



Quality Standards for Protecting Child Victims of Commercial Sexual Exploitation

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Introduction

As knowledge grows about the commercial sexual exploitation of children (CSEC) worldwide, efforts to prevent and combat this specific form of exploitation of children and young people have increased in many countries, especially during the past 10 years.¹ These efforts - conducted by national and international, state and non-state actors alike - include, for example, legal and policy reforms, awareness raising campaigns, and recovery work with victims of commercial sexual exploitation.² The diversity of actors has led to a variety of approaches and interventions whose effectiveness and quality are difficult to compare; moreover, there is general lack of systematic monitoring and evaluation. Added to this is increasing concern for the protection of children's rights, as studies have shown that victims of CSEC often do not undergo an adequate healing and recovery process. Rights of sexually exploited girls and boys are frequently violated during the process of rescue and in rehabilitation programmes.³ Moreover, many recovery and rehabilitation measures or programmes do not sufficiently address the profound and persistent traumatisation of victims of commercial sexual exploitation. This has sparked off the recent discussion in the international child protection community on the need for common quality standards in anti-CSEC interventions, and in particular in victim rehabilitation programmes.

Another factor motivating the discussion of quality standards is the increasing awareness of cases of institutional (sexual) abuse of girls and boys of all ages. This has fuelled the international discussion about developing child protection policy guidelines as well as institutional codes of conduct for organisations working with children, and for their staff. The development of a child protection policy and/or code of conduct can be an organisational process in itself. But it can also be made part of a comprehensive approach to install quality standards in an organisation or programme dealing with the recovery of CSEC victims.

As a response to these developments, many international and national actors have come up with guidelines for quality standards. Linking primary and secondary prevention is a key condition for any effective and sustainable approach to combating CSEC, and quality standards should apply to all interventions in this area. The present study, however, focuses primarily on care for victims of CSEC during the stages of recovery, rehabilitation and reintegration. It discusses some of the existing concepts of, and experiences with guidelines and quality standards in the recovery of victims of CSEC. It suggests criteria and elements for quality of care standards to support organisations that have already been engaging or wish to engage in such activities in partner countries. Hence, it may be used as a guideline or resource in a number of ways - for policy development, project planning, or for reviewing, monitoring and evaluating existing projects or programmes.

1 According to international law, the term "child" refers to a person below the age of eighteen years.

2 Many professionals prefer the term "survivor" to "victim" because it is more positive and emphasises agency. The term "victim" is however still widely used.

3 See, for instance, the accounts of victims in "Listening to Victims" by Rebecca Surtees (2007).

The first part introduces the concept of quality standards and the most basic principles regarding child protection. The second part applies these basic standards to specific care interventions in the victims' recovery process. Predominant elements of care are presented: care in shelters, psychosocial counselling, rehabilitation and case management, and reintegration.⁴ Based on a review and synopsis of the existing literature and interviews with selected German organisations engaged in development co-operation, this paper develops suggestions for basic quality of care standards for these areas of intervention.⁵ These in no way claim to be complete. Rather they may serve as starting points for further discussion and initiatives for the development of quality of care standards in specific institutions or programmes.

Most of the literature available about guidelines and standards for the protection, care and rehabilitation of child victims of CSEC has been published by international actors, in particular ILO-IPEC, ECPAT and UNICEF. Besides these, there is a body of studies and handbooks by IOM, OSCE and others with guidelines on the protection of trafficking victims, for instance during interviewing, legal procedures, and referral and return processes.⁶ These, however, generally do not distinguish between adults and children. While some guidelines or recommendations apply to both groups, girls and boys, as minors, have different legal rights and need different forms of protection and approaches than adults. Hence, these sources offer only limited insight.



It is fair to say that the process of developing quality of care standards for children in recovery is still in its infancy, and experiences with the implementation of such standards are therefore not yet well documented. The recommendations in this paper as well as the examples and experiences chosen do not claim to comprehensively represent all efforts being made globally but are rather selective, being based on internationally accessible information and the documentation, for the most part, of the above mentioned actors.

4 The whole area of quality standards for law enforcement agencies will be left out for reasons of space and because several studies, model standards and training guides are already widely available.

5 While many German development and women's organisations support anti-trafficking and anti-CSEC activities, only a few organisations could be contacted for purposes of this study (see annex). Their information and this "reality check" were, however, extremely valuable in assessing the main issues and problems for implementing quality standards.

6 See, for instance, the guidelines for interviewing by WHO (2003); the OSCE handbook on referral mechanisms (2004); or the IOM handbook on victim assistance (2006).

1 What are quality standards?



Quality standards are based on shared values of a community of actors in a given field of activity or work. Quality standards define aims based on these values, and they entail concrete measures or steps on how to reach these aims.⁷

In any field, quality standards may vary in their depth and elaboration in terms of prescribing structures or procedures for reaching a given aim. One can also distinguish between minimum and optimum standards. While reaching an optimum standard is often desirable, in reality, spelling out minimum standards may ensure better chances of success in reaching the desired goals. Having optimum goals in mind, organisations may start out with minimum standards, and building on their experience with these, evolve more comprehensive standards for reaching their optimum goals.

Depending on the institutional context, one may find a number of different approaches to defining and applying quality standards. Many institutions active in social work and care as well as in development cooperation work with a widely accepted and basic definition that distinguishes the following quality aspects:⁸

- Quality of structure, i.e., institutional infrastructure, resources, plans, legal environment of the activity, etc.
- Quality of process, i.e., strategies and measures taken in an activity
- Quality of output, i.e., defining anticipated output and assessing whether actual output conforms to it.

This is a useful analytical tool for developing quality standards and making a plan for their implementation based on a previously defined outcome⁹. It can be adopted by any organisation as it does not require expertise in quality management approaches. Hence, even small organisations with few or limited human resources can work with this approach and start with a form of quality standard development and management process that are appropriate for their institution.

When an organisation or agent initiates a process of setting and managing quality standards, the process should be as inclusive as possible. Only when all stakeholders or employees have a chance to participate in setting quality standards will they have a strong sense of ownership and responsibility for implementation. Also, quality standards should be developed at the beginning of a planned activity or project so that they may serve as a guide throughout the entire activity.

⁷ Definition based on Bundesverein zur Prävention von sexuellem Missbrauch an Mädchen und Jungen e.V. (2003), 11-13; Bundesverein zur Prävention von sexuellem Missbrauch an Mädchen und Jungen e.V. (2003); Bundesarbeitsgemeinschaft feministischer Projekte gegen Gewalt an Mädchen und Frauen e.V. Forschungsprojekt Qualitätssicherung (2004), 9-11.

⁸ See footnote 4 and, for example, medica mondiale (2004).

⁹ The outcome usually describes an overall goal, such as child rights protection, to which a project or measure contributes. A project or measure, however, is not solely responsible for reaching this outcome; it is only responsible for achieving the output it has defined for itself.

2 Basic quality standards

Coming up with quality standards to combat CSEC that are globally applicable to the work of any institution or organisation appears difficult at first sight.

Differences in cultural norms or in human, institutional and financial resources could all be seen as obstacles. However, a look at existing approaches by international organisations, such as UNICEF or ILO¹⁰, governmental or non-governmental actors, or models that have been proposed enables identification of the following basic principles or standards, which may apply to any anti-CSEC activity.

2.1 Protecting the human rights of girls and boys

The protection of children's human rights is the most fundamental principle for all major actors in the anti-CSEC community. The core reference document is the United Nations Convention on the Rights of the Child (CRC), which applies to all girls and boys up to the age of 18 years. It has been universally accepted (with the exception of Somalia and the United States), and its implementation is binding for national governments. A number of articles in the convention refer to the situation of sexually exploited children. The Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography specifically addresses the rights of children who are commercially sexually exploited. Other international legal instruments, such as the Palermo Protocol¹¹ or ILO Convention No 182 on the Elimination of the Worst Forms of Child Labour, complement the CRC.

UNICEF advocates and applies the following key principles, based on the CRC, to any anti-child trafficking programme or activity. All UN organisations subscribe to these principles, as do most other international and national actors in the child protection community.

Key principles to be applied in efforts to prevent trafficking, and to protect and assist child victims

The best interests of the child

In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. (CRC, article 3.1)

Non-discrimination

States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. (CRC, article 2)

Each child has a right to have his or her views listened to and taken into account in all matters affecting him or her. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. (CRC, article 12)

The child's right to privacy

No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation. (CRC, article 6)

(UNICEF 2006b: 11; source: UN Convention of the Rights of the Child)

10 For example UNICEF (2006b); ILO-IPEC (2002a), (2002c) (2006a).

11 United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons, especially Women and Children.

Based on these principles, UNICEF (2006a) developed guidelines for the protection of child victims of trafficking specifically. They apply to all stages and aspects of treating the victims of trafficking, from identification to rehabilitation and reintegration. They have been accepted and endorsed by many states, in particular South Eastern European states such as the Stability Pact member states.¹² In West Africa, efforts are currently being developed to adapt the guidelines to the regional situation there.¹³

2.1.1 National child protection laws and policies

The UN recommends that governments adopt national child protection laws and policies based on international human rights standards.¹⁴ In order to implement the CRC, UNICEF recommends that independent and easily accessible child protection councils, commissions or ombudspersons be in place to ensure the active protection of children's rights, including the rights of victims of sexual exploitation.¹⁵ Following the 1996 Stockholm Declaration and Plan of Action to Combat Commercial Sexual Exploitation of Children, countries should also have specific national plans of action.¹⁶ ILO-IPEC and ECPAT recommend that these plans include national minimum quality of care standards that apply to all child protection agents involved in any one or all recovery/ rehabilitation phases. Nepal, Sri Lanka and Bangladesh are examples of countries with national quality of care standards based on the child rights protection approach (see ILO 2002a, 208).

