

**Expert Consultation on Public Health Strategies
to Prevent and Mitigate the Global Health Impact of Child Prostitution**

Convened by ECPAT-USA

April 11, 2002

- I. Background**
- II. Introduction**
- III. Purpose of the Consultation**
- IV. Summary of Clinical and Public Health Presentations**
- V. Summary of Organizational Presentations**
- VI. Report from Workgroup meetings (Programs and Services, Research, and Funding) and Action Steps**
- VII. Acknowledgements**

Appendix A: Full presentations by Consultants

Appendix B: List of participants

I. Background

Global efforts to address the exploitation of children through prostitution began in the 1980s. The obligations of governments to protect children from prostitution were incorporated into the Convention on the Rights of the Child, which was adopted by the UN General Assembly in 1989. Then, beginning in 1990, NGOs in Southeast Asia concerned with the rapid rise in foreign tourists who were sexually exploiting children formed the coalition End Child Prostitution in Asia Tourism (ECPAT). In 1996, ECPAT joined UNICEF and the government of Sweden to convene the First World Congress on the Commercial Sexual Exploitation of Children in Stockholm.

During the 1990s, the UN Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography produced numerous reports on various aspects of child prostitution. These reports, along with reports from the First World Congress, discussed the health problems of prostituted children, especially the risk of infection with HIV. Finally, in 2001, the Second World Congress Against Commercial Sexual Exploitation of Children was held in Yokohama, Japan.

During the past decade, community-based organizations and NGOs have provided medical care to prostituted children on a local basis, and limited data, most qualitative in nature, on the health problems of prostituted children were collected. While many groups recognized the health risks to these children, there has not been a comprehensive public health approach to studying the factors that put children at risk for prostitution, the global health burden of child prostitution, strategies to permanently protect children who are prostituted, or the need for long-term physical and psychological treatments for children who are recovering from being prostituted. This lack

of data has also contributed the absence of guidelines for the clinical treatment of prostituted children.

This consultation is one of the first efforts to convene representatives of organizations that provide social and medical services to prostituted children to identify public health and clinical action steps needed to address the health needs of these children.

During this consultation, participants shared findings from their clinical and programmatic experiences, addressed the need for research, services, and funding, and proposed action steps to prevent the health consequences of child prostitution. This report summarizes these findings and action steps.

The consultation was organized by representatives of the US chapter of ECPAT. Funding for the meeting was provided by UNICEF, the Fund for Nonviolence, the F. Felix Foundation, and the Oak Fund. The Mailman School of Public Health of Columbia University donated the facilities for the meeting.

II. Introduction

Dr. Wendy Chavkin, from the Columbia University's Mailman School of Public Health, welcomed participants to the Consultation. She thanked participants for being committed to eliminating the sexual exploitation of children and looked forward to progress in this area.

Ms. Carol Smolenski, from ECPAT-USA, welcomed the group and commended them on being the first to participate in such a gathering of experts focused solely on the myriad unmet health needs of prostituted children. Experts from around the world were present to discuss public health strategies designed to prevent and mitigate the health impact of child prostitution. Ms. Smolenski thanked the funders who made the Consultation possible: UNICEF, the Fund for Nonviolence, the F. Felix Foundation, and the Oak Fund.

III. Purpose of Consultation

Mr. Brian Willis, Health Advisor to ECPAT-USA, discussed the two purposes of the Consultation: (1) to identify the immediate clinical and public health steps needed to address the acute health needs of prostituted children and (2) to identify the long-term strategies to prevent child prostitution and its related health problems. However, where prevention is not effective, there must be effective interventions regarding health needs. Additionally, long-term treatment is needed as sexually exploited children recover. It was acknowledged that although child prostitution is a form of CSEC, in addition to trafficking and child pornography, the focus of the meeting would be limited to child prostitution.

1. As there is greatly varying terminology regarding sexually exploited children, Mr. Willis suggested that for the purposes of this meeting the Convention on the Rights of the Child definition be used to define "child"—all those under 18 years of age. Mr. Willis pointed out that children are not prostitutes but they are exploited children. However, for the summaries of the individual presentations, the language of the presenter will be used.
2. Inherent in the investigation of sexually exploited children is the difficulty in obtaining accurate numbers of children involved. Numbers available in the field are

not always reliable due to the obstacles researchers face in accessing this population. Public health can greatly contribute to efforts to address child prostitution through developing a methodology to more accurately estimate the number prostituted children. These estimates are needed in order monitor and evaluate programs.

3. There are some examples of effective interventions, although it should be remembered that program implementation is not a case of one size fits all. Interventions must be appropriate to the individual community and/or country context.

In the April 20, 2002, issue of The Lancet, Mr. Willis and Dr. Barry Levy published an article on the global health impact of child prostitution, research needs, and interventions.¹ Following the classification in the article, Mr. Willis suggested that the health impacts of child prostitution could be categorized in the following ways:

1. Infectious diseases
 - This includes HIV, STDs, and malaria, and other infectious diseases such as tuberculosis (TB). Children who are infected with HIV are more likely to develop active TB.
2. Pregnancy-related health issues
3. Mental health
4. Violence
5. Substance abuse
6. Malnutrition
7. Health of infants born to prostituted children

IV. Clinical and public health presentations

The following is a summary of the clinical and public health presentations. For more detailed descriptions of the programs, please see Appendix A. The terminology used by the presenters has been incorporated into the summaries.

Bolivia

Presenter: Dr. Chi-Cheng Huang

Program: La Paz Street Children Project, La Paz, Bolivia

The La Paz Street Children Project helps street boys and girls involved in prostitution by keeping them off the streets for a night or two or providing them with a hot meal. In order to provide these children with safe shelter and a place of their own, in April 2001, the project built a home for street children who still work nightly on the streets. Other project objectives include teaching the local police about human rights abuses, providing medical care on the streets, and starting venture capital initiatives where the children have the opportunity to sell things on the street instead of themselves. The project also received \$5 million to build a hospital that will address street children's health needs as they are denied services in the local clinics. The website for the La Paz Street Children Project is www.bolivianstreetchildren.org.

¹ Willis, B. M., Levy, B. S. (2002, April 20). Child prostitution: Global health burden, research needs, and interventions. The Lancet, 2002 (April 20):359;1417-1422.

Canada

Presenters: Ms. Susanne Shields and Ms. Sandra Burton

Program: “Enhanced surveillance of prostitution in Canadian street youth: Prevalence and predictors” study, Health Canada

“Enhanced surveillance of prostitution in Canadian street youth: Prevalence and predictors” was a cross-sectional study of Canadian street youth (N=1733) recruited from drop-in centers in seven large urban centers across Canada. There was a broad range of criteria to capture the wide range of youth: (a) Being 15- 24 years of age (as it was discovered that youth in this age range had the highest percentage of gonorrhea and chlamydia); (b) Being able to understand French and English; (c) Not being intoxicated; and (d) **Being** absent from home for at least three consecutive nights. Youth who were prostituted were defined as those who had ever traded sex for money, good, shelter, clothes, or other material possessions, or those who had reported trading sex as a source of income.

Significant variables contributing to a greater risk of trading sex were found to be **being** homosexual or bisexual, **having** Aboriginal status, **having** experienced unwanted sex, **having** been dropped **or expelled from** school, and **having** lived in a group home. Individuals who had a combination of these factors were at an even greater risk for trading sex.

Colombia

Presenter: Mr. Timothy Ross

Program: Fundación Renacer, Bogotá, Colombia

Fundación Renacer works with sexually exploited children who are among the most stigmatized, excluded, and high-risk members of a society that is already a very high-risk environment. Renacer provides primary medical attention, on limited budgets, with **volunteer** doctors, donated equipment, and medications. Most of those who come to Renacer for medical attention have had little prior experience of or access to health care and have no idea of what infections they may have. Renacer also runs a day center where children can receive counseling, affection, training classes, and free condoms in addition to playing games or just hanging out and talking. Outreach and harm reduction strategies focus on taking interventions to the clients where they are located; medical care must be made in such a way that it is genuinely accessible to these children.

Hungary

Presenter: Dr. Maria Herczog

Program: Family, Child, & Youth Association, Budapest, Hungary

Children who are exploited in Budapest primarily come from other Eastern European countries. There has been a lack of services for children and young people involved in prostitution in Hungary primarily due to the total denial of the problem on the part of the government and professionals. Many prostituted children come from the public care system. A

high proportion of children becomes homeless after leaving public care and they are, therefore, more vulnerable to exploitation through prostitution. Although there are free health services, exploited children are not gaining access to public clinics **due to discrimination**. As a result, if they do seek treatment at all, it is informal and unregulated.

India

Presenter: Ms. Ruchira Gupta
Program: Apne Aap, Bombay, India

Apne Aap currently assists 480 women and 55 girls who are involved in prostitution and **are working** in brothels. The program addresses their health needs such as insomnia, complications following repeated abortions, skin diseases, STDs, posttraumatic stress disorder, and malnutrition as well as other issues such as developmental delays. More than 60% of the participants in Apne Aap have HIV and some have died of AIDS.

