).

- (3) Sexual and reproductive health education should be incorporated in the school curriculum. Both children and care providers must be aware of these issues in order to prevent the occurrence of sexual abuse and sexual exploitation of children (PP).
- (4) Articles in the Penal Law need to be reviewed. The different components of these crimes need to be specified more accurately, and the punishment should be made proportional to the severity of these crimes. In fact, there should be harsher penalties for the sexual abuse and sexual exploitation of children. In particular, more severe punishments should be stipulated by articles 113, 113a and 114, up to and including life imprisonment. In addition, the existing laws should be better enforced, and the capacity of the organizations that implement these laws should also be strengthened. Finally, an ordinance on the prevention of prostitution should be drafted and promulgated (PP).
- (5) Families and children at risk should have access to vocational training courses, revolving microfinance funds and employment to enable them to learn employable skills and earn an income (SP).
- (6) Sexually exploited children who are kept against their will in brothels should be rescued. The study indicated that the large majority of sexually exploited children were forced into prostitution and wished to leave the brothel to receive training in vocational and business skills. As a result, brothels that keep children against their will should be raided. The children rescued by these raids should be rehabilitated and reintegrated into their families and communities (TP).
- (7) More centres should be established to provide comprehensive care to sexually exploited and sexually abused children, including medical and psychosocial care, particularly in those provinces in which these services do not currently exist and in those with a high concentration of children in prostitution. To facilitate this, existing networks should be strengthened, activities should be coordinated and information should be exchanged. Finally, these services should be provided free of charge (TP).





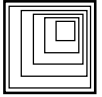
- (8) Sexually abused and sexually exploited children should be assisted in being fully reintegrated into their communities (TP).
- (9) Caregivers who work with sexually abused and sexually exploited children and with other categories of vulnerable children need to be trained and equipped with the proper skills to be able to identify the needs of these children (T).
- (10) Quantitative research should be carried out to identify the root causes of sexual abuse and sexual exploitation. Additional research on related legal measures is also necessary in order to combat these causes (R).
- (11) There should be additional exchanges and substantive collaboration between Viet Nam and other countries, especially those in the Greater Mekong Subregion, in order to prevent the sexual exploitation of children (subregional exchange).
- (12) The relevant government agencies in Viet Nam, including the Ministry of Labour, Invalids and Social Affairs and the Ministry of Foreign Affairs, should actively seek to participate in regional seminars sponsored by international organizations for the countries in the Greater Mekong Subregion (subregional exchange).

**Additional recommendations from the national HRD workshop held at Hanoi from 11 to 13 May 1999**

- (13) Vocational training and job-placement services should be provided to school drop-outs (SP).
- (14) High-risk groups, such as street children, children from big families and children working or living close to seaside resorts, should be protected from sexual abuse and sexual exploitation (SP).
- (15) Specialized agencies dealing with the legal issues of sexually abused and sexually exploited children should be established and should work closely with the police (TP).
- (16) Because a high percentage of sexually abused children become sexually exploited children, it is important to break this cycle of abuse and exploitation by providing timely treatment to sexually abused children (TP).
- (17) Schooling should be provided for sexually abused and sexually exploited children (TP).
- (18) Psychosocial counselling services should be provided for sexually abused and sexually exploited children and their families. These services should be provided not only in urban areas but also in rural areas and at the grass-roots level (TP).



- (19) Care providers should be properly trained in child development, child psychology and child health, with a particular emphasis on working with sexually abused and sexually exploited children, so that these care providers may be able to meet the psychosocial and medical needs of such children (T).
  
- (20) Research institutes should be established that would collect and analyse statistics on sexually abused and sexually exploited children in order to provide policy recommendations for the government. These research institutes and other qualified organizations should conduct research in those provinces of Viet Nam that have not been covered by the current report. Furthermore, these institutes and organizations should conduct research on children who have been sexually abused and sold into prostitution by their parents or close relatives and/or children who have been sexually exploited over a long period of time (R).



## ANNEX I:

# Interview Guides and instructions for filling in the Interview Guides

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There are four interview guides and one observational guide:

A. Interview Guide for project managers/coordinators

This includes questions on the organization in general, including the type and qualification of staff. There are also general questions on sexually exploited and sexually abused children and youth. Use the 'Health Inventory' as a guide to establish the most common health problems.

B. Interview Guide for health/social care providers

Observational Guide at the health/social care facility

You should interview those who have direct contact with sexually abused and sexually exploited children and youth on a day-to-day basis in government and non-governmental programme, such as social workers, nurses, medical doctors etc. The Interview guide includes specific questions on work tasks and needs of sexually abused and sexually exploited children and youth as perceived by caregivers.

Use the 'Observational Guide'. The Health Inventory should also be used as a guide to establish the most common health problems of the children and youth.

C. Interview Guide for teachers

Contains specific questions for teachers who have direct contact with sexually abused and sexually exploited children and youth.

D. Interview Guide for children, on factors affecting health

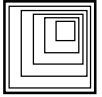
Interview Guide for children on factors affecting care utilization

These Guides also include some pointers on probing a young person's background and their history of sexual abuse and/or sexual exploitation



Use the Health Inventory to establish the health problems of the children and youth. When Questioning children, explore the use of diagramming techniques to complement verbal responses (see materials on participatory rural appraisal (PRA) methods with children).