These mechanisms provide children's rights organisations with a legal and policy framework for their work. Cambodia, for instance, is in the process of introducing a national plan of action and a memorandum of understanding between major child protection agencies and the government about responsibilities, services and quality standards for all agents. In countries where child protection laws and policies are non-existent or inadequate by international standards, children's organisations may be hampered in their work and in protecting victims' rights. In these cases, lobbying for and advocacy of the establishment of such norms are important tasks for civil society organisations seeking to secure adequate and child-rights-based services for victims.

2.1.2 Institutional child protection guidelines

Any agency or organisation working with children as their target group is obliged to protect and implement children's rights. Institutional child protection policies or guidelines are important instruments in this. They usually entail:

- rights-based child protection standards for institutional goals, programming and project implementation
- strategies (i.e., training) on how to implement these standards
- steps for monitoring and evaluating progress.

Reports of cases of institutional sexual abuse show that child sex offenders often seek employment in institutions working with girls and boys.¹⁷ To guard against this, any public or private organisation working with children as its beneficiaries or clients should have a code of conduct, applying to all staff. It should list staff duties and responsibilities in

¹² See UNICEF (2006b), 187. Originally designed for South Eastern Europe, the guidelines have been revised to apply to all regions. They are regularly updated taking into consideration new international standards and good practices. The most recent version of the guidelines is available at http://www.unicef.org/ceecis/0610-Unicef_Victims_Guidelines_en.pdf.

¹³ Information by Mike Dottridge via email, 18.7.2007.

¹⁴ See for instance the recommendations by Paulo Sérgio Pinheiro in the UN Report on Violence against Children, United Nations (2006), or those by the Special Rapporteur on the sale of children, child prostitution and child pornography, United Nations Commission on Human Rights (2003, 2004).

¹⁵ See "Fulfilling obligations under the CRC" http://www.unicef.org/crc/index_30208.html.

¹⁶ For a list of countries with such a national plan of action see http://www.ecpat.net/eng/Ecpat_inter/projects/monitoring/national_plan.asp.

¹⁷ See for example United Nations (2006); and Informationszentrum Kindesmissbrauch/Kindesvernachlässigung 2007.

terms of behaviour and interaction with children and young people as well as procedures to apply in case of violation. Often, such codes are part of institutional child protection policies. For efficient implementation, they must be an integral and binding part of the work contracts of all staff members.

For the avoidance of secondary traumatising, child protection policies and staff codes of conduct are particularly important in organisations working with victims of sexual abuse. The United Nations and many international non-governmental organisations, such as Save the Children or World Vision, have established certain forms of policy and codes of conduct. Based on their experiences, the Keep the Children Safe Coalition, a network of renowned national and international NGOs from the UK and Switzerland, published a toolkit in 2006. This toolkit is designed to serve any state or non-governmental organisation working in the field of relief and development work, either with or without a child focus, as a model for the development and implementation of institutional child protection standards and policies.¹⁸

Several German non-governmental organisations such as World Vision Germany and the Christoffel-Blindenmission / Christian Blind Mission (see box below) have developed a child protection policy. Picking up on the initiative of some member organisations, the network of non-governmental German development organisations, VENRO, is currently in the process of discussing with its members a common framework for child protection policies.

Today, child protection policies and codes of conduct should be standard for any governmental or non-governmental organisation working with children as beneficiaries, not only but also in the area of development cooperation. For these policies and codes to be efficient, clear implementation and monitoring processes must be developed. Staff must be aware of existing policies, and clear procedures for incident management must be in place so that all employees know exactly what to do in case of violation.

2.1.3 Being part of a child protection network

Any anti-child-trafficking or anti-CSEC activity and organisation should be made part of a larger national and/or regional network of agents. Ideally, this network should base its work on national child rights policies and a national plan of action. This ensures that all agents base their work with girls and boys on these rights-based standards, and that common strategies are developed to address the problems in a country or region. Embedding the activities of a child protection network in a national plan of action also enhances cooperation among the various actors as well as national or even regional alignment of child protection activities. It makes anti-CSEC work more effective, since each organisation, governmental as well as non-governmental, can contribute its specific expertise, resources and institutional structure to the common effort. Work within a network also permits effective connecting of prevention and advocacy with recovery/rehabilitation activities, since not all organisations are able to cover both aspects.

Example: Institutional child protection policy

Since 2005, the development organisation Christoffel-Blindenmission /Christian Blind Mission (CBM) has developed and started to implement a very detailed child protection policy (CPP) and a code of conduct (CC).¹⁹ The overall objective is to protect children and other vulnerable groups from sexual, emotional and physical abuse, neglect and exploitation. However, CBM's approach mainly focuses on institutional settings. The CBM policy and code apply to all 10 national member associations and to all CBM staff. Project partners in 112 countries are called upon to set up and implement their own policies and child protection systems based on the core standards designated in the CBM policy guidelines. Thus, a relevant clause is being integrated into partner agreements.

Method: In regional workshops, the CPP is introduced to focal persons representing local CBM staff and partner organisations. These focal persons feed what they learn back into their own local organisation – and, when asked, to other organisations in the area – where they conduct training sessions and initiate the development of child protection policies and codes. Training began in spring 2006; so far, parts of Asia (e.g., India, Philippines, Pakistan, China), West and East Africa and parts of Latin America have been reached.

Experiences/lessons learned: Local partner organisations are very open to the concept and instruments of CPP and CC; demand among them for training and advisory services is very strong. Integrating stakeholders from the very beginning into the process of developing institutional CPP is key to its success. Only when an organisation – large or small – and its staff own the process and the results of CPP and CC can the intended goals be reached.

Challenges: Translating and adapting the CPP to different cultural settings is a challenge. Differences in concepts about what constitutes appropriate behaviour towards children must be reflected in local CPPs. On the other hand, local concepts or customs must not be permitted to water down standards for the protection of child rights. Discussions between stakeholders and agents are important for finding appropriate solutions and reaching agreement on locally accepted standards which also harmonise with basic child protection values.

Capacity Development: The largest area of capacity development involves awareness-raising and building local capacity on the following topics: child rights; different forms of sexual (and physical) abuse of children; strategies of sex offenders; institutional policies and codes of conduct; processes of developing and implementing CPP and CC in an organisation; staff recruitment; monitoring and evaluating implementation of CC; and management of incidents of abuse, neglect and exploitation.

2.2 Recognising the respective needs of girls and boys

Implementing a rights-based approach for the protection of children and young people implies the development of instruments that meet the respective needs of girls and boys. Girls of all ages form the large majority of CSEC victims. Their abuse is often embedded within a larger social and political structure of gender-based discrimination. Thus, interven-

tions to prevent CSEC or to support girl victims contribute to the fight against gender-based discrimination and violence within a society. In recovery activities, specific measures for girls include providing them with a safe space, enhancing their empowerment and self-confidence, and giving them a voice.²⁰ Recovery of boy victims may, among other things, include helping them come to terms with their identities and roles as males in their society.

¹⁹ Based on the CBM Guidelines on Child Protection and an interview with Dr. Boris Scharlowski, Head of the Child Protection Unit, 31.5.2007.

²⁰ See ILO-IPEC (2003), for further details on the specific needs of girls, see below section 4.

Recovery activities also need to address specifically the different needs of various age groups (under 10 years; 10 -13 years; 14 -18 years). The needs of a 10-year old girl victim differ from those of a 16-year-old. A large group of victims of commercial sexual exploitation are teenage girls and young women. National laws often distinguish different ages, with younger children (often up to 12 or 14 years) being afforded more protection than older ones, who may legally and socially be treated as adults. This contradicts the international norm that all children under 18 years of age deserve the same form of legal and social protection. Although girls under the age of 18 require particular protection, drawing the line between girls up to 18 years and young women beyond the age of 18 is difficult in reality. For one, girls may pass the age of 18 during their recovery, and secondly, older teenage girls often wish to lead a more independent life than younger ones and are able to do so. However, this should still not mean that older girls should generally be treated like adult women, as is often the case in many recovery programmes.²¹ Solutions need to be found that recognise the specific right to protection of older teenage girls, while at the same time offering psychosocial support and educational and economic opportunities appropriate to their age. Teenage mothers are a vulnerable group with particular needs, such as specific psychosocial and medical counselling, child care support and reintegration measures that allow them to combine work, vocational training and education with child raising. Another factor frequently neglected in recovery programmes is disability. Boys and in particular girls and young women with disabilities are at an increased risk of sexual exploitation, and they often do not receive appropriate care in rehabilitation. Effective recovery programmes must develop specific approaches that meet the different needs of children and young people based on gender, age and disability, while at the same time respecting and protecting their rights.

2.3 Monitoring and evaluation

Monitoring and evaluation should be integral from the very beginning to the end of any project activity. An agent should constantly monitor and regularly evaluate implementation of the child-rights-based and/or child protection standards and measures as defined at the outset of a programme or project. Plans should be in place to allow the revision of strategies and instruments for achieving the child protection standards that were set in advance.

A number of monitoring and evaluation methods have been developed by various institutions: all cannot be introduced here. The GTZ-supported Convention Project "Protection of Minors against Sexual Exploitation" has compiled a guide specifically for organisations or projects combating CSEC.²²

One important evaluation factor for organisations working with children in general and for anti-CSEC projects in particular is to include the perspectives of girls and boys who are beneficiaries of an activity or service. For instance, girls living in a care home for victims of sexual abuse will have their own views about their living situation, their needs and how their rights are or are not being respected. Taking children's and young people's experiences and voices seriously is not only the key to securing the quality of activities for their welfare but can also contribute to their personal healing and development.

²¹ See for example UNICEF/UNHCHR/OSCE-ODIHR (2005), 47-48.

²² Monitoring and evaluation of projects to combat sexual exploitation of children (CSEC), by GTZ Convention Project "Protection of Minors against Sexual Exploitation", CD Rom and online available at www.gtz.de/nochildabuse.