Philippines

Presenter: Ms. Leona D'Agnes
Program: Program for Appropriate Technology in Health (PATH)

PATH assists Filipino children in sex industry to reduce the risk and harm of sexual exploitation and STD/HIV/AIDS. Cooperating with PATH is the AIDS Surveillance and Education Project (ASEP), a Department of Health (DOH) project that targets local NGOs to perform community outreach peer education, pharmacy partners to disseminate information on STD prevalence, and media to conduct public service advertising. Recent findings indicate the following programmatic impacts: (a) reported 70% increase in condom use by girl sex workers, (b) treatment of 150 STD cases in commercial youth sex workers, (c) an estimated 1500 other STD cases averted, and (d) an estimated 900 HIV infections in commercial youth sex workers averted over 10 years.

USA

Presenter: Dr. Curren Warf, Children's Hospital Los Angeles, California, Medical Director, High Risk Youth Program
Program: High Risk Youth Program (HRYP)

The High Risk Youth Program (HRYP) was initiated in 1982 to address the health issues of a sizable population of homeless and runaway youth in Hollywood, CA, and the surrounding communities through a standing clinic or a Mobile Health Team. Homeless youth, including youth engaged in survival sex, experience a variety of medical and health concerns. They tend to access services for acute problems that cause discomfort, frequently related to some aspect of their behavior and environment such as trauma or sexually transmitted infections. **These youth have similar concerns as youth who are not exploited**, such as the management of asthma and other chronic illnesses, access to contraception, and gynecologic care.

Zambia

Presenter: Mr. Adern Nkandela

Program: Children in Need Network (CHIN)

The Children in Need Network (CHIN) is a network of community-based organizations (CBOs), nongovernmental organizations (NGOs), and government departments working with children in need in Zambia. CHIN's multiple objectives include (a) promoting understanding of the impact of HIV/AIDS on children, their families, and communities; (b) developing strategies and guidelines to address the needs and problems of children in need; (c) disseminating information; (d) conducting research in areas of child development; and (e) organizational development of member organizations. CHIN works to mitigate health problems in prostituted children through capacity building by providing training to member organizations in psychological counseling skills, children's rights, street education, leadership skills, income-generating activities, sexual reproductive health and sexual rights, information sharing, reproductive health rights advocacy, and NGO networking. The CHIN website address is <http://www.chin.org.zm>.

The following action steps were identified by the presenters during the course of their clinical and public health presentations:

[Removed bullet relating to "resource areas"]

- Increase funding for services to sexually exploited children
- Provide technical assistance to the local population working directly in the field
- Provide/improve easy accessibility to health care as well as on-the-spot attention for children and adolescents in prostitution (reduce the delays and obstacles to accessing treatment)
- Make the existing official health care structure more client-friendly
- Advocate for law enforcement to consider the problem of child prostitution seriously
- Educate young children so that they do not associate sex with violence
- Create a program for men in the lives of **exploited women** to talk about their role in the woman's exploitation
- Ensure that children and youth are in more stable environments, particularly those who are leaving the foster care system
- Recognize and incorporate into programs the reality that homeless youth are more marginalized, alienated, and distrustful, and have more severe problems
- Recognize that serious substance abuse issues are pervasive
- **Develop programs and policies for the particular needs of homeless youth who are at extraordinarily high risk for participation in survival sex**
- **Ensure that programs and policies to address child sexual exploitation take into account exploitation of both boys and girls**

V. Organizational Presentations

The following is a summary of the organizational presentations. For more detailed descriptions of the programs, please see Appendix B. Representatives of the following entities made presentations regarding work on health strategies to prevent and mitigate the health impact of child prostitution: (a) UNICEF, (b) Medicins Sans Frontiers, (c) US Department of State, and (d) ECPAT-USA.

UNICEF

Presenter: Ms. Karin Langren, Chief, Child Protection Section, UNICEF

Ms. Langren presented information on UNICEF's initiatives to promote child protection through field programs and advocacy for global policies addressing child protection. UNICEF's overarching priority areas include addressing (a) the worse forms of child labor including CSEC, (b) violence, including traditional cultural practices, (c) children affected by armed conflict, and (d) capacity building. The focus of UNICEF is on the prevention, protection, and recovery of children. One goal is to mainstream child exploitation concerns into other disciplines, such as health and education.

Medicins Sans Frontiers (MSF)

Presenter: Ms. Bettina Schunter
Program: Sex Worker Project, Svay Pak, Cambodia

While Medicins Sans Frontiers (MSF) does not have programs specifically for prostituted children, some of the programs may have a component that deals with child prostitution. Staff of the Sex Worker Project (1999-2001) worked from the perspective that women deserve to be valued for themselves and empowered in their work. The objective of the MSF Sex Worker Project was to reduce the impact of HIV/AIDS in Cambodia on a national level. The key program goal was to make medical care accessible for all women and girls involved in sex work.

US Department of State

Presenter: Ms. Laura Lederer, US Department of State

Ms. Lederer presented information on current efforts against trafficking of persons in the USA. In order to address this growing, insidious problem, through a bipartisan effort, Congress passed the Trafficking Victims Protection Act in November, 2000. The Act increased the penalty for trafficking to 5-20 years to life. Other provisions included (a) broadening the definition of trafficking to include recruiters, transporters, buyers, sellers, guards, brothel owners, and anyone involved in the pipeline of trafficking activity; (b) creating a Presidential Interagency Task Force on Trafficking at the cabinet level; (c) creating a victim witness protection plan; and (d) creating a new "T" visa for victims who cooperate with law enforcement enabling them to have 3 years temporary residency in the USA and the opportunity to become permanent residents.

ECPAT-USA

Presenter: Carol Smolenski, Coordinator

To be added

The following action steps were identified by the presenters during the course of their organizational presentations:

- Mainstream child exploitation concerns into other disciplines, such as health and education
- Partner with the health arena which has access to sources of valid, reliable data
- Keep access to medical care open for all women and children involved in prostitution
- **ECPAT action steps**

VI. Report-back from Workgroup meetings (Programs and Services, Research, and Funding) and Discussion

The following summaries incorporate information from the specific workgroups as well as from the discussion by all consultation attendees at the following “report back” sessions.

Programs and Services

This workgroup discussed both physical and mental health components of programs and services. It was **thought** that program development and implementation should be approached from a human rights perspective, with a full range of services available and the complete situation of the client considered. Youth participation should also be included in a collaborative and ongoing way. This would not only improve programs but would also support youth leadership. Additionally, any intervention should be culturally sensitive.

There was much discussion on the issue of terminology during both the separate workgroup meeting and the report-back session. For the purposes of legislation and in order to create interdisciplinary linkages, participants **thought** that there needs to be some common understandings of the terms used to describe sexually exploited children so uniform data can be collected.

Global and local gaps and obstacles in care and in existing services need to be identified. Also, while there are numerous needs that are common to these children regardless of where they live, there may be important different health needs in different countries, and even within countries. Services available in each provider’s area should be mapped out to prevent overlap and to ensure adequate service coverage. Likewise, children are prostituted for different reasons. **Group members stated** that it is vital to offer these children feasible alternatives as part of an exit strategy. Such strategies could include **incorporating** formal and trade education.

Subsequent discussion focused on service provision and the need to put this issue on the medical agenda. Health services should be linked to non-health services. The range of services, which should be of good quality and flexible, should be taken to these children. It should be recognized that exceptional services are needed as sexually exploited children have exceptional

health risks. While existing structures should be utilized, new ideas are needed to reach these children.

Group members stressed that service provision should also focus on health care providers themselves—educating them on the severity of the situation for these exploited youth. Integral to this objective is finding out how existing programs are training their staff and finding funding sources for this type of education.

Discussion on programs included advocacy initiatives to raise national and international awareness and to highlight the need for health care structures serving this population, and marketing campaigns with media contacts and alliances.

As this is a multidimensional problem, interventions and funding are needed from both the private and public sectors. While many individuals and organizations have been working on child prostitution, the health profession has not been identified as **a collaborator** in addressing this issue.

Working group members created an list of action items they felt were central to addressing the health needs of sexually exploited children through programs and services:

1. Enable NGOs to assess and document existing health problems and services needs.
2. Create training and guidelines for health professionals providing services to prostituted children. An advisory group should be convened to develop recommendations and guidelines.
3. Advocacy for research on the health problems of prostituted children and funding for services needs to be increased. **Better data on this issue** is needed present to government entities and other possible funders.
4. Effective programs need to be identified so they can share with others and serve as templates.
5. Overarching strategies should include incorporating a human rights approach in the work with these children, providing viable exit strategies, and acknowledging alternative lifestyles.

