



Creating a Healing Environment

Volume II: Technical Papers

Psycho-Social Rehabilitation and Occupational
Integration of Child Survivors of Trafficking and
Other Worst Forms of Child Labour



IPEC Trafficking in Children-South Asia (TICSA)

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The ILO's International Programme on the Elimination of Child Labour (IPEC) is dedicated to the progressive elimination of child labour worldwide, emphasizing, as a matter of urgency, the eradication of its worst forms. IPEC works to achieve this through country-based programmes which implement concrete measures to end child labour; and through international and national advocacy and awareness-raising aimed at changing social attitudes and promoting ratification and effective implementation of ILO conventions relating to child labour.



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**11-14 June 2002
Kathmandu, Nepal**

Foreword

The ILO's International Programme on the Elimination of Child Labour has worked to combat Child Labour for over a decade and now runs comprehensive programmes in more than 60 countries worldwide. In 1999, this work was backed up by a new Convention, which by mid 2002 has been ratified by more than 120 member states. Promoting the ILO Convention (No. 182) concerning the Prohibition and Immediate action for the Elimination of the Worst Forms of Child Labour, 1999, is a high priority for the International Labour Organization (ILO).

The Recommendation (No.190, paragraph 2,) accompanying the Convention states that "Programmes of Action should aim at, inter alia:b) preventing the engagement of children in or removing them from the worst forms of child labour, protecting them from reprisals and providing for their rehabilitation and social reintegration through measures which address their educational, physical and psychological needs."

During its work against the worst forms of child labour, the ILO-IPEC launched a sub-regional project in 2000 against trafficking of children for exploitative employment in South Asia (TICSA). One of the technical areas that this project focuses on is the intake, rehabilitation and reintegration process for children withdrawn from sexual exploitation as a result of a trafficking process. The project realized early on that some of the children who are withdrawn from engagement in prostitution indeed have needs that demand special attention from the moment of intake. Psychosocial counseling was not well understood by many of the non-governmental organisations that worked in the field although their work was in many respects very well-intended.

The approach that was developed by TICSA in support of these non-governmental organisations included a focus on understanding the motivation and potential of the child while ensuring the child's own participation in her/his rehabilitation – reintegration. It was found that despite harsh working and living conditions under previous exploitative circumstances, some of these working children have developed resiliency, which they need to learn to put to use in a better way.

Acknowledging the difficult journey that children, who come from an abusive work situation to a classroom situation have to take, the ILO-IPEC decided to allocate time and resources to pursue and deepen the understanding of the psycho-social challenges that many of this children face on this journey.

An informal dialogue was started with individuals and organisations, who shared the same concerns as the TICSA programme and the preparations for the sub-regional Seminar took shape. The enthusiastic participation from paper presenters and participants alike made the Seminar a truly inspiring experience and NGOs and other partners showed a readiness for beginning to change the way they work with children. Request from NGOs and Gos to help develop national standards and guidelines for care facilities as well as professionalized, yet culturally contextualized, training for counselors are examples that show that the Seminar had an immediate impact on the mindset of all of us. The ILO IPEC is very pleased to present the outcomes of the Seminar in this publication.

This path from an exploited child to become a self-confident person holding hope for the future would necessarily involve contextual (cultural and socio-economic) healing processes with different kinds of adult guidance. Filling the gap between the removal or withdrawal from an exploitative and hazardous work situation, including prostitution and sexual exploitation in the work place, was necessary to ensure that maximum conditions are provided for, for the child to succeed as a learner and as an agent in her or his own development. Most of the children in South Asia, who hail from very poor family situations would grow up and become part of the unskilled labour force, if their right to recovery and education are not met. Through proper understanding of the barriers they face, psychological and physical, more children will be empowered to take control over their own lives and perhaps become part of the skilled labour force.

The Seminar also focused on replacing the paradigm of recreational skills training with training of adolescent survivors in skills they can use in building up their economic independence. Realizing that a new identity is closely inter-linked with the working identity, many survivors have emphasized again and again that they want real skills that they can use and which will give them status in the communities where they originally came from. Recreational skills such as weaving and knitting may be therapeutic, but not necessarily a solid source of income in an uncertain future.

I wish to convey my deep-felt thanks to those who provided technical inputs during the course of this initiative: firstly to John Frederick, together with whom the idea of convening the Seminar was conceived and who lend us his vast and long experience from working in South Asia with children, who have suffered trauma from being sexually abused. John prepared the initial concept papers and coordinated the papers as they developed, facilitated many sessions and wrote up the proceedings of the Seminar. John also edited the papers for inclusion in volume II of this publication. Without John, this Seminar would not have taken place. Secondly, I wish to thank all the paper presenters: Dr Shekhar Seshadri, NIMHANS, India, Ms. Atchara Chan-o-kul, CPRC, Thailand, Dr Elizabeth Protacio-de Castro, University of the Philippines, Mark Jordans, Center for Victims of Torture/Transcultural Psychosocial Organization, Amsterdam, Alexander Krueger and Ms. Margot Lobbezoo, who engaged in the process with enthusiasm and who participated in the seminar as professionals and as the persons they are sharing with us examples from their experience from their own world of work.

I hope that this publication will make a meaningful contribution and guide the way and the thinking behind interventions that seek to alleviate painful periods of many thousand children's lives.



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Abstract

This paper presents an overview of the case management process as conducted by the Center for the Protection of Children's Rights (CPCR) Foundation of Bangkok, Thailand, an organization that has been providing protection and rehabilitation for abused children for more than 20 years. It summarizes the case management process from the pre-intake stage of protecting children in immediate danger of abuse, through data collection, intake, assessment, treatment planning, rehabilitation activities and reintegration. The paper outlines the composition and roles of case management teams and presents CPCR's strategies for the protection of the child in the family and community.

Introduction

With more than two decades of practical experience, the Center for the Protection of Children's Rights Foundation (CPCR Foundation) has served and protected numerous children who have been subject to physical, emotional, psychological and sexual abuse. Some survivors were abused repeatedly, especially by their own families, neighbors, teachers, or whoever had easy access to them, and others were victims of trafficking for prostitution. Based on case studies and documented evidence, survivors of child abuse often develop signs and symptoms that reveal the difficult experiences they have undergone. Many children in our care have had to go through a lengthy period of emotional disorders before they could lead happy, normal lives again. For many, these traumatic experiences have had long-term effects on their lives.

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It must be borne in mind that survivors of child abuse are likely to become future abusers themselves, or if they are not adequately adjusted, are highly vulnerable to being abused again. Case studies indicate that most abusers were subject to abuse during their formative years. This issue is very complicated and sensitive, requiring a multi-disciplinary approach to finding solutions to their problems. To say the least, the issue calls for interventions and assistance from various agencies, with professionals trained in different disciplines. Abuse survivors generally require very individual attention and solutions to their problems. Their physical, psychological and social needs must be met individually and personally to ensure the best possible rehabilitation, with the best interests of the survivors considered paramount.

For this reason, one of the main tasks of the CPCR Foundation is to constantly make the public and concerned agencies aware of the importance of working together to address the issues in a sustainable way, as well as tackling the problems structurally.

In any country affected by trafficking or child sexual exploitation, four essential tasks are required to achieve these aims and objectives:

- 1) Building up a network of professionals and organizations committed to data gathering, fact compilation and verification, reporting and intervention on trafficking and child abuse cases.
- 2) Lobbying and advocating for the necessary legislative amendments and/or introducing bills which will effectively promote prevention, rescue, shelter and accommodation, rehabilitation and social reintegration.
- 3) Strengthening community and social awareness of the problems and issues, and laying the groundwork for public support in tackling the issues.
- 4) Through careful case management, providing the best possible services and support to trafficking and domestic child abuse survivors as well as their families.

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This document focuses on fourth task above: case management. It presents the conceptual framework, practical approach and working methods of the case management system employed by the CPR Foundation for the benefit of the survivors of child abuse and exploitation.

NOTE: It must be noted that when this document refers to 'child abuse', the term includes both sexual and physical abuse, and abuse both in the home/community and in a scenario of trafficking, child prostitution and forced child labour. In this document, significant reference is made to child survivors of domestic sexual abuse, because those comprise the majority of children who are these days presented to the doors of the CPR Foundation. We, and the editor of this paper, have included specific references to child trafficking for sexual purposes, and we feel strongly that basic case management procedures can and must be applied to all, with specific adaptations for the abuse history of the child.

Elements of the Case Management Process

In principle, child protection and service provided by the CPR Foundation are focused on the following:

- Children are guaranteed basic safety against repeated or future abuse, including the possibility of 're-trafficking'.
- Rehabilitation programmes, activities and services are directed at the survivor's needs and rights, and are carried out efficiently and effectively.
- To complement the skills of the CPR Foundation staff and to conduct activities in a multi-disciplinary manner, professional assistance and services are solicited from a network of qualified and properly trained specialists, including legal experts, social service specialists, medical doctors and therapists, rehabilitation experts, child protection activists, etc.
- In order to fully carry out rehabilitation and reintegration tasks, networking and mutual support are conducted among concerned agencies and committed personnel representing both GOs and NGOs actively engaged in addressing child abuse and trafficking in Thailand and the countries of the Mekong Basin region.

Child survivors who have been subject to various forms of abuse, whether sexual abuse, physical abuse, psychological abuse or neglect, face multi-faceted problems involving physical health, emotional well-being and social adjustment. They require adequate welfare and protection from repeated abuse, while needing proper rehabilitation for eventual reintegration, so that they may become well-adjusted members of the community, and not become future abusers. This can only be achieved by adopting a multi-disciplinary approach and method.

In usual case management, child survivors receive aid, assistance and support from multi-disciplinary groups, or Case Management Teams, composed of center staff and outside professionals assigned to each case by the center. (For a detailed description of the composition of Case Management Teams, refer to Annex A.) These professionals can include social workers, psychologists, psychiatrists and lawyers, among others. To provide the best possible care and services, each professional either provides the specific service her/himself, or coordinates with other specialists in the network. Assistance from this network can be solicited locally or from other countries in the region.

The basic features of the case management process are as follows:

- 1) Collecting facts and evidence: with a presented case of abuse, collecting preliminary data, followed by collecting and verifying in-depth information, and protecting the integrity of evidence
- 2) Protection: providing protection and welfare for the child survivor
- 3) Assessment and treatment planning: assessing the case, and planning a treatment and rehabilitation programme
- 4) Treatment and rehabilitation: executing the treatment and rehabilitation programme
- 5) Social reintegration: planning and executing a social reintegration programme

Once a case of abuse is filed with PCR, a social worker assumes the role and responsibilities of a Case Officer, forms a Case Management Team, and calls for the first of a number of case conferences.

The first case conference is called to explore proper approaches to execute an immediate protection scheme for the child, and to assign tasks related to collecting facts and evidence on the case. The Case Management Team identifies the most appropriate institution to place the child for sake of her/his safety, if necessary, for conducting interviews, and for assessing the physical, psychological and social impacts of the abuse.

Collecting Facts and Evidence

Collecting facts and evidence is an essential part of child protection and case management. This activity may apply to a child at extremely high risk of victimization or a child who has already been victimized, whether in a domestic situation, trafficking situation or other.

There are two basic steps in fact and evidence gathering: a) collecting preliminary data about the case, to indicate how actions should proceed; and b) collecting comprehensive facts and evidence that will determine the Rehabilitation Plan for the child, and will also be essential in conducting legal action against the abuser or trafficker.

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3.1 Collecting Preliminary Data

This process begins as soon as the child abuse case is reported or, in the case of trafficking, when the child is released from a brothel or other sex work situation. In standard procedure, the Case Officer (the person designated by the organization to conduct the enquiry) obtains necessary data and information that will confirm the basic situation and lead to the construction of a verifiable or substantiated case. Preliminary data that are necessary for both for legally filing a case and for proceeding with the intake and rehabilitation process include:

- Identity of the survivor, relatives, abuser and others involved
- Details of how to access the survivor
- Basic facts and evidence of the abuse situation that can be used to formulate a proper approach to collecting comprehensive facts and evidence
- Additional sources of reliable information

3.2 Collecting Comprehensive Facts and Evidence

Carefully collected and recorded facts are essential for proper needs assessment and for formulating plans to provide the most appropriate assistance. In the case of legal action, solid facts and evidence are essential for building up a case against the abuser, the trafficker or others involved which can lead to eventual prosecution in a court of law.

As a matter of principle, any attempt to establish facts and gather evidence calls for a survivor-centered approach. Thus it is imperative to solicit cooperation from each member of a multi-disciplinary team of professionals in medical science, forensics, police work, social work, psychology, psychiatry and law. This is to ensure a comprehensive compilation of material evidence, physical and psychological signs and symptoms, and social aspects of the case.

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3.2.1 *Creating a Dossier*

A dossier of data and information, and conclusions based upon that information, must be created in a professional manner. Maintaining a dossier is based on a clear methodology jointly carried out by the Case Management Team. Each discussion or consultative session must be systematically documented, with minutes of the meeting filed, and the time, place and participants noted for the record. If any new conclusions on the case are made and found to be different from previous conclusions, such changes must be duly recorded with clear explanations or justification. Contents of the child's dossier are kept in strict confidentiality, and are available only to members of the Case Management Team.

3.2.2 *Collect Evidence Carefully and Comprehensively*

To substantiate the physical and psychological effects on the survivor caused by the abuser or by the trafficking situation, all forms of evidence such as written notes, recordings, photographs and other material evidence must be collected properly, without jeopardizing the integrity of the evidence.

Never overlook any details of material evidence, physical signs and psychological symptoms that might indicate a connection of the abuse with the suspected abuser, how the survivor might have been abused or trafficked, and by what means. Vital evidence that might help identify the abuser must be collected properly, such as traces of semen, head hair or pubic hair, skin tissue, finger-prints, blood stains, etc. For this, the Case Management Team must work in close collaboration with the police. In the case of statements given by the survivor during an interview, each session must be recorded on audio or video tape. It is a standard practice that the interviewer should never use a leading question or closed question, because any response to such questions carry less weight in court. Bear in mind that a statement made in the survivor's own words in response to an open question carries more weight and is much more helpful for the prosecution.

3.2.3 Respect and Protect the Confidentiality, Feelings and Well-being of the Child

Careless investigation can harm the child. It is the role of the Case Management Team not only to collect evidence, but to protect the child while evidence is being collected. All members of the investigation team should be sensitive to possible impact on the child. Unskilled questioning can exacerbate the child's existing trauma, and careless questioning of friends and neighbors can put the child in a bad light in the community or in her/his family. Care should be taken to protect the child from harmful questioning by police, and from intrusion by the press, neighbors or onlookers. From the very beginning, all information must be kept in strict confidentiality.

3.2.4 Identify the Starting Point of the Abuse

Understanding and identifying the starting point of the abusing process are very important in building up a case. In the case of domestic abuse, this would include how the abuser began, how she/he might have had access to the survivor, what the first contact was, and how the survivor might have been primed by the abuser. In the case of trafficking, the manner in which the child was trafficked, whether abducted through duplicity or whether purchased from the family or community members, must be ascertained.

For example, one can seek answers to the following questions. How might the survivor have been lured into a vulnerable situation? How might the survivor have been approached? Was there any talk of sexual relations? Was the survivor exposed to pornographic materials? All these questions can help reveal the pattern of abuse committed by the abuser.

3.2.5 Look for Patterns of Abuse

Determine if there is a pattern of abuse present. That is, determine if there was abuse of one victim by several abusers, and/or the abuse of several victims by the same abuser. These are significant in investigating both domestic abuse and trafficking cases. The Case Officer must try her/his best to find out if the case might be a serial offence. Are there any similarities or differences between certain opportunities or circumstances? How long had the abuse been taking place? When did the abusing process start and end? Had the survivor been subject to similar or different forms of abuse prior to or after the reported case? In case there were additional abusers involved with the same survivor, or in case the suspected abuser had abused or trafficked other children, this process may be used to gather evidence and establish facts for those additional cases.

3.2.6 Developing a Family Tree for the Child Survivor

A family tree is a basic, practical tool for a Case Officer. In a simple way, it shows the immediate family and extended family ties and relations of the child, as well as indicating the size, quality and other details of family environment. A family tree can help identify possible problems and issues involved in the case. As well, a family tree can help to clarify possible solutions to certain problems, such as a possible substitute family for a child survivor, or sources of possible long-term support for the child.

A family tree is drawn out, showing at least two generations of the child's family, with the necessary details added for each family member, as below:

- Status of each member of the family, including biological grandparents, own parents, stepfather or stepmother, brothers and sisters, half-brothers or half-sisters, etc.

- Sex, male or female
- Age
- Education
- Profession
- Relations between family members, including how influential a certain person is, which members if any are abusers, and which can have positive influences or function as a protector
- Other details of family members that might have bearing on the case, including presence of communicable disease, mental illness, genetic abnormalities, etc.

3.2.7 Considerations in the Case of Trafficking

In the case of trafficking of a child from her/his home to a brothel, there is inevitably more than one person who can be considered the ‘abuser’. As much as possible, evidence must be collected regarding the sequence and roles of different ‘abusers’. These include: the initial ‘purchaser’ or ‘thief’ of the child; the ‘seller’ (who may be a family member) if the child was purchased; the person who transported the child to the brothel; the ‘purchaser’ on the brothel side (who could be the brothel owner or manager); and the person(s) who forced the child to conduct prostitution, including the brothel manager and brothel ‘enforcers’.

Because of the criminal institutionalization of trafficking, including protection from the community and from criminal gangs, determining and prosecuting all ‘abusers’ and collaborators is nearly impossible. However, it is an obligation to collect as many facts and as much evidence as possible, not only for prosecution, but to determine the best methods of treatment and rehabilitation, and to determine if the child can be safely reunited with her/his family and community.

3.2.8 Considerations in the Case of Domestic Abuse

One cautionary note to any Case Officer. One must not overlook the fact that in some cases, the survivor might have been subject to sexual priming or sexual stimulation without fully understanding the effects on him or her.

Bear in mind that the survivor might have been exposed to some sexual contact causing her or him to act in a manner that might be considered to be a tempting act to some bad-intentioned adults. These type of child belongs to a specific high-risk group and is extremely vulnerable to abuse, especially by adults who have detected such behavior in the child.