- For each organization with direct services for sexually abused and sexually exploited children and youth, you will be required to fill in Interview Guides A, B and D. If the organization has a non-formal or vocational school, then you will also fill in C. If children attend a school situated close to the organization, find out the name of the school and the grade (class level) of most of the sexually abused and sexually exploited young people and make arrangements to interview the teachers who teach those grades/classes.
- Please write as clearly as possible, preferably in BLOCK LETTERS. If possible, enter the information into the computer at the end of each day.
- Do not be discouraged if you cannot get answers to a question. Try to get as much information as you can. Remember, in qualitative research it is the richness of the discussions that counts.
- The 'Health Inventory' requires you to fill in the number between 1 and 5, choosing one alternative from the scale provided. With service providers you should only fill in the MOST COMMON health problems of the children under their care. When using the Health Inventory with the children, however, you should fill in ALL their health problems.
- It will take, on average, 10 days to conduct interviews in one location. Interview all service providers and not more than 20 sexually abused and sexually exploited young people in each research site.
- Ask for organization publications and review these for additional information.



## A. INTERVIEW GUIDE FOR PROJECT MANAGERS

NAME OF ORGANIZATION:

MAILING ADDRESS:

CONTACT PERSON/PROGRAMME:

TELEPHONE:

FAX:

E-MAIL:

TYPE OF ORGANIZATION:	Governmental University Religious	Non-governmental Hospital/Clinic Other, specify
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DATE OF ESTABLISHMENT:

BRANCHES/CENTRES:	No use separate interview guides for each centre	Yes (list + address)
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- 1.
- 2.
- 3.
- 4.
- 5.

ORGANIZATIONAL STRUCTURE:  
(sketch on separate paper if more space required)

WORK STRUCTURE:

ANNUAL BUDGET:

BUDGET ALLOCATED TO EACH AREA OF WORK:

COMMENCEMENT OF CSEC/SA ACTIVITIES (month/year):

TOTAL NUMBER OF STAFF:  
(specify number in each area of work/profession)



**PREFERRED AGE OF WORKERS:**  
(specify area of work/profession)

**PREFERRED SEX OF WORKERS:**  
(specify area of work/profession)

**NUMBER OF PAID STAFF:**  
(specify number in each area of work/profession)

**PROFESSION OF PAID STAFF:**  
(specify for each area of work/profession)

**SALARY LEVEL:**  
(specify for each area of work/profession)

**NUMBER OF VOLUNTEERS:**  
(specify number in each area of work/profession)

**PROFESSION OF VOLUNTEERS:**  
(specify area of work/profession)

**CRITERIA FOR SELECTION (what do they look for in their staff?):**  
(specify area of work/profession)

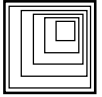
**MINIMUM EDUCATIONAL QUALIFICATIONS:**  
(specify qualifications for area of work/profession)

**MOTIVATION (what makes the workers stay):**  
(specify motivation for each area of work/profession)

**STAFF BENEFITS (e.g. housing, transport, medical insurance):**  
(specify benefits for each area of work/profession)

**OPPORTUNITIES FOR STAFF DEVELOPMENT**  
(e.g. training, supervision and support):  
(specify opportunities for each area of work/profession)

**SUMMARY OF WORK AND SIGNIFICANT ACHIEVEMENTS:**  
(ask for brochure and annual report(s) if available)



PROGRAMME OBJECTIVES:

TYPE OF SERVICES/CARE PROVIDED:

FACILITIES AVAILABLE:

NUMBER OF CHILDREN AT TIME OF INTERVIEW:

TOTAL NUMBER CARED FOR IN PROGRAMME:

TARGET GROUP:

(e.g. street children; indicate if children from specific ethnic groups are targeted)

AGE GROUP:

SEX:	Female	Male
	Both	

LENGTH OF STAY AT INSTITUTION:

DURATION OF CARE/SUPPORT:  
(for those not in institutions)

HOURS OF SERVICE (when do they open and close?):

COMMON HEALTH PROBLEMS/NEEDS OF CHILDREN:  
(see physical and psychosocial inventory)

HOW ARE THEY DEALT WITH:

DIFFICULTIES ENCOUNTERED IN DEALING WITH CHILDREN:

DAILY ACTIVITIES:  
(describe a typical day at the institution)



WEEKLY/MONTHLY/ANNUAL ACTIVITIES:

WHAT IS REQUIRED OF BENEFICIARIES:

MAIN SOURCES OF FUNDS:

MONITORING AND EVALUATION OF PROGRAMMES:

METHOD OF FOLLOW-UP OF BENEFICIARIES:

COLLABORATING AGENCIES:	Governmental	Non-governmental
	University	Hospital/Clinic
	Religious	Community
	Other, specify	

SPECIFIC AREAS OF COLLABORATION:

STRENGTHS OF THE ORGANIZATION:

CONSTRAINTS:

FUTURE PLANS:

INFORMATION/DOCUMENTATION AVAILABLE:  
(Please list all materials available. Use additional paper if necessary)

***Unpublished papers/reports:***

***Published papers/reports/books:***

***Bibliographies:***

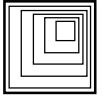
***Training materials:***

***Videos:***

***Posters:***

***Others:***





ONGOING AND/OR PLANNED RESEARCH:

METHOD OF DISSEMINATING INFORMATION LISTED ABOVE:

WHAT IMPORTANT THINGS SHOULD CHANGE IN YOUR COUNTRY TO  
PREVENT SEXUAL EXPLOITATION AND SEXUAL ABUSE OF

CHILDREN?

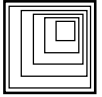
WHAT MEASURES IN YOUR OPINION SHOULD BE TAKEN TO HELP  
SEXUALLY EXPLOITED AND SEXUALLY ABUSED CHILDREN TO CHANGE  
THEIR SITUATION?

IS THERE ANYTHING ELSE YOU WISH TO ADD?



