EXPERT PAPER

THE RECOVERY AND REINTEGRATION OF CHILDREN

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INTRODUCTION

Child sex trafficking and commercial sexual exploitation of children (CSEC) are major public health problems throughout the world. Some manifestations of CSEC include “prostitution, pornography, trafficking of children for sexual purposes and sexual exploitation during travel and tourism”. It is estimated that as many as 1.8 million children are exploited in prostitution or pornography worldwide.[1]

The UN Convention on the Rights of the Child (UNCRC) guarantees that children everywhere should live free from all forms of violence.[2] The UNCRC (Article 34) provides the right to recovery and reintegration of children from sexual exploitation. The purpose of the present paper is to understand the challenges in providing medical and psychosocial services to support the right to recovery and reintegration of child victims of sex trafficking and exploitation worldwide.

RECOVERY & REINTEGRATION OF CHILDREN FROM SEXUAL EXPLOITATION IN TRAVEL AND TOURISM

Developed Countries' Initiatives

The Council of Europe Policy guidelines on integrated national strategies for the protection of children from violence include their recovery, rehabilitation and social reintegration.[3] These guidelines support the promotion of a culture of respect for the rights of the child and encourage the setting up of child-friendly services and mechanisms. Sexual exploitation results in children suffering harm and causes significant damage to their physical and mental health. Some children and young people may be supported to recover

whilst others may suffer serious life-long impairments which may, on occasion, lead to their death.

In England, the Government has published specific statutory guidance, Safeguarding children and young people from sexual exploitation,4[4] to support local agencies in their effective application of the core inter-agency guidance, Working Together to Safeguard Children, used for all types of child abuse and neglect. It is intended to help local agencies develop local prevention strategies, identify those at risk of being sexually exploited, take action to safeguard and promote the welfare of particular children and young people who are being, or may be, sexually exploited and take action against those intent on abusing and exploiting children and young people in this way. This specialist guidance provides an example of what Governments can do by clearly setting out the roles and responsibilities of all professionals and agencies (statutory and NGO) in both preventing commercial sexual exploitation and addressing the needs of children affected by it.

Developing countries' experiences

In developing countries, child rights, protection and sexual exploitation are intimately linked to poor socioeconomic conditions in a huge population base.[5] The urban underprivileged, migrating population and rural communities are particularly affected. In large cities, there are serious problems of street children and child labourers. Children in difficult circumstances, such as children affected by disasters, those in conflict zones, refugees and HIV/AIDS, are also at risk of commercial sexual exploitation.[6] The interaction of poverty and gender-based violence in developing countries heightens the risk of sex trafficking and CSEC. Prevention efforts should work to improve economic opportunities and security for impoverished children, educate communities regarding the tactics and identities of traffickers, as well as promote structural interventions to reduce sex trafficking.[7] The South Asia Association of Regional Cooperation (SAARC) convention on preventing and combatting trafficking of women and children for prostitution was signed in January 2002; since then, better-targeted tools to combat child trafficking, strong policy commitments, exploitations of synergies between socioeconomic issues and human development efforts have been developed.[8] However, different contexts, socio-economic conditions and other drivers of child exploitation may require adaptation of developed country solutions or the creation of new prevention and management strategies.

In today's South Asia, globalisation is causing profound social and economic changes that challenge, and often undermine, traditional norms, while simultaneously creating a gateway for vast numbers of children to become victims of commercial sexual exploitation. Throughout South Asia, for example, marriages motivated by love are far outnumbered by those tied to traditions such as the dowry system. Poverty and traditional gender roles encourage families to rid themselves of daughters, as they are seen as an economic burden. The notion of family honour leads parents to marry their daughters off at a young age to avert potential "dishonour," in case the daughter strays. Each of these traditional practices increases the risk of sexual exploitation for girls. In combination with today's vastly expanded availability of technology, increased ease of crossing national borders and persistent failure to register children at birth, contribute to a favourable environment for the growth of commercial sexual exploitation of children (CSEC),[9] where prostitution of children, child trafficking, online exploitation and abuse and sex tourism are affecting all countries. In Sub-Saharan Africa, the sexual exploitation of children appears driven by poverty and the need to provide for oneself, and in many instances siblings, and other members of the family.[10]

MEDICAL EVALUATION

Medical evaluation of CSEC and sex trafficking is an emerging area of research and practice, and few healthcare settings have established screening practices, policies and protocols.[11] Victims of CSEC rarely self-identify, due to fear and shame as well as concerns about loss of income for oneself and/or family. Although some victims have no risk factors or obvious indicators, children at risk for CSEC may have a history of running away from home, truancy, child maltreatment, involvement with child protection services (CPS) or the juvenile justice system, multiple STIs, pregnancy or substance use or abuse issues.[12] Medical care may be sought for a variety of problems, including sexual assault, physical injury, infection, exacerbations of chronic conditions, complications of substance abuse/overdose issues, or pregnancy testing, contraceptive care and other reproductive issues. [13]Evaluations of CSEC victims may be challenging. Children are rarely forthcoming about their actual history and it requires patience and a secure environment to gain their trust. A comprehensive history related to injuries/abuse, reproductive issues, substance use and mental health symptoms should be obtained with a nonjudgmental and open attitude.