3 Quality of care standards

“We use standards for psychosocial care for the same reason that we use standards for medical care - people hospitalised with a fractured arm have the right to receive the same quality of care wherever they are in the world. The same applies to the fractured life of an abused child.” (Frederick 2003, 1)

Children and youth who have been commercially sexually exploited have generally experienced extreme forms of physical, emotional and psychological violence which may result in various physical and mental health problems.²³ The frequently deep traumatising during exploitation often leads to many emotional and behavioural problems for girls, young women and boys and to difficulty in building (healthy) social relationships. These consequences of commercial sexual exploitation underlie the whole recovery process and often affect the success of rehabilitation and reintegration efforts.²⁴ Any intervention must therefore be guided by an approach that recognises this traumatising and provides adequate support for victims in coping with it. Addressing these issues and protecting the rights of girls and boys must thus run as constant themes through the development of quality of care standards for all stages of recovery.

According to ILO-IPEC, care for victims takes place in three different stages:

1. intake / first contact / first assessment
2. interim care and recovery support
3. reintegration and continuing care.²⁵

ILO lists thirteen essential rights and services that should be provided during these three stages (see the chart below) and can be taken as a rights-based framework for specific quality of care standards. The purposes of such standards are:



- To provide the most effective and compassionate care to victims and to address all of their material, legal, health, social, educational and psychological needs
- To develop and maintain professional, transparent and accountable care practices
- To help and support caregivers.²⁶

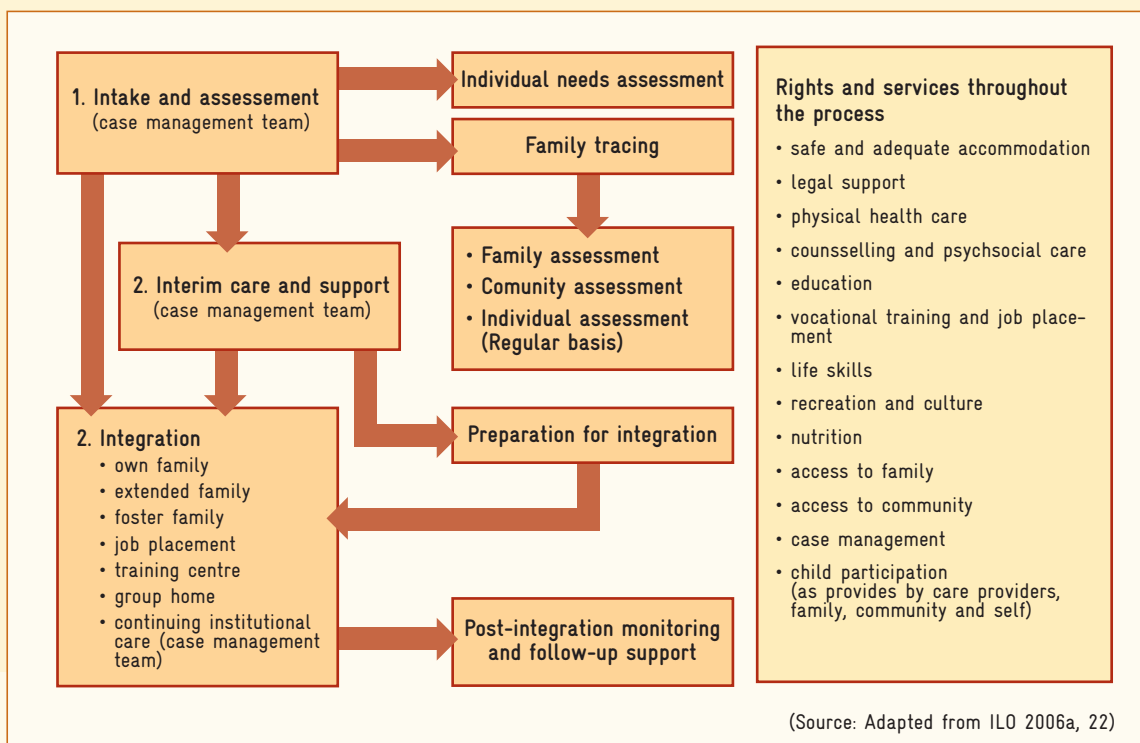
The stages of recovery and integration and rights/services throughout the process are shown on the next page.

²³ On the mental and physical consequences see Zimmermann (2006); Tautz/Bähr/Wölte (2006), 252-254.

²⁴ Although both girls and boys suffer the consequences of CSEC, it should be kept in mind that girls and young women make up the majority and are therefore most affected.

²⁵ ILO-IPEC (2006a), 21-28. One may broadly distinguish two groups of victims who pass through these stages differently: 1. Trafficked boys and girls who enter the recovery process by having been “rescued” or picked up by law enforcement officers, e.g., during raids. The first contact of these children is usually the police, who subsequently refer them to caregiving institutions 2. Girls or boys who wish to cease serving as prostitutes and/or leave a brothel or a pimp and who may, for instance, seek initial contact with or support from a drop-in centre, after which they move into a residential rehabilitation home.

²⁶ Taken from Frederick (2002), 206 and expanded.



In the following, quality of care standards (QCS) and guidelines are suggested based on the child rights approach. In developing these, the above distinction between activity structure, process and output is observed. QCS are suggested for four interrelated elements in the recovery and rehabilitation process:

- running a caregiving facility or shelter
- psychosocial counselling
- rehabilitation and case management, including a multidisciplinary approach
- reintegration.

All of these elements are closely linked and overlapping. Most CSEC victims, mostly girls or young women, stay at some point in their recovery process in some form of shelter or caregiving facility. A few others may receive non-residential support. But for all of them, psychosocial counselling is central for healing and recovery, so that they can come to cope

with the consequences of exploitation. Thus, such counselling should be an integral part of all recovery activities. Effective case management and a multidisciplinary approach also contribute to the success of recovery. Clearly, then, the challenges connected with recovery from commercial sexual exploitation call for a multisectoral approach that recognises the many interlinkages between victims' medical, psychosocial, educational and income-generating/economic needs. Finally, careful reintegration and after-care measures should secure lasting integration of CSEC victims into society. Developing QCS in these areas thus contributes to the overall aim or outcome of providing the best possible care for CSEC victims so that they can heal psychosocially and physically and live a safe and healthy life that is personally, socially and economically stable.²⁷

²⁷ The quality of care standards recommended in this paper apply generally to work with girls and boys. It should be kept in mind, however, that the large majority of CSEC victims are girls. Although the terms "children" or "youth" are frequently used in the following, girls are therefore the primary target group to benefit from these measures.

3.1 Quality of care standards in caregiving centres and shelters

"After we were rescued, we were kept in a shelter home...for seven months. We had to go through health check-ups and the doctors were not very cooperative with us. We spent a very regimented type of life in the shelter. Several girls during their stay there even requested the shelter to send them back to the brothel or to their house." (ILO-IPEC 2006: 8)

Victims of commercial sexual exploitation often take refuge in or are taken to residential caregiving facilities, commonly termed shelters. These may be emergency shelters, rehabilitation centres, long-term shelters or transit homes. They may house few or many children or young people; they may be independent houses or they may be linked to churches or hospitals. Most of them are shelters for girls or young women, as they generally make up the majority of the victims. Shelters for boy victims of commercial sexual exploitation are rare in most countries.²⁸ Commercially sexually abused boys more often enter rehabilitation programmes for street children and stay in their residential facilities when

available. Drop-in centres may offer health care, counselling, meals, or educational or recreational activities for girls, young women and/or boys, but no place to stay. Still, they can be important entry points for commercially sexually exploited girls or boys on their way to entering a residential rehabilitation programme.

Experiences in many countries show that shelters have often been established on an ad-hoc basis driven by the immediate need to offer CSEC victims places to stay. Despite good intentions and committed staff, they often lack the resources, knowledge and capacity to respond adequately to the specific needs of children.²⁹ For these reasons, guidelines and standards have been suggested by several organisations, most importantly ILO, IOM and ECPAT.³⁰ These standards apply to any form of residential or non-residential caregiving facility. Where possible, these standards should conform to national guidelines on caregiving institutions and plans of action against CSEC. The following suggestions for quality standards (QS) are based on these.

Child rights protection

QS Structure An explicit child rights and protection policy is formulated, spelling out the rights of the residents/clients. A complaint mechanism for children and youth is in place in case of problems or rights violations.

Children and young people have their own personal and sleeping spaces.

QS Process Girls and boys are informed about their rights in the shelter and can use procedures for registering complaints.

The facility provides safety for the children without confining them and without having a prison-like appearance.

Staff is trained on how to communicate with children in a respectful manner and to keep information on the individual cases confidential.

Staff is trained on how to communicate with children in a respectful manner and to keep information on the individual cases confidential.

QS Output Girls and boys enjoy the rights to: safety, confidentiality, privacy, participation, freedom of movement and freedom from discrimination, harassment and abuse.

²⁸ See on this point Surtees (2007), chapter 4, p. 53.

²⁹ See for instance Frederick (2002).

³⁰ For detailed model guidelines for shelters, which also served as resource for this section, see Frederick (2002) 222-232; ILO-IPEC (2006a); IOM (2007); ECPAT (2006).

Standard of living and shelter services

QS Structure	<p>Facilities are run on the basis of operational guidelines. The capacity of a facility is not exceeded.</p> <p>Boys and girls do not stay in the same facility.</p> <p>Shelters are clean and well maintained, with adequate heating, ventilation, and lighting.</p> <p>There are separate areas for meals, sleeping, washing and recreation/play and studying.</p> <p>Children receive regular, healthy meals.</p> <p>Shelters are decorated in a homey, child-friendly manner, with toys and adequate play/recreation opportunities for all age groups.</p> <p>Clear shelter rules are in place and are familiar to all residents. Children and young people know their responsibilities.</p> <p>Children and youth staying longer than a few weeks in a shelter have access to schooling appropriate for their age group.</p> <p>In-house psychosocial support is available to residents.</p> <p>Shelters cooperate with a network of experts/institutions in legal, medical, psychosocial, educational fields and offer these services.³¹</p>
QS Process	<p>The implementation of operational guidelines is continuously monitored, and necessary improvements are made. Newly arriving children are informed about shelter rules and their responsibilities. Shelter rules are enforced by staff in a constructive manner.</p> <p>Children and youth participate in setting up, implementing and monitoring shelter rules, and in decorating the shelter. They assume responsibility for certain tasks in the shelter.</p> <p>Shelter staff facilitate access of victims to shelter and external services.</p> <p>Residents know how and where to speak to staff when they need immediate psychosocial support.</p>
QS Output	<p>Children and young people live in a safe, well-organised, friendly place, where their needs are met and their rights are respected.</p> <p>Shelters provide residents with access to adequate health, social, legal, mental, psychosocial, educational and recreational services.</p>

The interaction of staff with shelter residents is an important determinant in creating a safe and healing environment so that girls, young women, and boys can recover from their experiences and feel secure and supported. It is therefore important that the qualifications and capacities of staff working in shelters meet QCS.