These cases, if detected, should be handled with extreme care. A Case Officer should immediately try to find out if the child had previously been sent to any juvenile institution, or had been admitted to a hospital due to sexual assault or attempted abuse. The family background and situation must be checked to ascertain if the parents themselves have contributed to these conditions in the child.

3.2.9 Applying Facts and Evidence to the Rehabilitation Plan

The facts and evidence collected will be joined with medical, psychological and social assessment upon intake, and developed by the Case Management Team into a Rehabilitation Plan. This plan will indicate whether the child should receive treatment and rehabilitation interventions, or whether she or he can move rapidly into reintegration.

The facts and evidence will help indicate potential sources of trauma in the child that may not be clearly evident. Facts carefully collected can also point out certain significant events during the formative years of the abuser, her/his family and others that will be helpful in carrying out the needs assessment of the survivor.

Regarding immediate reintegration, facts and evidence will help indicate whether the family and community are receptive to the return of the child. Domestic child abuse and trafficking both can have repercussions on those close to the survivor, including teachers and classmates at school, who may make it difficult for the child to be easily reintegrated. As well, parents and relatives who care for the welfare of the child survivor are likely to develop depression, anxiety, anger and animosity towards the offender, and in some cases towards the child survivor as well.

These facts and evidence will help establish risk factors for the child upon her/his return. They will help indicate, among else, whether the family is 'safe' for the child or whether the same or potential abusers or traffickers are still a threat. Facts collected properly can help indicate the type and level of relations between the child survivor and the abuser/trafficker, the child survivor and her/his family, and the abuser/trafficker and the survivor's family. They can also help determine if the family comes up to minimum standards of child care and rearing, or if the family needs social work interventions to help them provide a safe and healthy home for the child.

If the risk factors can be eliminated, if it is clear that the family can meet the minimum standards of child care and rearing, and if there are no serious signs and symptoms of traumatic suffering, the child survivor is then ready for social reintegration, and the fact gathering and evidence collecting process can be concluded.

However, if risk factors are present, if the family and community are 'unsafe' for the child, or if the child needs therapeutic treatment and rehabilitation, then the child enters the intake phase of the case management process.

Protection

A Child Protection Plan for providing adequate protection for each child survivor must be developed by the Case Management Team. This is designed to prevent repeated abuse, return to an abusive situation, or often in the case of trafficking survivors, possible harm or threats to the child or family by the traffickers.

A Child Protection Plan may include four phases of protection. The first phase is essential, and the other three phases may or may not be necessary, depending on the estimated safety of the child.

- Protection provided during the critical intake period
- Protection provided during the process of assessment of the child survivor and the family
- Protection provided during the rehabilitation period
- Protection or preventive measures adopted for the reintegration period

In situations where collected facts and evidence may not be adequately collected for the formulation of a long-term Child Protection Plan, a short-term plan for the initial protection and safety of the child survivor is nevertheless paramount.

After having accomplished the initial collection of facts and evidence, the Case Management Team determines the protection activities necessary under two categories:

a) protection through the social service system; and b) protection through a legal aid programme or the criminal justice system.

4.1 Social Protection

When the child survivor is still exposed or vulnerable to danger or threat, it is necessary to provide initial protection by separating the survivor from the vulnerable situation or environment and placing them in a safer setting for further detailed assessment of the case. The separation of the survivor for the sake of safety can be arranged by referring the child to a number of alternatives, such as temporary stay in a foster home or the home of relatives, in an emergency shelter or half-way house operated by the CPCRF Foundation or a similar organization, or in a government welfare home.

Any removal of the child from its family must be strictly based on the conclusion by the Case Management Team that the family situation is unsafe for the child. When considering the physical situation to place the child, the team should be aware that her or his case may require a variety of services and different forms of assistance, and the child must be both protected and cared for while being available for medical, psychological and legal assessment.

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4.2 Child Witness Support

Protection given by legal means and procedures normally requires a rather prudent and analytical approach, especially when the child is abused or trafficked by one of her/his own family members. Any undertaking must be carried out with the best interests of the child survivor at heart. Once the Case Management Team has decided that the case can be prosecuted in a court of justice, it usually begins by filing a proper complaint with the local police, and pressing charges against the accused wrongdoer. At this point, the Child Witness Support programme must begin in earnest, preparing the child survivor as a witness in the criminal justice system as well as for court appearance, testifying, and being cross-examined by the defense lawyer.

The following are recognized as essential practices in preparing the child witness:

- Familiarize the child survivor with the procedures of the justice system.
- Help the child survivor to understand and see the benefit of obtaining facts and speaking the truth for the prosecution of the case.
- Make it possible for the child survivor to participate in or to have a role in the justice process.
- Minimize other pressures on the child survivor, such as their immediate physical and emotional needs, before getting involved in the legal proceedings.
- Arrange for psychological counseling and support for the child survivor, in order help her/him to withstand the impact of the legal proceedings.
- Offer guarantee of support and assistance for the child survivor and her/his family, making them feel more secure and safe.

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Each step of this process calls for collaboration and co-operation between concerned agencies and organizations, both GOs and NGOs, in order to provide all the assistance and expertise necessary to support the efforts of the focal organization that is caring for the child.

In a functional Child Witness Support system, numerous players work together as part of a nation-wide network. These include committed specialists and experts in medicine, law, psychology and police work, as well as qualified volunteers. Each has a specific role to play in the process and each makes a meaningful contribution to a common cause. With such an established network, Child Witness Support can be provided in different parts of the country, to ensure efficient and effective response on behalf of many child survivors.

Intake Assessment, Needs Assessment and Treatment Planning

5.1 Intake Assessment

After having rescued the child survivor and brought her/him to temporary safety, assessment of the physical, psychological and social impact of the abuse or neglect must be made in order to determine what medical or psychological treatment or social service she/he may need.

Once again, the procedure involves the work of a Case Management Team, for they must investigate multi-faceted impacts on the child survivor and the family. Members of the team from the CPR Foundation include the CPR Case Officer, Case Coordinator or Child Development Supervisor, social workers, and a psychologist or psychiatrist. To assist in the intake assessment, additional teams of specialists are solicited from outside sources. These include:

- Medical and Health Team, composed of a forensic doctor, pediatrician, psychiatrist, psychologist and hospital social workers.
- Social Service Team, composed of social workers from both GOs and NGOs who may be recruited or are working for central or local agencies, as well as local community leaders, teachers, and others.
- Legal Team, composed of a lawyer, legal expert, police and public prosecutor.

At this point, the case management process formally begins, and a case file is started for the individual child. Each child has her/his own case file, the contents of which are kept under strict confidentiality. This file includes written assessments by experts, results of interviews, and other information collected, as well as all meetings of the Case Management Team. All information collected should be recorded in standard form, with attached photographs, sound recordings of interviews, and video tapes. This

information may be used as evidence for legal purposes as well as for determining the next course of action in providing services to child. The case file also includes the child's vital documents, including copies of the birth certificate, house registration documents, citizenship certificate or passport, educational records, health records, etc.

The intake assessment will lead, through the mutual efforts of the Case Management Team, to a needs assessment and the formulation of a Rehabilitation Plan and a Reintegration Plan. The process and mechanisms employed for intake assessment are described below.

5.1.1 Physical and Psychological Examination

The child survivor is referred to a hospital or other center for medical and psychological conditions that can only be detected and documented by specialists. Medical assessment includes weighing, height measurement, general and specific health status and the state of the child's development, among others. Psychological assessment includes mental and emotional development, present psychological status, explicit and non-apparent behaviors, and level of trauma, among others.

5.1.2 Social Assessment

Social assessment is conducted by the social worker with both the child and her/his family and community. Factors assessed are relations with adults and peers, home or community environment, home welfare and security, presence of high-risk behavior in the family and community, and family socio-economic status, among others.

5.1.3 Interviewing

Additional information is gathered through interviews with the child survivor, witnesses, members of her/his family, relatives and other individuals who might be helpful in supporting the child witness in some ways. Data collected include the background and up-bringing of the survivor, any possible past experience of being mistreated, abused or neglected, and any other information relevant to the case.

5.2 Needs Assessment and Formulation of a Rehabilitation Plan

In a second case conference, the collected facts and evidence and the results of the intake assessment are compiled and given consideration by the Case Management Team, in order to get a clear profile of the child survivor and her/his family. This information is vital to the legal actions to be taken and to conducting the needs assessment of the child.

The needs assessment of the child is conducted jointly by members of the focal organization and by specialists. The needs assessment covers physical, psychological and social needs, which may include counseling or social work with the family.

Following the individual needs assessment, a case conference is held to develop the Rehabilitation Plan. This plan needs to be carefully prioritized. The strategic plan should first include a Child Protection Plan, if deemed necessary. Following that, the overall plan should have a two-stage approach: first, an immediate-action plan for care during the early critical stage; and second, a longer-term plan of activities required for the survivor.

The Rehabilitation Plan will include various activities recommended by different members of the Case Management Team. So that all of these activities work together in a concerted manner, they should be clearly presented and shared among the members of the team. The team then links the individual activities together to form a comprehensive and effective plan of action.

Verifiable indicators are included in the Rehabilitation Plan, in order to reflect the outcome of the different activities. In each subsequent case management meeting, the child's situation is checked against these indicators. If there are shortcomings in the child's development vis-à-vis these indicators, the team notes clear explanation or justification in the case file, and proceeds with re-assessment if necessary, makes necessary adjustments in the activities, and seeks solutions to the problems.

If it is established that the child survivor requires a specific programme of therapy or rehabilitation, she/he may be referred to a specific rehabilitation center or programme. If an in-house rehabilitation programme is not required, the child survivor can then be referred to her/his family or relatives, or placed under the temporary care and supervision of someone she/he can trust and feel secure with. This can be a long-term arrangement, depending upon the state of the child and her/his needs for rehabilitation or therapy. If there are significant risks in the child's family or community, long-term care may require substitute parents or an adopted family.

Later, when the abilities, wishes and needs of the child are more clearly determined, a Reintegration Plan can be developed.

Treatment and Rehabilitation

Treatment and rehabilitation addresses three key impacts on the child survivor:

Physical Effects. A survivor may have wounds caused by physical abuse, or may have contracted a sexually transmitted disease, including HIV/AIDS. In the case of victims of trafficking in South Asia, tuberculosis may be a factor. Many who have been abused for long periods of time or have been victims of trafficking from a young age are found to be shorter than average height, under-weight, and slow in both physical and intellectual development.

Psychological Effects. Survivors may present psychological symptoms which must be dealt with immediately, such as Post Traumatic Stress Disorder (PTSD), including intense feelings of anxiety, fear and isolation. Suicide or self-inflicted violence may be a tendency found among some child survivors. Even if these are attended to in the early stage of treatment, most children in long run cope with low self-esteem, self-doubt, guilt and lack of trust.

Social Effects. Apart from separation and alienation from family members, child survivors often exhibit broader social constraints, including anti-social behavior, being unable to fit in with peer groups, and being unable to establish relationships with others, both adults and children.

Throughout the rehabilitation phase, case conferences are routinely held which focus on monitoring and evaluating the child's progress vis-à-vis the indicators in the Rehabilitation Plan. The Case Management Team may recommend adjustments in the Rehabilitation Plan according to that information. This process continues until the case is finally closed.

From its decades of experience, the CPR Foundation has found it convenient to place treatment and rehabilitation activities into the following categories of activity:

- Crisis and preliminary interventions
- Basic rehabilitation activities
- Specific rehabilitation activities for certain signs and symptoms
- Activities for child and family development

6.1 Crisis and Preliminary Interventions

Crisis intervention may be necessary at any time during the rehabilitation process, but is most often administered in the early critical time of intake, assessment and adjustment to the treatment surroundings. Crises may arise while separating the child survivor from the abusive situation or threatening environment, or arise as part of the assessment process when both the child survivor and members of her/his family are subject to careful assessment. At this time, crisis intervention is aimed at minimizing pressures on them, making them feel more physically, emotionally and socially secure, and helping them to gradually regain some degree of control of the situation.

Crisis intervention may involve immediate physical treatment for injuries or diseases. This response is conducted by a team of specialists including pediatricians, obstetricians, neurologists, etc. Crisis psychological treatment may be necessary to respond to PTSD, deviant behavior, paranoia, sudden outbursts of emotion or self-destructive tendencies. Under these circumstances, a psychiatrist must be on call to provide professional treatment, while such activities conducted in the shelter home should be administered by a psychologist and trained staff.

Crisis social support usually involves providing a caring and understanding person or family who can render moral and emotional support to the child survivor, particularly while she/he is going through the process of comprehensive assessment, or at difficult times during the rehabilitation period. It is important throughout this period to foster healthy relations between the child survivor and the people around her/him, especially

people in her/his family, community or peer group. Providing social support in terms of friends and relationships is of course important throughout the entire process of rehabilitation.

And, as described above, the child needs special support during her or his interaction with the justice system and legal procedures, much of which takes place during the early, critical period.

6.2 Basic Rehabilitation Activities

Basic rehabilitation activities are the mainstay of the rehabilitation programme, and are often simple activities of child participation and enjoyment that are conducted by non-professional members of the center staff. Based on its experience, the CPR Foundation sees basic rehabilitation activities as fulfilling five essential purposes:

Fostering Healthy Relationships. These activities are designed to establish positive relations between the child survivor, her/his peer group and the staff. In this programme, she/he is given proper attention under appropriate supervision, proper care and understanding, and a chance to participate in sports, recreational games, folk plays, entertainment, etc. with other children.

Building Confidence and Trust. These activities are aimed at making the child survivor feel secure, self-confident and trusting of those around her/him. These are part of a self-revealing type of process, allowing the survivor to feel confidence in her/himself while learning to trust others. Importantly, a child survivor should know that she/he is not isolated, because there is always someone around to talk to, someone whom she/he can relate to and even share some secrets, as every child wants to do. In this process, the child is given counseling to help regain her/his self-respect, self-esteem, etc.

Self-learning. These activities encourage the child to re-discover her/himself, and stimulates her/him to re-discover the roles of people who are meaningful to her/him, i.e., the roles of parents, peers, etc. She/he also

has a chance to learn how to be better adjusted to the social environment. The child learns about different roles she/he can play in the social setting and about beneficial role models through activities involving art, music, plays and performance, song, dance, etc.

Behavioral Adjustment and Character-building. These activities are meant to have positive, long-term effects on the child survivor by giving guidelines, role models and counseling on how to build up her/his own individual character. The child learns how good behaviors will be rewarded, while destructive or negative attitudes should be avoided. Children participating in this programme are encouraged to exhibit the true content of their characters, enabling the staff and specialists to help them.

Giving Happiness and Enjoyment. These activities are especially designed to make up for things that children have been deprived of. Many child survivors have actually lost their childhood, being denied play and enjoyment in a youthful setting, or have had the enjoyments of their earlier childhood erased by bitter experiences. This programme is essentially aimed at making children happy, by offering sports, games, music, art and crafts, imaginative plays, gardening, flower arrangement, collecting individual favourite things, stamp collecting, physical exercise, aerobic dance, etc.

6.2.1 Examples of Basic Rehabilitation Activities

Child Participation. It is essential that children participate and have a voice in their own process of rehabilitation. Regular meetings with children are provided to give them an opportunity to join in planning activities relevant to their daily existence, determining how activities should be run, and developing activities themselves, such as the menu of the 'cooking class'.

Problem Identification. These are counseling activities conducted to help the child survivor to deal with her/his feelings of low self-esteem, depression, inadequacy due to lack of love, care and understanding, powerlessness, etc.

Dialogue about Oneself. Regular dialogue sessions enable the child survivor to help identify her/his potential, talents and aspirations, which can then be fulfilled by encouraging the child in activities which most suit her/him.

'Circle Time'. This is a participatory activity organized on a regular basis, in which children form a circle to talk about themselves and things meaningful to them. It is a forum for sharing feeling and concerns, talking about weaknesses and strengths, and gaining confidence by sharing with others.

Art Therapy. These sessions enable children to create something beautiful and to express themselves through various simple media, in order to bringing out their imagination, dreams and aspirations.

Creative Classes. These provide an opportunity for children to join with others in making 'nice things' out their own imagination. Their 'work' can be shown to visitors, which builds the confidence of the children, and can be sold as well, so that the children can learn the basics of working and earning.

Cooking Classes. This is a valuable self-learning experience for child survivors, who gain confidence and self-esteem when they make things everyone can eat and enjoy, and perhaps can even be sold.

Agricultural Classes. These allow children to experience nature, and to gain enjoyment and feelings of accomplishment by planting things such as vegetables and flowers which can be picked to eat and to decorate their living areas.

Creative Drama. Putting on drama performances is one of the most fun-filled activities for children, and is very therapeutic. They effectively build up children's self-esteem, sparking creative ideas and allowing them to 'pretend' many different roles, which can be useful in future life. By presenting themselves before an audience, and even being subject to play reviews, children gain much self-confidence.

Public Service. These activities, which can include caring for pets and being involved in carefully selected community-oriented services, help the children to 'look outside themselves', and feel that they are capable of doing something for the common good.

'Letter Links'. Children are helped to establish a linkage with a 'Key Person', an individual who cares for her/him. It connects the child with the outside world and helps the child build up healthy relationships, trust and attachment.

'My Favourite Object'. This is an important activity in which the child is encouraged to have something of her/his own which they create and/or care for. By caring for 'My Favourite Object', the child learns how to give love and care, which so often they long for.

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Visiting a New Environment. Excursions to parks, art museums, shows, etc. allow children to feel close to nature, listen to good music, see art and dance, and interact with the world. These activities are designed to give the child confidence that there is a new and bright side of the world.

Participation in Non-competitive Sports. Sports are important for a child's physical and mental well-being. However, in sports the child should not have to compete with anybody, or have feelings of winning or losing. Fulfilling non-competitive sports include swimming, aerobic dance and gymnastics, among others.

6.3 Specific Rehabilitation Activities for Certain Signs and Symptoms

Certain activities specifically address signs and symptoms which children may exhibit. Symptomatic therapies are considered a must for the overall programme. The activities should be assigned only by members of the Case Management Team, such as psychologists or professional counselors.

6.3.1 Addressing General Psychological Concerns

Because most child survivors have gone through some of the worst life experiences at a very young age, they often develop a sense of despair, feelings of hopelessness, mood changes, fear, anger, anxiety, stress, even suicidal tendencies. Some of them may prefer to be left alone from time to time, thinking about past events, feeling confused about how that terrible thing could have happened to them. Often, a “Why me?” question keeps emerging. Certain activities can assist survivors of abuse to address their feelings, put the events of their history into perspective, and start living again.