Research

This working group focused on areas for research, including **how** to conduct research and identifying funding opportunities. Group members agreed that they **know** there **are** health problems among prostituted children, but the challenge **is** to gather valid and reliable data in order to support programs and services, and to use when seeking funding. It was agreed that their needs to be more quantitative data as opposed to anecdotal data, and that programs should be based on valid, reliable research findings. However, because of the hidden nature of CSE and the fact that these children are hard-to-reach and do not always conform well to research designs that could produce quantitative data, some members asserted that qualitative studies (such as ones which **gather** life stories) **are** also valuable and important in terms of their contribution to research.

Additionally, there should be involvement of youth in research from the beginning. For example, one group member noted that in creating a community-based needs assessment for this population, he took it to children to get their feedback on what was acceptable and appropriate for them.

Members grouped research into the following categories:

- Contributing factors;

- Access to vaccines;
- Health problems;
- The economic impact of child prostitution;
- Service delivery;
- Successful exit strategies and programs;
- International collaboration;
- The possibility of developing global surveillance of STIs and CSE;
- Program evaluation
- Men who purchase sex

There was much discussion on research protocols, particularly the need to protect study participants. It was widely agreed that researchers should apply the Convention on the Rights of the Child in addition to the legal standards and ethical considerations set forth by their respective Institutional Review Boards (IRB).

Some group members expressed frustration with IRBs, stating difficulties with getting approval of proposals focusing on children. Research requires informed written consent (or assent for anyone under 18 and consent from parents), although some group members stated that for research on populations that have strained relations or severed ties with families, parental consent can be waived. Collection of biological samples may affect assent/consent as the study participant's partner must be notified **if the participant receives a positive result for a STI**. Inherent in this type of research is asking intrusive questions. How can research participants be protected from emotional harm during a study? While a peer intervention model could be appropriate, some members were concerned with youth gathering information on other children and youth, particularly regarding confidentiality. Additionally, safety issues for participants and researchers need to be addressed.

The National Institutes of Health (NIH) are interested in HIV risk, child and adolescent development, and migration research. One group member noted that there was more interest in basic research than in interventions at NIH. The National Institute of Child Health and Human Development (NICHD) is interested in funding research—over 70% of what is funded is not in response to RFAs or RFPs but is investigator-initiated. These grants are very competitive but available. A representative of NICHD distributed “Goals and Opportunities 2002-2006” from the Demographic and Behavioral Sciences Branch (also available online). Group members felt that CDC and USAIDS were more program-focused. Representatives from Canada **stated** that the reason why their study had been successful was that they were able to create a common denominator and rally various groups around one goal: decreasing STIs. Although it was a national program, the cost was only \$175,000. Additionally, they recommended collaborating with other groups who have data. Another possibility would be to seek funding for secondary data analysis; one group member gave an example of a study that had disaggregated data on sex workers aged 12-40 **that** could be utilized for a study focusing on children.

The group also discussed the outcomes of research and how they should be utilized and disseminated. One suggestion was that interventions should come out of research to benefit the target population. In terms of data dissemination, some members **expressed** that there was a strong need to compile data on CSEC, and for what data did exist, there was poor dissemination. Members discussed the need for a mechanism to disseminate research findings quickly so that other researchers and practitioners would have access to and could benefit from them. One suggestion was to disseminate information through the lay press. Another suggestion was to use

the Children's Rights International Network or the Focal Point Project (www.focalpointngo.org) to aid in information dissemination, possibly by establishing a list serve or publishing the material online. In response to that, however, some members expressed concern regarding security. There would need to be security measures in place to avoid perpetrators or organized crime networks accessing these data.

Funding

This workgroup focused on what type of research should be funded, who should be approached for funding, and how this could be implemented. It was felt that funding should be available for global awareness/advocacy on health issues of sexually exploited children. One group member suggested the need to conduct health-needs field assessments. In order to accomplish this, one would need to look at the commonalities across countries, so the development of a cross-cultural assessment tool was suggested to gather this information. Funding should also go toward country programs, strategies for advocacy, and networking, conferences, and other venues for information dissemination.

Regarding who should be approached for funding, one group member brought up the need to involve governments, local and international NGOs, foundations, and research centers at universities. Some governments have small grants available, such as the Dutch Government. Funding should be sought from international organizations including the International Labor Organization's International Program to Eliminate Child Labor, IMF, UNICEF, and WHO/PAHO, and development agencies such as Canadian International Development Assistance (CIDA), Swedish International Development Assistance (SIDA), and AUSAID in Australia. Suggested regional entities included the European Union and the Asian Bank for Development. Private entities such as oil companies could be targeted as well since their employees notoriously sexually exploit children.

Group members suggested contacting the following foundations for funding on this issue: the Annie E. Casey Foundation, Ford Foundation, Gates Foundation, Levi Strauss Foundation, Turner Foundation, and Soros Foundation. Individuals who are concerned about this issue could also be approached. Regarding university involvement, group members suggested investigating which universities have received funding for CSEC research, such as the University of Iowa, and partnering with them.

Group members suggested forming coalitions, perhaps creating something like an International Campaign Against CSEC or gather more organizations under ECPAT-International's umbrella. It was pointed out that the International Campaign to Ban Landmines was hugely successful, although it was solely focused on a specific treaty. Another participants suggested looking at the Mayor's Coalition Against CSEC as a template. A CSEC campaign could be a campaign to generate global ratification of the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography.

The following action steps were identified from the workgroup meetings and report-back discussion:

Action steps for Programs and Services:

- Approach program development and implementation from a human rights perspective;

- Incorporate youth participation in programs in a collaborative and ongoing way;
- Create a common understanding of the terms used to describe prostituted children;
- Identify gaps in care and in existing services as well as global obstacles to addressing the health needs of prostituted children;
- Link health services to non-health services;
- Address lack of access due to discrimination against prostituted children;
- Educate health care providers on the severity of the health situation of prostituted children;
- **Advocate** for initiatives to raise national and international awareness and to highlight the need for health care structures serving these children;
- Provide viable exit strategies;
- Recognize alternative lifestyles;
- Enable NGOs to be able to assess health problems of prostituted children and evaluate existing services and programs;
- Develop recommendations and guidelines for services to prostituted children for the American Academy of Pediatrics, the American Psychological Association, the American Public Health Association, and the Society for Adolescent Medicine as well as international groups; and
- **Identify effective programs to serve as** examples.

Action steps from Research:

- Create a climate in the research arena for mutual support through sharing data;
- Involve youth in research from the initial stages;
- Identify and implement mechanisms to disseminate research findings quickly so that other researchers and practitioners have access to and can benefit from them; and
- Study the economic impact of health problems of child prostitution.

Action steps from Funding:

- Approach governments, local and international NGOs, foundations, and research centers at universities for funding;
- Fund country programs, strategies for advocacy, and networking, conferences, and other venues for information dissemination;
- Develop a cross-cultural assessment tool **for gathering** information on the **health problems and service needs** information in the field; and
- Create an international campaign against CSEC similar to the International Campaign to Ban Landmines or the Mayor's Coalition Against CSEC.

VII. Acknowledgments

This consultation would not have been possible without the support and encouragement of Dr. Allan Rosenfield, Dean of the Mailman School of Public Health. Dr. Ron Waldman provided valuable guidance in organizing the consultation. Two graduate students at the Mailman School of Public Health, Jennifer Crawford and Sara Jacoby, were indispensable in handling all the logistics of the consultation. It would not have been possible to bring together so many people from the organizations that provide services to prostituted children without the generous financial support of UNICEF, the Fund for Nonviolence, the F. Felix Foundation, and the Oak Fund. Finally, credit for the success of the consultation goes to the participants, many who traveled a great distance, and all of whom gave their time, energy, and expertise to this meeting.

While members of the faculty and staff of Mailman School of Public Health of Columbia University assisted in organizing this meeting and provide logical support during the meeting, neither their participation nor the use of Columbia University facilities constitute an endorsement of this report or the action steps contained within.

ALTERNATIVE:

While this meeting was organized by ECPAT-USA in consultation with faculty and staff of the Mailman School of Public Health and was held at Columbia University, the input of these individuals and the use of Columbia University facilities does not imply an endorsement of this report or action steps by the faculty or staff of the Mailman School of Public Health or Columbia University.

VIII. Conclusion

This meeting was a first step towards bringing together representatives of community-based organizations who provide direct services to prostituted children with clinicians and public health professionals in order to address the public health and clinical issues of child prostitution.

Considering the global health impact of child prostitution (See *Willis B, Levy B. Child Prostitution: global health burden, research needs, and interventions. The Lancet 2002; 359: 1417-1422.*) there was insufficient time to during this one-day meeting to address all these issues. Additional meetings, both international and at the country level, are needed. In addition to the limited time for this meeting, our ability to more fully explore action steps would have been enhanced with the participation of additional public health experts with expertise in the health problems experienced by prostituted children and representatives of additional NGOs and international health organizations.

We hope that the recommendations of the experts and action steps from this meeting will not only be useful to those who work with prostituted children, but will also lay the foundation for future meetings and the implementation of additional interventions to protect from this health and human rights tragedy.