Capacity of staff

QS Structure	<p>Staff is selected based on their qualifications and their capacity to relate to CSEC victims. Clear job descriptions are provided.</p> <p>Staff gender must be appropriate for the position; i.e., in a girls' facility, the director must be female.</p> <p>A code of conduct for all staff is in place and implemented.</p> <p>Specific tasks (such as medical, legal, trauma counselling) should be carried out only by personnel with adequate expertise.</p>
QS Process	<p>All staff receives training on CSEC and supportive ways of interacting with CSEC victims; staff involved in care has training in caregiving; staff involved in psychosocial counselling receives adequate training in this subject.</p> <p>Measures are in place for supervision and to prevent staff burn-out.</p>
QS Output	<p>Staff is able, competent and trained to interact with and support traumatised girl or boy victims of CSEC and to provide good care.</p>

Good practice examples:

Participation

Children who are long-time residents of the Maiti Nepal shelter home provide orientation to newcomers through a peer support "buddy" system.³²

Safety and confidentiality

Visitors to a rehabilitation centre in Cebu City, Philippines, are not allowed to enter the area where the girls stay but are taken to a separate small building.³³

Standard of living and services

The Rumah Perlindungan Sosial Anak Center in Indonesia is child-friendly and spacious, with good facilities and sufficient private space for the children. It works very closely with a network of organisations that provide referral, recovery, reintegration and legal protection services. This comprehensive approach is in line with nationally defined priorities to strengthen child welfare and protection.³⁴

32 ILO-IPEC (2006a), 36.

33 Information by Thomas Westermann, Karl Kübel Stiftung, 5.7.2007; for a more detailed account of the centre see below section 3.4 on reintegration.

34 ILO-IPEC (2006b), 23.

3.1.1 Experiences and recommendations for capacity development

Some of the main challenges in care facilities arise from a lack of human and financial resources. Besides, operational policies may not be in place in shelters. To step up services without exceeding finances, semi-professionals and volunteers can help out with daily shelter routines, provided they are given adequate training on how to properly interact with the girls or boys living in the shelter. Also, enough time and funds must be set aside for developing the capacity to enhance and monitor shelter policies.³⁵

All staff, semi-professionals and volunteers involved in caregiving and counselling need regular training, supervision and support. Especially in countries with rigid gender roles and significant discrimination against women, local female staff may need considerable professional support, since their work may challenge local norms (e.g., their work with ex-prostitutes) and may thus not be well accepted socially.³⁶

For trafficked girls or boys, safety and security are the major concerns. If possible, it should not be known that a shelter houses trafficking victims, as such knowledge could jeopardise the victims' safety and cause stigmatisation in the community. Sometimes safety concerns may conflict with residents' needs for education, recreation and freedom of movement. This is particularly true of older teenagers. Individual safety plans and creative solutions need to be found to prevent girls or boys from being confined to the shelter.

Due to the limited availability of shelters in many countries, girl victims of commercial sexual exploitation may have to stay in the same facility as women, or with victims, for instance, of domestic

sexual/physical abuse. In such cases, mechanisms need to be in place to ensure that the girls receive adequate care in terms of counselling, medical, legal and educational support and also education. In countries or areas with boy prostitution, shelters and programmes must address their recovery as well.

In general, smaller shelters (housing not more than 30 residents) under the care of "house parents" are more conducive to girls' and boys' recovery than larger ones because of the more personal and family-like atmosphere.³⁷

3.2 Quality of care standards in psychosocial support and counselling

Psychological recovery is at the core for girls and boys who have survived (commercial) sexual exploitation. Emotional and social problems resulting from traumatisation are a major obstacle to the recovery of CSEC victims and to their reintegration into normal social life.³⁸ Victims often suffer various psychological problems, commonly including depression, anxiety or hostility symptoms and post-traumatic stress disorders; other disorders may be self-inflicted violence or even schizophrenia.³⁹ Psychosocial support thus needs to be an integral part of all activities at all stages of the recovery process. All institutions involved in this process, including law enforcement agencies, should thus be in a position to provide some degree of psychosocial support.

Victims may need different types and levels of psychosocial intervention, depending on their experiences, the problems they have that are traceable to the traumatisation, and their individual resilience and ability to cope. A distinction is often drawn between counselling, psychological treatment and psychiatric care.⁴⁰

³⁵ On this see Frederick (2002).

³⁶ This also applies more generally to supportive or counselling work with women and girls in the area of sexual/reproductive rights of women. Experience/lessons learned by medica mondiale, as expressed in an interview with Karin Griese, 22.6.2007.

³⁷ On this see Frederick (2002); similar information by Thomas Westermann of the Karl Kübel Stiftung.

³⁸ See ILO-IPEC (2006a), 42.

³⁹ See Zimmermann et al (2006), 16– 22.

⁴⁰ See for example, ILO (2006), 42; ILO-IPEC (2002b); UNICEF (2006b), 71.

Psychological treatment, usually as psychotherapy, deals with the mental and behavioural problems connected with traumatisation. It helps the girl or boy to learn to cope with the feelings associated with it. Ideally, such interventions should be carried out by specially trained psychologists, psychiatrists or counsellors. Psychotherapy can take place individually or in small groups.

Psychiatric care responds to the more serious mental disorders, like schizophrenia, which also require medical treatment.

Psychosocial counselling refers to support for girls and boys that boosts their self-confidence and decision-making and interpersonal skills, and that helps them to reconnect socially and to come up with strategies to protect themselves against discrimination, etc. It involves client-centred components and problem-solving strategies. This type of counselling is the most common and may be provided by social workers or other specifically trained para-professional staff.⁴¹

The overall goal of any form of psychosocial support is to empower children and youth and enable them to heal their emotional, mental and/or psychological wounds. This means enabling them to:

- live and deal with their traumatic experiences and associated feelings
- stop feeling powerless, manipulated and subject to others' commands
- activate their internal and external resources to help themselves
- build up new relationships
- (re)gain self-confidence and a sense of control over their lives and future.⁴²

Any form of psychosocial support takes place in a specific national, cultural and social context which also needs to be taken into account. Cultural and religious norms have a major influence on the ability of children and youth to recover from abuse and find coping strategies for social and cultural reintegration. On the one hand, these may constitute limits in terms of taboos or gender-specific restrictions on behaviour, identity development or also educational or professional choices, especially for girls and young women. On the other hand, successful psychosocial healing and rehabilitation may also mean drawing on positive cultural resources, such as spirituality, rituals, cultural activities or establishing culturally/socially embedded strategies for social reconnection with others.⁴³

Most psychosocial support is part of a long-term rehabilitation scheme. Some victims, such as older girls, may also seek more ad hoc or short-term counselling for specific problems, for instance, in drop-in centres. All institutions providing psychosocial care for sexually exploited and abused children, however, must have standards or guidelines geared towards the provision of safe, respectful, supportive and empowering counselling of victims. The following suggestions are drawn from various sources, both international and German. They apply predominantly to psychosocial care as the most common form of support, and to some extent to psychotherapy.⁴⁴

41 For training manuals for counsellors and para-professionals working with trafficked children see ILO-IPEC (2002b) and ECPAT (2005a), (2005b).

42 See for example UNICEF (2006b), 71; medica mondiale (2004), 362.

43 How indigenous knowledge can be strategically integrated into psychosocial support and counselling for child victims of (commercial) sexual abuse has not yet been systematically explored. Yet this is presumably part of individual counselling practice in many contexts, as cultural aspects play an implicit (or even explicit) role in any counselling process. On this issue see Procacio-De Castro (2002).

44 The sources are most notably the above mentioned manuals by ILO and ECPAT and the publications on quality standards by the Bundesverein für Prävention von sexuellem Missbrauch an Jungen und Mädchen e.V (2003) and the Bundesarbeitsgemeinschaft feministischer Projekte gegen Gewalt an Mädchen und Frauen (2004). Transferring standards from German or Western settings to non-Western countries may be problematic, as the latter, for various reasons, may not have adequate resources for fulfilling these standards. Therefore, only basic standards are extracted which also correspond to the general UNICEF guidelines or ILO-IPEC standards on victim protection. Psychiatric care is not included. Specific quality standards for psychotherapy should go into greater depth regarding diagnosis, specific interventions for various symptoms, etc., which are too detailed for the scope of this paper.