Counseling is an important process for the benefit of child survivors, helping them understand and work with feelings of depression, hopelessness, low self-esteem, etc. Almost all children need, at first, regular counseling to help them cope with their past history. However, counseling which delves into the child’s traumatic history should *only* be conducted by professional, trained persons. In some individual cases, psychotherapy may be recommended. In other cases, family therapy can be recommended, particularly if there are family members likely to cause problems upon return of the child.

In addition to counseling, art therapy is effective in many cases for helping children work out their history. Child survivors are encouraged to do drawing, painting, sculpture, or tell a story to other people around them. These activities are very helpful to child survivors, especially when they need to vent their anger or frustration, or need to project their feelings without being restricted by normal conditions.

6.3.2 Therapy for Extreme Trauma and PTSD

Dealing with extreme trauma and PTSD should be done only by experienced, professionally trained persons. Among other techniques, Cognitive Therapy can help the child survivor to feel strong enough to face reality, accept things that have happened in her/his life as facts, recognize her/his past situation as something that can be avoided and won’t happen again, and look ahead towards a new life.

Although professional counseling and therapy are necessary, there are important contributions which come from the facility and the staff. In the facility, the atmosphere, the attitudes of the staff, and the whole environment must make the child survivor feel safe and secure enough to trust the people and the surroundings.

Art and creative craft activities, among others, are often readily welcomed by child survivors, giving them a way to look away from their traumatic events. Being allowed to feel free to express themselves through artistic work, such as drawing, painting or working with clay, even if it is something very simple, can mean a great deal to child survivors in mental pain.

6.3.3 Sexualization and Therapy

Some child survivors have developed certain sexual tendencies if, for example, they have been forced into prostitution, or have been confronted with extensive sexual manipulation in the abuse process. Symptoms associated with sexualization, such as sexual obsession or sexual deviation, can be complicated to deal with, and may have long-term consequences such as becoming a perpetrator of sexual abuse.

With proper orientation, child survivors can learn to re-establish their sexual identities through selected activities. Counseling on sexualization and the child's sexual tendencies is basic, and should be conducted only by a professional counselor. Counseling sessions can be linked with regular activities of the center that assist the counselor's work. For example, dance, sports and aerobic exercise can be encouraged to distract child survivors from sexual obsession.

All children should be given sexuality and reproductive health education. Learning how the body develops and how to stay healthy is an important part of working towards a healthy sexual orientation. Gender education, including understanding the equality of the sexes and the prescribed and potential roles of males and females, is important. As well, specific sex-related life skills, such

as learning to say ‘no’ to a potential sex offender and learning how to deal with the opposite sex, are necessary in the child’s preparation for reintegration.

6.3.4 Therapy for Anti-social Behavior

Some child survivors display anti-social tendencies, such as running away from the center, going out without permission, telling lies, talking aggressively, experimenting with drugs, or fighting with others. These tendencies can be specifically addressed by counselors and psychologists, but many basic activities can be applied by center staff to reduce anti-social behaviors.

Activities that build self-esteem, such as art therapy or drama, are very important. Other activities, such as public service or ‘circle time’, above, can help the child relate to other people and the outside world, and find support from them. Life-skills development and activities involving role playing, social expectations and situational responses can help the child gain confidence, learn how to relate with others, and reinforce positive behaviors. Teaching the child emotional management, such as coping skills, relaxing skills, etc. helps to reduce inner tensions and thus anti-social behaviors. In some cases, ‘time out’ activities, such as outings and fieldtrips, help the child to break away from their normal situation and get a new and more relaxed view of life.

6.4 Activities for Child and Family Development

Beyond the rehabilitation activities above, which are directed at healing the pain and trauma of sexual abuse and trafficking, certain activities are necessary to promote the child’s general development, both physical, intellectual, emotional and social, and the development of the child’s family as well. These are the activities that, once the child is healed, lay the groundwork for the child’s full and successful reintegration into society.

6.4.1 Physical Health and Physical Development

Activities to promote the health and development of the child begin with assessing her/his physical health and development to see if they are appropriate to her/his age. Participating in sports, dance and aerobics

stimulate proper anatomical development and body coordination. At the same time, the child is taught basic skills of health and hygiene, proper dress and basic safety rules, such as how to play safely, avoid risky situations and prevent accidents. Classes are provided to teach children basic reproductive health education appropriate to their age, as well as the basics of nutrition.

6.4.2 Intellectual Development Activities

Many child survivors have had little access to intellectual stimulation, and for some, intellectual development may have been slowed due to their environment, inadequate nutrition or emotional problems. Caregiving should include specific activities intended to stimulate the child survivor's intellectual growth and development.

Children should be assessed for their IQ and intellectual capacity. Testing can be arranged through hospitals, schools or other institutions. With this assessment, and taking into account the child's educational history, child survivors are provided with either formal or non-formal education, depending upon individual potential and wishes. When the child enters formal schooling, counselors from the facility should coordinate closely with school officials in monitoring and stimulating the proper development of the child survivor.

Within the center, children's intellectual development can be promoted by mind-challenging games and puzzles, and by taking them to have first-hand experiences of concrete situations, such as field trips and exposure visits.

Some children may require therapy or special attention if they have difficulty adjusting to learning situations. Some may be slow-learners, or have attention deficit or hyperactive disorders which give them difficulties in attending classes in the formal school system. They may need counseling and special help in a non-formal setting prior to being enrolled in a regular school programme. After entering the formal system, special classes for these children can be conducted in late afternoon, weekends or holidays, enabling them to keep up with academic work and exercises.

6.4.3 Emotional Development Activities

Beyond the healing and therapeutic activities for acute problems discussed earlier in this paper, all child survivors need regular activities that promote their emotional development. Due to their past, many have difficulty dealing with their own emotions. They may often act in irrational ways, not listening to reason or developing negative attitudes towards others. Many of these children simply do not know how to deal with everyday stress. Beyond counseling, regular activities in the center's roster can help children strengthen themselves emotionally.

Role models are easily understood by these children, and can be very valuable. Their relationships with the staff working with them are very important, provided of course that the staff are available and committed to their work.

Among everyday activities, self-esteem can be acquired from learning how to do something meaningful, whether doing public service for the common good or simply doing something for the people around them in their daily life. Daily chores offer them opportunities to be useful, contribute to the general welfare of the other children, and learn to share responsibilities. These simple activities can make them proud and develop a sense of self-esteem and self-confidence, which in turn lead to the development of positive behaviors.

6.4.4 Relaxation and Self-control Activities

Teaching children how to exercise self-control and deal with stress in their daily lives is one of the keys to the success of a programme for child survivors of abuse. Among everyday center activities, meditation and/or yoga can be taught so that they may discover their inner strength and learn skills for self-control and self-discipline.

6.4.5 Social Development Activities

Many survivors of abuse lack socializing skills. When they re-enter society, they can have difficulties in adjusting to the greater social world. Because most people around them do not have patience and understanding of their

problems, in many cases these children are not given a fair chance of overcoming their difficulties and limitations. Adults tend to look at them as undisciplined, rebellious, anti-social and hopeless, and think that they should be abandoned and/or discarded. Such children often run away from home, play hooky at school, become 'drop outs', and have inappropriate relationships in an effort to get attention from others.

In planning activities for child survivors, care should be given to help them learn their proper roles in their society or community, to understand and accept the healthy social norms, rules and regulations that everyone lives with. To help the children learn family members' roles in daily living, the staff can play an important part by acting as parental models for the children.

Among regular center activities, group participation is central in helping children learn how to interact with others. Activities in which children share new experiences are very beneficial in helping them learn social skills. Such activities include exposure or field trips where the children experience things that other children take for granted, such as public parks, exhibitions and movies. Children's outdoor camps can be organized to provide 'adventures' for children, creating opportunities and favourable conditions for child survivors and staff to foster closer relations, while enabling the children to learn social skills vital to their survival.

As well, 'daily-life skills' equip a child to survive in the social world. For instance, children can be taught how to use a phone, how to travel on a bus, and how to communicate in an appropriate manner with people they meet. Here, the staff can be very helpful in providing both learning and role models.

Vocational skills not only enable child survivors to develop to their fullest potential in the economic world, but also help them to become socially well-adjusted. Prior to vocational training, it is imperative to engage in a needs assessment of each child in terms of a long-term vocation or career. The

child should participate in this assessment. This is particularly important for children who have academic difficulties or are slow learners. The focus should be on helping them find employment of their own choice and capacity. With appropriate vocational skills, once the children have been exposed to the real and concrete environment outside the center, they can more easily make the necessary social and psychological adjustments, as well as sustain themselves economically.

6.4.6 Family Development Activities

Based on case studies and indicators from dossiers, it is discovered that many child survivors come from families with their own problems or families who have difficulties in child rearing. Parenting skills are obviously lacking in many cases. Many parents of abused children have never developed the skills necessary for managing their family affairs or attending to problems affecting their children. For example, they might not be able to communicate effectively or are not capable of providing positive role models. Most importantly, some of the parents themselves come from families with a history of abuse in one form or another. In many cases, the parents are not emotionally mature or are psychologically unstable, as well as having the problems of living at the lowest economic strata.

If the child is to be reintegrated into her/his family, which is the desired course of reintegration, the CPR Foundation deems it necessary to initiate a family therapy programme and supporting activities. The process starts with making a needs assessment of the family, analyzing each case in close consultation with experts in family therapy, and then formulating a family therapy plan of action in collaboration with the child and the family.

After having adequately assessed the needs of the child survivor and her/his family, a family conference is usually called. In this conference, the family is informed of the problems faced by their child so that they can develop a child-friendly plan of action which will provide the best solutions to their problems, with the assistance and support of the CPR Foundation.

Enhancing parenting skills for the family is a must in most cases. Parenting skills include basic child rearing skills, dealing with emotional problems and crises, and communication skills. The CPR Foundation engages in joint activities with the family designed to help them develop child-friendly household activities, involving cooking, home décor, child safety awareness, and creating a pleasant domestic environment.

Family counseling is organized to assist parents and children to identify problems, allowing them to talk freely together, sharing and solving their problems with people who are professionally trained. This has proven to be one of the most effective ways to help families seek a common approach in dealing with problems and crises.

For families with members who have a detrimental effect on family life, family therapy may be called for. Family therapy normally makes it possible for children and parents to speak out voluntarily and freely, and is conducted complementary to the regular family counseling programme. Therapy may also be necessary if there are indications of sexual abuse within the family. Sexual abuse prevention lessons and exercises can be given at skills training sessions, such as “Saying Yes!, Saying No!” and others. To support families if crisis situations arise, crisis management assistance is sometimes offered by the Case Officer or a social worker who is trained to provide strategies for both parents and children on how to deal with crisis situations.

Among other ways to ‘bring the family together’, Family Camps are offered to create stronger ties between the child survivor and her/his family, based on newly acquired understanding and good intent generated by the counseling sessions and other activities. In Family Support Groups, several families can learn together by sharing mutual problems and concerns. This activity creates an environment for child survivors and their families in which they can share their experiences, successes and failures with others and thus learn from one another. Families recognize similar challenges in others, become more socially aware, and often become willing to help each other with their problems.

Economic stress can have negative social consequences within the family. Thus, vocational or career support can be provided for the family based on their own potentials and inclinations. This can include job placement for members of the family or granting school scholarships to children under the care and supervision of the family. Medical assistance may also be provided for the child survivor and other members of the family if necessary.

Social Reintegration

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After a child has completed the rehabilitation process, the task of child protection does not simply end there. This is just the starting point of the social reintegration process, which requires continued well-coordinated efforts of the Case Management Team. The reintegration process involves the concerted efforts of physicians, lawyers, social workers and, notably, members of a community network, including school teachers, local public health officers, local health clinics or community hospitals, village leaders, local administrators and other concerned volunteers. The list also includes neighbours, relatives and members of the child's family. The process involves a number of steps and procedures, which the CPCR Foundation has developed over the years to help child survivors reintegrate successfully into their respective communities.

7.1 Assessment of the Social Environment

The first task in the reintegration process is an assessment of the social environment of the child survivor, which includes the family, school and local community. This is conducted by the CPCR staff of social workers, in close collaboration with outside specialists. In this case, great attention is paid to all existing risk factors that have in the past caused problems for the child. It must be ascertained whether those risk factors can be controlled or whether necessary measures must be introduced. In the case of a trafficked child, for example, the continued presence of traffickers in the home community must be taken into account. Risk factors can be identified in the family, school, community and among extended family members as well.

Even if the family has gone through a process of rehabilitation, there may still be some conditions which are not favourable for the return of the child survivor into the family. Whether or not the family is ready to receive the

child, it is still subject to a pre-reintegration assessment to ensure that the family is capable of assisting the child in a smooth and child-friendly reintegration process.

If the child is re-entering a formal school situation, then the school is also subject to assessment. Different aspects of the school and its system must be assessed, including the general environment, the teaching system, the attitudes of school officials, students and teachers towards the child, and whether teachers are capable of assisting the child and addressing the issues involved. All of these must be assessed and information provided to the Case Management Team, which will integrate the findings into the Rehabilitation Plan. In this case, the plan should include strategies for working closely with school officials and teachers.

Community assessment is normally required to ensure that the child will be secure and protected on return to her/his own community. It must be borne in mind that the safety of the child is paramount. Information must be collected on the social environment of the community, both about individuals who are likely to have access to the child as well as individuals who might be prepared to help protect the child, if the situation arises.

Once the overall social environment assessment is done, the Case Management Team should be able to determine an appropriate reintegration strategy and process, and be able to judge if the child is capable of a temporary or a long-term reintegration.

7.2 Developing a Reintegration Plan

Following the social environment assessment, a case conference is called and a well-formulated Reintegration Plan is jointly made between the CPCR staff, the child and the family. This plan includes fostering proper relations between the child and members of the family, providing basic material necessities, providing counseling on parenting, and providing capacity-building for family members, such as problem-solving skills and communication skills. Social workers play an important role in this process,

and can help a great deal in soliciting both material and non-material assistance for the family.

All of these efforts are aimed at making the family aware of the need to provide proper protection to the child in a comprehensive and sustainable manner. To achieve this, each member of the family has to contribute to the overall effort. To support them, outside assistance can be solicited through the supporting network.

In addition, a local back-up support system for the child needs to be put in place, made up of concerned individuals, supporting groups and supporting organizations or government agencies. These include local hospitals, village health clinics, local administrators, welfare offices, village leaders, youth groups, neighbors and relatives.

7.3 Preparing the Child Survivor

Prior to reintegration, a multi-faceted preparation process follows the assessment process. The child survivor must be prepared for the situation that awaits her or him, and the 'destination' home of the child, whether family, relatives, substitute family or another residential shelter, must be prepared to receive the child. At the same time, preparation must be made in the community, to promote a gentle and welcome reception to the child and to plan for services which the child may need.

In preparing the child survivor, it is essential to help her/him establish a positive outlook in life and understand what might be in store for her/him in the future. The child is encouraged to review her/his past and present situations, and look toward the future full of hope and aspirations. With the help of counselors, the child is assisted in identifying her/his most relevant lifetime goals. Guidance for this is based on the comprehensive assessments previously conducted by the Case Management Team.

The child should be familiarized with the future situation by giving her/him full information about the place she/he is going and the people who will be

associated with her/his reintegration, including an actual visit to the next home. The child should be allowed to digest the information, ask questions and clarify her/his future role in the destination home or halfway house.

A pre-reintegration visit to the future home or shelter offers an opportunity for the child survivor to acquaint her/himself with other children and adults in the home, as well as the other people involved in the process. Prior to the actual visit, it is always advisable to show photographs and other forms of reference, so the child is comfortable during the visit. A pre-reintegration visit also provides an opportunity for the child to acquaint her/himself with new friends. These visits normally make the child survivor gradually feel secure and safe, and feel that she/he can have some control of the situation.

In situations in which there is anxiety in the child, a Trial Residence Period in the new home may be required for a child survivor to actually take the step towards a final reintegration. The child can be started with a short Trial Residence Period, then return to the facility and build up her/his confidence to stay for a longer period. In this situation, it is important that the child is constantly observed and can be aided at any point by social workers and other staff.

7.4 Preparing for Entry into the Child's Family or Relatives

If the child is returning to her/his family, before the return it is important to gradually build up rapport between the child and the family through letter-writing, telephone conversations, occasional home visits or visits of the family to the facility. It is important that members of the family participate in family-building activities organized by the facility, such as Family Camp, Family Activity Sessions, or attending youth activities organized at school or facility where the child is attending.

Family Conferencing is used as a forum where different families can give mutual support to reintegrated children as well as family members. Sharing practical experiences and approaches usually helps parents to understand the reintegration process, as well as understand the benefits of helping each other through a supporting network.

7.5 Preparing for Entry into a Substitute Family

In case a child survivor is not yet ready or is unable for welfare reasons to return to her/his family or relatives, a substitute family must be identified and prepared to accommodate the child at least temporarily, and in some cases permanently.

First, the social worker or Case Officer embarks upon a thorough assessment of the potential substitute parent(s), for they must be ready physically, emotionally and socially to accept and live with a child who may have some personal problems. The relationships between members of the potential substitute family, as well as potential relationship of each member to the child, are subject to assessment. As well, assessment should include the reasons, approach and conceptual framework of the substitute family towards dealing with the problems which the child has undergone.

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The background of the child and the child's needs must be clarified to all members of the potential substitute family, so that they clearly understand and appreciate their roles and responsibilities in the undertaking. A substitute family is fully entitled to detailed information on the child. Sharing particulars of the child's case file and providing comprehensive information on the physical, emotional and social status of the child are necessary in order to properly prepare the substitute family. These include specific and sensitive points of concern, such as behavior patterns, stage of development and the results of rehabilitation and adjustment programmes.

Rapport should be established between the two parties, starting from a trial communication link as a means to gradually build up confidence and trust between all parties. With this rapport properly forged, a child can feel secure with the home and the people in due time. In some circumstances, counseling can be provided to the potential substitute family as another way of generating support and understanding. During this preparation period, it is essential to closely monitor the growing relations between the child and the potential family, to be certain that the match is appropriate.

7.6 Preparing for Entry into Another Residential Home or Facility

In cases where child survivors are not prepared or not able to return to their families, relatives or a substitute families, then the option is another residential home or shelter, either operated by an NGO or the government. For older children, this would also include small 'peer group' living situations, with or without live-in supervision.