Appendix A – Complete clinical and public health program presentations

Bolivia

Presenter: Dr. Chi-Cheng Huang

Program: La Paz Street Children Project, La Paz, Bolivia

Dr. Chi-Cheng Huang provided information on the La Paz Street Children Project. He described himself as a practitioner first, then an advocate for street children, and then a researcher. He worked for 1 year in La Paz where he would walk the streets of the city from 10pm to 3am trying to locate children who might need assistance with various issues. These were children who were hiding from the police, who raped and extorted them, and from johns, who exploited them. The project, which has had more than 4,000 visits by street boys and girls involved in prostitution, helps these children and young people by keeping them off the streets for a night or two or providing them with a hot meal.

Dr. Huang recounted the story of one girl, Rosemary. She had left home because her parents abused alcohol and beat her daily. To earn money initially, she had been selling potato chips on the street for \$1 per day. One day, someone approached her, describing to her how she could make much more money. When Dr. Huang met her, she had been involved in prostitution for 7 years. When asked if she took drugs, she responded yes—marijuana, cocaine, crystals, alcohol, and paint thinner. Had she been raped, been in dangerous situations? Yes, she answered, by other boys on the street. She complained of stomach pains and Dr. Huang provided her with medicine after asking various health-related questions to diagnosis her illness. She had not been to the local clinic because the clinic discriminated against street children and would not treat them.

The average age of street children in La Paz is 12 years old. It was primarily the girls who were exploited by former street boys turned pimps. These boys were most often between 18 and 25 years of age. However, based on Dr. Huang's observation, there also appeared to be some professional pimps who were between 30 and 50 years of age. The major drug used by these children was paint thinner; the high cost of cocaine and marijuana precluded its widespread use. Most of the children involved in the project were battered street children who had no connection to home or parents. The majority suffered from wounds and cuts, urinary tract infections, sexually transmitted diseases (STDs), and abortion complications. The perpetrators all appeared to be Bolivian businessmen as opposed to foreigners.

In order to provide street children with safe shelter and a place of their own, in April 2001, the project built a home for street children who would still work nightly on the streets. Other project objectives **include** teaching the local police about human rights abuses, providing medical care on the streets, and starting venture capital initiatives where the **children have** the opportunity to sell things on the street **instead of** themselves. One reason that police were targeted **is** their involvement in the perpetuation of exploitation of street children. Once a month, pimps host parties for police where street girls are available for free sex. The project also

received \$5 million to build a hospital that would address street children's health needs as they were denied services in the local clinics.

The address for the La Paz Street Children Project is www.bolivianstreetchildren.org. Dr. Huang's recommendation for helping these children was to raise more money for services and provide technical assistance to Bolivians involved in the field.

Canada

Presenters: Ms. Sandra Burton and Ms. Susanne Shields

Program: "Enhanced surveillance of prostitution in Canadian street youth: Prevalence and predictors" study, Health Canada

Conducted under the auspices of the Division of Sexual Health Promotion and STD Prevention and Control, Centre for Infectious Disease Prevention and Control, this study was a cross-sectional study of Canadian street youth recruited from drop-in centers in seven large urban centers across Canada. Researchers recognized that different areas of Canada had different demographics and possibly different issues. For example, the Vancouver area has high injection drug problems, while this problem was not prevalent in the other city sites. Youth were recruited using snowball sampling from at least two drop-in centers per city (N=1733). This phase of the project, Phase II, was launched in 1999 with data collected from over a 9-month period (February to October). Participation in the study included a team of researchers from federal, provincial, and local government as well as street youth. There was a broad range of criteria to capture the wide range of youth: (a) Being 15- 24 years of age (as it was discovered that youth in this age range had the highest percentage of gonorrhea and chlamydia); (b) Being able to understand French and English; (c) Not being intoxicated; and (d) **Being** absent from home for at least three consecutive nights. Youth who were prostituted were defined as those who had ever traded sex for money, good, shelter, clothes, or other material possessions, or those who had reported trading sex as a source of income.

Research nurses administered a structured multi-section questionnaire (both female and male versions) to participants. Completion of the questionnaire took approximately 1 hour. Questions covered demographics, drug/alcohol use, sexual orientation, mental health, history of sexually transmitted infections (STIs), level of education, sexual partnering, and unwanted sexual activity. Urine was collected to test for gonorrhea and chlamydia and blood (sera) was collected to test for Herpes, Hepatitis C, Hepatitis B, HTLV (a strain similar to HIV), and HIV. Eighty-four percent of participants agreed to urine testing and 77% agreed to sera testing.

For the data analysis, 1612 youth were included. Data showed a high percentage of youth who trade sex; 22.7% (366) were identified as trading sex. The overall gender ratio was 1.5 males to 1 female. The mean age of study participants was 18.8 years with a standard deviation of 2.5 years. The mean age when participants started trading sex was 15.9 years of age with a standard deviation of 2.7 years and a range from 7 to 23 years of age. Descriptive statistics of the 366 youth who traded sex showed that the majority were female, heterosexual, older, and had Aboriginal status. Those with Aboriginal status fell in to one of four categories: Inuit, Metee, North American, or Indian. Those with recent parental connections were less likely to trade sex. Almost 50% had experienced unwanted sex. It was found that study youth who had been dropped **or expelled from** school more frequently traded sex than those who had not. A

significant finding was that living in a group home was found to be a background characteristic more frequently for those who traded sex than for those who did not.

Logistic regression was performed in order to determine subgroups most at risk for trading sex. Results revealed what individual factors contributed to a greater risk of trading sex for those who trade sex. Significant variables were being homosexual or bisexual, having Aboriginal status, having experienced unwanted sex, having been dropped or expelled from school, and having lived in a group home. Individuals who had a combination of these factors were at greater risk for trading sex. Therefore, Aboriginal youth who are bisexual/homosexual or report being in a group home have an increased risk for trading sex. Presenters pointed out that not all youth who experienced unwanted sex are exposed to the same level of risk for trading sex.

Presenters discussed study limitations. First, because of the sampling technique (snowball sampling), generalizing the findings was limited. However, this type of sampling method was needed as random sampling was not feasible. To address generalizability issues, presenters noted that for future studies, the area where youth were sampled would be expanded. Second, the study was limited to youth who spoke English or French. This may have excluded those immigrants or Aboriginals who were unable to communicate in either language. Third, participants' responses may have been affected by recall bias. For future studies, shorter time periods could be used so that participants would be better able to recall information.

Colombia

Presenter: Mr. Timothy Ross

Program: Fundación Renacer, Bogotá, Colombia

The summary of this presentation was adapted from the hand-out provided by Mr. Timothy Ross, presenting the work of Fundación Renacer in Bogotá, Colombia.

The children and adolescents with whom the Fundación Renacer works in Colombia are among the most stigmatized, excluded, and high-risk members of a society that is already a very high-risk environment. Political conflict and resulting displacement, trauma, and destruction of families and traditional cultures, leakage onto local markets from the illicit drugs business of large amounts of pure and very cheap cocaine, heroin, benzodiazepines, and synthetics including ecstasy and methylamphetamine, and the exceptional levels of street crime, violence, and murder that are not related to either insurgency or organized trafficking are just part of the daily facts of Colombian life and death. The homicide rate, by the most conservative estimates, is about nine times that of the USA and more than 40 times that of Europe. Less than 1 murder in 90 ends up with a conviction, and the scandals of official corruption and misuse of power that make up a major part of the daily news coverage rarely lead to any real sanctions or controls.

For sexually exploited children in Colombia, this environment only meets the expectations they have grown to accept through personal histories filled with abuse, neglect, and abandonment. Their perceptions of the macro-society, the authorities, and most adults are of alien hostile forces, to be contended with, avoided, or, in turn, manipulated and exploited. Extreme violence, disease, and early death are seen as part of the natural order of things. Therefore, a key early focus of therapeutic interventions with this population is on generating change in perceptions of self and society that allows them to value themselves, their health, and their lives. Unfortunately, the available resources for attending this population are not sufficient to create and sustain the low-threshold, client-centered structures required to engage them.

Obstacles to treatment include (a) lack of official resources, (b) stigmatization and exclusion, (c) lack of identity papers, (d) lack of public health insurance coverage, (e) expectations of rejection, (f) fear of and hostility to officialdom, (g) cost, (h) chaotic drug use, and (i) low tolerance for frustration and delay.

Mr. Ross provided an illustrative vignette of the situation of exploited children in Bogotá:

One night at the free clinic in Renacer's central Bogotá day center, 15-year-old Rosa Maria arrived with her 9-week-old baby. Possibly because of first trimester drug consumption, the baby displayed poor reflexes as well as had minor dermatological infections. On leaving, Rosa Maria vaguely said that she wanted to ask about something else, a vaginal discharge—so she came back in for a gynecological examination. The exam revealed an IUD in an eroded cervix with a heavy discharge and signs and symptoms of **Pelvic Inflammatory Disease (PID)**. It turned out that in one of the supposedly better Bogotá women's clinics, an IUD had been inserted, despite the fact that she had an existing and incompletely treated STD and despite knowing she was engaged in street prostitution and at higher risk for further infections and would clearly have difficulty in raising **money for further appointments**. Therefore, she would probably not return for follow-up consultations. There was a total failure to take into account the special conditions and needs of this girl. Because she was experiencing serious pain and inflammation, it was decided that the IUD should be removed immediately and a hospital appointment should be made for lab tests and PID treatment. Despite the fact that one of the two volunteer doctors attending was from the STD/HIV program of a large Bogotá hospital, the best that could be arranged for Rosa Maria was for her to go the next day, 45 minutes by bus, to register for an appointment that would probably be 2 to 7 days later. After that appointment, she would be given a further appointment to return for lab tests, which she would collect 2 to 4 days later and request a new appointment with the gynecologist for treatment.