Enabling conditions for counselling/psychotherapy

QS Structure	<p>Facility/rooms for counselling/therapy are accessible yet apart; they have a friendly ambiance and are physically comfortable.</p> <p>All information is kept confidential and is accessible only to the case management team.</p> <p>Sufficient adequately trained staff for psychosocial counselling is available for the children and youth in a shelter or drop-in centre, so that long waiting lists are avoided.</p> <p>Counsellors speaking the language of the girl or boy are available, and if possible are of the same/similar ethnic, religious and class (caste) background. They respect the child's cultural/ethnic/religious background.</p> <p>Child protection policies for counselling are in place; the two-person rule is observed when possible.</p> <p>The girl or boy has one counsellor who is consistently responsible for her/him.</p> <p>Different types of therapy or interventions are available to children and youth, i.e., individual, group, and other creative forms of therapy.</p> <p>Counselling/therapy are provided in the victim's mother tongue when possible, or with the help of an interpreter trained in counselling/interviewing techniques.</p>
QS Process	<p>As part of case management, an individual counselling plan/programme is developed that takes into account the child's or young person's age- and gender-specific psycho-emotional development and needs.</p> <p>Children and young people participate voluntarily in counselling/therapy, i.e., in defining their aims and in expressing their desires and complaints. They are not forced into counselling against their will.</p> <p>A girl or boy has regular sessions, with appointments that are scheduled in advance and take place reliably. Individual counselling sessions generally do not exceed 45 minutes.</p> <p>All staff coming into contact with the children is aware that the child is undergoing psychotherapy/counselling. In their interactions with the girl or boy, staff members are guided by the aim of supporting her/him in regaining a sense of security, predictability and control.</p>
QS Output	<p>Counselling/therapy takes place in a safe, friendly and protective space; the rights and needs of girls and boys are respected.</p>

One important key to achieving psychosocial recovery and empowerment is the rapport between the counsellor/therapist and the child or young person. Only when a girl or boy experiences the healing experience as a safe, reliable, protective, empathetic relationship with the counsellor/therapist can she or he regain confidence, trust and empowerment.

Therefore, the personality, qualifications and skills of the professional therapists or counsellors, which they apply in counselling, are highly important.

Care by counsellors/psychotherapists

QS Structure	<p>Role distribution among staff in a facility providing psychotherapy, psychosocial counselling and non-counselling is clearly defined.</p> <p>All staff members involved in psychosocial care and therapy have qualifications and/or are adequately trained in: diagnosis; the context for sexual exploitation of girls and boys; gender/age aspects; treatment techniques; communication skills; listening skills; appropriate behaviour towards the children.</p> <p>Counsellors/psychotherapists cooperate with other professionals and institutions as part of the case management team and can, when necessary, refer the child to other services (e.g., on drug abuse, psychiatric care, etc.).</p> <p>Counselling staff is not overloaded with more cases than they can handle.</p>
QS Process	<p>Counsellors/psychotherapists participate regularly in training sessions on specific issues and new developments in the treatment of victims of commercial sexual exploitation.</p> <p>Progress in counselling/therapy is regularly considered in the case management process.</p> <p>Counsellors/psychotherapists are supervised, with feedback and an opportunity to reflect on their cases and counselling methods.</p> <p>Counsellors/psychotherapists receive assistance/training in meeting their own emotional/psychological needs and avoiding burn-out syndrome.</p> <p>The staff members have no inappropriate physical contact with individual CSEC victims and cultivate no private contact with them.</p>
QS Output	<p>Counsellors/psychotherapists are able to assess victim treatment needs, provide adequate counselling/psychotherapy, and take any measures needed for the children's psychosocial recovery.</p>

3.2.1 Experiences and recommendations for capacity development

A major area for capacity development is the training of staff working with CSEC victims during their recovery and rehabilitation. First, staff of all organisations involved in providing recovery services to CSEC victims, including law enforcement and medical personnel, should be sensitised to and trained regarding specific victim needs, counselling and interviewing methods, and developing a supportive attitude towards the girls, young women or boys. Second, in many countries, training sessions for counsellors and psychotherapists on CSEC, appropriate intervention strategies and counselling skills need to be developed and implemented.

Handbooks and training guides for psychosocial counselling and care with high quality of care standards are already available, e.g., by ECPAT (2005a; 2005b) and ILO-IPEC (2002b). These may have to be adapted or further developed for the specific country or socio-cultural context, but they can serve as a useful starting point for the development of training programmes.

Training should be available for psychologists and social workers alike; ideally it should be geared to the specific professional profiles of each group. The distinction between psychosocial counselling and psychotherapy may be difficult to maintain in reality. A country may have few psychotherapists readily

available, especially professionals qualified to work with child victims of (commercial) sexual abuse. When such therapists are not available, social workers must be trained so that they are well equipped to treat psychological problems. Furthermore, social workers in shelters may have to deal with the psychological consequences of traumatisation during everyday shelter life as well as in counselling sessions. This means that a high standard of expertise for social workers is essential, which must be provided for them through adequate training.

Training for social workers and psychotherapists on CSEC and violence against children, including gender-based violence, must be founded on a human rights approach. In particular, when dealing with victims of commercial sexual exploitation, such training must also emphasise gender-specific aspects and the needs and rights of girls and adolescent women. Most effectively, training sessions should not be limited to individual institutions but should be conducted nation-wide for both state and non-state institutions. Ideally, they should be an integral part of the development of national standards for CSEC counselling, which should in turn be in line with international child rights protection standards as applied within the specific cultural context. At international and/or regional workshops, agents and organisations may draw on the experiences of other organisations or countries regarding the development of specific training for intervention strategies and counselling skills.

Good practice example on listening skills

Comments child and adolescent victims of trafficking have made during workshops about their experience of being interviewed – how they feel when they are listened to:

- Relief
- Not alone
- Recognition
- Loved, valued, cared about
- Belonging
- Affirmed
- Respected
- Important
- Trusted
- Self worth
- Unburdened
- Wider view
- Different perspective
- Clearer understanding
- Challenged
- I sorted it out for myself with your help
- Real
- Exploring

(Adapted from UNICEF 2004, 42)

Training in specific counselling and communication skills

An important issue in counselling/therapy are victims' different needs and how they can develop the strategies, tools and techniques they need to deal with these. For instance, young children may not be able to speak about what has happened to them so that play or art therapy approaches may be useful. They also need a more protective approach than older girls and boys, who may be treated more like adults, with stress on aspects such as freedom and self-control.⁴⁵

Good practice example of therapeutic work with younger children

In Bangladesh, Nari Unnoyon Shakti children's home uses art therapy and drawing as a way of getting younger children to open up and discuss their feelings (Source: ILO 2006a, 42).

Moreover, victims from different ethnic, religious or cultural backgrounds may have experienced exploitation differently, since discriminatory patterns play an important role in sexual exploitation. They might be reluctant to speak about their experiences with other children or a counsellor/therapist from a different background. Putting victims with very diverse backgrounds or experiences into a single group may cause tensions within the group and thus jeopardise the recovery process and therapeutic success.

Adolescent girls who have been sexually exploited need particular reassurance and support to regain their self-esteem, learn how to protect themselves, and say "no". Pregnant girls and teenage mothers also need specific psychosocial counselling to learn to cope with the additional stigma they often experience in addition to their child-care responsibilities. Sexually abused boys may be particularly reluctant to speak about what has happened to them, as it not only involves physical and emotional violations but also violation of the social/cultural norms of masculinity to which they aspire. Depending on whether boys were exploited by men or women and depending on whom they prefer to be counselled by, both male and female counsellors should be available to them. Creative techniques of therapy to support male self-confidence-building may have to be developed.⁴⁶

Linking counselling to developing life skills and culture-specific resources

For successful psychosocial recovery and regaining of self-esteem, victims may need support in enhancing life skills. The self-confidence gained through knowledge acquired or specific educational/vocational qualifications (see below section 3.3) may support psychological healing. Focussing on these aspects may particularly help those girls and boys who do not wish to talk about their experiences. In addition, counselling on issues such as substance abuse, sexual and reproductive health and rights, access to contraceptives and HIV/Aids prevention/ testing may also need to be offered to help girls, young women or boys gain control of their lives.

Good practice example of building self-confidence and creating a positive self-image

As part of its micro-project programme, ECPAT is supporting RAICES, a member of ECPAT Chile, to run a three-month journalism workshop for CSEC victims in the process of recovery. Participants will create a video on a topic they consider important, assisted by an experienced journalist and RAICES staff. The aims include allowing participants the opportunity to shape a positive image of themselves on camera and to develop their skills and sense of accomplishment.

(Source: ECPAT international newsletter, ECPAT 2004b)

⁴⁶ On the specific situation and needs of boys and intervention strategies see Hernández (2005).

Drawing on cultural practices and resources in psychosocial care and counselling may be another important factor in the treatment of victims of CSEC. There may be specific indigenous communication patterns, spiritual or religious practices, or practices for the treatment or nurturing of children which could also play a part in the overall caregiving or counselling process. Also, social norms and cultures shape the behaviour as well as the choices (and, often better known, the limitations) of strategies for recovery of CSEC girls and boys. As most guidelines and manuals on standards for the recovery and rehabilitation of children and young people stem from international sources and organisations, integrating indigenous knowledge and perceptions on healing or health as a resource for the recovery of exploited children has not yet been sufficiently explored.⁴⁷

Linking individual counselling with prevention

Psychosocial counselling of CSEC victims should not be seen as individual interventions but should be placed within the larger political and social context of CSEC and of interventions against it. The success of individual counselling may be heightened through measures for primary prevention, advocacy or awareness raising. Protective laws, anti-CSEC campaigns or campaigns to create a supportive institutional environment for CSEC victims may help them feel less isolated, stigmatised, fearful, and abandoned. Such measures need to be geared towards preventing secondary victimisation of CSEC victims by society and the communities they live in. Placing the battle against CSEC on the political agenda may help society become more aware and sensitive not only to the dangers of CSEC but also to the problems CSEC victims face.

Good practice example for linking individual support and advocacy

Making the connection between individual counselling of women and girls and political advocacy of changes in discriminatory laws, norms and practices is a key quality standard of medica mondiale. In Afghanistan, the organisation has had good experience with linking individual psychosocial support and counselling to a campaign against child marriage. The campaign made the public and decision-makers more broadly aware of the problems and issues involved. This in turn made it easier and more legitimate for victims of child marriage to seek help in the medical counselling centre of the local medica mondiale partner organisation.⁴⁸

3.3 Quality of care standards in rehabilitation and case management⁴⁹

The rehabilitation of victims of CSEC is a complex process covering physical, mental and social recovery. The goal is to empower children and young people personally and socially and to equip them with the skills and resources they need for social reintegration and to lead a life free from exploitation. Three major aspects for successful rehabilitation are:

- psychosocial and physical healing and empowerment of the girls and boys
- economic/educational prospects, so that they are not trapped into sexual exploitation again
- finding a durable and supportive living situation which provides care for them – a community, family or other form of institutionally supported living arrangement.