## B. INTERVIEW GUIDE FOR HEALTH/SOCIAL CARE PROVIDERS

- What is your profession and in which service do you work?
- How long have you worked in this organization? And in this particular service?
- Why do you work in this particular service and how did you begin? What motivates you?
- Are there things you would like to change in your present work?
- What proportion of your patients are sexually exploited or abused children? What proportions of these are male or female?
- What are the most common health problems among the children you see? Among girls? Among boys? (use the health inventory)
- Do you encounter problems associated with or arising from: sexual relations, pregnancy and childbirth, induced abortion, sexually transmitted diseases including HIV infection, AIDS, substance abuse, psychological disorders, developmental delays?
- What difficulties do you face dealing with these children?
- What interventions are included? Play therapy, social skills training etc?
- What procedure do you follow after admitting a child to your centre?
- Do you provide contraceptives or contraceptive information? Do you provide condoms for the prevention of STD/pregnancy? Does your service provide abortion to the children?
- How does a child of either sex have access to your service? Is it through referral or can she/he come directly? Is an appointment necessary? Is the consent of an adult or partner necessary?
- Are some services restricted by age, sex, marital status, ethnic group or citizenship?
- How do you deal with children who cannot be catered for in your programme?
- In a case of referral, where do you refer? How do you follow up the children?
- Do you receive children referred from other centres/organizations?
- To what extent is the service confidential? How many people within the service will have access to the child's name and/or file? Is the individual's name reported for some health matters to others subsequent to the visit?
- Do the children express satisfaction after visiting the service? How is this communicated?



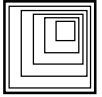
- What are the main barriers to the use of your service by children and what, in your view, could be done to overcome them?
- To what extent do you believe the health problems of sexually abused and exploited children are preventable?
- What, in your opinion, could be done in your service to make it more accessible to sexually abused and exploited children in need?
- What, in your opinion, could be done in your service to make it more effective for sexually abused and exploited children in need?
- Have you had any special training to deal with the special health problems of sexually abused and exploited children? If you have not, would you like to have that opportunity?



## HEALTH/SOCIAL CARE FACILITY DIRECT OBSERVATION

***Direct observation to assess how health services are actually provided when children are clients. Assess the level and quality of services they receive by using children as clients.***

- What (health) services exist, for whom, where, when, why, how much?
- Who brings the children to the (health) centre?
- How accessible is the (health) centre in terms of location?
- Does the centre have a waiting room for children/service users?
- Do the children/service users encounter problems in getting somebody to attend to them?
- For how long do they wait before they are attended to?
- Do they feel at ease with the environment?
- Are there enough posters in and around the premises? What types?
- How explicit are those posters?
- Does the centre have beds, do children have to leave after being attended to or both?
- If they have to leave, how does it deal with serious cases?
- In case of admission, what procedures are followed?
- In a case of referral, where do they refer?
- In which situations do they refer?
- How do they treat cases of referral from other (health) centres?
- What other follow-up do they use after a child/service user leaves the centre?
- Do they have special rooms to deal with children/service users who have personal problems, that is, with more privacy for discussions?
- How many types of services do they offer at the same time?
- Are there specific provisions for dealing with sexually abused and exploited children?
- What are the facilities available at the centre and what are they short of?
- Can the children using the (health) centre come without appointment?
- Do they require anything from the child before they are attended to?
- How do they assist those who cannot, for instance, fill in forms?
- Do they pay for the treatment/service? Do they pay before or after receiving the treatment/service? How much?



- How are children/service users who cannot pay immediately treated/ provided care?
- What are the characteristics of the children using the service with regard to age, sex, marital status?
- What difficulties do they face in presenting their problems?
- Do they make their requests (personal and medical) known to the (health) workers?
- What are the characteristics of the (health) workers with regard to age, sex and training?
- What is the approach or general attitude of the (health) workers to their duties and the children/service users?
- Are the (health) workers approachable?
- Apart from providing health and social services, do they give advice to patients when necessary, especially sexually abused and exploited children?
- How do the (health) workers decongest the centre of those who are not service users?
- How are the children taken care of in terms of feeding?
- Are there hawkers around who sell food to children/service users who are hungry in the course of receiving treatment/care?

***State of physical structures, care and interactions***

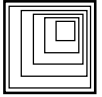
- Number of buildings and size
- Condition of buildings
- Facilities available: telephone, cooking, bathroom and toilet, sleeping arrangements, clothing, recreation (games, toys and books)
- Approach and attitude of caregivers to their duties and children
- Quality of care, hygiene, health and nutrition
- Do children show sign of psychological neglect, inadequate stimulation, malnourishment?
- Does the centre have any contact with community members?



Additional comments:

NAME OF INTERVIEWER/OBSERVER: .....

DATE AND PLACE OF INTERVIEW: .....



## C. INTERVIEW GUIDE FOR TEACHERS

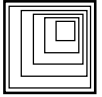
- What subjects do you teach? Where do you teach? What grade/age do you teach?
- What are the most common questions children have about sexual abuse and exploitation?
- Do you provide sexual, family life and reproductive health education or information on sexual abuse and exploitation to children?
- If so, of what age and sex?
- Have there been opportunities to involve young people in outlining the education course, and have you made use of young people in any subsequent modifications?
- Have parents been involved in the development or implementation of the activities?
- What are the major lessons you have learned about what makes the education effective?
- Are there opportunities for students to practise skills that would assist them to communicate their feelings and wishes assertively, request assistance, respond to persuasion and deal with threats and violence?
- Do you find it difficult to address issues of sexual abuse and exploitation?
- Do the children find it difficult to discuss these issues?
- What differences in behaviour do you find between the younger and older children?
- What differences in behaviour do you find between the sexes?
- Have you had any special training to deal with sexual abuse and exploitation? If you have not, would you like to have that opportunity?
- Is specific information provided about local health and social services which could meet the needs of sexually abused and exploited children?
- Does the education provide field visits to local health and social services and places where children are engaged in sexual exploitation?
- Is individual counselling provided by you or others in the school which covers sexual abuse and exploitation?
- Have you come across children who are sexually abused or exploited in your school?
- How were they identified and what action was taken?
- Do these children have learning and/or concentration difficulties? Probe for forgetfulness, uneven levels of concentration and difficulties in undertaking simple tasks.
- Do these children socialize with other children in the school easily?
- What other problems do they have that differ from those experienced by other children in your school?
- In your opinion, can the school and teachers play an important role in preventing sexual abuse and exploitation of children? If no, why not? If yes, how?
- What role can the school/teachers play in the reintegration of children who have been sexually abused and/or exploited?