First and foremost, assessment must be made of the social environment, living conditions and relations between the children and the staff working at the potential residential home. This is done regardless of whether the home is being operated by a governmental or non-governmental agency. How the children are being cared for on a regular basis and how they are cared for during an emergency or crisis clearly reflects the attitudes and conceptual framework of the administration. With all things considered, any decision must be made in the best interests of the child survivor.

The aims and objectives of referral and the philosophical commitment of the referring agency must be made perfectly clear to the receiving agency, prior to the actual transfer of responsibility.

For each child, a preliminary case conference must be held with the case management counterparts of the receiving agency as well as its staff. Proper rapport and healthy relations are crucial to the smooth transfer of an individual case to the care and supervision of the new home, staff and administration. A Trial Residence Period would be helpful to make child survivors gradually gain confidence and trust in their new home, new Case Officer, new staff and new system of administration.

In some cases, occasional counseling or consultative sessions may prove to be helpful to those involved directly with the child survivor at her/his new home. Within this context, counseling should be seen as a professional collaboration.

During the preparation period, systematic monitoring and assessment of the potential new situation are required, and proper adjustment of plans must be made if necessary. Only agencies which have passed the assessment shall be qualified to take child survivors under their care and supervision. Thus, the CPCR Foundation only refers cases of child survivors to qualified homes or halfway houses administered by such agencies.

7.7 Preparing Community Support

Prior to the placement of the child in a new setting, the present Case Officer or staff should establish a support network of community people and local institutions to provide ongoing assistance to the child. These include schools, doctors, community clinics, local hospitals and local administrators, among others.

A preliminary case conference with this network should be organized, to formulate an action plan for child protection, and to ensure that the child survivor is provided with proper services for her/his physical, emotional and social rehabilitation and development. This effort should be followed up by periodic assessment of the case with this network support group.

7.8 Ongoing Support for the Reintegrated Child

The referring caregiving facility which has overseen the child's initial intake and rehabilitation has an obligation to continue its work with the child for some time. Social workers in particular should work closely with survivors of child abuse during the initial phase of their social reintegration. They also should participate with the destination facility, whether family, foster family or care setting, in designing and facilitating activities deemed to be most relevant to the child's protection and care.

Social workers from the referring facility provide routine monitoring and periodic assessment of the child's situation and the condition of the new surroundings. Follow-up visits and consultations with the new caregivers, particularly families and substitute families, on child development,

supervision, problem-solving, communication, role-modeling and daily-life skills are to be documented and used as criteria for evaluation.

Follow-up economic support can be provided to child survivors and their families, substitute families or new caregiving facilities. For families, these can include scholarships for the child, vocational training for the family, or funds for families to start an income-generation activity. As mentioned above, mutual family support groups can be of great assistance. For all receiving situations, support is also given by identifying potential sources of help from the supporting network established in the community. Residential homes can be supported by strengthening their capacity to take care of child survivors, by means such as providing specific training relevant to the work of child protection.

In the case of child survivors who are unable for some reason to return to their families, these children should be closely monitored for some time, while their relationship with their families should be maintained with proper form and distance, with the desired goal that children can in time return to their own families. Most importantly, during the final reintegration process, regular and ongoing dialogue sessions should be held between the representatives of the original facility, the child, and the new caregivers, whether the parents, relatives, substitute parents, or new caregiving facility.

Annex A. Case Management Teamwork

In situations of child abuse, protection, rehabilitation and prevention require the formation of multi-disciplinary teams of professionals who work in a concerted manner for a common goal: ensuring the well-being of the individual child.

Generally, the CPCR Foundation utilizes three basic kinds of teams:

- Child Protection (and Intervention) Teams, which intervene on behalf of children who are being abused;
- Rehabilitation Teams, of several forms, which provide recovery and reintegration to the abused child; and
- Prevention Teams, which conduct Primary Prevention Activities for the general public, as described in Annex B.

Teams are composed of members of the CPCR staff, and include professionals from various disciplines. It should be noted that the first two teams are Case Management Teams. These are formed to work on individual cases of child abuse. Each case is considered separately, as each child has a unique background and requires individualized strategies of recovery and reintegration. Teams are organized according to the requirements of each case.

Each individual case is under the direction of a Case Officer, who is usually a social worker. A single team may conduct case management for a number of children. The composition of the team overseeing an individual case may change as different aspects of the case are under consideration, and as the needs of the child change.

Three key professional disciplines form the core of the Case Management Teams:

- The medical discipline: team members may include, as necessary, a pediatrician, psychiatrist (specializing in young teens, for example), forensic physician, obstetrician, other medical specialists competent in treating or assessing child survivors, medical social worker, psychologist, counselor or nurse.
- The social welfare discipline: team members include a social worker who acts as the Case Officer, a social worker who specializes in community service, and others qualified to handle cases of child abuse.
- The legal discipline: these can include a lawyer, police, public prosecutor, judge and other legal advisors.

In addition to the above-mentioned specialists, other professionals and concerned people can contribute to the success of child protection and recovery activities, such as local teachers, community leaders, mentors and others. These people play direct and significant roles, starting from the intake of a child survivor into a programme, through the process of rehabilitation, to the time when the child is undergoing social reintegration. The CPCR staff works closely with these persons throughout the process, involving them in regular consultative conferences, planning sessions, monitoring and evaluation, social environment assessment and assistance in social reintegration.

A.1 Child Protection (and Intervention) Teams

Any member of the Child Protection Team is prepared to handle distress calls concerning abuse against children. When this occurs, a Case Officer, usually a social worker, is immediately assigned to compile initial evidence and verify the basic facts of the case. A dossier of the child is developed based on the facts and evidence compiled.

Each case adopted by CPCR is normally assigned to a team with rotating staff responsible for different aspects of the case. Under normal circumstances, each child protection case is the joint responsibility of a social worker and a lawyer. A child psychologist provides additional input regarding assessment, monitoring and evaluation of the child's psychological well-being.

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As a standard procedure, following the collection of preliminary facts the team meets for strategic planning prior to collecting in-depth facts and evidence. CPCR receives distress calls from all over Thailand, and the staff have to mobilize local police, school officials, administrators, etc. to participate in the work of child protection. These persons would potentially become part of the team providing services and assistance to the abused child and her/his family.

The social worker usually conducts the preliminary interviews in order to develop a proper dossier. The dossier includes relevant details about the physical, emotional and social situation of the child, including family background, patterns of behavior and other particulars about members of her/his family. All information in the dossier is confidential and subject to periodic assessment and re-evaluation.

Social workers may obtain reliable information by different means, including observation, interviews, making initial and follow-up visits, and gathering information from the survivor's family, community or school, as well as the local public health station and hospital.

The responsibilities of key members of the Child Protection Teams are listed below:

A.1.1 Lawyer

- Takes distress calls on child abuse cases.
- Provides legal advice and counseling on children's rights, welfare and benefits.
- Compiles facts and evidence for two purposes: to develop a solid case against the abuser; and to provide information so that social workers can determine preliminary requirements for social services.
- Takes necessary legal steps to ensure the safety of the survivor, while protecting her/him from possible further abuse.
- Prepares the child survivor for entering the justice system, and supports the child throughout the process.
- Coordinates with the social worker, physician and/or therapist to prepare a rehabilitation programme for the child and her/his family.
- Follows the results of the judgment passed by the court and files a report of the case for submission if it is deemed necessary to conduct further legal action.

A.1.2 Social Worker

- Takes distress calls on child abuse cases.
- Provides advice on social service and benefits.
- Gathers and verifies preliminary facts and evidence to develop a proper dossier of the case. This includes exploring the causes and motives of the offense committed, the relationship between the abuser and the child survivor, and information about people living in the child's immediate environment, including the abuser.
- Makes an assessment of the status of the child survivor and her/his family, particularly addressing the safety issue and any urgent and immediate precautionary measures to be taken, such as temporarily separating the child from the abusive situation.
- Arranges for medical examinations and the assessment of psychological and social aspects of the impact by psychologists, psychiatrists, etc., and collates the information from professionals involved in the case.
- In close collaboration with the lawyer, prepares the child for entering the justice system.
- Coordinates with other persons involved in the case to ensure the best possible protection of the child witness during the legal process.
- Provides necessary assistance to the child survivor to alleviate impacts from having to go through the investigation process.
- Calls for multi-disciplinary team case conferences, particularly in cases in which the abuser is a parent, close relative or friend, in order to explore the best possible approach and procedures.
- Summarizes the problems and seeks the best means to provide social service and psychological support to the child, in case the court decides to sentence someone within the family on abuse charges.
- Commences the social reintegration process, in case the child survivor is not admitted to the programme run by the CPR Foundation.

A.1.3 Child Psychologist

- Conducts preliminary psychological assessment of the child and undertakes necessary crisis interventions.
- Arranges for psychiatric sessions with specialists in the network for further assessment of psychological status, levels of intellectual, emotional and social development, and patterns of behavior.
- Closely monitors and documents signs of disorders and notable psychological and social behaviors, and passes findings and opinions on to other professionals and staff concerned with the case.
- Provides consultations on group and individual activities in the home/community in case the child survivor is not admitted to a shelter home and assessment indicates that special activities for the child are needed.
- Provides counseling and psychological support in case the child survivor is being negatively affected by the procedures of the justice system.
- Works in collaboration with other CPR personnel and supporting professionals in assessing the status of both the child and her/his family.

A.2 Rehabilitation Teams

To undertake the process of providing recovery, rehabilitation and social reintegration to an abused child, the CPR Foundation utilizes three forms of Rehabilitation Teams.

- The Gate House (Assessment) Team works in the CPR Intake/Assessment Unit and is responsible for the critical time of intake, assessment and, if necessary, crisis response for the child entering rehabilitative care. This team conducts assessment of the physical, psychological and social effects of the child survivor, and is critical in providing recommendations for her/his Rehabilitation Plan.
- The Rehabilitation Home A Team is assigned to work in CPR rehabilitation centers for younger children, 3-12 years old, and to conduct rehabilitation activities directed at children's physical, psychological and social needs.
- The Rehabilitation Home B Team is assigned to work in CPR rehabilitation centers for teenagers, 13-18 years old.

Each of the three teams consist of a social worker and activity staff headed by an Activity Leader, as well as specialists in law, social welfare, psychiatry and child care and development.

The responsibilities of key members of the Rehabilitation Teams are listed below:

A.2.1 Social Worker

- The social worker is the pivotal person in the rehabilitation process, and is required to gather, coordinate and communicate all available details on the child, including personal information, social conditions and the results of needs assessments.
- Calls and coordinates case conferences, which includes CPR staff, experts and/or members of

the Child Protection Teams, and assists the Case Management Team in setting appropriate courses of action and determining individual responsibilities for carrying out the activities.

- Gathers information from a social work perspective about the people and environment in which the child survivor was living, enabling the Case Management Team to analyze and determine proper approaches to rehabilitation.
- Documents and compiles all available references on the child survivor and her/his family.
- Works closely with the families of abused children, provides social services and welfare, arranges for medical service and benefits, educational and legal assistance, and other services to which the child survivor and her/his family are entitled. The social worker also provides advice to the family, helping them acquire skills appropriate to daily living.
- Functions as a key person in linking the child and family with the multiple agencies involved in the case, such as those providing an immediate safe environment for the child, if necessary.
- If long-term residence is needed, the social worker identifies and secures commitments from an appropriate institution, agency or facility where the child survivor may feel secure and may be accommodated.
- Prepares the child survivor for eventual social reintegration, by working in a concerted manner with the Case Management Team and supporting agencies and institutions.
- Closely monitors the result of assessments made on the child survivor and her/his family, so that assistance can be dispatched at once, if needed.

A.2.2 Child Psychologist

- The psychologist assigned to the halfway house or shelter home normally assists the child only during the crisis or critical period and thereafter refers the case to the rehabilitation team.
- Gathers information on the psychological behavior of the child and her/his family and submits this information to the Case Management Team for the purpose of determining an appropriate rehabilitation programme and activities.
- Arranges for psychiatric sessions for the child as necessary.
- Conducts rehabilitation activities based on the priorities set by the Case Management Team regarding the needs and requirements of both the child survivor and her/his family.
- Coordinates with administrators and staff of a halfway house or shelter home in documenting observations and details of progress regarding the physical, psychological and social condition of the child.
- Generally monitors individual children's rehabilitation and reports on their progress.
- Makes necessary adjustments in the rehabilitation programme and activities in order to meet the changing needs of the child survivor.

A.2.3 Child Care and Child Developmental Worker

- Supervises the daily life and activities of the child survivors, including food, sleeping quarters, exercise, discipline, health, development, safety and recreation.

- Maintains children's schedules of medical examinations, physical check-ups, visits for therapy, and meetings with professionals for assessment.
- Organizes recreational activities, including field trips, exposure visits, games and others.
- Provides a role model for child survivors, and maintains a child-friendly family setting within the rehabilitation center.
- Takes notes, makes records and files reports for use by the Case Management Team regarding children's ongoing physical, psychological and social conditions, the progress of their development, changes in personality, and others.
- Organizes specific activities designed to stimulate the positive intellectual and social development of the child.
- Actively participates in Case Management Team meetings, working sessions and case conferences.
- Monitors the social relationships of child survivors with other children and adults at the halfway house or shelter home, and files reports and updates for the Case Management Team.
- Makes necessary changes to the Daily Activity Programme at the facility in order to respond to the needs and levels of development of the child survivors.

A.3 Prevention Teams

These teams are responsible for Primary Prevention measures (discussed in Annex B), including establishing networks of public support, strengthening family and professional supporting groups, and actively lobbying for institutionalized mechanisms of child protection at the national level. The teams are mobilized and coordinated by a Preventive Activities Coordinator.

The responsibilities of the key member of the Prevention Teams are listed below:

A.3.1 Preventive Activities Coordinator

- Plans and executes activity plans for families, schools and communities.
- Coordinates work with local organizations, leaders and administrators to ensure smooth and concerted actions on behalf of survivors.
- Coordinates with the above-mentioned organizations, individuals and others to ensure the provision of public service and welfare for survivors' families.
- Strengthens and supports families in the network, as well as local school and community groups.
- Extends prevention activities in families, schools and communities to other areas throughout the country.

A.4 Management of Case Conferences

Once a case is filed with CPR, a social worker assigned to the Child Protection (and Intervention) Team assumes the role and responsibility of a Case Officer. The Case Officer calls for case conferences, which are attended by a multi-disciplinary team of professionals – the Case Management Team – comprised both of persons working for CPR and the supporting network.

The first case conference is called to explore proper approaches to execute an immediate protection scheme. In this case conference, the Case Management Team identifies the best or most appropriate institution for the safety of the child, for conducting interviews, assessing the child's status, and determining the physical, psychological and social impacts on the child from the abuse. The division of tasks and responsibilities should be concluded as soon as possible.

The second case conference is required to collate and compile all the facts and evidence on the case, in order to get a clear profile of the child victim and her/his family. This includes data on medical history and the physical, psychological and social effects, all of which are vital to the legal actions to be taken, as well as to the needs assessment to be carried out. A systematic compilation of these data, facts and evidence are crucial to strategic planning and the formulation of action plans.

After having concluded the second case conference, it is advisable to establish the priority of services to be given to the child survivor, both quantitatively and qualitatively. Because services are provided by a multi-agency arrangement, it is necessary to develop a well-coordinated plan of action, with indications of the proper priority needed to achieve the best results for both the child survivor and her/his family. High responsiveness to the child's needs is one indicator which proves the success or failure of the efforts made. More importantly, working in a multi-agency fashion requires clearly agreed-upon and clearly assigned responsibilities based on commitments and expertise. Assigning the right agency with the right personnel and completing tasks within an agreed-upon time-frame are always a must.

The management of the organization must fully realize the importance of accepting the responsibilities of monitoring, evaluation, supervision and follow-up, and working towards the common objectives as agreed upon in the multi-disciplinary setting. In the final analysis, the organization must deliver as committed and agreed upon at the case conference.

The third and subsequent case conferences are normally focused on monitoring, implementation of plans, and evaluation of the actions and the implementation. Due consideration is given to any changes which have occurred to the child survivor and family as a result of interventions from CPR and/or the multi-disciplinary team. If found to be satisfactory or meeting the expected results, those activities are continued with regular assessment or follow-up activities. Case conferences for the purpose of following-up activities are called from time to time until the case is finally closed.

If activities don't meet planned expectations, a subsequent case conference is called to analyze and identify the causes of failure or shortcomings, and to enable the Case Management Team to find solutions. For example, facts and/or evidence gathered might be inadequate, incomplete or misinterpreted, leading to wrong conclusions on some points. There might have been some human error or discrepancies on the part of staff, and consequently some of the specialists or other members of the team may have to assist the executing personnel or supervise the operations more closely.

Annex B. Prevention

Preventive measures and mechanisms are part of the CPR Foundation's standard child protection strategy. CPR conducts prevention activities at four levels, as follows:

- Primary Prevention: activities to mobilize the general public and professionals to participate in the prevention of child abuse.
- Secondary Prevention: activities to prevent abuse of children in high-risk situations or those who have already been abused.
- Third Level Prevention: activities to protect children who are being abused, without removing them from their families.
- Fourth Level Prevention: activities to prevent a previously abused child from becoming an abuser.

B.1 Primary Prevention

This is a public service designed to pre-empt child abuse in general. The CPR Foundation promotes preventive measures and vigilance to be employed in homes, schools and public places, and encourages the public to become part of a child abuse watch mechanism. CPR assigns this specific task to its Child Abuse Prevention and Campaign Team under the direct supervision of the CPR Children and Social Development Department to carry out the activities described below.

B.1.1 Prevention Measures for Families

Family Activity Clubs (FACs) are organized specifically for parents who wish to learn about child-friendly parenting. FACs are educational by nature, and include a series of group discussions and family camps for parents, as well as the design, development and production of media for parents on parenting and child abuse prevention. FAC activities are developed and carried out with the cooperation of parents from different families.

In the future, CPR intends to develop Family Activity Clubs into a network of substitute parents for child survivors of abuse. This will strengthen mutual support among FAC members, as well as provide protection for children who are abused by their parents.