The medical examination and diagnostic evaluation should focus on the following: (a) assessing and treating acute and chronic medical conditions; (b) assessing dental health and care; (c) referral to appropriate sexual assault response team, with forensic evidence collection, as needed; (d) documenting acute/remote injuries, genital/extra-genital and skeletal fractures; (e) assessing overall health, nutritional status and hydration; (f) assessing for mental health issues; (g) testing for pregnancy, STIs and HIV; (h) urine and/or serum screening for alcohol and drug use, as clinically indicated; (i) offering contraceptive options, with particular focus on long acting reversible contraception; and (j) offering prophylaxis for STIs and pregnancy[12].

The physician should be aware of state laws regarding conducting medical evaluations (including sexual assault evidence kits) without guardian consent. In many cases, the guardian does not accompany the victim, and laws regarding consent to examination, photography, testing, treatment, and obtaining forensic evidence are complex. A second member of the staff should be present during the examination, and the child may want the person accompanying them to be present as well. However, if that person is a suspected exploiter, his or her presence should be avoided if at all possible. Children may need referrals for medical care, including gynecological care, family planning, obstetric care (for pregnant patients), human papillomavirus vaccination, drug rehabilitation, HIV prophylaxis monitoring and a mental health assessment.

MULTIDISCIPLINARY REFERRALS AND PSYCHOSOCIAL SERVICES

To provide for the many needs of the CSEC victim, all multidisciplinary professionals must comply with child abuse mandatory reporting laws and existing legislation in their regions/country.[14] Victims of CSEC are likely to have immediate non-medical needs (for example, for shelter, food, clothing and emotional support) and long-term needs (housing, education, life skills and job training, victim advocacy, family services). Transnational victims often need interpreter services and legal assistance with immigration issues. Existing child helpline services can be used to make appropriate referrals. Child abuse professional organisations may offer additional medical, psychosocial services, forensic interview, mental and behavioural health services. All necessary care and actions are conducted in such a way as to ensure no further harm to the child. Safety and security are emphasised in the World Health Organisation's recommendations for interviewing trafficking victims.[15]

The aim is to reintegrate these children back into childhood/adolescence and support their normal developmental growth and development. It is vital that children are enabled to participate in age appropriate activities, including attending school or college, and make friends within their own age group. A further priority for the child's care is the identification and provision of a safe house to enable the physical protection of the child. Those who exploit children commercially often threaten the child with severe consequences, if they try to leave the situation of abuse. This may present an on-going risk to the child, as well as to those who share or manage the child's placement. It must be remembered that children in this situation are treated as "saleable and valuable assets" by exploiters.

Psychosocial care must include a careful and detailed assessment of the child's psychosocial needs and the impact of the exploitation on the child in order to inform the focus of counselling. Each child requires individualisation in the process of psychosocial care, as trafficking and sexual exploitation is de-personalising and destructive of the child's sense of self. Counselling may include helping the child deal with difficult emotions such as betrayal of trust, a sense of disconnect from their own bodies due to the actual sexual exploitation and traumatic sexual acts, feelings of disempowerment, alienation in social relationships due to a sense of being different from peers, and reconnecting to and participating in family relationships if this appears safe for the child and appropriate. Depression is linked to the loss of childhood, family relationships, educational opportunities and is common as well as anxiety, which may be associated with fears about safety, acceptance by peers and family when family reunification is planned. Some children benefit from medication in order to reduce depression and anxiety to levels that enable them to make use of counselling.

CONCLUSIONS

Medical and psychosocial evaluation of CSEC is an emerging area of research and practice. There is an urgent need to establish healthcare settings with screening practices, policies and protocols to help the victims of CSEC within a multidisciplinary approach. These guidelines should support the promotion of a culture of respect for the rights of the child and encourage the establishment of child-friendly services and mechanisms. The aim of all interventions is to support these vulnerable children achieve their normal growth and developmental potential and experience age appropriate stages of their childhood/adolescence as well as being helped to recover from the traumatic effects of CSEC.

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