## **D. INTERVIEW GUIDE FOR CHILDREN – FACTORS AFFECTING HEALTH**

- Tell me about yourself. Probe for age, family and educational background, ethnic group, type of work. (See separate paper on page 15 for pointers)
- Describe in detail the setting in which the children live
- Describe in detail the setting in which the children work
- What do you like/dislike about your work?
- Can you leave if you wish to?
- What are your dreams and future aspirations?
- Do you ever think of returning to your family and/or marriage?
- How often do you visit your family?
- What are your daily activities from the moment you wake up to the time you go to sleep? Probe for working/sleeping hours
- Do you have a day off? How do you spend your free time?
- How much money do you earn? How much is kept by the brothel/bar owner and how much do you receive? Do you share the money you earn with others? How much and how often?
- How much of this money do you send to your parents/family?
- At what age did you enter commercial sex? At what age were you sexually abused?
- Were you forced, sold or did you enter “willingly”? If sold or forced, by whom?
- Were any of your family members or close friends and relatives involved? How?
- How long have you been working?
- What type of sexual exploitation are you involved in?
- Do you have someone to turn to for support when in need?
- Do you have friends? How do they define them?
- Do family members, friends and service providers approve of the work you are doing? Why? How is it communicated?
- Have you been physically or sexually abused at your place of work? By whom? How did it happen?
- How many clients do you have per day? Describe them. Probe for age, sex, profession, nationality of the client.
- Do you use condoms during sexual encounters?
- Do you use them all the time or only with some people? If selective, which people and why?



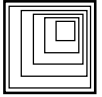


- Have you suffered from STDs previously? or/and been pregnant?
- What did you do? Probe for the decision to abort or deliver the child and how it was made.
- Did you seek care? Where? What was the reaction of your friends, family members and service providers?
- Have you ever taken any substances? Do you take any currently? If yes, which ones?
- Why do you choose these particular substances? Probe for effects, availability and cost.
- What is/are the slang name(s)? How do you take the substance(s)? Probe for methods of using substances.
- How frequently do you use it/them?
- Do different types of children prefer different substances? Probe for substances used by younger/ older children; boys/girls and children in various work contexts.



## INTERVIEW GUIDE FOR CHILDREN – CARE UTILIZATION

- What are your medical, psychological and social needs?
- How are your needs/complaints handled by caregivers?
- What preventive methods do you use?
- When do you use health services? Drop-in centres? Rehabilitation centres?
- How frequently do you visit these services?
- When was the last visit? Did you go alone? If no, who accompanied you and why?
- How do you know about these facilities?
- What do you get in terms of services, supplies and advice when do you go there?
- Are there services you do not go to?
- If yes, why? If no, why? Probe for accessibility and acceptability.
- What would you suggest for improving the situation?
- When was the last visit to a doctor?
- What was the diagnosis and length of treatment?
- Was the care and medicine provided free of charge or was there a fee paid?
- If you paid, how much was it and who paid?
- Do you use medicines which were prescribed or suggested by others?
- What kind of help would you wish to have?
- Do you have any recommendations to prevent sexual exploitation and abuse of children in your country?
- What measures should be taken to help victims at various stages of sexual exploitation and sexual abuse?



## **PROBING THE CHILD'S BACKGROUND AND HISTORY OF ABUSE/EXPLOITATION**

### History of sexual exploitation/abuse

description of the child victims in terms of age, sex, socio-economic background, educational level, parents' occupation and educational background, family size, number of siblings, their age and sex, position of victim in family etc

### Who the molesters/agents are

are they adults, strangers, neighbours, someone they know, family members, employers? Probe on how abuse/exploitation took place and the possible reasons. (e.g. a possible cause in domestic sexual abuse is poor marital relationships, death of mother, separation of parents).

### Age when molested or when entered commercial sex?

### Duration and type of sexual abuse/exploitation

did it only happen once or was it recurrent? Did the sexual abuse include genital penetration or was it only playing/fondling with genitals? Were the children threatened if they disclosed the abuse/exploitation?

How did they stop/end the sexual abuse/exploitation? What was the reaction of peers, teachers, family members, caregivers, officials etc?



# Physical Health and Psychosocial Well-being Inventory

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Name of organization: .....

Age-range of children: .....

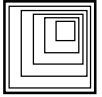
Sex of children: .....

Fill in a number between 1 and 5 choosing one alternative from the scale below:

1. Not at all/never
2. Rarely
3. Sometimes
4. Frequently
5. Very frequently

## PHYSICAL HEALTH PROBLEMS

	<i>Female</i>					<i>Male</i>				
	1	2	3	4	5	1	2	3	4	5
Sexually transmitted diseases										
Early childhood diseases										
Gastrointestinal illness										
Fatigue										
Skin Infections										
Ear Infections										
Respiratory Infections										
Allergies										
Chest Pains										
Sleep Disturbance										
Bed wetting										
Nail biting										
Accident Proneness										
Lack of appetite										
Overeating										
Grittled Teeth										
Headache										
Dizziness										
Infected wounds										
Back pains										
Fever/colds										
Body lice										
Body cleanliness										



Name of organization: .....

Age-range of children: .....

Sex of children: .....