Family Relations Activities are community-based activities intended to strengthen the network of parents and families in particular communities. It aims to strengthen communication skills for parents to help them relate to children under their care and supervision. Parents are encouraged to form their own self-help groups in order to forge healthy relations within individual households and between different families in the neighbourhood.

With the groundwork established by Family Activity Clubs and Family Relations Activities, family networks should be able to reduce and prevent cases of violence committed against children in their own communities.

B.1.2 Preventive Measures for Schools

“Saying Yes! Saying No!” is an educational activity which teaches children nine to 12 years old how to defend themselves against sexual abuse. It has been developed for eventual incorporation into the standard school curriculum. CPR has introduced Saying Yes! Saying No! Activity Camps for children of Grades 4 to 6, and a teacher training course called the Saying Yes! Saying No! Workshop has been offered to elementary school teachers. It is hoped that this activity will soon be incorporated into the standard nationwide school curriculum, equipping all children of a vulnerable age with basic skills to defend themselves against abuse.

B.1.3 Community-based Family Service Centers

Initiated by the CPR Foundation, community-based family service centers attempt to reach out to parents in various communities with services aimed at reducing or minimizing the risk factors leading to child abuse. The centers are basically educational and are equipped with a small library or book-corner. They also provide counseling and advisory services regarding social welfare, medical support, legal advice and other available facilities. Center activities are organized by parent groups in their respective communities.

B.1.4 Preventive Measures for the General Public

‘Big Friendly Tree Activities’ are an innovative intervention developed to promote members of the general public as active participants in child abuse prevention. Violent acts against children can be minimized or deterred with the help of individual adults volunteering to be a ‘Big Friendly Trees’ which protect children against abuse. On certain occasions, CPR organizes a ‘Big Friendly Trees Day’ where concerned and committed adults can meet and share their ideas, concerns and experiences, and discuss ways in which they can actively work to prevent abuse in their communities. Through this, members of the community develop mechanisms to ensure public safety for children, allowing them to enjoy a good quality of life, free from all forms of abuse.

‘Child Protection Network Activities’ represents another approach to longer-term prevention of child abuse through the mobilization of selected professionals and the development of practical handbooks and manuals on child abuse for professionals from different disciplines. Committed professionals contribute to the overall efforts of prevention, or become part of multi-disciplinary teams working directly with child protection. It is the intention of the CPR Foundation to develop “best practices for child protection” for the different professional disciplines, while encouraging professionals to join in lobbying for new legislation or necessary amendments to existing laws. So far, a variety of concerned agencies and organizations that are active in Thailand have agreed that specific laws on child protection

should be enacted without further unnecessary delay. In the opinion of CPRC, an established network of professionals combined with diverse mechanisms of child protection can greatly reduce child abuse in every country.

At a regional level, specifically the Mekong River Basin countries of Southeast Asia, CPRC attaches great importance to the document "Best Practices for Child Protection", which is endorsed and adopted by all member countries of the Basin. As a result of this consensus on effective prevention activities, concerned agencies and committed organizations in different countries can share information and experiences and can generate mutual support to minimize and reduce cases of child abuse throughout the region.

B.2 Secondary Prevention

Secondary prevention targets children of high-risk groups as well as individual survivors of child abuse. The intention of secondary prevention is to identify and reduce risk factors for the child and her/his family in order to minimize the possibility of initial or repeated abuse. The identification of children at immediate, high risk of abuse, and protection measures to help those children are an integral part of the CPRC Foundation's programme.

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As with intake, rehabilitation and reintegration, immediate protection requires case management, and utilizes a multi-disciplinary team to accomplish the task.

The children targeted by secondary prevention activities include:

- Children in general, who have not yet been abused in any form, but who belong to a high-risk group.
- Children belonging to a high-risk group and who are living with parents or guardians with a history of abuse, including trafficking their children.
- Child relatives of abused children who are living in the same or a similar abuse-prone family environment.

Within CPRC, secondary prevention activities are carried out through the joint efforts of CPRC's Child Protection Team and its Rehabilitation Team, with the support of outside professionals, agencies, volunteers, etc. as needed. The first step is the identification of risk factors surrounding the individual child.

Risk factors are divided into two categories: environmental factors and human factors.

B.2.1 Environmental Risk Factors

- The nuclear family is living in isolation from other members of its extended family, children are deprived of close care and supervision from relatives, and/or the family is socially isolated from others in the same community.

- The family resides in a low-income, vice-prone community or an otherwise unhealthy environment, such as a slum area in which there is considerable prostitution, drug addiction, gambling and criminality.
- The family home is a living situation which lacks private bedrooms separating adults and children, in which children are growing up without a strong sense of privacy and must share living and sleeping quarters without due regard for their development and safety.
- In the family environment, hazardous substances or dangerous chemicals are not safely kept out of reach of children, resulting in children being routinely exposed to dangerous materials.
- The family is undergoing economic hardship and unemployment, and parents lack vocational skills and have no access to basic social welfare.

B.2.2 Human Risk Factors

- Health-related problems, either physical, psychological or behavioral, are apparent among family members.
- Parents lack adequate social skills, are incapable of dealing with problems, are not equipped with parenting skills, do not accept parental responsibilities, or show other indications of inability to provide adequate parenting and role models.
- Dossiers of parents show that one or both of them were subject to some form of abuse in their childhood, were deprived of proper upbringing, or were subject to neglect as children.
- The mother was an unwed or unprepared mother.
- The family is dependent on only one bread-earner.

B.2.3 Secondary Prevention Activities

The following secondary prevention activities are carried out for each child at risk:

1. When alerted to the presence of a child in danger, a staff member, working collaboratively with a team of professionals, gathers preliminary data and evidence, assesses the potential victim's physical and psychological status, social background and up-bringing, and conducts an assessment of her/his family.
2. The child is provided necessary services and community-based rehabilitation support. Appropriate services and assistance are also provided to the family. These services can include health care, education, social welfare, parenting skills, safety training, local police support, legal services, civic registration and transportation, among others.
3. Proper counseling is provided to both the potential victim and her/his family.
4. Parenting skills, healthy child-rearing methods, and crisis management techniques are provided to individual family members.
5. The child and/or family are provided appropriate economic aid and assistance necessary to minimize risk factors, such as scholarships, or seed money to start a vocation or income-earning scheme.
6. If necessary, the potential victim is provided a thorough medical examination and psychological assessment.

If the risk of abuse is considered extremely probable if the child remains in the family, then the organization must consider removing the child from the situation. This is done by providing protection and emergency welfare, such as a boarding school, temporary shelter or substitute home, as well as necessary income-generating employment, and basic needs in terms of food, clothes, medicines, etc. No child should be removed from her/his family environment unless it is clearly determined that the child is in immediate and probable danger.

Secondary prevention activities are conducted by teams, similar to standard case management activities, and utilize members of CPR's staff, as well as supporting professionals. In addition to professionals, certain local individuals can be of great value in the process. It may be possible to identify people with whom the child survivor may find comfort and understanding. This could be a family member or some other person who can communicate effectively with the survivor's parents, or someone at school or in the community, such as a member of a Parents Club or Housewives Group, a social worker, or a kind and understanding teacher.

B.2.4 Guidelines for Secondary Prevention

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Some basic guidelines concerning prevention teamwork are listed below.

- Planning of secondary prevention activities is conducted in multi-disciplinary case conferences.
- Active coordination among concerned professionals at the local level is a key to success. These include community-based social workers, local teachers, nurses, community organizations and village headpersons, among others. In Thailand, most of these people are sympathetic to the cause of child protection, and can be recruited to be on the alert for possible violations of children's rights in their community. Some may be mobilized to pay home visits to survivors of child abuse, and help assess the conditions, circumstances and risk factors concerning particular children.
- Another key to success is clear division of services among individuals, agencies and organizations working in abuse prevention. These services include, among others, legal registration, child abuse watch or child protection alert, follow-up visits to families, child and family activities, and monitoring and evaluation.
- For each child/family, a Plan of Action to Minimize Risk Factors should be established by the teams. This includes proper guidelines for receiving services and prioritizing the services needed for the benefit of children and their families. It is imperative that activities build the potential of the families to create a healthy child-friendly environment in the future, such as vocational training or support for starting an income-generating activity. Child survivors or those at high risk should be provided with necessary scholarships and support as well as counseling services, psychiatric help and camp activities together with their parents.
- In prevention as well as rehabilitation activities, the tasks of monitoring, assessment and evaluation must be performed in a comprehensive manner, covering physical, psychological, social and family aspects, and including all activities participated in by the child and her/his family.

- It is essential that individual Plans of Action are adjusted as indicated by evaluation to be responsive to the needs of both the child and the family. It should be borne in mind that there is always room for improvement and change in a Plan of Action.

B.3 Third Level Prevention

Third Level Prevention is intended to protect an abused child from continued abuse without removing her/him from the family/community situation. This task is entrusted to the Children's Rights Protection Department of the CPR Foundation. As in Second Level Prevention, certain services and support must be given to the child survivor and her/his family. However this programme and related activities involve legal recourse, including filing formal charges against the abuser, and working with police and public prosecutors, as well as facilitating rehabilitation for the abuser. Some of the steps and activities of Third Level Prevention are as below:

- Compiling facts and evidence for submission to the police.
- Giving support to police investigators and/or the Case Officer in terms of arranging interviews and documentation, ensuring that all act in full compliance with the Criminal Procedures Code when interviewing the child witness, and ensuring that Child Witness Support procedures are applied in the case.
- Providing adequate protection to the child survivor, responding to her/his immediate needs, and guaranteeing security and safety for the child against any possible threat or retaliation.
- In cases where local police are inactive or insufficiently attentive to the case, encouraging them to act fully and efficiently in accordance with police duty. In some instances, CPR may have to go to higher levels of the police chain of command and draw attention to the case from higher officials.
- Arranging for psychiatric assistance in case the abuser needs professional help. This is applicable when the abuser is not capable of changing her/his criminal behavior due to personality disorders.

B.4 Fourth Level Prevention

This activity is meant to ensure that the abused child does not develop abusive tendencies or become a future abuser her/himself. Case studies indicate that many abused children have grown up in an environment which lacked proper parental role models. Even grandparents, aunts and uncles may have had negative influences on a child (although, on the other hand, they may have provided positive supportive models for the child).

To prevent the abused child from repeating the negative actions of her/his own family, the CPR Foundation has initiated a programme and relevant activities aimed at recruiting voluntary substitute parents or 'Weekend Parents' who can act as positive role models during holidays, school recess, or any period deemed to be appropriate for both parties. This provides the child a "once in a life-time experience" of having good parents and being part of a child-friendly family. In this way, the child is given a chance to learn about parenting roles and family development, and how to respond positively when she/he enters a parental or caregiving role in the future.

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Integrating Indigenous Knowledge and Practices into Psychosocial Help and Support for Child Survivors of Trafficking and Sexual Abuse

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Abstract

Following a background of sexual exploitation and abuse of children, this paper presents the existing paradigms which determine healing responses to the child survivor. The paper argues for a new paradigm which emphasizes utilizing children's inherent competency and resiliency in resisting and surviving sexual abuse. It discusses cultural considerations of the concept of children and childhood, and presents theories, arguments and examples reinforcing the necessity to seek healing strategies from indigenous practices in the child's culture, to secure the full participation of the child in the healing process, and to utilize 'positive deviance' approaches in seeking strategies for the recovery and reintegration of abuse and trafficking survivors.

Aim and Objectives

The aim of this paper is to build and enhance the capacity of caregivers to understand and assist child survivors of commercial sexual exploitation by:

- providing a brief understanding of the phenomenon of commercial sexual exploitation and abuse of children, its effects and the various responses to the problem;
- critically examining the current thinking and practice in this area with special focus on child development;
- presenting the various perspectives and changing paradigms in bio-psychosocial help;
- showing how the critical use of culture and tradition can foster healing and assist recovery; and
- identifying and examining various ways by which indigenous knowledge and practices can be integrated into provisions for bio-psychosocial help.

Context and Background

2.1 The Phenomenon of Sexual Exploitation and Abuse of Children

A great number of men, women and children all over the world are presently involved in the sex industry. Some are survivors of the flesh trade (prostitution, pornography and trafficking); while others are part of the highly organized network of abusers, e.g. customers, pimps, police and other law enforcers. Alarming, children are being brought into the flesh trade at an increasing rate. The figures are confusing and largely 'guesstimates' because there is no consensus as to the exact number of children involved (Ennew, 1996).

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Sexual exploitation is defined as a practice by which person(s) achieve sexual gratification, financial gain or advancement through the abuse of a persons' sexuality by abrogating that person's human right to dignity, equality, autonomy and/or physical and mental well-being. Sexual exploitation can range from prostitution through seduction to actual rape. It can use 'non-violent' means such as promise of money, coercion and/or emotional blackmail. Sexually exploited children are defined as children, male or female, who for money, profit, or any other consideration due to coercion or influence of any adult, syndicate or group, indulge in sexual intercourse or lascivious conduct (Di Giovanni, 1997, cited in Protacio-Marcelino et al., 2000a).

Prostitution is just one of many forms of violence against women and children. To understand the whys and wherefores of prostitution is to come to grips with deeply embedded societal mores which hold the assumption that women and children are the property of men. It is a product of male domination, sexual violence and enslavement. In the Philippines and Thailand for example, sex tourism has become one of the largest

underground industries for foreign travellers. 'Sex tours' vacation packages offer incentives and bonuses for businessmen, providing unlimited sexual choice and gratification from Asian women and children.

Child pornography, the photo documentation of the sexual abuse of children, is another way by which children are sexually exploited. Most child pornographic materials in circulation in the world today are produced in Third World countries. Although the circulation of pornography and its consumption is a debatable issue, many people are of the same mind that child pornography is definitely not acceptable in civilized society.

Women and children have been sold to different countries and housed in brothels in the most deplorable conditions. They usually enter foreign countries illegally and use fake passports and visas. Because they are illegal entrants, they are unable to ask for assistance and cooperation. This is true even for women and girl migrants who find themselves not in brothels but similarly bound in forced marriages.

Thousands of Nepali girls are sold every year to brothels in Calcutta, Bombay, Delhi and other urban centers. Non-governmental organizations continuously reported cases of girls sold to Indian brothels years before the 1996 mass repatriation of Nepali girls sold to Indian brothels, which made girl-trafficking an issue of national concern. The cases presented stories of deception, abuse and torture. A preference for sons, poor economic conditions, low status of women and the girl child, poor social structure, poor legal enforcement and modern consumerist culture are factors often mentioned as causes of the high prevalence of trafficking of women and girls in Nepal (Protacio-Marcelino and Camacho, 1998). The trafficking network has spread, new trafficking areas are emerging and new routes are continually being created due to the insatiable demand for young girls.

It is clear from the many stories that sexual exploitation is perpetuated by recruiters, pimps, procurers, and sometimes even local law enforcers and government officials at the expense of the lives of women and children.

Most literature on child abuse depicts abusers acting as individuals. While this may be true in some cases, commercial sexual exploitation of children should be seen in the context of a triangle of abusers that includes users, suppliers and protectors (dela Cruz et al., 1997).

The same study also noted that ‘protectors’ can also be ‘users’ and the ‘users’ usually become ‘suppliers’. This shows a complex, often organized network of abusers, each one reinforcing each other’s interests. Thus, it is referred to as the ‘sex trade’, a very lucrative industry that has become more vicious and tries to mask itself with some form of legitimacy through ‘sex tours’ and web sites that are available to anyone (Cullen, 1994, cited in Protacio-Marcelino et al., 2000a).

According to Hiew (1995), the heart of the problem is the “exploitation of the powerless by the powerful (male over female, adult over child, rich over poor, devious over naïve, organized over unorganized)”. O’Grady (1992, cited in Protacio-Marcelino et al., 2000a) emphasized “materialism, consumerism and patriarchy” as factors that promote the idea of children as commodities. Narvasen (1988), on the other hand, stated that “urbanization, colonialism, machismo, plus religious and cultural factors” were the main reasons for child sexual exploitation.

2.2 Bio-psychosocial Effects of Sexual Exploitation and Abuse

Children in sexually exploitative and abusive situations experience oppressive and de-humanizing conditions and suffer extreme hardships such as client brutality, police harassment, social stigma, and lack of basic social services and legal assistance. Children in these situations are less likely to finish their education, have less job opportunities and fewer options in life. As such, they have not much to look forward to.

Physically and psychologically, sexual exploitation and abuse wreak havoc on young lives. These children have been found to suffer from feelings of inadequacy and low self-esteem, sometimes leading to depression. They

often feel that they are to blame for the abuse and perceive such as a form of punishment for the wrongs they did. They begin to see themselves as outcasts in society and are likely to exhibit anti-social and self-destructive behavior (Protacio-Marcelino et al., 2000b). If not given professional assistance, there is also the risk that the child him/herself will become a perpetrator, starting a cycle of violence and abuse.

Just as serious are physical health risks. These children are likely to have poor nutrition and be generally in poor health. They are susceptible to infectious diseases and physical injuries due to battering and torture, and are in constant danger of contracting HIV/AIDS and other STIs (UNICEF, 1997). A review of various studies (Tan, 1998, cited in Protacio-Marcelino et al., 2000b) has shown that despite numerous AIDS awareness campaigns in the Philippines, for example, the child survivors of the sex trade are still largely ill-informed about STI risk reduction. They are also susceptible to drug, tobacco and alcohol addiction, and unwanted pregnancies.

2.3 Various Responses to the Sexual Exploitation and Abuse of Children

The multiplicity of factors involved in the problem of sexual exploitation and abuse of children also means that there are different perspectives and approaches in finding a solution to the problem. The common reaction to the problem is to 'rescue' these children and place them in institutional 'homes'. Many NGOs open 'homes' and try to treat and rehabilitate them by providing various alternative activities (e.g. income generation programs) and services (e.g. counseling). Others offer livelihood projects, vocational courses and scholarships to selected children. Some religious groups evangelize among prostituted children and persuade them to leave the industry because it is immoral and a sin. Still others conduct public awareness campaigns to educate the community on the seriousness of the problem and set up community-based programs that will empower the children and their families.

Most attempts at providing simple treatment, rehabilitation and income-generating programs have not reported any long-term success. At best, they have provided immediate relief and palliative remedies. There is a need therefore to address the root causes of the problem and search for more lasting solutions from a holistic perspective and integrated approach.