Even though she was facing the daunting prospect of multiple trips and bus fares, we think Rosa Maria may manage to comply, as in her sporadic day center treatment over the past 7 months she has stopped her chaotic drug use, substantially reduced prostitution, and improved her self-perception and care.

This much was only possible because Rosa Maria already had an identity card, and as she had previously spent some weeks in Renacer's residential home and had been registered under the Child Care authorities as eligible for subsidized health care, including prescription medications. Without this coverage, it would be extremely difficult to get attention and if given prescription medications she would have to pay for the medications herself. This is impossible for most street youth whose every last cent goes to survival and purchasing illicit drugs. If she had had no identity papers, current city health department regulations would have banned the hospital from offering any treatment.

For most of the sexually exploited children on the street in Bogotá, the chances of getting treatment are **slim**. A majority does not have identity papers—in one sample of central city high-risk youth and young adults, almost 80% were without papers and 97% had no kind of health coverage or access to care. However, even with identity papers and a referral letter from the foundation, children are frequently turned away by public hospitals. More importantly, though, are the lack of sense of self-efficacy, expectations of rejection and fear of all forms of official structures, coupled with chaotic drug use and an unwillingness to leave the dubious safety of

their bounded territories. Together these mean that about half of those referred never arrive for their appointments, even when initially presenting with serious or painful problems. Hostility to anything official generally stems from a life-style embedded in the criminal subculture, from the experience of arrest and forcible institutionalization and often from cases pending with the juvenile justice system.

Most of those who come to Renacer for medical attention have had little prior experience of or access to health care and have no idea of what infections they may have. Problems include (a) STIs, (b) poor compliance with condom use, (c) chaotic, dependent, and compulsive drug use, (d) drug sequelae and lung damage, (e) malnutrition, (f) psychological problems such as personality disorders, posttraumatic stress disorder, and depression, (g) parasitic infections, (h) wounds, and (i) educational deficits.

It is not surprising that the self-report questionnaires on STIs administered to a sample of 793 children attending Renacer during 1 year revealed that 13.3% reported a previous diagnosis of an STI, of which 42% referred to gonorrhea, 5% of the total. Only 2.4% reported being HIV positive and 1.9% reported having syphilis. However, when a doctor checked a small sample of those attending the day center, 36% of the girls and 27.8% of the boys were diagnosed with gonorrhea and chlamydia and 10% had generalized lymphadenopathy suggesting possible HIV infection. Ten percent were diagnosed with suspected TB and 22% of the girls tested positive for pregnancy.

A cohort of those entering the residential program who gave informed consent for Elisa tests and Western Blot confirmations showed 15% of the girls and nearly 60% of the boys were HIV positive. Current Health Ministry estimates put the total for reported and unreported HIV cases in the general population at about 0.5%. Of 531 girls entering the residential homes in 1 year, 29.8% reported current or previous pregnancy, and 10% said that they had aborted once or more—almost certainly substantial under-reporting.

This population has serious, multiple problems and their sexually transmitted and other blood-borne infections are often complicated by malnutrition, lung damage from cocaine smoking and glue sniffing, infected wounds from knives and broken bottles, fungus infections and scabies, a variety of attention, memory, and cognitive problems, personality, behavioral, and affective disorders and other consequences of early and prolonged abuse, neglect, and continued re-victimization, violence, and drug abuse on the street. This children and adolescents are a reservoir and vector of transmission of many infections, and their access to health care and treatment is not only a matter of their individual social and legal rights, but also has an impact on public health. Therefore, it is essential that just as outreach and harm reduction strategies are based on taking interventions to the clients where they are located—in their spaces, in their times, and on their conditions—medical care must also be made in such a way that it is genuinely accessible to these children.

These enormous difficulties in obtaining medical care through the formal health care structures have led Renacer to provide primary attention, on limited budgets, with volunteer doctors, donated equipment, and medications. If lab tests are required to confirm a diagnosis the child is not likely to get up in time to go to the laboratory nor has the money to pay for tests. Experience, knowledge of probabilities, a good clinical eye—and a good sense of smell—often have to substitute for unavailable lab tests. Additionally, it has been found that if a course of 10 days of Erythromycin is prescribed, compliance is poor: the tablets are lost or forgotten or the effects are neutralized by alcohol consumption. One-shot doses are given whenever possible instead of longer courses of treatment.

Low or no-threshold on-the-spot attention and treatment from empathetic people who go to see them on their own street corners and in the bars and brothels has been observed to be effective with this population. The day center is a friendly environment, in the children's own territory, where they can also get counseling, affection, training classes, and free condoms in addition to playing games or just hanging out and talking. There is no cost for treatment or medications and no identity papers are required. There is good compliance and return for follow-up appointments and there is a reduced rate of reinfection. The girls are beginning to bring in their regular non-client sexual partners for checkups and treatment, and are acting as peer leaders, inviting other friends to get checked for infections. There is evidence of more positive attitudes to self-care, particularly regarding hygiene, nutrition, contraception, early treatment of infection, and childcare. This seems to have led to an increased sense of self-efficacy and a reduced sense of exclusion. The doctors and health educators give them all the time they need. The same child sometimes comes back to the consulting room multiple times in one afternoon with different questions or before overcoming his or her shyness about a genital exam.

It is hard to measure impacts other than by these observations, but the program seems to be working. Mr. Ross proposed that this model of easy access attention be considered as one key element in meeting the health care needs of children and adolescents in prostitution. The second element is to make the existing official structure more client-friendly and to reduce the delays and obstacles to accessing treatment. Instead of being at the end of the line for health care, these young people should be a nation's first priority.

Hungary

Presenter: Dr. Maria Herczog

Program: Family, Child, & Youth Association, Budapest, Hungary

After political transitions in the late 1980s, individuals and groups began thinking about the problem of CSEC. While Hungarian society has become more "open," this has produced both advantages and disadvantages. Budapest has been called the Bangkok of Eastern Europe. The children who are exploited primarily come from other Eastern European countries: there is evidence of boys coming from Romania and girls coming from Ukraine. The perpetrators are primarily Westerners. There has been a lack of services for the children and young people involved in prostitution in Hungary primarily due to the total denial of the problem on the part of the government and professionals. Concentration has been on early childhood—0 to 5 years of age.

Echoing the findings from the Canadian study, Dr. Herczog noted that many children involved had come from being in care in the public care system. A high proportion of children becomes homeless after leaving public care and they are, therefore, more vulnerable to exploitation by prostitution. Approximately 500,000-700,000 Roma children are involved in the public care system, greatly over represented among the children who are exploited compared to their percentage in the general Hungarian population. Drug abuse, excluding alcohol, is not so widespread among exploited children yet. This is due to cost issues. However, alcohol abuse and smoking are ubiquitous.

Although there are free health services, exploited children are not gaining access to public clinics due to discrimination. As a result, if they do seek treatment at all, it is informal and unregulated.

There is evidence of trafficking of girls from Eastern Europe. Destination countries include Austria, Germany, Italy, and the USA. Police suspect that organized crime networks are controlling trafficking in the region which makes addressing the problem more difficult. Organized crime networks are coordinated and **are** hard to find and eliminate. When police do apprehend children who are involved in prostitution, they are put in detention centers. However, because of a lack of services, once children leave the detention centers, they often return to the streets and to further exploitation.

India

Presenter: Ms. Ruchira Gupta

Program: Apne Aap, Bombay, India

“Apne Aap” translates to “self-help” in Hindi and was taken from a documentary looking at women and children involved in prostitution in India called “Selling of Innocence”. As this consultation was focusing on public health strategies to prevent child prostitution, Ms. Gupta emphasized that the best health strategy is an exit strategy. **Apne Aap** currently assists 480 women and 55 girls who are involved in prostitution and **are working** in brothels. The program addresses their health needs such as insomnia, complications following repeated abortions, skin diseases, STDs, posttraumatic stress disorder, and malnutrition as well as other issues such as developmental delays.

In some brothels in Bombay, girls are locked up, given only one meal per day, are made to see around 25 clients per day, are encouraged to become addicted to alcohol, and are encouraged to have children so they cannot go back home. Pregnancies in childhood present particular problems as children’s bodies are not mature and there is a greater risk of miscarriage. It is difficult to access health care for this population as hospital staff deny them care based on their unkempt appearance and sometimes strong body odor. Being denied care in hospitals forces them to find alternative, informal, sometimes dangerous paths to treatment. Police extort money from exploited girls as well as the mafia, but the women participating in Apne Aap are protected because of the program’s powerful board members.