Fill in a number between 1 and 5 choosing one alternative from the scale below:

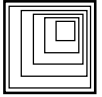
1. Not at all/never
2. Rarely
3. Sometimes
4. Frequently
5. Very frequently


**PSYCHOSOCIAL WELLBEING**

	<i>Female</i>					<i>Male</i>				
	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
Fearful										
Anger and Frustration										
Guilt/Self Blame										
Sadness										
Concentration Difficulties										
Forgetfulness										
Lack of self confidence										
Anxious										
Difficulty in making decisions/ planning for the future										
Tearful										
Suspicious										
Restless										
Aggressiveness										
Irritability										
Tantrums										
Attention-seeking										
Blank stares										
Afraid to be alone										
Overactive										
Provoking others										
Jealousy										
Prefers to be alone										
Quarrelsome										
Lying										
Running-away										




	<i>Female</i>					<i>Male</i>				
	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
Substance abuse										
Stealing										
Over sexualized										
Suicidal										
Destructive of other and/or property										
Lack of motivation										
Self-rejection										
Excessive Emotional Attachment										
Language and Communication Difficulties										
Loneliness										
Uneven levels of alertness										
Present time orientation										
Sense of floating										
Inability to ground themselves in reality										
Escape in sleep										
Feeling trapped										
Feelings of humiliation										
Self-injury/self mutilation										
Feelings of despair										
Sexual aggression										
Feelings of dejection										
Poor concentration										
Low self esteem										
Physical aggression										
Feeling powerless										
Threatening others										



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**Children in Especially Difficult Circumstances**

**Module One: Social Context of Children in Especially Difficult Circumstances (CEDC)**

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**CEDC – A DEFINITION**

- First used by UNICEF in 1986, with the idea of “CEDC” seen as describing certain categories of children in need of additional services.
- 1996, UNICEF moved from the idea of CEDC to the idea of “especially difficult circumstances” that cause gross violations of the rights of children, and the need of special protection measures.
- 18 years is the age defined by the Convention on the Rights of the Child as the outer limit of childhood.

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**IMPORTANT ASPECTS OF CHILD DEVELOPMENT THAT ARE GREATLY IMPAIRED ARE:**

- Physical development, including the overall health coordination, strength, vision, hearing, etc., need to survive and contribute to adulthood.
- Cognitive development, including literacy, numeracy, basic cultural knowledge, vocational skills, and other knowledge required to live a reasonably successful life.
- Emotional development, including adequate self-esteem, family attachment, feelings of love and acceptance, etc., necessary to establish and maintain family ties as an adult.
- Social and moral development, including a sense of group identity, ability to cooperate with others, distinction of right from wrong, respect for laws, respect for the property and person of others, and other capacities needed to live successfully within a social context.

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**CATEGORIES OF CHILDREN IN ESPECIALLY DIFFICULT CIRCUMSTANCES**

1. Street Children.
2. Child Labourers.
3. Children with Disabilities.
4. Child/Adolescent Mothers.
5. Child Brides.
6. Children of Imprisoned Mothers.
7. Children in Armed Conflicts.
8. Sexually Abused Children.
9. Sexually Exploited Children.
10. Children with/and Affected by AIDS.

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**CATEGORIES OF ESPECIALLY DIFFICULT CIRCUMSTANCES**

- Child Labour;
- War and Other Forms of Organized Violence;
- Sexual Abuse and Exploitation of Children;
- Childhood Disabilities;
- Loss of Family and Primary Care givers; and
- Deficient Laws and Juvenile Justice System.

children are often subjected to many difficult circumstances at once; and certain sets of circumstances reinforce others. For example, some type of employment such as domestic work makes children vulnerable to sexual exploitation.

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**CIRCUMSTANCES OF CHILD LABOUR**

- This includes economic exploitation and any other circumstance under which children perform paid or unpaid work that might be directly detrimental to their development, or that might prevent them from exercising their other rights, including the rights to education, health and leisure.
- Circumstances of abusive child labour are found in the formal and informal work sectors, including the streets, markets, households of employers or children's own households.

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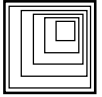
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**CIRCUMSTANCES OF WARFARE AND  
OTHER FORMS OF ORGANIZED OR  
LARGE-SCALE VIOLENCE**

- Forced migration;
- Involuntary separation from the family; and
- Recruitment of children into the armed forces, the militia and guerilla cadres, or organized crime networks or gangs.

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**CIRCUMSTANCES OF SEXUAL ABUSE  
OR EXPLOITATION**

Any sexual commerce involving children (including trafficking, prostitution and pornography), or any use of children for the non-commercial sexual gratification of adults, including child marriage.

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**CIRCUMSTANCES OF SEXUAL ABUSE  
AND/OR EXPLOITATION**

- Sexual abuse is any sexual contact:
  - Between an adult and a sexually immature child for the purposes of the adult's sexual gratification;
  - With a child and made by force, threat or deceit to secure the child's participation;
  - In which the child is incapable of consenting by virtue of age or power differential and the nature of the relations with the adult.

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**SEXUAL EXPLOITATION**

- Child prostitution.
- Trafficking.
- Pornography.

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**CIRCUMSTANCES OF DISABILITY**

- Vaccine-preventable diseases;
- Pregnancy and delivery complications;
- Those stemming from malnutrition caused by iodine or vitamin A deficiencies; and
- Those caused by accidents, warfare or violence.

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**CIRCUMSTANCES OF TEMPORARY OR PERMANENT LOSS OF FAMILY AND/OR PRIMARY CARE GIVERS**

- The death of family members.
- Incapacity of family members.
- Family breakdown caused by divorce, incarceration of a parent or care giver, or separation.
- Separation due to armed conflict and disasters.

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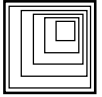
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**CIRCUMSTANCES OF DEFICIENT LAWS AND/OR ABUSIVE LEGAL AND JUDICIAL PROCESSES**

- Systems that arbitrarily or improperly deprive children of liberty;
- Legal systems and law enforcement agencies that fail to protect children from maltreatment or abuse;
- Systems that deprive children of identify due to a deficient or non-existent vital registration system; or
- Systems that allow the sale and trafficking of children and adoption that is not in the best interest of the child.