⁴⁷ See Procacio-De Castro (2002).

⁴⁸ On medica mondiale's quality standards see medica mondiale (2004), 119-130. The example was provided by Karin Griese from medica mondiale in a telephone interview, 22.6.2007.

⁴⁹ In particular, ILO-IPEC, with its Trafficking in Children South Asia (TICSA) Programme, developed guidelines for case management based on the practices of several NGOs and children's facilities in Southeast Asia, such as the Centre for the Protection of Children's Rights Foundation (CPCR) in Bangkok. For a detailed account of standards and guidelines based on CPCR experiences see Koompraphant, et al (2002).

As already mentioned, CSEC victims have a variety of needs that must be met if they are to recover and be enabled to lead a life free from exploitation in future. Successful rehabilitation depends on an integrated strategy that addresses all of the medical, health, psychosocial, educational/vocational, economic and legal needs and issues that arise during recovery. Such a strategy also includes services in the area of sexual and reproductive health and rights, which are often essential, especially for older girls and young women who have been commercially

sexually exploited. Being able to access these services is one of the fundamental rights of girls and boys and is part of a rights-based approach to rehabilitation of CSEC victims. Rehabilitation and case management must therefore take a multidisciplinary approach with links to actors or organisations providing these services to victims. It must set up structures and processes that ensure effective cooperation between these organisations and their services to the girl, boy or young adult.

Multidisciplinary approach⁵⁰

QS Structure

A multidisciplinary team is formed of medical, psychosocial and legal professionals – people from inside and outside the residential facility where the girl or boy is staying. Communication channels and a cooperation structure among team members are established.

Cooperation agreements between various institutions offering relevant services to victims and local government departments for social/youth affairs are in place (in particular when the issue of custody is involved).

A structure or mechanism is in place for the supervision of case management.

QS Process

As soon as possible after the child is admitted to a recovery facility, his or her case should be reviewed in an intake assessment that covers the history of exploitation, risks, and a needs analysis. A detailed individual rehabilitation plan should be established with the participation of the girl or boy, and when possible the family.

Regular case conferences and planning sessions take place, with all relevant organisations present. The implementation of the plan is documented by the case manager and monitored, with a review at least every 60 days.

Team members undergo regular training on case management methods and improving their services.

QS Output

Case management covers all of the victim's legal, medical, psychosocial, social welfare, educational and economic needs. It takes steps towards planning a child's future life in all these areas and measures to implement and follow-up on them.

⁵⁰ This section on multidisciplinary approach is largely based on ILO-IPEC (2006c).

Rehabilitation needs may be specific to each individual case and depend on many factors, such as age and sex of the victim, the circumstances, conditions and nature of their sexual exploitation, personal resilience and coping capabilities, education, familial and community background, culture and religion. These differences must be taken into account by professional case management. Also, the participation of victims in their own rehabilitation management and especially the voluntary decision by older girls and boys to stay in a rehabilitation centre or programme are prerequisites for successful case management and rehabilitation.

According to ILO-IPEC, "case management is a system of planning, assessing and responding to each individual child from the point of intake up to and including monitoring their reintegration"⁵¹. In this system, a child is ensured individual care,

protection and integration according to the assessed needs and his/her expressed wishes. Ideally, case management begins with the intake assessment, when a girl or boy comes to a rehabilitation centre and a protection, rehabilitation and reintegration plan is formulated and implemented. Case management is usually located within the caregiving facility where the boy or girl is staying.

Five basic features of case management:

1. Collecting facts and evidence
2. Protection and welfare of the child
3. Assessing the case, treatment/rehabilitation planning
4. Executing treatment/rehabilitation plan
5. Planning and executing a social reintegration plan

(Source: ILO-IPEC 2006a, 32)

Child rights protection in the case management process

QS Structure	National guidelines for collecting facts/evidence; intake, interviewing, medical and forensic care and legal protection are in place and are observed by all state and non-state institutions involved in intake, case management and rehabilitation processes. Policies and guidelines are in place for child participation in case management.
QS Process	Children and young people are informed about all steps in case management, and their views and wishes are taken seriously. They participate in all decisions on their case. All staff involved in intake and case management are trained in child rights protection and child participation methods. A case officer and/or guardian is appointed to the child; the child has regular contact with her/him and can approach her/him with wishes and concerns.
QS Output	Victims are protected from being criminalised, retraumatised or disempowered at any stage of case management, e.g., during intake, interviewing or plan-making.

3.3.1 Experiences and recommendations for capacity development

One challenge for implementing a multidisciplinary approach is to establish good cooperation between the actors from the different fields. In addition, certain services, such as medical services, may be easier to provide in some regions than other services, such as legal services, psychological treatment or vocational training. Services belonging to the multidisciplinary approach should also include counselling and support on matters concerning sexual and reproductive health.

to facilitate effective cooperation in multi-disciplinary teams, teams and team members should receive adequate training and supervision. Such training should also extend to conducting case conferences and managing cases in general. The formal management system may be another challenge. Keeping records of a case – i.e., data on a girl or boy, the rehabilitation plan and all measures taken – which are accessible to all team members can speed up a rehabilitation process. Formalised computer systems may be helpful (see example below).

Good practice examples on implementing a multidisciplinary approach

Centre for the Protection of Children's Rights Foundation (CPCR) in Bangkok⁵²

The CPCR developed a multidisciplinary approach to case management that was adopted as national law in 2003 and applied to all government homes for trafficked children. The CPCR assisted a government home in establishing the multidisciplinary approach to case management. As a result, the home now has more diversified staff, including psychologists, lawyers and teachers from outside the shelter, who come together regularly for case conferences. A CPCR advisory team visits the shelter monthly to follow up on cases referred to it and to assist in improving the integration of a multidisciplinary approach.

Transferring the CPCR approach and lessons learned⁵³

Under the ILO-IPEC TICSIA I Programme, the CPCR approach was transferred to and successfully implemented at the NGO HELPLINE in Nepal, which runs a transit home, where it has been supplemented by a computerised management information system. This allows team members access to data and updating and permits reliable reporting, which has proved very useful in case conferences.

Adequate and on-going training of staff and top management is necessary for the development of an efficient case management system. Networking with local service providers for support is another key to effective management. Tools for letting children and young people participate in case management need to be developed.

Effective case management depends on functional communications networks between institutions and professionals from different institutions. Establishing these may be a difficult task, not only nationally but also for bilateral cooperation, for instance when the rehabilitation/return of trafficking victims from another country is involved. There are a number of reasons why members of multidisciplinary teams may not cooperate well, including differing case assessments, little understanding of the professional views of team colleagues, or work overload. In order

⁵² ILO-IPEC (2006a), 34; see also ILO-IPEC (2006c).

⁵³ ILO-IPEC (2006b), 43.

Good practice example of individual case management⁵⁴

Maiti Nepal uses three simple monitoring forms for individual case management assessment and assistance. An intake form includes background information and initial assessment of the child; another form includes a rehabilitation plan developed by the child and the case worker together, plus monitoring information on the child's progress; and the exit form assesses the child's status on departure from the rehabilitation home, contact information, follow-up support plans, and sections for monitoring education, vocational training, health status, legal procedures, family/social status, etc. This approach helps case managers to monitor and maintain support for the children and young people, which gives them a better chance of embarking on a new, safer life.

Meeting the individual needs of a girl or boy may be difficult in circumstances with limited resources and when certain legal and medical procedures are given. Developing satisfactory individual solutions within given structures and with certain constraints may pose quite a challenge to a case management team, which must display a high level of creativity and commitment.

The participation of a child or young person in case management presents another major challenge. Even when care-givers seriously intend to integrate children and young people into case management, they encounter difficulties in reality. Depending on the age as well as the physical and emotional state and experiences of a victim, the level of his or her cooperation/participation in case management may be low. In particular, following intake, a child may not be able to cooperate well with the team because of mistrust, fear, confusion or preoccupation with physical recovery, for instance, from drug abuse, etc. Thus, girls and boys may not be very open or may be unable to voice their needs. They may even resist participation in case management. Hence, instruments need to be developed to support staff in dealing with these problems and in applying different tools with regard to different age groups. These can include: communication techniques, participation games and methodologies of decision-participation, value clarification and life planning.

Finally, a more fundamental problem for rehabilitation efforts is outreach to victims of commercial sexual exploitation. As already mentioned, children and youth are usually admitted to rehabilitation centres or shelters as a result of compelled withdrawal, mostly by the police. Although it may be more conducive to the girls' and boys' rehabilitation if they themselves to decide to leave prostitution, this may not be easy to achieve. It is difficult to reach CSEC victims in the first place, and difficult, too, to convince them to leave prostitution and with the lure of better prospects. One existing outreach approach consists of drop-in centres in red light districts or areas with street prostitution. These can provide services such as meals, counselling (e.g., on sexual and reproductive health and HIV/AIDS), condom distribution, or recreational activities. Mobile health clinics, street-worker teams that approach street children, or interception points at places where prostitution is widespread may also offer outreach opportunities which could be expanded.