Perspectives in Bio-psychosocial Help: The Need for a Paradigm Shift

3.1 Bio-medical Perspective

In many countries, the first level of help for sexually exploited and abused children is usually provided from a bio-medical perspective. This approach basically follows the medical model of treatment of a disease and is therefore curative in its approach. Underlying this model is the assumption that children are sick. For example, when a child is raped, he/she is brought to a medical doctor for physical examination and appropriate treatment or alleviation of psychological distress. The prevailing orientation is that the abused child is 'damaged' and needs 'repair' or 'cure' whether the symptoms are physical or psychological. In order to control further damage, 'intervention' is necessary to remove or eliminate the problem. This is very similar to a surgical solution, and tends to be clinical in its diagnosis of and solution to the problem.

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Fajutagana and Marcelino (cited in Teodoro and Sicam, 1995) described this model as: a) focused more on disease than general health; b) placing greater emphasis on physical than psychosocial problems and being insensitive to psychological factors; and c) giving more attention to individual care than collective care. In terms of ideological position, this model is characterized by "objectification, reductionism, professional dominance and medicalization of life events".

3.2 Social Welfare Perspective

Another approach to helping sexually exploited and abused children uses the framework and methods of social work and community development. Unlike the biomedical model, the social welfare model has both curative as well as preventive components. It also recognizes the importance of external factors in the child's social environment; thus, it includes relief,

rehabilitation and protection in the package of services. It looks at the child in a more holistic way and recognizes the importance of the child's physical, intellectual, emotional, social and moral development.

The language and the practice have also changed in the course of using this model. It is no longer only treatment but also recovery, reintegration and healing; not only victim but also survivor; and not only psychiatrists, psychologists, doctors, but caregivers and facilitators.

Most government and non-government organizations currently find this perspective very useful and various networks have been established around this model. This model has been proven to be effective in raising awareness of the issues and advocating for reform and changes in legislation.

3.3 The Vulnerability Paradigm

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The general response to the problem of helping children involved in sexual exploitation and abuse is premised on certain assumptions regarding children and their situation, resulting in varying approaches to the issue. One assumption is the belief that what works for adults also works for children. Thus, theories and techniques that are good for adults are immediately adopted in helping children without consideration for age, gender and cultural differences. Of course, an assumption of the bio-medical perspective is that what works for animals may also work for human beings, including children.

Another major criticism to the two above-mentioned perspectives is the assumption that children who have experienced abuse are totally helpless and powerless and have a diminished capacity for self-help. It focuses on the lack of capacity or inability of the child to respond adequately to the situation. This is further underscored by frequently-used terms such as 'children in difficult circumstances', 'children at risk' and similar labels.

This approach is called the 'vulnerability paradigm'. Here, the main goal is to identify the problem, causes and solutions, under the assumption that

all children who experience abuse will sooner or later develop symptoms or problems and exhibit socially unacceptable behavior. The idea is to immediately address the problem and provide the necessary treatment and interventions (Bautista et al., 2001).

Caregivers and many others in the helping professions often work along this paradigm. We see this operating in sponsorship programs where children are presented as poor and pitiful, complete with pictures that touch the heart, thus bringing more funds for the programs.

Thus, there is a need for a 'paradigm shift' that will recognize the children's internal and external resources to help him/herself. This is necessary to prevent further harm to the child as well as hasten the child's recovery and reintegration into society.

3.4 The Competency Paradigm and the Child Rights Perspective

This paradigm recognizes the strength and capabilities of children that enable them to deal with difficulties within given circumstances. Children are seen as active agents of their own development, and in the case of abuse, their own healing and recovery. This does not mean they should be left alone without any kind of support, but rather they should not be treated as passive recipients of assistance (Bautista et al., 2001).

Children have knowledge, skills and attitudes that may help prevent abuse or mitigate its effects. They also have the potential to build and enhance their inherent strengths and capabilities. Based on this view, the participation of children in their own development and recovery is of paramount importance. It not only recognizes children's competencies, but also acknowledges children's resilience.

Resilience is "the human capacity to face, overcome, and be strengthened or even transformed by the adversities in life" (Grothberg, 1995, cited in Bautista et al., 2001). It is "successful adaptation to stressful life events" (Werner and Smith, 1982, cited in Turner et al., 1993, subsequently cited

in Bautista et al., 2001). Interest in resilience started when researchers and practitioners wondered why everyone who grew up under difficult circumstances and amidst serious disadvantages did not become dysfunctional. Stated simply, it is “the ability to survive against all the odds and learn from one’s experience”. This implies that resilience is more than just coping or surviving but is also learning something positive and growing from the negative experience. It also has moral and spiritual elements since the resilient child exhibits socially approved responses to difficult situations as well showing inner strength in the face of adversity. (Osborne, 1993, cited in Vanistendael, 1995, subsequently cited in Bautista et al., 2001).

The concept of resilience does not ignore the vulnerabilities and risks that are present in the child’s environment, which includes the family, school and community. Resilience is a process that involves the interaction of risk and protective factors in the environment. Risk factors are stressful life events that include poverty and other threats to the child’s healthy development. Protective factors are those elements in the environment that provide and enhance the child’s development, such as warm and loving relationships, positive school and home environments, etc. This further reinforces the notion that social and cultural contexts play an extremely important part in healing and recovery

The competency paradigm is consistent with the child rights perspective. The UN Convention on the Rights of the Child recognizes the basic and inherent dignity of the child as a human being. Thus, it ensures that all the needs of children are adequately met and properly addressed by society, focusing not only on reducing risks and vulnerabilities but also securing the child’s well-being. The well-being of children here is considered concrete and measurable, and their concerns are addressed both in terms of the individual child and children as a group.

The recognition of the child’s ability to form opinions and his/her right to be heard is crucial in re-defining the view of child abuse, and in understanding children’s competencies as well as resilience. According to

Himes (1993), cited in *Standing Up for Ourselves* (ECPAT International et al., 1999), “the child’s right to participate means acquiring increased recognition, both as a legitimate reflection of children’s ability to think, speak for themselves and also as an essential component of their preparation for participating responsibly in democratic societies”.

However, children’s participation is not limited to expressing views and opinions. In recognizing their active role in development, adults are compelled to build an environment in which children can actively participate according to their level of maturity. This means allowing children to obtain sufficient, appropriate information and sufficient avenues for discussion with concerned individuals and groups so that they can develop their views on issues. This means letting them identify opportunities and allowing them to join activities where they can address issues that concern them.

The point is to find out whether our programs and services are able to support their strengths and enhance their capabilities. It is important not only to know what the child can do but also what the child wants to do.

Table 1. Comparison between the Vulnerability and Competency Paradigm

	Vulnerability	Competency
Orientation Where do we stand?	We do it for/to the children	We do it with/ by the children
Outlook What is our prospect for the future of the child?	Child as beneficiary/recipient Victim	Child as partner Survivor
Views How do we see the child?	Child is seen but not heard Little adults	Child with rights With unique characteristics and needs
	Possession or property Extension of the parents Incomplete human beings Tabula rasa Passive Helpless	Human beings Child with potential Childhood is life itself Innate qualities Active agent of change Active contributors of own development
Attitude	Weak “I know all the answers” Mistrust of child’s capabilities	Resilient Listening or learning attitude Recognition of child’s capabilities
Approach	Discriminatory (class, race, gender, age, religion) Looks at difficult situation Identifies weaknesses (negative)	Gender and culturally sensitive Looks at opportunities Identifies strengths (positive)
Nature/ Character	Output-oriented Rigid Formal Statistical Predetermined Preconceived	Process-oriented Flexible Informal Descriptive Evocative Consultative

	Vulnerability Paradigm	Competency Paradigm
Method	Clinical/diagnostic	Participatory
	Detached	Grounded
	Compartmentalized	Integrated
	Palliative/immediate relief	Holistic/enriched helping relationship
Key players	Curative	Participatory
	Dole-out	Empowering
	Drug therapy	Uses creative arts, play, indigenous methods
Relationships	Only professionals	Child and the environment
	Authoritarian/paternalistic	Democratic, as equal human beings with rights
Results	Vertical relationship	Child as a human being with the same value as adult
	Individualistic	Shared meaning
	Learned helplessness	Self-trust, self-esteem
	Dependence	Social participation
	Immediate relief	Long-term solutions
	Stigmatization/alienation	Shared meaning

The Concept of Child Abuse

A recent review of literature on child abuse in the Philippines revealed several contradictions in the terms and definitions used for 'child abuse' (Protacio-Marcelino et al., 2000b). The researchers noted that although the term was generally used to describe a broad range of phenomena, it was usually placed in the framework of 'children in especially difficult circumstances' (CEDC). Under this framework, child abuse was often embedded in the discussion of risks and hazards faced by street children, those engaged in prostitution, and child labourers. Discussions of child abuse as a distinct social phenomenon were sorely lacking.

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Ennew (1996, cited in Protacio-Marcelino et al., 2000b) stressed that child abuse must be considered as a phenomenon in itself instead of making it one feature among others of CEDC. This means making child abuse a central issue that requires examining. One should also dismiss the notion that child abuse is always manifested in extreme forms as reported in the media. This repudiates the idea that child abuse occurs only in certain types of families (e.g. dysfunctional families). The popular view, often derived from Western literature, is that dysfunctional families bring about abuse and that poverty contributes to the perpetration of abuse. While these views are plausible, they have never really been empirically validated.

Several issues were raised with the use of CEDC as a framework in the conceptualization of child abuse. First, the concept of CEDC treated such situations and problems as peripheral to the concerns of so-called 'normal' or 'mainstream' children. Although the concept called attention to the needs of CEDC, the label also excluded a large number of children in a cross section of families, including those not classified as 'marginal' or

'dysfunctional'. Confining child abuse within 'especially difficult circumstances' was tantamount to encouraging the specialization of programs for only a sub-category of children. Thus, there is a whole range of services geared towards very specific situations of children.

We need to look at child abuse as a phenomenon in its own right and recognize its own specific features, structure and nature. An understanding of its various manifestations and the different contexts or situations in which it occurs should also consider the historical, cultural and psychological dimensions of the problem. There is also a need to reassess the concepts of childhood, family, education work and values based on local knowledge and practices, and do so in consultation with children. In order to better understand child abuse and its contexts, we need to unpack the cultural meanings and notions of children and childhood.

Notions of Children and Childhood

When working with children, there are usually certain notions we have about children and assumptions about childhood that are not often articulated and discussed. For example, as mentioned earlier, we view children as mini versions of adults and because they are small and weak, assume that adults have the right to assert power and authority over them. Consistent with this idea is the notion that children do not have personalities and are born *tabula rasa*. They are like blank sheets of paper that parents and adult society can simply write on or are like sponges that will absorb anything poured into them.

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Another notion is that children come from their parents and are very much like them; therefore they are considered property of their parents, who can do whatever they want with them. This results in the thinking among parents that they can sell their children, use or abuse them.

In their review of child development, education, psychological and anthropological literature, Boyden et al. (1998) noted how Western theories predominate in the explanation and analyses of different phenomena related to childhood. The theories of Jean Piaget, who focused on the cognitive development of children, and Erik Erikson, who is known for his theory of the socio-emotional development of children, left a legacy whose influence has made an imprint in several ways.

Even among professionals, it is often assumed that childhood is the same as child development. We tend to forget that there is a socio-historical-political context to children's development and this is the larger context of society. Thus, childhood is socially constructed.

In the same review of literature (Boyden et al., 1998), the authors made several significant observations. First, that these theories asserted that childhood is a natural and universal phase of the human life cycle in which biological and psychological factors have a stronger role to play than social and cultural forces. Simply said, it is implied that all children go through the same stages of development under uniform and similar conditions.

Second, these theories assert that children progress according to a linear pattern of growth and change, and that those who do not conform to this pattern, using norms based on school children in Western and Northern countries, are in some ways at risk, in trouble or even 'abnormal'. This linear pattern is considered the mainstream, ideal childhood. This is typically the urban, educated, middle class type of childhood. Obviously, a large number of children in Third World societies would probably fall short of these standards.

Third, the notion that there is a pre-set path of development patterns provides the basis for thinking that children are passive in the face of compelling biological and psychological forces. This leads to the notion of excluding children in the adult world and confining them to the world of school where socialization and development can be institutionalized and controlled.

This is closely related to the fourth notion: that childhood is an extended period of dependence. Here, childhood is viewed as a preparation for adulthood. Childhood is not appreciated or enjoyed for its own sake.

Fifth, the focus of research on infancy and early childhood has led to the belief that behaviors and experiences during this period are causally related to developmental achievements and adaptability in adulthood. This effectively ignores the influence of experiences and behaviors developed in middle childhood.

A universalist theory of child development containing many of these ingredients has now assumed credibility globally and underpins important

international instruments like the ILO Minimum Age Convention and the UN Convention on the Rights of the Child. Because we are using the CRC as the framework in much of the work with sexually exploited and abused children, this has raised several issues on the application of universal standards. By now it is probably quite obvious that there is no standard blueprint or simple formula to address these issues.

In this review of literature, Boyden et al. articulated nine broad principles of child well-being and development which apply to children in different social and cultural contexts. They also suggested that these principles serve as a guide to orient policies and programs with regards to child protection. These principles are as follows:

- The development and best interests of children are likely to be defined differently in different places.
- Within any given society, children are not all regarded equally and this profoundly affects childhood experiences.
- Children are not passive recipients of experience but are active contributors to their own development.
- Child development is mediated by an array of personal and environmental factors and hence children's experiences have indirect and complex consequences on their well-being.
- The relationships between different aspects of child development are synergistic.
- Children have multiple capacities which need to be fostered, and different societies present different demands and opportunities for children's learning, producing different developmental outcomes.
- Different child protection strategies have different child developmental outcomes.
- Children are highly adaptable and develop in the context of constant change and contradiction.
- Acceptance by the family (however defined) has important developmental outcomes in societies which recognize group rights above those of the individual.

5.1 Perspectives from Indigenous Psychologies

Psychology as an academic discipline and profession in Asia is usually viewed as contiguous with the development of psychology in the West. Historians of psychology consciously or unconsciously drop the word 'Western' when they write about the history of Western psychology. On the other hand, Asian psychology is always properly designated as 'Asian' (e.g. Murphy and Murphy, 1972, cited in Pe-Pua and Protacio-Marcelino, 2000). Thus, introductory textbooks in psychology have titles like "Introduction to Psychology" instead of the more appropriate "Introduction to American Psychology" in the case of psychology taught in the Philippines, for example.

Reference to Asian psychologies is not new at all. Psychologists talk about Chinese, Indian, and Philippine psychology. What should be noted, however, is that they usually mean psychology in China, India and the Philippines in the Western tradition and not Chinese psychology, Indian psychology or Philippine psychology in the Chinese, Indian or Philippine tradition. It is no surprise then that North American psychologists feel at home writing extensively about "psychology of, by and for" natives of a Third World country such as the Philippines without being immersed in the native culture and at least having learned the local language.

Reservations regarding the appropriateness and applicability of Western models in the Third World setting have been expressed by a growing number of social scientists (Enriquez, 1987 and 1992; Diaz-Guerrero, 1977; Sinha, 1984, all cited in Pe-Pua and Protacio-Marcelino, 2000). However, although Third World social scientists acknowledge the problem, they shrug them off on the grounds that there are no alternative indigenous models/theories, concepts and methods to use, while others are convinced that any departure from the Western tradition is a blasphemy at the altar of science.

The Philippine experience has proven that approaching psychology using these models cannot fully capture the subtleties and nuances of Asian culture and realities. This gave rise to a movement to develop an indigenous Philippine psychology that would truly reflect the Filipino 'psyche', anchored

in Filipino thought and experience as understood from a Filipino perspective. Initial work on this concentrated largely on simple translation and modification of concepts and methods into the local language. For example, psychological tests were translated and modified in content, so that a Filipino version of the originally borrowed test was produced and then applied to the local context.

This is called 'indigenization from without' (Enriquez, 1982, cited in Pe-Pua, 1982). Put simply, it is a transfer of technology from the First World to the Third World characterized mainly by cultural assimilation or making indigenous versions of imported foreign systems. On the other hand, another type of indigenization was given more emphasis after translation and modification attempts failed to capture the subtleties and nuances of local culture and realities. This is called 'indigenization from within', which means identification of key indigenous concepts/theories and methods followed by semantic and lexical elaboration, with the source of knowledge coming from *within* the culture as experienced and articulated by the culture bearers themselves. In other words, it is not merely clothing a foreign body with a local dress.

However, the term 'indigenization from within' is semantically anomalous because how can you 'indigenize' something that is already indigenous? The term is used only as a convenient tool to show the difference between the development of Third World cultures in their own terms as a natural process and 'indigenization' as seen by people who habitually perceive the Third World countries as recipients and targets of culture and technology transfer. The phrase 'cultural validation' or better still 'contextualization' is more acceptable because it moves away from the political undertones of the term 'indigenization'. It also leads to us to confront the more fundamental issue of human values and philosophies. Finally, it answers the more basic question of identifying appropriate and relevant ways of describing and explaining human behavior in varying contexts.

Which brings us to the main point of whether we can 'indigenize' the caregiving process. By saying this, there is an implicit assumption that

Western methods and approaches are good and valid for everyone, thus should be simply accepted as such. Do we merely adapt these methods and approaches and try to make them culturally appropriate ('indigenization from without')? Or do we start with an inherent appreciation and understanding (not necessarily total acceptance) of indigenous methods and approaches as they are practiced and have proven effective in the local culture, regardless of whether or not it is accepted or recognized in the West? For example, the uncritical use of 'psychological tests and measurements', including counseling methods, immediately become questionable because of their Western norms and standards and often patent inapplicability to local contexts.

For a very long time, most social science practitioners tended to ignore indigenous knowledge and practices; instead they adopted theories, methods and practices from their Western counterparts. It is only lately that more and more social scientists have come to appreciate and recognize the indigenous roots and contemporary social and behavioral manifestations of a 'less civilized' psychology. The issue has been the assumption by many First World people that everyone shares their reality and that the First World way of thinking and doing is universally acceptable and applicable. This, of course, is not the case. It is not saying that one way or the other is better or best. They are just different. It does not discount the importance of Western influences in the development of psychological thought in Asia.

There are at least four filiations in psychological thought and practice: the academic-scientific (Western tradition); academic-philosophical (clerical/institutional religious tradition); ethnic/indigenous tradition; and psycho-medico-spiritual tradition. Indigenous knowledge and practices fall under the third and fourth filiations. These reflect differences in world views as well as philosophies and should be taken into consideration when designing programs to help children. Underscoring the importance of contexts and the influence of culture, let us examine the concept of child abuse and the construction of childhood in Asian societies to illustrate these points.