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**SHOULD WE USE THE DESCRIPTOR CEDC AND THE CATEGORIZATION OF CHILDREN INTO GROUPS?**

- To define children by the circumstances that have negatively affected them is to characterize them as deviant from social norms instead of recognizing that they are victims of socially deficient structures and policies.
- Labeling is disliked by the children themselves because it reinforces negative social attitudes towards them.
- It is difficult to avoid categorization of children in especially difficult circumstances for purposes of coherent analysis and programmatic design.
- The categorization helps in the development of a perspective for assessing the different especially difficult circumstances in which children live and for arriving at appropriate programmes to meet the needs for special protection measures.

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**SOME GLOBAL ESTIMATES**

- 10 million – 100 million street children depending on definition used (UNICEF, 1991).
- 100 million – 200 million children in developing countries are involved in child labour (ILO).
- In war alone, over the past decade:
  - 4-5 million children have been disabled.
  - 12 million children have been left homeless.
  - More than one million have been orphaned or separated from their parents.
  - 10 million have been psychologically traumatized.

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**SOME GLOBAL ESTIMATES**

- Over two million children enter child prostitution every year. (UNICEF, 1995)
- 10 million children are victims of today's sex industry. (UNICEF, 1995)
- 120 million – 150 million children with disabilities. (WHO)
- 3 million children have lost one or both parents due to AIDS. (WHO)

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**SOME GLOBAL ESTIMATES**

- Global estimates of numbers of children affected in various categories of circumstances should be treated with caution.
- Estimates are useful as indicators of the magnitude of the problem.
- The design of programme policies and strategies should be based on national and local research and analysis of both quantitative and qualitative information.

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**CAN WE NUMBER THEM?**

- It is difficult to estimate the numbers of children affected by any particular circumstance due to the deficiencies in understanding what data are needed and devising the best methods to collect it.
- It is difficult to arrive at exact numbers because the circumstances that place children in need of special protection are often illegal, therefore, hidden from public view, making them hard to uncover and research.
- In many countries the government authorities responsible cling to very low estimates apparently in an effort to deflect criticism at home and abroad.
- Estimates now widely used are inadequate because they are rarely disaggregated by age, although the age of the child in question is a key determinant of degree of risk, vulnerability, exploitation and potential long-term damage.
- Statistics are rarely disaggregated by sex, which prevents better understanding of abusive practices based on gender discrimination, including the disproportionate neglect or abandonment of girl children.

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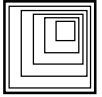
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**LEVELS OF POTENTIAL ACTIONS**

- Prevention of especially difficult circumstances – primary prevention focusing on the main child population;
- Reduction of risk for the especially vulnerable and those with impairments – secondary prevention;
- Compensatory support for groups of especially disadvantaged children whose situation is fluid or whose emergency circumstances can be relieved; and
- Rehabilitation for children with conditions of permanent disability.

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**PRIMARY PREVENTION**

1. Policies and laws.
2. Provision of basic services.
3. Provision of information and education.
4. Training on CRC, work ethics, parenting, child care, etc.

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**SECONDARY PREVENTION**

1. Increasing opportunities for school attendance.
2. Providing poor families with vocational training.
3. Early detection of impairment.
4. Telephone crisis line.
5. Reducing prospects of family separation during war.

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**TERTIARY PREVENTION**

1. Support services for those in fluid situations, e.g., providing schooling and information in the workplace.
2. Treatment programmes (including (re)habilitation).
3. Inclusion of children in mainstream services.
4. Social and economic (re)integration.

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**REHABILITATION**

1. Disability.
2. Mental impairment from drugs and alcohol use.
3. Absence of families or effective ties.
4. Criminal behavior.
5. Persistent conflicts with the law.

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**REQUIREMENTS OF A REHABILITATION PROGRAMME**

1. A one-one-one casework.
2. To establish and maintain safety and security.
3. To re-establish normal, daily life.
4. To re-establish significant attachments and alternative care arrangements.
5. To provide the opportunity to express feelings and discuss worries in a supportive environment.
6. To re-establish self-esteem.
7. To provide a secure economic base.
8. To prevent further abuse and exploitation.
9. To provide community-based services.

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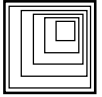
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**OTHER ACTIONS**

- Research.
- Training.
- Advocacy.
- Creation of Networks.

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**RESEARCH**

- Development of approaches whereby children and families are protected from especially difficult circumstances and disease prevention and treatment as well as rehabilitation of those already experiencing difficult circumstances.
- Development of methods of measuring changes in the degree of disadvantage affecting children and assessing the effectiveness of programmes relevant to CEDC.
- Research institutes and NGOs with local organizations taking the primary role and with the participation of the children.
- Children themselves must be the primary source of information on circumstances of disadvantage.
- Research approaches have to be primarily qualitative.

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**RESEARCH**

- Especially difficult circumstances such as childhood mental and multiple disabilities; children in institutions and children working in agriculture and other invisible occupations such as domestic service, accommodation and catering.
- Children's downward progression from circumstances that place them at risk into more permanent conditions of special disadvantage.
- Link between child work on the streets and the tendency towards criminal behaviors.
- Push and pull factors leading teenagers towards certain settings to become victims of sexual exploitation.