More than 60% of the participants in Apne Aap have HIV and some have died of AIDS. The needs of the children whose mothers have died of AIDS must be addressed. Some customers use condoms and some do not. Some who do not **use condoms** believe that using a condom lessens virility. Additionally, **it was heard from perpetrators that using a condom is not why they want to come to prostitutes.**

Strategies need to be integrated to prevent children from being sold or lured into prostitution. The most successful interventions are community based. Exploited children must be presented with feasible exit strategies. Their spirit to survive must be encouraged in order to mitigate the health impact of child prostitution. This could be done by providing exploited children with mentors as well as educating policymakers on the importance of the issue.

Ms. Gupta made the following recommendations regarding mitigating the health impact of child prostitution: (a) **increase awareness of available resources**, (b) advocate for law enforcement to take the problem of child prostitution seriously, (c) educate young children so that they do not associate sex with violence, and (d) create a program for men in the lives of **exploited women** to talk about their role in the woman’s exploitation.

Philippines

Presenter: Ms. Leona D'Agnes

Program: Program for Appropriate Technology in Health (PATH)

Representing the Program for Appropriate Technology in Health (PATH), Ms. Leona D'Agnes provided information on the situation of Filipino children in sex industry and ways to reduce risk and harm of sexual exploitation and STD/HIV/AIDS in this population. Based in the USA (Seattle and Washington, DC), PATH is an international nongovernmental organization (NGO) with field offices in Europe, Africa, and Asia. The focus of the program is on health and sustainable development. A cooperating agency is the AIDS Surveillance and Education Project (ASEP), started in 1993 and funded by the USAID Philippines. This is a Department of Health (DOH) project that targets local NGOs to perform community outreach peer education, pharmacy partners to disseminate information on STD prevalence, and media to conduct public service advertising. An evaluation in 1995 reported on the effectiveness of ASEP's targeted information, education, and communication intervention strategy and praised the innovative public-private sector partnerships that the education component has fostered at local levels.

It is estimated that there are 1,000,000 prostituted women, men, and children in the Philippines (WedPro, 1994). In 2001, the World Health Organization estimated the exploited population at 400,000-500,000 of which 100,000 are children. The Department of Social Welfare calculated that there are more than 100,000 exploited children (under 18 years of age) in the Philippines. In 1996, there were only 2,613 cases of child sexual abuse; approximately 14% involved prostitution.

From 1998-2001, ASEP was implemented in eight sites. Four groups were targeted: "freelance" female sex workers, male clients, injecting drug users, and men who have sex with men. **Commercial** sex workers were not included in the target population because they are a registered group with access to government clinics and mandatory weekly check-ups. Approximately 107,000 women and children sex workers were contacted. Twenty-four percent (25,181) were children under 18 years of age. The children were mostly girls ranging from 12 to 17 years of age. ASEP partners screened 1,052 youth (under 18) in sex work during 1998-2001. Of 1,052 children, 150 (14%) tested positive for STDs. The majority of the cases consisted of genital discharge. HIV risk factors at the sites were found to be age, number of new partners per week, STD knowledge, and condom use. While HIV prevalence was found to be low, the prevalence of syphilis was high. HIV transmission was found to be primarily through heterosexual sexual contact.

There are several constraints to treating STDs for prostituted children and young people. First, there are no national guidelines for the treatment of children with STDs. Second, commercial youth sex workers under 18 are ineligible for STD care at government social hygiene clinics. Third, donors are reluctant to finance STD drugs for children and young people. Fourth, the socially marketed STD kits are too costly for prostituted children and young people. Finally, there is poor compliance on the part of prostituted children and young people; they often forget to take their medicine or fail to finish the 7-day course of treatment. In response to the last obstacle, ASEP outreach workers dispense medication to increase compliance and supply kits for \$3, which provides medicine for the full course of treatment.

Ethnographic studies of prostituted children and young people show that they need early intervention programs on drugs, alcohol, and tobacco abuse. Also important are community-

based services and “early rescue” assistance, especially for those that decide to exit after 3 months. Other needs include condoms that fit adolescents, peer group support programs, and 24-hour clinics that are child-friendly.

Members of ASEP have found numerous trigger factors that can cause children and young people to be prostituted. A key initial trigger factor is an urgent individual or family problem, such as pregnancy, school dropout, or death of the families’ main breadwinner. This can lead to an association with and referral by peers and adults already involved in prostitution. Another trigger is already being sexually active—this makes the transition of sexually active youth from unpaid to paid sex less of an obstacle. Additionally, there is the presence of organized trafficking networks that illegally recruit and kidnap children and young people for prostitution purposes.

ASEP implements multi-level interventions. At the client level, ASEP utilizes interactive tools (street theater, puzzles, and pop-up books) developed in collaboration with children, peer education and STD referral to NGO outreach posts, and linkages with social services. For NGO workers, information, education, and communication tools for community health outreach workers, a frequently asked questions and answers format for sexually exploited children under 16, and STD syndromic case management training are used. At the level of the health providers, the program employs comprehensive guidelines and STD management in children and medico-legal training for public health workers. At the community level, ASEP works with a local legal action group and provides paralegal training, helping them to mobilize resources. At the final level, the city level, ASEP works with multisectoral AIDS councils and advocates for 100% condom compliance and for policies addressing the health impacts of prostitution.

Most recent findings indicate the following programmatic impacts: (a) reported 70% increase in condom use by girl sex workers, (b) treatment of 150 STD cases in commercial youth sex workers, (c) an estimated 1500 other STD cases averted, and (d) an estimated 900 HIV infections in commercial youth sex workers averted over 10 years.

USA

Presenter: Dr. Curren Warf, Children’s Hospital in Los Angeles, Medical Director, High Risk Youth Program

Program: High Risk Youth Program (HRYP)

This summary is based on a handout provided by Dr. Warf as well as his presentation of material on the health risks of youth engaged in survival sex in Hollywood, California.

The High Risk Youth Program (HRYP) was initiated in 1982 through a grant from the Robert Wood Johnson Foundation to address the health issues of a sizable population of homeless and runaway youth in Hollywood, CA, and the surrounding communities. A United Way study had documented as many as 20,000 homeless youth living in the area at the time. These youth had no services directed toward them, and were subject to a variety of health concerns resulting from exposure and injury, general acute medical issues, some chronic medical conditions, sexually transmitted infections, substance abuse and its complications, and other situational health stressors. Contraceptive access and management of pregnancy emerged as particular concerns. Without access to legitimate means of survival and without supportive families, these young people commonly resorted to methods of survival that compromised their

health and often brought them in conflict with the law. These included involvement in exchanging sex for money, food, drugs, or a place to stay and in the drug trade.

Initiated as a collaborative program between the Division of Adolescent Medicine, Children's Hospital Los Angeles, a major academic hospital, and the Los Angeles Free Clinic, a community-based organization, HRYP has received funding through the Homeless and Runaway Youth Act of the State of California, through Health Care for the Homeless, the Bureau of Primary Health Care of the Department of Health Services, and from several private sources.

A system of care for homeless youth evolved in Los Angeles that involves the collaboration and coordination of public and private agencies to provide shelter, health care, legal services, substance abuse treatment, job referrals, and so forth. Currently, the numbers of homeless youth are somewhat reduced since the beginning of the program. Nonetheless, there are estimated to be 7,000-8,000 youth on the streets of Hollywood every year.

Between 1992 and 1995, the Centers for Disease Control (CDC) conducted a study of HIV risk-related activities of homeless youth in six cities including Los Angeles. In Los Angeles, data was collected during two 2-month "sweeps." This study focused on unaccompanied homeless youth. Seventy percent of the sample was drawn from homeless youth at "hangouts" for youth in the community; 30% were youth randomly selected from agencies providing services to street youth in Hollywood. Youth were between 12 and 23 years of age, had lived on the streets without families for 2 or more consecutive months and/or were integrated into the street economy. The sample size was 1103.

Analysis of their economic survival revealed that 52% were involved in panhandling, 23% obtained money from family, friends, or lovers, 21% were engaged in prostitution, 19% had jobs, and 16% dealt drugs. Of those engaged in prostitution, involvement of pimps inhibited access to female sex workers. Twenty-six percent of interviewed males disclosed sex work as opposed to 10% of females. Females were more likely (67%) to utilize panhandling as the primary means of support than males (46%). Males were more likely to be employed (21%) than females (14%). Youth engaged in survival sex commonly have a "main partner" with whom they share an emotional connection. This person may also act as a pimp. With this partner, they are less likely to use condoms. With occasional partners, or partners with whom money is exchanged for sex they are more likely to use condoms. However, in the sex trade a premium may be paid to not use a condom, which may be irresistible to young people with limited to no means.