Indigenous Knowledge and Practices: Focus on Health and Healing

The concept of indigenous knowledge, according to Olanyan (1982, cited in Castro-Palaganas et al., 2001) is “the ability to survive in harmony with the environment and to cope with traditional occupations like hunting-gathering, agriculture, handicraft and healing”. Thus, such knowledge acts as a tool used by the local people to make a living in their particular environment. Evolving from sociological and ecological particularities, indigenous knowledge is specifically tailored to the needs of local peoples and conditions. This does not mean that indigenous knowledge is a closed system that does not allow outside influence. On the contrary, indigenous knowledge is creative and experimental, constantly incorporating outside influences and innovations to meet new conditions. Rovillos (1999, cited in Castro-Palaganas et al., 2001) notes that locals “adapt new technologies to their needs and blend them with indigenous knowledge”.

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Indigenous knowledge systems are by and large ecological (Shiva, 1997, cited in Castro-Palaganas et al., 2001). They present a holistic view of reality. They are not an accidental accumulation of knowledge but are organized, dynamic systems of investigation and discovery. They are based on experience and often tested over centuries of use (ERP, 1999). The various forms of knowledge are stored in people’s memories and activities, and are expressed in stories, songs, folklore, proverbs, dances, myths, agricultural practices, equipment, materials, plant species and animal breeds (Grenier, 1998, cited in Castro-Palaganas et al., 2001).

Indigenous knowledge has both general and specialized aspects. General aspects refer to knowledge shared by all or by a large section of society such as home remedies, birthing practices, agricultural practices, and everyday maintenance activities, while specialized aspects are known and

practiced by a select group covering detailed aspects of agriculture, crafts, medical practices and rituals.

There are two views regarding societies and cultures as bearers of indigenous knowledge. The first identifies only indigenous peoples as bearers of this knowledge, e.g. the original inhabitants of a particular geographic location like the aboriginal peoples of an area who have a culture and a belief system distinct from the so-called 'international system of knowledge' (ERP, 1999). The other view offers a broader definition that includes peoples who may not be the original inhabitants in the area but have lived in it for a long time and have evolved and continue to evolve a body of knowledge specifically adapted to the requirements of the local environment. The terms used to designate indigenous knowledge in this respect include traditional knowledge, local knowledge, cultural knowledge, folk knowledge, rural knowledge, oral knowledge and traditional wisdom.

Available literature on indigenous health knowledge systems includes various terminologies. These are referred to as traditional medicine (Landy, 1977 and Tan, 1987, cited in Castro-Palaganas et al., 2001), traditional pharmacological knowledge, traditional human health competence, cultural health customs and practices (Negussie, 1988), and folk medicine and local health practices (Jocano, 1973 and 1997, cited in Castro-Palaganas et al., 2001).

Traditional medicine is defined by Landy (1997, cited in Castro-Palaganas et al., 2001) as "those practices, methods, techniques and substances imbedded in a matrix of values, traditions, beliefs, and patterns of ecological adaptation that provide means for maintaining health and preventing and ameliorating disease and injury to its members". In traditional societies, notions of health and illness are inextricably linked to social relationships and the magico-religious-spiritual world (Amundsen, 1987). Almost always, religious interpretation is the highlight of people's explanation of health and illness.

Tan (1987, cited in Castro-Palaganas et al., 2001) gives an exhaustive definition of traditional theories of the causes of illness in Philippine society and provides a good picture of indigenous world views. Quoting Murdock, Tan defines personalistic theories as based on the premise that impairment is an automatic consequence of the survivor's act or experience (e.g. in the Panay Islands in the Philippines, there is a belief that menstruating women are dirty, contagious and polluting and therefore should be avoided).

Mystical theories assume that illness is caused by the active and purposeful intervention of supernatural beings, deities or non-human beings such as evil spirits or dwarfs. Naturalistic theories are those that attribute disease to natural forces such as cold, heat, wind, etc., and an overall imbalance of those elements in the body.

The value and importance of indigenous knowledge is undeniable because it has been consistently validated by the practice of countless generations and various studies that have spelled out its significant contributions.

6.1 Integrating Indigenous Methodologies in the Helping Process

The development and application of local, culturally-sensitive and innovative methods drawn from indigenous knowledge and practice are significant in two ways. It is a shared cultural responsibility and more importantly, an antidote to the monopoly of the West on the production of knowledge. As a necessary first step, it is important to underscore the use of indigenous languages in communicating with children, as well as adults. We can not afford to ignore such a rich resource because herein lies the solution to understanding many pieces of the puzzle in indigenous ways of coping and healing.

The analysis of human interaction as observed in everyday life and as codified in the language of the people reveals much about a people's psychology and world view. Human interaction is a highly valued aspect of life in any culture. For this reason, various levels and modes of interaction rooted in collectivist cultures should be identified. Critical to this process

is a concept in Filipino of *pakiramdam*, which refers to a special kind of sensitivity to cues which guides caregivers in their interaction with children. It requires the use of all our senses and is important especially in cultures that use a more indirect and non-verbal manner of communicating and expressing thoughts, attitudes and feelings. It is through *pakiramdam* that one knows when to ask personal questions and when not to pursue them, and how to correctly interpret children's responses like 'yes' and 'no'.

Using the various phases/steps in the case management process and even applying some principles of counseling, let us illustrate how we can adapt a more culturally sensitive and appropriate methodology to help child survivors of abuse and violence.

1. **Intake Interview.** The use of the methodology of *pakapa-kapa*, which literally means the 'groping technique', is useful here. It is a suppositionless approach to getting initial/baseline information from the survivor in which one tries to suspend the use of overriding theoretical models in psychology and attempts to discover cultural peculiarities. It implies an exploration into cultural, social and psychological data and works with traditionally accepted procedures.
2. **Observation.** A method called *nakikiugaling pagmamasid* is an indigenous variant of participant observation. Coined by Bennagen (1985), *pagmamasid* means observation and *nakikiugali* means adopting the ways and behaviors of a particular group as one's own. It means not only actively taking notes of behavioral indicators and symptoms, but also observing inconspicuously and with care, allowing events to take place with little intervention from the observer. Two forms of observation methods include *padalaw-dalaw*, frequent visits to the place under temporary and short-term arrangements, and *pakikipanuluyan*, residing in the local context of the problem or situation for an extended period of time.
3. **Problem Identification.** The problem here is identified not only by the professional caregivers but by the child survivor as well, who is encouraged to be part of the process. It also listens to the community

of culture bearers who are asked to collectively articulate their view of the issues and their concerns related to the problem.

4. **Data Gathering.** Data collection follows what Viney (1988) described as the mutual-orientation model, in which both the data collector and the contributor give something to and gain something from the process. The use of *pagtatanong-tanong*, a Filipino word which means to intermittently and casually ask questions, is appropriate here. Although it is sometimes interpreted as an informal interview – and indeed there are some similarities – it is not exactly the same. *Pagtatanong-tanong* is participatory in nature where the informant has an input in the process in terms of defining its direction and flow. There is also an assumption of equal status between the informant and the person gathering data. It is also appropriate and easily adaptable to individuals as well as groups of informants or natural clusters of family and friends.

Another method of gathering data is *pakikipagkuwentuhan*, which means telling stories or narratives. This is defined by Orteza (1997) as “an informal, free social process of exchanging information, thoughts and knowledge that are innate to the individual or group’s everyday life experiences”. In the process, children tell their stories in a relaxed, spontaneous and non-threatening environment where they engage other participants to join in and add, subtract or share their views about different topics under discussion, thus leading to analysis and interpretation.

5. **Assessment.** This usually involves looking into the expressed and felt needs of the children as well as the resources available to support them. It also means arriving at some analysis and interpretation of their condition. This calls for the application of two indigenous approaches: *pagmumuni-muni*, or a sensitive reflection of what is happening, and *pagsusuri*, a straightforward examination and analysis of the problem together with a search for possible solutions.
6. **Treatment or Helping Plan.** At this point, one is ready to propose a plan of action to help child survivors individually or collectively. However, this involves several steps before one arrives at solutions and courses of action. These steps were outlined by Santiago and Enriquez

(1975) by their conceptual distinction of at least eight behaviorally recognizable levels of indigenous social interaction in the Filipino and, possibly, the Asian context. These are: a) *pakikitungo* (level of amenities or civility); b) *pakikisalamuha* (level of casual mixing); c) *pakikilahok* (level of joining or participating); d) *pakikibagay* (level of conforming); e) *pakikisama* (level of adjusting); f) *pakikipagpalagayang-loob* (level of mutual trust and rapport); g) *pakikisangkot* (level of involvement); and h) *pakikiisa* (level of full trust and oneness).

7. **Recommendations.** Finally one gives advice or concrete recommendations as to alternative ways of solving the problem. However, in the Filipino context, this has to be subtle in approach; thus the method of *pagmumungkahi*, or giving suggestions in an indirect and non-prescriptive manner.

Below is a table summarizing the methodologies discussed above.

Intake Interview	Pagtatanong-tanong (asking questions)
Observation	Pagmamasid (casual observation)
Home Visit	Padalaw-dalaw (intermittent visits)
Problem Identification	Pglalahad ng problema (stating the problem)
Data Gathering	Pakapa-kapa (groping techniques) Pakikipagkwentuhan (story-telling)
Assessment	Pagmumunimuni (intuitive reflection) Pagsusuri (cognitive analysis)
Helping Plan (Treatment Plan)	Pakikipagtulungan (family and community collective helping) Pakikitungo (level of amenities/civility) Pakikisalamuha (level of mixing) Pakikisama (level of adjusting) Pakikibagay (level of conforming) Pakikipagpalagayang Loob (level of mutual trust/rapport) Pakikilahok (level of joining) Pakikisangkot (level of getting involved) Pakikiisa (level of fusion, oneness and full trust)
Recommendation	Pagmumungkahi (to recommend)

Examples That have Worked in Different Contexts

7.1 Australia – The Laceweb Network

There is a little known Australian social movement that dates back to the 1940s known as The Laceweb. It is an informal network of indigenous psycho-social healers that is spreading throughout Southeast Asia, Oceania and the Australasian region. It is presented as an example of using self-help, mutual support groups in resolving problems of well-being. Well-being means the experience of wellness and not simply the absence of disease. What constitutes wellness may vary considerably between different cultures, communities and peoples (Spencer et al., 2002)

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The purpose of The Laceweb is to: a) mutually explore, enable and support the development of neighborhood networks to promote indigenous issues and concerns; and b) provide direct and enabling well-being assistance to inter-indigenous and inter-cultural groups. Thus it is also known as a local well-being action network, an informal network of 'enablers' and 'nurturers'. These are humane caregivers, typically present in any community who are usually culture bearers, and are carriers or users of local wisdom. They engage in 'peacehealing' which is a collection of mutual help well-being processes. This means 'making whole or integrated' using the original meaning of 'healing' (Spencer et al., 2002).

Such local well-being ways are deeply imbedded in the social fabric. They draw upon the cultural history of the people and are resonant with local knowledge and ways of understanding and relating to the world. By their very nature, such local and indigenous well-being actions actively reconstitute the social fabric of shattered communities while acting at the inter-individual level.

7.2 Vietnam – Shrimps and Greens Project

This is an example of what is called ‘positive deviance’, a phrase coined by Save the Children Fund (SCF), an international NGO helping children. It means responses to a given problematic situation that deviate from the normal in a positively beneficial way. In early 1990s, SCF embarked on a project to help severely malnourished children in Vietnam. They realized that simply providing lots of food was not a sustainable solution. There were many inter-related issues contributing to malnutrition, such as poor local knowledge of hygiene and nutrition, lack of clean water, poor sanitation, etc. A simple solution was found in the poorest villages.

They observed that a few children in the village were not malnourished. Their families were making nutritious meals from rice mixed with fresh water shrimps and the vitamin-rich leaves of sweet potato which were easily and freely available. These families were local nurturers and positive deviants. They started a process that radically altered child nutrition throughout Vietnam (Pascale, Millemann and Gioja, 2000, cited in Spencer et al., 2000).

These natural ‘nurturer’ mothers showed others what to do and how to get their children to accept new tastes. Their practical ways were passed on to other families in the same village. Once made visible, the local nurturers’ wisdom was obvious. Once energized, local action was self-organizing, essentially self-funding and sustainable. There was local participation and ownership of these actions. The shrimp and leaf diet solution was not expanded to other villages; rather the process was replicated in a way that local wisdom, intelligence and capacities were respected. No single solution was turned into a big package solution and imposed on everyone but rather each local solution was spread locally. Within five years, the Vietnamese government had adopted the practice of ‘positive deviance’ with great success.

7.3 Philippines – Basic Christian Communities

The Philippines, being a predominantly Christian and Catholic country, has a wide variety of groups that promote religious faith with varying shades of interpretations. There are several prayer groups or bible study groups that have a large following all over the country. They come under different labels such as 'born again' groups, 'healing crusade' groups and the Catholic Church approved 'basic Christian communities' or BCCs. These BCCs are spread throughout the country, have a large membership and meet regularly for prayer and bible study.

During the eruption of Mt. Pinatubo in the early 1990s, there was initial shock, chaos and disorder all around. In an attempt to find meaning in the midst of massive destruction and devastation, some members of the BCCs spontaneously initiated a simple prayer ritual of grief and mourning. They gathered members of the affected communities to join in processions around the affected sites. Carrying candles and rosaries in the dark while chanting prayers and singing songs of praise to God, they encircled their homes, which by then were already buried deep in ashes. It was a sight to behold and people who saw this on television were moved to tears. From a psychosocial perspective, this is an example of a community's attempt to begin the difficult path of healing by way of local rituals and prayers.

This shows that local people know how to respond in their own way and have deep feelings of what is missing or lacking in their lives, no matter how intangible these may be. They have the capacity for self-healing even under the most distressing and traumatic circumstances. However, it must be stressed that they may also need some enabling support from people outside the community and the larger society. The point is to understand how to nurture the locally emergent context imbedded within the situation of disaster, that is, enabling the local voices, resources, wisdom and capacities to reconstitute themselves according to local ways.

The Experience of Prostituted Children in the Philippines

Much of the examples so far do not directly address the issues of child trafficking and abuse of children, but are being presented as generic examples of local grassroots community action using and integrating indigenous ways. Perhaps similar to the Vietnamese experience, natural nurturers may be found among survivors of child trafficking and abuse. These are the local equivalents of 'shrimp and green' for bio-psychosocial help and support. These could be called by different names: gurus, faith healers, astrologers, shamans, etc. They may do this using simple well-being ways that fit into the local way of life or culture.

Another term for 'positive deviance' used in the Vietnamese project is 'resilience' or the ability to survive against all the odds in a healthy and meaningful way. Mentioned earlier in this paper, such resilience in the face of adversity was elaborated in the study of Bautista et al. (2001), where they found several resilience themes in the narratives of abused children.

These were:

- a) accepting and adjusting to the demands of difficult situations
- b) functioning competently amidst problems
- c) learning from adversity
- d) making oneself a teacher and source of valuation
- e) seeing things in a different perspective
- f) finding happiness in the midst of difficulties
- g) keeping sane in the face of traumatic experiences
- h) keeping a good and wholesome character amidst deprivation
- i) having an ethical mindset
- j) recovering from past wounds

- k) having a therapeutic construction of reality
- l) being other-centered
- m) seeing situations as temporary, and
- n) resisting temptations

There are clear examples of children in the sex industry in the Philippines who do not resign to the situation of abuse and victimization but rather transcend these difficult situations and use it to their advantage. Strategies of resistance are behaviors and activities that children actively employ to solve, prevent, or avoid the problems they face. As 'culture bearers', they are able to intuitively use indigenous knowledge handed down to them to protect themselves from being hurt or cheated by customers. It also highlights the point made earlier that children are proactive agents of change in their own lives and development.

In the study of Protacio-Marcelino et al. (2000a), three categories of strategies were identified from the children's stories:

- a) strategies to resist abuse and violence,
- b) strategies to maximize benefits, and
- c) strategies to minimize the possibility of being discovered.

The strategies for resisting abuse and violence were simple. These included asking peers to accompany them when meeting customers, agreeing to go with customers only in familiar places where they know how to seek help, and fighting back and saying no to abuse and harassment whenever possible.

In dealing with customers, children develop certain skills that help them to maximize the benefits they get. These come in creative ways, such as outwitting the customers in threatening situations, coaxing the customers to give them more money and favors, stealing from the customers, and choosing only 'good' and inexperienced customers so that they don't get beaten up or further taken advantage of. The possibility of being discovered by others and losing face is a real concern for children involved in the sex industry. In order

to preserve their dignity, they use aliases or resort to elaborate excuses and lies so that family and friends do not find out about their real work.

As revealed in their life stories, peers figure prominently in the social relationships of children beyond the context of family. The experiences of children and young people in the study contain an enormously wide variety of peer group activities and behaviors. These are valid responses to the physical, emotional and material hardships they encounter, as they try to make sense of their world within the sex industry and struggle to find meaning and gain control of their lives. Corsaro (1997) pointed out that children and young people strengthen their group identity by developing rituals, language and routines that challenge adult rule and authority. Thus, children in prostitution together create a sub-culture in order to cope with the violence of their world and survive the trials and adversities in their young lives. From a typical adult point of view, not all these responses are socially acceptable coping strategies; but it must be noted that these are survival mechanisms, coming from a basic knowledge of cultural contexts, that have worked successfully for the children. From a psychosocial point of view, it may be the only way for them to preserve self respect and sanity in the face of overwhelming abuse, degradation and exploitation.

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Human Resources Development for the Care of the Sexually Abused and Sexually Exploited

A Resource Document on Training Programmes

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Abstract

This paper is a resource mapping of training materials for caregivers in the psychosocial rehabilitation and reintegration of survivors of trafficking and sexual abuse, and is directed at the human resources development of care facilities in South Asia. Materials were drawn primarily from South and Southeast Asia, and represent some, though not all, of the core training materials now actively utilized or with potential to be utilized in South Asia. Of approximately 50 sets of materials collected, 32 are analyzed in terms of the presence or absence of basic activities performed by care institutions in the intake, rehabilitation and reintegration of survivors. Ten sets of materials directed primarily at counseling for survivors are analyzed in terms of the level of coverage of basic issues, theories and practices. Consideration is given to the cultural, family and community settings in which survivors live, and to the rights of children as presented in the Convention of the Rights of the Child and other documents.