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**ESCAP Project on Sexual Abuse  
and Sexual Exploitation of Children  
and Youth in the Greater Mekong  
Subregion (GMS) and South Asia:  
Research and Intervention  
Phases**

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**PRESENTATION CONTENTS**

1. Objectives
2. Methodology
3. Main findings
4. Main recommendations

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**OBJECTIVES**

- To collect and analyse existing information on sexual abuse and sexual exploitation of children/ youth
- To identify their common health (medical and psychosocial) problems and needs
- To explore the range of services available to these children and the service capacity of different agencies

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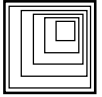
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**11 PARTICIPATING COUNTRIES**

- **Greater Mekong Subregion (GMS):**
  - Cambodia, China (Yunnan Province), Lao PDR, Myanmar, Thailand, Viet Nam
- **South Asia:**
  - Bangladesh, India, Nepal, Pakistan, Sri Lanka

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**METHODOLOGY**

- Developed by CEDC Expert from Uppsala University, Sweden
- Based on qualitative research methodology she has successfully used in Kenya and Thailand for street children and children in prostitution

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**METHODOLOGY**

- Qualitative
- Primary research based on target group needs
- Approach: learn from children and care providers

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**TARGET GROUP**

- Primary: Sexually abused and sexually exploited children and youth under age 18
- Secondary: Health and social care providers

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**DEFINITIONS**

- **Sexual abuse:**
  - Rape and incest
- **Sexual exploitation:**
  - Prostitution, trafficking, pornography
- **Children:**
  - Those under age 18

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**NATIONAL RESEARCH TEAM SELECTION**

- National research teams in all 11 countries
- Researchers from diverse backgrounds
- Researchers with some experience in research and working with young people

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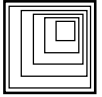
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**RESEARCH SITE SELECTION**

- Rural and urban areas
- Large numbers of children in prostitution
- Areas of origin, transit and/or destination for trafficked children

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**RESEARCH TEAM TRAINING**

- Trained by ESCAP and Uppsala University on data collection methods and techniques
- Taught to establish trust and friendship with children and care providers
- Familiarized with “snowball” sampling techniques

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**“SNOWBALL” METHOD**

- Identifies a few victims to begin the interview process
- Relies on them to expand contacts with other victims
- Consult with other community sources to avoid sample bias

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**PRIMARY DATA COLLECTION**

- 727 children (260 in GMS + 467 in South Asia) with history of sexual abuse and exploitation and those at risk were interviewed
- Adequate sample size obtained when data revealed consistent information patterns
- Such data reliable in explaining behavioral trends

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**ACCESSING THE TARGET GROUP**

- Surveyed brothel areas
- Went undercover
- Reviewed medical and police records
- Consulted care providers, friends and relatives of sexually abused/exploited children, brothel owners

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**INTERVIEWS WITH THE CHILDREN**

- The ESCAP/Uppsala University team members advised researchers to:
  - Reveal true identity
  - Explain interview purpose
  - Obtain child's consent before interviewing
  - Use a tape recorder only when trust established

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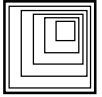
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**DATA COLLECTION METHODS**

- Documentary analysis
- Observation
- In-depth, semi-structured interviews
- Group discussions
- Questionnaires

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**PROBLEMS ENCOUNTERED**

- Lacked sufficient time to establish adequate trust with children
- Some children were shy and reluctant to talk
- Male researchers had difficulty asking girls about sexual health

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**PROBLEMS ENCOUNTERED**

- Sexual abuse cases hard to identify
- Some researchers harassed
- Some brothel owners did not cooperate
- Cultural taboos and illegal nature of sexual abuse and sexual exploitation made open discussion difficult

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**MAIN FINDINGS**

- Sexual Abuse and Sexual Exploitation

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**SEXUAL ABUSE: MAIN FINDINGS**

- Prevalence:
  - Occurs in all countries
  - Most hidden and unreported form of sexual violence against children
  - Cuts across all socio-economic classes
  - Issue not widely discussed

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**SEXUAL ABUSE: WHO ARE THE VICTIMS?**

- Girls more vulnerable than boys
- Age: 6-12 years in GMS and 10-15 in South Asia
- Male victims generally younger than females
- Dysfunctional families

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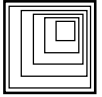
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**SEXUAL ABUSE: WHO ARE THE VICTIMS?**

- Many parents abused substances
- Thailand: Children with developmental disabilities more at risk
- South Asia: Street children, child domestic workers and child

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**SEXUAL ABUSE: WHO ARE THE PERPETRATORS?**

- Usually a family member or close relative/ neighbour
- Others included home tutors, babysitters and domestic help
- Often substance abusers

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**SEXUAL EXPLOITATION: MAIN FINDINGS**

- Prevalence:
  - Occurs in all countries
- Push factors:
  - Poverty
  - Low educational levels of families and victims
  - Dysfunctional families
  - Socio-cultural norms

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**SEXUAL EXPLOITATION: OTHER CONTRIBUTING FACTORS**

- Local demand plus international sex tourism
- Well-established trafficking networks
- High premium on virginity (seen to enhance virility in men)
- Demand for younger children believed free of HIV/AIDS
- History of sexual abuse

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**SEXUAL EXPLOITATION: WHO ARE THE VICTIMS?**

- Girls and boys in all countries
- Majority nationals aged 13 to 17
- Some refugees or victims of cross-border trafficking

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**SEXUAL EXPLOITATION: WHO ARE THE VICTIMS?**

- Girls more visible, except in Sri Lanka & Pakistan (NWFP)
- Majority entered "willingly"
- South Asia: majority forced

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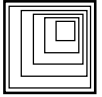
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**SEXUAL EXPLOITATION: WHO ARE THE PERPETRATORS?**

- Majority nationals
- Except in Sri Lanka, where sex tourism was prevalent source
- Variety of backgrounds

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**VICTIMS: PHYSICAL HEALTH**

- Variety of backgrounds
  - High rate of STDs, including HIV/AIDS
  - Poor nutrition and hygiene
  - Poor general health (frequent colds, fever)
  - Genital tearing
  - Unsafe abortions
  - Unwanted pregnancies
  - Substance abuse