Of the street youth interviewed, 30% disclosed having ever engaged in survival sex. Other studies of risk behaviors of homeless youth have found that as many as 52% have engaged in sex for drugs, money, or a place to stay. Of those aged 13-17, 22% reported engaging in survival sex. In the 18-23 year old group, 34% reported engaging in survival sex. Thirty-three percent of males reported engaging in survival sex versus 23% of females. This however may be an artifact as girls may be more involved with pimps who may have restricted access to interviewers.

Regarding perceptions of HIV risk among youth engaged in survival sex, of those interviewed (N=300), 24% felt it was "not at all likely," 55% felt it was "somewhat likely," 9% felt it was "very likely," 3% reported that they were already HIV positive, and 9% responded that they did not know.

Homeless youth, including youth engaged in survival sex, experience a variety of medical and health concerns. They tend to access services for acute problems that cause discomfort, frequently related to some aspect of their behavior and environment such as trauma or sexually transmitted infections. These youth have similar concerns as youth who are not exploited, such

as the management of asthma and other chronic illnesses, access to contraception, and gynecologic care.

Though one of the studies sampled youth on the street, most of the data are from youth who accessed services through either a standing clinic or the Mobile Health Team. It is recognized that a self-selection process takes place; many more youth remain highly distrustful and alienated and will not access health services at all. This is a very difficult population to study and little data are available. Undoubtedly their risk behaviors are graver and their health problems even more prevalent than those who do access health services. These data do not reflect the extent and pervasiveness of serious substance abuse, in particular the use of amphetamines, heroin, serious alcoholism, and injection drug use. Also, these data do not capture concerns with mental health, particularly suicidal behavior, depression, and psychosis, nor issues related to pregnancy and childbearing.

The studies found that many young women have experienced pregnancy while homeless. The outcomes are highly variable. For some, pregnancy could provide compelling motivation to seek stabilization and support, sometimes including renewal of communication with family. Many opt for pregnancy termination. Some continue the pregnancy, and claim that they reduce, if not eliminate, drug and alcohol use. Their access to and compliance with prenatal care is very uneven. While the study did not have access to statistics on outcomes, from Dr. Warf's observations, homeless young women with small children commonly come to the attention of the Department of Children and Family Services (DCFS) and the infants are usually taken into the system. It is not uncommon for the young mothers to become pregnant again, usually with a heightened level of vigilance to avoid contact with DCFS.

Finally, sexually transmitted infections are quite common among young people engaged in survival sex. The typical spectrum of STIs is common; the only positive news in this area is that syphilis is currently of such low prevalence that cases are rarely encountered. While HIV continues to be a relatively uncommon diagnosis among minors, these youth are at extraordinarily high risk for this infection. For youth that remain engaged in these behaviors, and commonly engage in injection drug use, the risk of HIV infection over time is quite high. Hepatitis B infections have not been seen in a year, which could be due to increased vaccinations.

Dr. Warf provided the following conclusions to the discussion of homeless youth in Hollywood:

- Unaccompanied youth are at higher risk than sheltered youth for prostitution. Therefore, ensure that children and youth are in more stable environments, particularly those who are leaving the foster care system.
- Homeless youth are more marginalized, alienated, and distrustful, and have more severe problems.
- Serious substance abuse issues are pervasive but commonly minimized.
- Once youth are enmeshed in these behaviors, it is very difficult to leave.
- Homeless youth are at extraordinary high risk for participation in survival sex.
- Even without participation in survival sex, homeless youth may be at very high sexual risk.
- Male participation is higher than female participation.

Zambia

Presenter: Mr. Adern Nkandela

Program: Children in Need Network (CHIN), Lusaka, Zambia

Mr. Nkandela presented information on the role of the Children in Need Network (CHIN) in mitigating the health impact of prostituted children in Zambia. This summary is based on a handout from Mr. Nkandela. The number of orphaned children in Zambia was estimated at 1.6 million for the year 2000, and it is expected to rise to 38.6% of the total child population by 2010. In 1993, a group of organizations that were addressing children's issues in Zambia who had contacts with UNICEF decided to form a network that would help them improve their work with children in need. In 1995, they decided to formalize their association and create a network with a secretariat.

CHIN is a network of community-based organizations (CBOs), nongovernmental organizations (NGOs), and government departments working with children in need in Zambia. Its mission is to "strengthen the ability of families and communities to protect and promote the welfare of children in need in Zambia through developing and sustaining a network of concerned NGOs and CBOs, and government departments." CHIN's multiple objectives include (a) promoting understanding of the impact of HIV/AIDS on children, their families, and communities; (b) developing strategies and guidelines to address the needs and problems of children in need; (c) disseminating information; (d) conducting research in areas of child development; and (e) organizational development of member organizations.

There are numerous health problems that prostituted children in Zambia face. These include unwanted pregnancies, abortions resulting in problems with reproductive organs, HIV/AIDS and other STIs, health problems associated with alcohol abuse, and death.

A study conducted by the Zambia Association of Research and Development (ZARD) and the Movement of Community Action for the Prevention and Protection of Young People Against Poverty, Destitution, Disease, and Exploitation (MAPODE) of 937 prostituted girls seeking medical attention found that 59% sought help in a government clinic, 18.4% received no medical attention, 8.4% bought pain killers from shops for self-medication/treatment, 5.7% utilized a private clinic, 4.8% visited a traditional doctor, and 3.3% begged for medicine—0.3% did not respond.

CHIN works to mitigate health problems in prostituted children through capacity building by providing training to member organizations in psychological counseling skills, children's rights, street education, leadership skills, income-generating activities, sexual reproductive health and sexual rights, information sharing, reproductive health rights advocacy, and NGO networking. This is accomplished through financial assistance to member organizations that provide HIV/AIDS prevention. This spectrum of activities facilitates the right to protection against sexual exploitation and sexual abuse, consequently eroding the possibility of health problems. Through this capacity building, it is hoped that institutions will improve their efficiency and outreach programs to stop prostitution. The envisaged impact is the enhancement of capacities of families to respond to or cope with economic crises. As a result, children will not seek out prostitution as a means of economic survival and health problems will diminish.

CHIN invariably recognizes the rationale for promoting networking among such organizations and promotes lobbying and advocacy to end child prostitution. The networking

attracts the formation of community-based childcare programs. Such initiatives incorporate programs that address health problems arising from child prostitution.

From the global perspective, maintaining the CHIN website (<http://www.chin.org.zm>) is an integral aspect of mitigating health problems to provide an interface for networking purposes among international stakeholders. Relevant member organizations could be encouraged to create partnerships in order to find solutions to ending child prostitution. Research in areas of child development can provide information to policymakers and programmers to recognize the right of access by exploited children to appropriate health care services, which will address health problems caused by prostitution. CHIN provides a resource center for members to access information from various research activities to help them in their planning process to mitigate the health problems caused by child sexual exploitation.

UNICEF

Presenter: Ms. Karin Langren, Chief, Child Protection Section

Program: UNICEF

Ms. Langren presented information on UNICEF's initiatives to promote child protection through field programs and advocacy for global policies addressing child protection. UNICEF's work is guided by the Convention on the Rights of the Child, particularly freedom from exploitation and assistance with recovery from violence and trauma. UNICEF's overarching priority areas include addressing (a) the worse forms of child labor including CSEC, (b) violence, including traditional cultural practices, (c) children affected by armed conflict, and (d) capacity building. In keeping with their first priority area, in 1996, in response to increasing concerns about the protection of children and evidence of heinous violations of children's rights, UNICEF, in collaboration with the Swedish government, ECPAT-International and the NGO Group for the Convention on the Rights of the Child planned the First World Congress Against Commercial Sexual Exploitation of Children. Hosted by the Swedish government in Stockholm, the Congress gathered together a diverse group of government leaders and governmental agency representatives from 122 countries, representatives of intergovernmental and nongovernmental organizations, service providers, researchers and members of the media to focus on child prostitution, the trafficking and sale of children for sexual purposes, and child pornography.

The focus of UNICEF is on the prevention, protection, and recovery of children. One goal is to mainstream child exploitation concerns into other disciplines, such as health and education. There are three priority areas: AIDS issues, girls' primary education, and discrimination and exclusion. First, with the spread of AIDS, there has been an increased demand for child partners for sex. This has resulted in a greater infection rate of children and a greater number of children orphaned by AIDS. It is estimated that AIDS has orphaned 13 million children. That estimate is expected to grow to 40 million by 2010. Second, girls' primary education has been linked to sexual exploitation. Sex is traded for better or passing grades or to escape corporal punishment. Third, discrimination and social exclusion play a part in the sexual exploitation of children. For example, it has been recently reported that in West Africa children and women refugees, a highly marginalized population, have been exploited by employees of humanitarian aid agencies, trading sex for protection, food, and so forth. Isolated groups such as refugees also find themselves excluded from routine services such as immunizations.

Data on these groups are poor and hard to obtain. Gathering data from children is particularly difficult. There has been little interest on the parts of governments in whose countries this exploitation has been found. However, the health arena has access to sources of data and would make good partners in this task of protecting children.