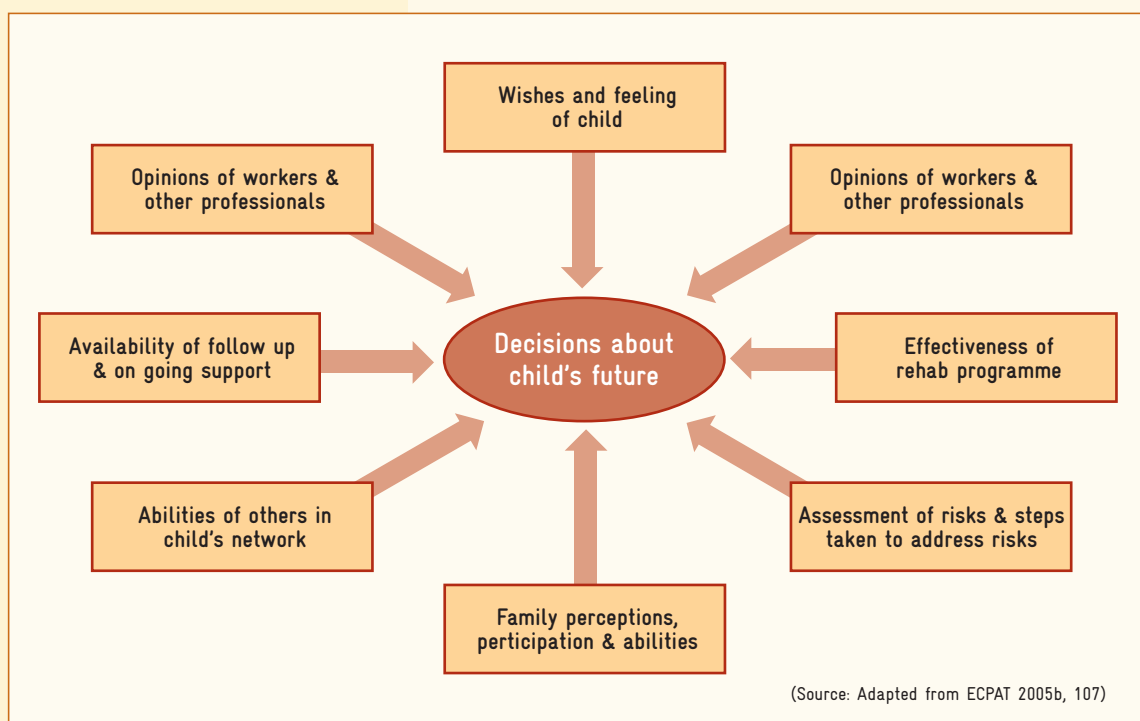
3.4 Quality of care standards in reintegration

The full and permanent reintegration of a victim of commercial sexual exploitation into his or her family, community or other independent living arrangement is the primary goal of recovery efforts. An integration process should begin only when a number of preconditions have been met:

- The girl or boy has physically and mentally recovered from the traumatisation and is able to deal with the emotions and memories connected with it.
- He/she has developed interpersonal and life skills.
- The family and/or other main persons in the community to whom the child will closely relate have been positively assessed.
- The child or young person has some educational and/or economic prospects.

Most national and international organisations recommend that children and young people be placed into a family context, including foster care, rather than into a permanent institution. In order to assess the progress of integration, they also suggest regular monitoring for at least 12 months and as much as three years.⁵⁵

ECPAT has developed the following model of aspects to be considered in decision-making about a child's future and reintegration:



55 For instance ILO-IPEC (2006a), 28.

Victim's reintegration into family and/or social community

QS Structure The reintegration programme is embedded within an institutional structure. Services are in place and are integrated into case management to support all of the child's rights and needs throughout the reintegration process.

QS Process An acceptable and safe place for the child to live is found; the risk of re-exploitation is assessed.

Measures are taken to ensure safety, education, vocational training, income generation and job placement.

The child or young person is assisted throughout the entire reintegration process by her/his case officer or a social worker known to her/him.

She/he receives care and support during and after the placement process; confidentiality about her/his history is ensured. Regular monitoring is conducted. A local partner organisation may serve as a caregiving organisation and/or link to the original rehabilitation organisation.

QS Output Responsibility for the girl or boy is placed in the hands of the family/community legally responsible for the child's care and welfare.

Her/his safety and economic, physical and mental well-being are secured.

The reintegration solution corresponds to the wishes of the child or young person.

3.4.1 Experiences and recommendations for capacity development

Rehabilitation and reintegration measures in Cebu City⁵⁶

Since 2002, the German Karl Kübel Foundation and the W.P. Schmitz Foundation have been supporting a rehabilitation centre run by the Christian order "Sisters of the Good Shepherd" in Cebu City, where child prostitution is rampant. Originally intended for pregnant girls and teenage mothers wanting to escape prostitution, it today houses about 30 girls and young women with and without children and about 20 children from 13 to about 25 years of age. They can stay in the centre up to three years and receive psychological care in the form of individual and group therapy, counselling, health care (for instance, for pregnancy or drug abuse), legal support (e.g., with legal proceedings against pimps/traffickers), education in cooperation with the local schools and recreational activities. In preparation for reintegration, the girls acquire life skills and are trained in domestic chores and informal income-generating activities. Individual reintegration plans and solutions are developed. Since its inception, the centre has treated more than 100 girls. It is estimated that about 30% left the centre to go back to prostitution, 40% were placed with their original families (where it was not possible to follow up what happened to them, however) and for the other 30% other solutions were found, such as jobs as a household helper with a Christian order, etc.

Lessons learned: Rehabilitation and reintegration are very difficult, in particular with girls and young women who were employed as prostitutes for a long time. Long-term care and specific solutions are required for each individual case. Profound psychological problems and drug abuse are major challenges, and their treatment is a prerequisite for successful rehabilitation. Teaching life skills and providing economic perspectives are equally central. A small residential home with "house parents" and social workers provides a family-like atmosphere, which is important for healing in a cultural context such as that in the Philippines, where family and community are important pillars of social life and for the individual. Such homes give the girls and young women a chance to develop new social relationships. Keeping singles and young mothers with children together, however, is not ideal and can cause conflicts. For those girls who cannot go back to their families (yet), an after-care project including group housing and support with income generation activities, vocational training and/or job placement has now been set up and is the first of its kind in the area.

National repatriation schemes or bilateral repatriation cooperation agreements are often a major problem for the successful reintegration of trafficking victims, since they often call for speedy repatriation of the victims. This may not always be the best solution for the boys or girls and may run counter to their needs and rights and to recommendations by child protection organisations. Lobbying and advocacy for special child-protection migration policies and laws for child victims of trafficking, for example, are thus an integral part of working for successful rehabilitation of children.

Reintegration into families or communities of origin is often not possible for a number of reasons. Families may refuse to take the children or young people back for fear of stigmatisation and shame. In particular teenage mothers may not be able to go back to their communities. Sometimes and in particular when the victim has lived for several years in prostitution, families of origin are difficult to locate: for instance, when the family used to live in a slum and has moved somewhere else. Also, many families of origin are themselves dysfunctional and abusive to their children. In other instances, girls or boys themselves may not want to go back to their communities out of shame, fear of being stigmatised or because they do not have the strength to face the questions and reactions of the community.

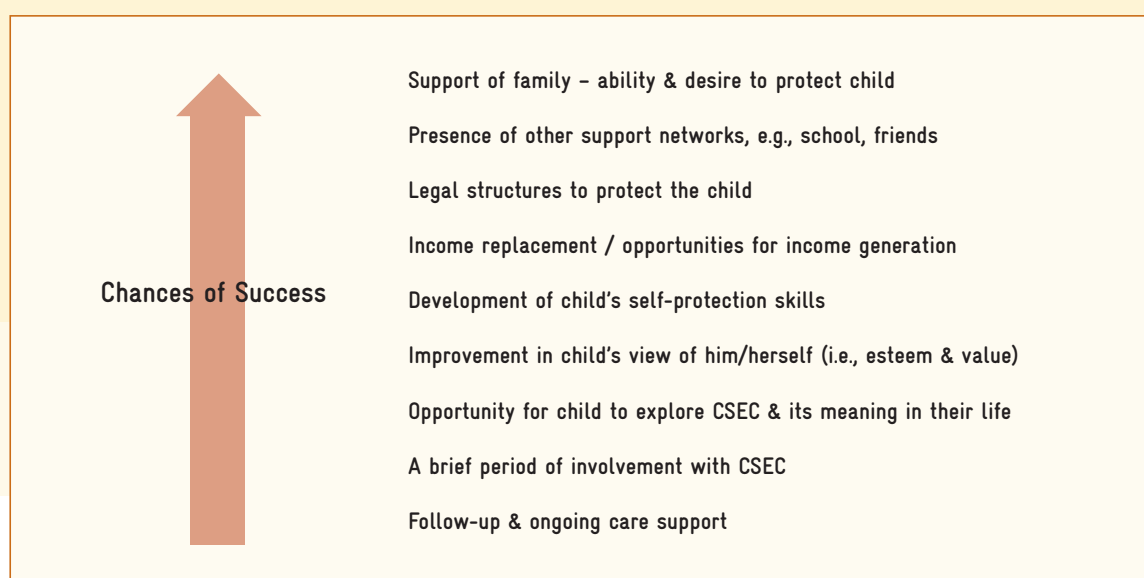
⁵⁶ Information taken from the interview with Thomas Westermann on 5.7.2007; for description of the centre see also www.kkstiftung.de.

To find foster families may prove equally difficult in many countries. In addition, there is no guarantee that the victim is entering a healing environment or that she or he will not be exploited or abused once more. Semi-independent housing schemes may provide an alternative living arrangement for teenagers. Teenage mothers need special housing as well as support programmes with child care, income generation, vocational training and/or job placement. Stable and long-term solutions with supportive institutional and informal networks are of particular importance to them.⁵⁷ Options for long-term care for CSEC victims who cannot return to their families are however rare in most developing countries and in (South) Eastern Europe as well.⁵⁸

Many children and young people who have been sexually exploited for a long time and consequently traumatised have problems acquiring basic life skills and abilities as a result. As already indicated, they may have emotional problems, difficulty in building social relationships, or simply trouble concentrating for a longer period of time. They may not be able to deal with having to attend school on a daily basis or with taking over family/ communal respon-

sibilities. Money may also be an issue. While victims of child prostitution are usually deep in debt during prostitution, especially older teenage girls are nevertheless able or permitted to buy themselves nice clothes sometimes. Having no or little money at their disposal during reintegration and/or having to do some other form of hard work for little pay may thus, discourage some girls and may be a factor inducing them to return to prostitution.⁵⁹ Thus, it is clear that returning girls or boys may have to cope with a number of problems, and that they need adequate time for psychological recovery, emotional healing, and building up their self-esteem and skills prior to reintegration. Also, they may need ongoing psychosocial support during reintegration to deal with the new situation and its challenges. Such support may extend to the entire family, to enable them to provide a healthy environment for the victim.