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**VICTIMS: PSYCHOSOCIAL HEALTH**

- Behavioural problems
  - lying, withdrawal, chronic bed-wetting, aggression
- Emotional problems
  - guilt, fear, depression, low self-esteem, sense of hopelessness, anxiety, feelings of humiliation
- High-risk behaviour
  - self-mutilation, suicide attempts, sexual promiscuity, substance abuse

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**AVAILABLE SERVICES**

- Grossly inadequate: limited or non-existent
- Low public investment
- Poorly trained staff
- Uneven service quality
- Focus on physical (not psychosocial) health
- Urban concentration
- Mostly by NGOs/private practitioners

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**COUNTRY HIGHLIGHTS**

- Bangladesh:
  - 68% forced into the sex trade
  - 86% of girls in prostitution: never attended school
  - 69% of children in prostitution: STD-infected
- India (Mumbai):
  - 61% of children in prostitution: no contact with the “outside world”
  - 63% of children in prostitution: no condom access
  - 80% of customers: never used condoms

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**COUNTRY HIGHLIGHTS**

- Nepal:
  - Sexual abuse of young girls in the workplace
  - Majority forced into prostitution
  - Many trafficked into India
- Pakistan:
  - 66.7% of girls sexually abused by family member or neighbour
  - 53.7% of boys sexually abused by teachers or strangers
  - In some provinces, boy prostitutes more prevalent
  - None of the children tested for STDs, incl. HIV/AIDS

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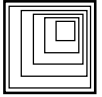
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**COUNTRY HIGHLIGHTS**

- Sri Lanka:
  - 74% of victims of sexual abuse aged 9-15
  - Majority of victims of sexual abuse: domestic workers
  - Sexual exploitation of boys fueled by international sex tourism (beach boys)

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**COUNTRY HIGHLIGHTS**

- Cambodia:
  - 98% of girls in prostitution: main providers for their families
  - 71% of girls: eldest child
  - 85% of victims: physically abused by brothel owners or clients
- China (Yunnan Province):
  - 78% of girls: worked as “pornographic attendants”
  - 30% of girls: prior history of sexual abuse

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**COUNTRY HIGHLIGHTS**

- Lao PDR:
  - Girls in prostitution: majority aged 14-18
  - Girls in prostitution: majority alcoholics
- Myanmar:
  - Girls in prostitution: lacked knowledge of contraceptives, condoms and HIV/AIDS

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**COUNTRY HIGHLIGHTS**

- Viet Nam:
  - 49% of girls in prostitution: victims of prior sexually abuse
  - 70% of sexually exploited children: STD-infected, incl. HIV/AIDS
  - One-third of children in prostitution: substance abusers

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**THAILAND HIGHLIGHTS**

- Sexual abuse:
  - Onset age: between 4 and 15 years
  - 77% abused by a relative (24%-uncle; 18%-stepfather)
  - 77% from broken homes
  - 53% from families with substance abuse problems

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**THAILAND HIGHLIGHTS**

- Sexual exploitation:
  - Boys: aged 6 to 10
  - Girls: aged 11 to 15
  - 80% from dysfunctional families
  - 31% prior history of sexual abuse

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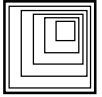
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**THAILAND HIGHLIGHTS**

- Physical Health:
  - 38% of sexually exploited children: STD-infected
  - 24% of sexually exploited children: malnourished
- Psychosocial Health
  - Sexually abused children: many had developmental disabilities
  - Sexually exploited children: 55% depressed, 55% felt hopeless, 31% were suicidal

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**THAILAND HIGHLIGHTS**

- Services:
  - Services concentrated in Bangkok
  - Demand for case management training
  - Caregivers overloaded
  - NGOs: major role in care provision

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**GENERAL OBSERVATIONS**

- Taboo
- Strong political commitment
- Limited service provider capacity
- Some governments deny problem
- Issue relegated to NGOs
- Pattern of blaming external parties
- Fear of losing face in international community

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### MAIN RECOMMENDATIONS

- Study recommendations concern prevention, protection, recovery and reintegration, cooperation and coordination

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### MAIN RECOMMENDATIONS

- **Prevention**
  - Governments should ensure compulsory, including non-formal, education for all children
  - Governments, NGOs and the media should undertake national and community awareness-raising campaigns on child rights, child sexual abuse and exploitation, and to break related taboos and stigmas, and prevent HIV/AIDS and substance abuse

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### MAIN RECOMMENDATIONS

- **Protection:**
  - Governments must enact specific legislation to address child sexual abuse and sexual exploitation
  - Laws should impose severe penalties on perpetrators and decriminalize victims
  - Governments should ensure strict law enforcement

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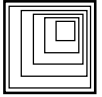
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**MAIN RECOMMENDATIONS**

- **Recovery and reintegration:**
  - Governments must allocate resources to develop and expand integrated services for victims
  - National personnel must be trained in service provision methods, including psychosocial treatment and prevention and treatment of substance abuse and HIV/AIDS
  - Programmes should be targeted at the individual, family and community levels

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**MAIN RECOMMENDATIONS**

- **Coordination:**
  - Multi-sectoral coordination (legal, law enforcement, social welfare, medical and education) is required to combat sexual abuse and sexual exploitation

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**HONOURING OUR COMMITMENT**

*"I wish that the government would close down all brothels and free the children"*

-15-year old victim of forced prostitution

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**ESCAP HRD COURSE ON PSYCHOSOCIAL AND MEDICAL SERVICES**  
**FOR SEXUALLY ABUSED AND SEXUALLY EXPLOITED CHILDREN AND YOUTH**



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**HONOURING OUR COMMITMENT**

Join us in combating sexual abuse and sexual exploitation of children and youth in Asia

Thank you

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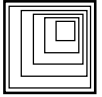
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