Medicins Sans Frontiers (MSF)

Presenter: Ms. Bettina Schunter

Program: Sex Worker Project, Svay Pak, Cambodia.

Ms. Schunter gave a presentation on MSF's Sex Worker Project, conducted in Svay Pak, Cambodia, from 1999 to 2001. This summary is adapted from a handout provided by Ms. Schunter.

While MSF **does not have programs specifically for prostituted children**, some of the programs may have a component that deals with child prostitution. MSF's work in Svay Pak, Cambodia, was limited by the parameters of access. **The key program goal was to make medical care accessible for all women and girls involved in sex work.** Program staff **worked from the perspective that women deserve** to be valued for themselves and empowered in their work. Staff collaborated with sex worker organizations in Asia, particularly Empower in Thailand, in developing the program.

In 1995, MSF opened a clinic in the Svay Pak area, 11 kilometers north of Phnom Penh. Svay Pak, a fishing village, has a large concentration of Vietnamese sex workers. The clinic started out as **a** STD clinic with a condom promotion program. Since the beginning of 2000, the project focused on the well being of the sex workers, introducing non-medical services in the Lotus Club on the second floor of the clinic. The shift to activities that improve the well-being of the sex workers was seen to be a necessary preliminary step in getting the women to assume more responsibility in their own lives and, thus, health care. The activities in the clinic and the Lotus Club were mutually supportive and referrals were made between them.

The objectives of the MSF Sex Worker Project were to reduce the impact of HIV/AIDS in Cambodia on a national level. On the local and regional level, the objectives were to reduce the vulnerability of sex workers in Svay Pak, Siem Reap, Sisophon, and Poipet, and to increase safe sexual behavior in men. Expected outcomes for sex workers included (a) being better equipped to make life decisions, (b) protecting themselves from STI/HIV transmission, (c) having access to quality health care in a noncoercive environment, (d) **having access to care and social support for those with AIDS**, and (e) **having access to treatment to slow the disease for those who are HIV positive** (in Svay Pak only).

In a Horizons Population Council Survey (2000), 171 sex workers were interviewed. When asked to list the first three things that they would like to change in their lives, the most frequent first choices were:

- Don't want to be a sex worker, change job
- Work hard, pay off debt and go back to Vietnam
- Have money to go back to live with family
- Taking care of family, want my parents to be sufficient
- Want more clients, get more tips
- Want a lot of money to give to my mother, help my family
- Pay off my debt then go back to live with my parents

Statistics collected from January through June 2001 reflect data of sex workers seen by the program who were from the brothels as well as a few "indirect" sex workers from outside Svay Pak. Although the women told staff that they were 18 and over, it was known that many of

them, nearly half or more, were under 18. The brothel owners **tell** them to say that they **are** 18 so that they **are not** rescued. Most who come in the brothels are virgins, the average age being 16. However, Ms. Schunter noted that children as young as 7 (a boy) and 11 (a girl) were found working in one brothel. The formal counseling figures, which ranged from 13 to 33 during the time period, are not as high as the amount of actual counseling that went on. The counselor often spoke informally with the women and children about their situations. The varying percentages of brothels covered in the study reflects the direct link between the “raids” that went on and the effect they had on the access of the women for health and social coverage.

The syndromic approach was used in the clinic; staff did not test for STIs. Through the syndromic approach and risk assessment, cervicitis (ulcerous cervix) and vaginitis had the highest incidence. Genital warts were visible but, unfortunately, staff only had podofilin for treatment. There were some chronic cases of cervicitis that may have been pre-cancerous or cancerous, but staff had no way to determine if this **were** so or provide treatment even if there were an affirmative diagnosis. There was one organization (Reproductive Health Association of Cambodia) that did PAP smears but they were costly and could only be read in Thailand.

Operating under a harm reduction model, project activities for the clinic included (a) sex worker STI screening and treatment, (b) general health, (c) HIV/AIDS care and treatment including home-based care support, (d) reproductive health for the general population, (e) female condom outreach, (f) a men’s program and outreach, (g) counseling for the general population, and (h) Condom Promotion Day. Activities at the Lotus Club included (a) counseling, (b) life skills workshops, (c) occupational English, (d) Vietnamese literacy, (e) occupational Chinese, (f) children’s programs/life skills workshops, and (g) karaoke/library/lounge.

Small shacks behind the clinic/club were at times used for sex as opposed to the brothels. A customer, usually German, American, Chinese, or Japanese, would approach a mama-san in a brothel who would then contact a family with a small girl. These contacts were prearranged and the brothel owners knew exactly which families they could approach. Japanese clients were found to be buying oral sex from girls as young as 5 years old for \$30. Penetration started with girls as young as 10 or 11. More and more of the girls, and rarely their mothers, would come to see MSF’s staff social program coordinator and counselor. Staff started to do monthly education with the children, informing the parents that staff were teaching general health education. Issues of health, assertiveness, and self-esteem were addressed. The health educator and the counselor chose the topics. Before each session (two times per month) staff let the parents know they would be calling the children. Between the sessions, many of the children would come to the Lotus Club—either for language classes or just to hang out. This is how staff received most of their information about the children. They were not sent to the clinic for check-ups.

Children’s topics included:

1. Likes and dislikes
2. The meaning of HIV/AIDS or SIDA / What do you know about HIV/AIDS?
3. Being assertive (Why be assertive? How can one be assertive?)
4. Body parts and the language of sex
5. Peer pressure and persuasion
6. Good touch and bad touch, including Stop! I value myself, and so forth
7. Delaying or not delaying sex (feelings around choice or no choice)
8. What is a condom?
9. What is a family? What does it do?
10. What is responsible behavior?

11. What do I choose for my life?

A 4-month monitoring period and evaluation provided information as to why the Children's Program was effective: (a) It was found that children were willing to participate and share ideas; (b) The facilitator could use words and ask about sex with the children without their feeling embarrassed; (c) The children liked watching educational videos; (d) They liked role-playing and enjoyed setting it up themselves; (e) The children came on time and trusted the facilitator; (f) They wanted to know everything about sex and the topics being discussed; (g) The program helped the children, even if they were already engaged in penetrative sex; and (h) The program fit with the children's participatory needs.

For the male client program, MSF staff developed a pamphlet in English, Khmer, and Japanese. Staff used a friendly approach, giving the clients tips on how to treat the sex workers more fairly as well as information on Cambodian laws regarding child prostitution and documented cases of prosecutions. Staff also listed the HIV statistics for the country. This pamphlet has been widely praised and there have been discussions with other agencies to distribute it to other parts of the country where child and other prostitution **are** prevalent.

US Department of State

Presenter: Ms. Laura Lederer, US Department of State

Ms. Lederer presented information on current efforts against trafficking **in persons** in the USA. She provided a vignette of one girl's story of being trafficked into the USA. Rosa was 13 years old and working in Mexico. One day she was approached by an acquaintance who told her that she could make more money working in a restaurant in the USA. In order to further encourage her, this person told her that she could have free transportation to the USA and that if she did not like the job in the restaurant, she could change it. Rosa walked 4 days and nights, crossing the border into Texas where she was picked up by a van and driven to Florida. There, she was dropped off at a trailer brothel. When Rosa began her journey, she was a virgin. When she arrived at the Florida brothel, she was gang raped and forced to have sex with more than 20 men per day. Drugs were put into her food. She became pregnant twice and was forced to have two abortions. This was a particular burden for Rosa because she was Catholic. Eventually she was apprehended and placed in a detention center. By this point, she was addicted to drugs and had several health issues related to the previous abortions. This is just one example of thousands who are trafficked into the USA each year.

Currently, children are being trafficked into the USA primarily from Russia, the Middle East, and Africa. Australia is a destination point mostly for Southeast Asian traffickers. In the USA, 20 cities across the country have become prime destinations for trafficked children. In order to address this growing, insidious problem, through a bipartisan effort, Congress passed the Trafficking Victims Protection Act in November, 2000. The Act increased the penalty for trafficking to 5-20 years to life. Other provisions included (a) broadening the definition of trafficking to include recruiters, transporters, buyers, sellers, guards, brothel owners, and anyone involved in the pipeline of trafficking activity; (b) creating a Presidential Interagency Task Force on Trafficking at the cabinet level; (c) creating a victim witness protection plan; and (d) creating a new "T" visa for victims who cooperate with law enforcement enabling them to have 3 years temporary residency in the USA and the opportunity to become **permanent residents**. The Office

to Monitor and Combat Trafficking in Persons staffs the Presidential Interagency Task Force on Trafficking, coordinates the implementation of the Act, produces annual Trafficking in Persons reports, assists foreign countries in addressing trafficking issues, and assesses countries progress each year. Resources such as funding for cultural exchange can be taken away for those countries for which there is no progress. This is particularly applicable for wealthier countries that are held accountable just as other, less prosperous countries are.

ECPAT-USA

Presenter: Carol Smolenski, Coordinator

To Be Added

Appendix B: List of participants