As a guideline for developing and assessing reintegration measures, adapted from ECPAT (2005b; 109) has developed the following indicators of the likelihood of successful rehabilitation and reintegration into the family of origin⁶⁰:



⁵⁷ On the needs of teenage mothers and intervention strategies see Fernández (2005).

⁵⁸ See for instance for South Eastern Europe Surtees (2007), 152.

⁵⁹ Information by Thomas Westermann, Karl-Kübel Stiftung, referring to the Cebu centre, 5.7.2007.

⁶⁰ ECPAT (2005a).

After-care support

After-care support for individual victims of CSEC and their families or foster/adoptive families is an important factor for securing successful and sustainable integration. Such support should entail individual psychosocial counselling for the girl/boy as well as for the family on how to care for and support the victim. Experience has also been good with counselling on income generation, education, life skills for the individual girl or child and, where necessary, for the entire family.⁶¹

Ongoing after-care support for victims and their families is still the weakest area within support strategies for reintegration.⁶² It is difficult to monitor reintegration and provide continuing care once victims have been (re)integrated into families. For one thing, most organisations and services are located in capitals or major cities, while the victims' homes are usually outside of these cities, often at a great distance from them. Second, victims may not want to stay in touch with their rehabilitation organisation or any other local organisation serving as a link to the rehabilitation organisation for fear of stigmatisation in their old/new community. Hence, organisations lose touch with the victims and may not be able to protect them against sexual re-exploitation. In many cases, reintegration is not successful, and the girls and boys become victims of (commercial) sexual exploitation and trafficking once again. For example, of 1000 girls and women removed from Indian brothels, 25% were reported to have ended up in prostitution again.⁶³

Devising strategies for securing after-care services is thus a major task for policy development generally and for the particular projects/strategies of organisations. An integrated approach is needed for this: networking with local organisations, schools, police, and health professionals (such as local nurses) may be one element in support for an individual victim and her or his family. Connecting these to wider local prevention and awareness-raising measures in cooperation with local institutions may help to sensitise a community about CSEC and prevent secondary victimisation of victims.⁶⁴ There has been good experience with the development of local protection schemes against trafficking and traffickers who come to villages to recruit children, for instance in the Philippines.⁶⁵ When communities are aware of trafficking, and when victims and their families enjoy after-care support without fear of being stigmatised, the risk for boys and girls of being re-trafficked can be reduced.

"Peer-to-peer" projects, in which victims of trafficking become peer counsellors in drop-in centres or part of awareness-raising campaigns, have also been implemented, one example being, again, the work of the rehabilitation programme in Cebu, Philippines.⁶⁶ This approach is promising because of its high degree of authenticity. However, organisations need to be very careful and act responsibly in selecting victims who are able to deal mentally and socially with this task.

61 Information by Kindernothilfe about experiences in Africa, via email, 10.9.2007.

62 See for example "Withdrawal to Integration – a long complex process", by Anil Raghuvanshi, ECPAT Newsletter 46/1, ECPAT (2004a) as well as the whole study of Surtees (2007).

63 These numbers are taken from "Withdrawal to Integration – a long complex process", by Anil Raghuvanshi, ECPAT Newsletter 46/1, ECPAT (2004a).

64 Information by Kindernothilfe about experiences in Africa, via email, 10.9.2007.

65 Interview with Thomas Westermann, Karl Kübel Stiftung, 5.7.2007.

66 Interview with Thomas Westermann, Karl Kübel Stiftung, 5.7.2007.

Good practice example on after-care support⁶⁷

"One woman explained how she had started her own small business and was doing well after some time. But an economic problem in her family meant that she suffered setbacks which were only remedied by targeted assistance.

[The organisation] helped me to start my small business, which deals with selling second-hand clothes. That period in my life was an excellent one. The business was better and better the whole year. I am very grateful to them but I didn't keep my word to invest the money in my business. It happened so that my husband's parents fell ill. I needed money for their treatment.

Because assisting organisations were able to respond to the emergency needs of this woman and her family – medical needs as well as some humanitarian support – it was possible for the woman to get her business back on track. Importantly, assisting organisations coordinated the provision of these services to meet her different needs and, in the end, led to her successful reintegration."

(Quoted from Surtees 2007, 153)

Success story

"Gabriela (pseudonym) from Peru left the city of Cusco, because she could not start a new life so close to her former life. She now has a regular job in the jungle area of Peru where she buys raw gold and sells it to third parties. Slowly Gabriela is making a new beginning."

(Quoted from Goulet 2001, 97.)

4 Conclusion

This paper suggests a number of quality of care standards for major factors in the victim recovery process. Based on existing literature and practice, the following detailed recommendations are made for core areas of caregiving:

1. Caregiving institutions and shelters:

- Improving the child rights approach and child protection policies
- Raising the standard of living and shelter services
- Developing the capacities of shelter staff

2. Rehabilitation measures

- Applying a multidisciplinary approach
- Improving the case management process

3. Reintegration

- Improving measures for the victim's reintegration into the family and/or social community, including after-care

4. Psychosocial support and counselling

- Setting up enabling conditions for counselling/psychotherapy
- Improving knowledge, care and skills of counsellors and psychotherapists

The main areas of capacity development needs in all of these fields are on three levels:

1. Human resources level: Training of staff regarding child rights protection measures, communication and caregiving skills, child participation tools/techniques, psychosocial counselling. Training concepts and guidelines need to be developed and applied, when possible nation-wide, to the training of counsellors, therapists and care-givers.



2. Institutional level: Developing a multidisciplinary institutional network of protection, services and care for victims. This includes linking and cooperation among different psychosocial, educational, health, legal and youth/children's services. It must also extend to services in sexual / reproductive health counselling and HIV/AIDS prevention/counselling.

3. Policy level: Developing an enabling political and social framework for the protection of CSEC victims through legal and policy measures on a national and/or regional level and by linking prevention with rehabilitation efforts. Rehabilitation programmes need to be placed within the larger context of a national plan of action. This enhances cooperation between organisations and the effectiveness of programmes as they are rooted in a common framework and are part of a larger package of nation-wide strategies.

All activities in capacity or programme development and implementation must to be rooted in a rights-based approach that treats children and youth as rights bearers. The approach must also be gender- and age-specific and geared specifically to the target groups, who are mostly girls.

Having read all the detailed suggestions for QCS, one may say: "Well and good. But in reality, there are too many constraints on caregiving for CSEC victims to implement these ideas." And it is true that in most caregiving institutions, staff are already struggling just to cope with their everyday work, often because of the scope of the problem or their limited resources. As a result, staff in care houses or rehabilitation centres may consider the development of QCS an additional burden which is too bureaucratic, costly and a distraction from actual care.⁶⁸

Nevertheless: developing QCS need not and should not be viewed as a theoretical exercise alone. For one, children have fundamental human rights which must be protected: here there must be no compromises. Stakeholders and agents must make every possible effort to ensure this protection. But beyond this legal and ethical responsibility, QCS may be a very useful tool, one that can offer an opportunity for systematically assessing the current situation of an organisation, institutional network or policy – a guideline for a clearer idea of what direction to follow and how to reach the goal. Aims may be small or large, depending on the situation of an organisation or network of actors and their capacities. Introducing QCS also means commitment to an approach that focuses on the output and impact of interventions for recovery and reintegration of victims. In this sense, QCS may be viewed as a vision – and this paper as a source of ideas for what this vision, or some components of it, might look like.

QCS need not be seen as an additional burden but as an integral part of caregiving in that they help to ensure that the highest possible standard of care is sought. The process of developing QCS is in and of itself a contribution to good care as well as an exercise in professional and personal development. In organisations, the existence of QCS may create

clarity in terms of aims, structure and processes, as well as roles and responsibilities and rules. Such clarity may in fact be very helpful in guiding staff and employees in the performance of their everyday tasks. Besides, the development of QCS need not be expensive. Introducing QCS may enhance not only the effects but also the efficiency of a project or programme dealing with rehabilitation and thus contribute to the responsible management of resources. What is crucial is staff commitment to implementation of QCS within an institution.

What is essential for the successful development and implementation of QCS, then, is the establishment of a culture of quality standards for institutions and staff. This can be achieved through specific training and an ongoing process of development, improvement and monitoring of quality standards. The promotion of a QCS culture should be considered an integral part of personal, professional and institutional conduct.

The development of quality standards for the care of CSEC victims should not take place solely in individual institutions. Rather, such standards should be embedded within a larger national and regional framework of actors and policies. It is therefore important that all national and international, governmental and non-governmental actors develop common basic quality-of-care standards for a country or region and make a commitment to implementing these standards, by, for instance, providing the necessary resources. This may also strengthen the commitment of governments and donors to this crucial issue and spur them to make the improvements that are so urgently needed in care for child victims of commercial sexual exploitation.

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Abbreviations and Acronyms

CBM	Christoffel-Blindenmission/Christian Blind Mission
CC	Code of Conduct
CPCR	Centre for the Protection of Children's Rights Foundation
CPP	Child Protection Policy
CRC	United Nations Convention on the Rights of the Child
Csec	Commercial sexual exploitation of children
ECPAT	End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
ILO	International Labour Organization
ILO-IPEC	International Labour Organization - International Programme on the Elimination of Child Labour
ILO-IPEC TICSA	ILO-IPEC Regional Project on Combating Child Trafficking for Labour and Sexual Exploitation
IOM	International Organization for Migration
KVSA	Konventionsvorhaben "Schutz von Minderjährigen vor sexueller Ausbeutung"
NGO	Non-Governmental Organisation
NPA	National Plan of Action
OSCE	Organization for Security and Cooperation in Europe
QCS	Quality of care standard(s)
QS	Quality standard(s)
STC	Save the Children
UN	United Nations
UNHCHR	United Nations High Commissioner for Human Rights
UNICEF	United Nations Children's Fund
VENRO	Verband Entwicklungspolitik deutscher Nichtregierungsorganisationen e.V.
WHO	World Health Organization

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