Background

The last decade in South Asia has seen growing attention to the situation of children who have been trafficked into prostitution and other worst forms of child labour. In some countries, particularly India and Sri Lanka, this has been accompanied by concern about children and women who suffer domestic violence and sexual abuse. In South Asia, concern about trafficking for prostitution is most pronounced in Nepal and Bangladesh, both of which 'supply' trafficked girls to other countries. The existence of trafficking, although common knowledge in brothel areas and many local communities, came into general public awareness in South Asia in the early 1990s, through international media coverage and the activities of a few local non-government organizations (NGOs) and human rights activists. The concern was quickly disseminated by local media. By the mid-1990s, the prevention of trafficking had become a sub-agenda for many donor organizations working in South Asia, developed upon a foundation of existing interventions to address 'children in difficult circumstances', particularly street children. Many local NGOs, most of which had previously worked in areas such as women's economic empowerment, forestry and agriculture, quickly developed 'anti-trafficking' programmes. From the late 1990s to the present, governments have taken increasing interest in trafficking issues, and preventive measures have been supplemented by interventions to provide 'rehabilitation' (a.k.a. recovery) and 'reintegration' to child survivors of trafficking.

At present in South Asia, facilities for the rehabilitation and reintegration of survivors of trafficking are rapidly growing in number. Some facilities are adaptations or expansions of existing government institutions, some have been developed from the existing facilities of local NGOs working with street children, and the majority have been recently established by NGOs

working in other fields, in part due to extensive support from the donor community. However, until recently, this rapid growth in psychosocial care facilities has not been accompanied by full comprehension of the necessary requirements for establishing a professional and accountable psychosocial care system, equivalent to the medical care system. Focus has been on providing physical structures in which survivors are placed, and insufficient attention has been placed on the operation of psychosocial care facilities and the qualifications of staff working with often severely traumatized individuals. This has led to some concern, particularly expressed by the survivors themselves, of the 'quality of care' of many new caregiving facilities.

With the growth of facilities, there is a growing need to develop and mobilize human resources of a variety of forms. The majority of staff in the facilities are untrained, and the management of most new facilities have limited experience in the administration of psychosocial caregiving institutions. As of mid-2002, no caregiving facilities in South Asia operate under uniform guidelines to ensure minimum standards of care, and none utilize standard case management practices in working with survivors. (However, some NGOs have developed 'in-house guidelines' for operations.) Comprehension of the needs of survivors of trafficking and sexual abuse is limited primarily to 'counseling' and job training, to the exclusion of the majority of responses necessary for successful recovery and reintegration. Survivor and family participation in the recovery and reintegration processes is still virtually non-existent.

At present, human resources for caregiving are limited. Among professional human resources, while facilities in larger urban areas can draw upon a small, though perhaps sufficient, number of physicians and psychologists, these professionals in general have limited clinical training and experience in psychosocial care for the trafficked and sexually abused. Other professionals, such as counselors and social workers, are few. Almost all professional human resources are unavailable to most rural-based facilities.

Despite the paucity of professional human resources, their skills remain underutilized. NGOs and supporting donors have limited experience in operating psychosocial services according to a multi-disciplinary case management system, and most services are provided 'in-house', insufficiently utilizing outside professional persons. Within NGO and government facilities, there is as yet inadequate understanding of the roles of support staff (those not trained for specific tasks) and para-professional staff. In some cases this has led to inadequately trained persons conducting 'counseling' with survivors, exacerbating their trauma, and in most cases to insufficient recognition of the essential roles to be played by support staff and para-professionals in the healing process.

The establishment of facilities for the care of trafficking survivors in such a short time is remarkable and the constraints outlined above are to be expected. Within the last few years, these constraints have been recognized by the majority of donors and by many innovative NGO and government leaders. Work is in progress in several South Asian nations to establish national minimum quality of care standards. Although training is still unavailable in case management procedures, more members of the caregiving community are becoming aware of its necessity.

There is growing recognition that resources development goes beyond the establishment of facilities, to the establishment of a unified psychosocial care system at the national level, which not only attends to the needs of trafficking survivors, but in the future will attend to the needs of a vast range of women, men and children with psychosocial concerns.

The Purpose of this Document

In the last five years, a number of training programmes have been developed to address the human resources needs of institutions working with the trafficked and abused in the developing world. This paper intends to provide an overview of many, though not all, training programmes which are presently available to organizations in South Asia.

This paper will do three things:

- a) It will indicate the general foci of available training programmes, as evidenced by training materials received during this resource mapping, in terms of the training needs of the various participants in the caregiving process, from intake through reintegration. Through this, lacunae in available training programmes can be identified.
- b) It will indicate the information and/or practical skills provided by training programmes directed specifically at the psychosocial rehabilitation of survivors, as evidenced by the materials received. Through this, lacunae in information and/or practical skills in available programmes can be identified.
- c) In conclusion, the paper will provide suggestions for the development of new training programmes to accommodate yet unaddressed human resource needs, and will provide suggestions for future additions of information and practical skills to training programmes directed specifically at the psychosocial rehabilitation of survivors.

The Scope of this Document

This paper is not an assessment of individual training programmes, nor is it an assessment of the training needs of individual organizations. Conclusions presented in this paper are drawn from a review of training materials provided by various training organizations.

A review of training materials necessarily has some limitations: a) in most cases it cannot review all of the training activities, such as the lectures of the trainers or practical exercises; b) it cannot assess the 'output', that is, the skills of the trainees following training; c) it cannot assess the 'training environment', nor the qualifications of the trainers; and d) unless indicated in the training materials, it cannot ascertain if the training is reinforced by follow-up trainings and refresher courses.

What a review of training materials can do, among other things, is: a) summarize the primary content of the courses presently available; b) ascertain the curricula, or training content, of specific courses such as counseling, in terms of theories, concepts, issues, skills and practices (A comprehensive checklist of curriculum content, by trainee target group, is provided in Protacio-Marcelino et al. 1998. *An Analysis of the Training Needs of Caregivers*); c) ascertain the comprehensiveness of instruction in different subjects; d) indicate what particular kinds of caregivers the training is most applicable to, and what kinds of activities are not included in the present selection of training programmes.

Human Resources for the Caregiving Setting

4.1 Target Groups

Due to the present international, regional and national concern for trafficking in South Asia, the majority of newly-developed psychosocial caregiving facilities are directed at female child survivors of trafficking for prostitution. These facilities complement numerous shelters developed for street children since the early 1990s as well as, in India particularly, a number of shelters and outreach facilities for female survivors of domestic sexual and physical abuse. There have been some psychosocial care programmes developed in response to survivors of non-sexual labour exploitation, war and natural disasters, although these have been primarily outreach or community-based programmes rather than facility-based programmes.

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Although the target group is limited in the present development of caregiving facilities, it is expected that these facilities will in time benefit a wide range of children and adults. Thus, in order to assess the future wider-spectrum benefits of caregiving training, it is necessary to clarify those who are presently not included in the primary target group. Throughout South Asia, with the exception of India, the primary caregiving focus is on children, not adults. With the exception of Sri Lanka, the focus is on females, not males. Within the spectrum of trafficking of human labour, the focus is on trafficking for prostitution, rather than other forms of abusive labour, including slavery-like situations, harmful work environments, drug production and war. Within sexual exploitation, the focus is on children who are trafficked, rather than on non-trafficked child prostitutes, trafficked adults, adults performing forced prostitution, or survivors of domestic sexual abuse. It should be noted, however, that the above groups comprise a portion of the residents in many caregiving institutions.

In general, trafficking survivors who are HIV-positive or have substance abuse problems are a 'gray area' in terms of target group. The medical and psychological concerns of HIV-positive trafficking survivors are frequently separated in the planning and support of caregiving facilities, due in part to the separation of funding priorities in the donor community and in part to the specific needs of those persons. In South Asia, there are many available training programmes for counseling and caring of those with HIV/AIDS or those with substance abuse problems. These training programmes are directed at a variety of caregiving roles, and many are of very high quality. These programmes have not been reviewed in this paper.

4.2 The Needs of Trafficking Survivors

Human resources development activities are, in essence, directed at creating trained persons who answer the needs of the children. The needs of trafficking survivors in South Asia have not been extensively articulated, owing much to the relative inexperience of those working on survivors' behalf and to a significant lack of research on the subject. At present, 'needs' are generally simplified to 'counseling for psychological problems' and 'training for future employment', and this is reflected in the content of available training programmes in South Asia. The needs of survivors, along with the administrative requirements of caregiving facilities, determine the activities conducted by the facility, and consequently the designation of staff and their training needs.

A broader view of survivors' needs is emerging among caregivers and supporting partners in South Asia. This is based on three things: a) new paradigms regarding children's healing process; b) revised concepts of the function of caregiving facilities; and c) recognition of effective social reintegration as the ultimate goal of the caregiving process.

There is a growing recognition of children's inherent capacity to cope, adjust to unfortunate circumstances and become active agents of change on their own behalf. This 'competency paradigm' is contesting the existing 'vulnerability paradigm', which perceives children as helpless victims,

beneficiaries of care, and persons in need of help from ‘those who know better’. While the vulnerability paradigm – still prevalent in caregiving in South Asia – is based on a clinical/diagnostic approach to children’s problems and prescribes ‘solutions’ such as counseling for the children’s ‘problems’, the competency paradigm is based on a participatory, consultative approach in which children’s potential, rights, and capabilities are recognized and cultivated. Survivors’ needs according to this paradigm include expression, participation, self-definition of ‘problems’, and being listened to, among others. Thus, responses include participatory activities, creative arts, play activities and trust-building activities, among others.

Similarly, there is a growing response to the prevailing concept of caregiving facilities as ‘institutions’, similar to hospitals or prisons, in which trafficking survivors are placed ‘for their own good’. To date, most present facilities, whether located in urban or rural situations, are ‘center-based’, that is, facilities are self-contained in terms of services and provide residents limited interaction with the surrounding community. There is increased recognition of the detrimental effects of prolonged institutionalization, and of survivors’ needs for a ‘healing environment’, one which provides more interaction with the survivors’ community, family and friends, and one which provides a stepping-stone to living in the outside world. Children’s needs from a healing environment perspective include personal space, participation in facility activities, excursions and field trips, and interaction with family and community members, among others.

Finally, there is increasing recognition that following immediate medical and psychological needs, the primary ‘need’ of survivors is reintegration: to be re-established in their own culture and community. Facilities are being seen less as institutions that indefinitely hold ‘children with problems’, and more as places in which children can learn the skills and confidence to live in the greater world. Consequently, ‘needs’ are now seen to include tools which will help children in the future, and interventions with families and communities to facilitate children’s return. These needs go beyond job

training, to include life skills, social interaction skills, life-planning activities, and confidence-building activities.

4.3 The Operation of Caregiving Facilities

Human resources development activities are also directed at answering the needs of the management and staff regarding the operation of care facilities and the coordination of resources to provide the most effective care for the children. As in hospitals or medical clinics, caregiving facilities require standards and guidelines in order to clarify operational procedures, and ensure professional care and accountability of practices. While these standards and guidelines need to be developed collaboratively among all stakeholders at a national level, training and orientation for facility staff among other forms of support are necessary in order to put standards and guidelines into routine practice.

As with medical care, activities for the rehabilitation of the abused must be conducted according to case management procedures, which ensure assessment and response for each individual survivor, continued monitoring of the survivor's situation, and the responsible application of interventions through the decisions of a multi-disciplinary team of persons skilled in different aspects of rehabilitation and reintegration. Case management requires the collaborative efforts of numerous persons in the care of each individual survivor. Both management and staff must be trained to operate facilities in a way which can accommodate the changing variety of responses necessary for the care of a number of survivors.

Finally, human resources development must also accommodate the needs of the caregivers themselves. Training is necessary to help facilities establish procedures for emergency medical or psychological situations, to prevent abuse within the facility, to protect the survivors, and to provide psychological support for those working with survivors.

4.4 The Roles of Caregivers

Caregiving for survivors of trafficking and sexual abuse requires the services of a variety of caregivers, ranging from the day-to-day care and support provided by support staff to the technical expertise provided by, for example, pediatricians. At present, most facilities rely (with the exception of occasional input from physicians or attorneys) on untrained center staff to conduct all activities. This has led, as mentioned above, to inappropriate psychosocial interventions on occasion, but more importantly has resulted in the omission of many aspects of the caregiving spectrum.

4.4.1 Role Designations in Terms of Training and Activity

There are four general role designations applicable to caregiving facilities: management, professionals (both resident staff and outside persons), para-professionals (again, both resident staff and outside persons), and support staff. Professionals are persons with long-term training as specialists in a particular field. These include physicians, psychiatrists, psychologists, counselors, lawyers and social workers, among others. Their tasks are primarily related to activities requiring professional expertise and experience, including forensic medical assessment, psychosocial response to acute trauma, family assessment and legal advice.

Para-professionals are persons with comprehensive but medium-length training (4 months to 2 years) in a specific field. These include para-counselors (also called lay counselors), para-social workers, para-medics, and para-legal persons. These persons perform the majority of specialized tasks in a caregiving facility, including general counseling for non-acute emotional problems, general family and community assessment and outreach, first aid and emergency care, and routine legal preparatory activities.

The important role of support staff, who presently comprise most of the staff in caregiving facilities in South Asia, is frequently underestimated. In the 'working day' of the caregiving facility, support staff provide the vast majority of care, support, companionship and guidance to survivors. Support

staff are essential for assisting survivors in developing communication and social skills, developing feelings of confidence and self-worth, learning to resolve conflicts and manage stress, clarifying their needs and hopes for the future, and learning to accept the responsibilities and constraints of living in society. Careful training and supervision of support staff are imperative to the successful operation of a caregiving facility.

4.4.2 Specific Roles within the Case Management Framework

With the present limited understanding of the necessity of providing care to trafficking and abuse survivors within a case management framework, there is also limited understanding of the variety of roles needed in caregiving. Generally, the specific roles most frequently identified in caregiving facilities in South Asia are ‘counselor’ and ‘physician’. Among professional and para-professional roles, the social worker and para-social worker have important tasks, including the background assessment of the survivor at intake, the assessment, strengthening and preparation of the family (or alternative family) and community prior to reintegration, and outreach/support for the survivor following reintegration.

Within the spectrum of ‘rehabilitation’, there are many activities which complement ‘counseling’ in the successful recovery of the survivor and her/his preparation for reintegration. Specific roles include: experiential therapists, that is para-professionals and trained support staff who help children heal through art, play, dance and theatre; ‘guidance counselors’ and trained support staff who help survivors identify their aspirations and choose the ways they want to live and work in the future; para-legal persons and others who teach survivors their legal rights and assist in legal redressal from their abusers; and occupational trainers who not only teach job skills, but also help survivors identify viable occupations, teach basic business management and assist them in piloting small enterprises.

As well, among the roles of caregivers, there is the collective ‘role’ of the case management team. Coordinated by a ‘case officer’, who is usually a social worker or para-social worker, the case management team oversees

and recommends all activities conducted on behalf of each individual survivor from the time of intake through post-reintegration support. The case management team is a multi-disciplinary group comprised of professionals and para-professionals from all the relevant disciplines (including psychology, medicine, law and social work), as well as other staff members.

Mapping of Training Resources Available in South Asia

This resource mapping seeks to provide information on the training programmes that are ‘readily available’ for caregiving institutions in South Asia. By ‘readily available’, it is meant training programmes that are developed for South Asian caregiving facilities or programmes (primarily from Southeast Asia) that are easily adaptable to the South Asian context. To access documents regarding the development of human resources for the care of the sexually abused and sexually exploited, approximately 200 persons and organizations were contacted. The majority of those persons and organizations operate within South and Southeast Asia, and the remainder, with some exceptions, oversee programmes which include those regions. They were asked to provide materials under the following criteria:

// We are compiling a resource document on existing training programmes in psychosocial care for the sexually abused and sexually exploited, particularly trafficking victims.

“These training programmes can range from short ‘orientation’ courses to extensive trainings. They include training in counseling skills and experiential therapies such as art therapy or recreation therapy, as well as facility operations, case management, social work and family assessment, basic psychology for caregivers, and others.

These can be directed at professionals, para-professionals, management, general facility staff, ‘barefoot’ workers, or peers. They can be directed at center-based, community-based, drop-in, outreach, ‘barefoot’ or hospital activities.

We would like to obtain descriptions of training programmes with syllabuses, training documents, 'textbooks', reading materials and descriptions of clinical or 'hands-on' practice, if they are part of the course. //

In this resource mapping activity, suggested and provided materials were cross-checked both through the 'network' of concerned organizations and individuals, and through the internet and bibliographies in an attempt to identify what materials existed, and to obtain ones that were missing.

There was no attempt to collect or review materials or documents regarding professional training for 'experts' in the care of the sexually abused and exploited, such as Bachelors, Masters, Doctorate, post-graduate or special courses for psychologists, doctors and psychiatrists, professional social workers or counselors, lawyers, psychiatric nurses, etc. As well, training materials related to HIV/AIDS counseling, substance abuse counseling, forensic medical and psychological assessment, and legal procedures were not sought.

Through this exercise, approximately 50 documents of training programmes were collected. Of these, 32 documents were selected for review in this resource mapping. The documents received varied widely in their 'purpose' (although the purpose was not always clarified), and generally fell into two categories: general orientation on the basic issues, and training to respond to and counsel the abused. Some documents, however, were directed at specific activities (trauma/crisis response, telephone counseling, video interviewing children for forensic purposes, and clarifying the role of the caregiver, among others). Some documents were included, by reason of their relevance or comprehensiveness, that were directed at working with street children, refugees, or other target groups besides the trafficked or sexually abused. In one case, a document developed for a region (Africa) outside South and Southeast Asia was included. Documents from Europe, New Zealand and North America were not included.

Activities not reviewed include: HIV/AIDS counseling; drug counseling; occupational training; nutrition and hygiene training; family economic assistance activities; legal procedures; and medical, psychological and legal assessment by professionals.

In this overview, an assumption is made that the materials collected represent many (although certainly not all) of the core training materials now actively utilized or with potential to be utilized in South Asia. It must be recognized, importantly, that some materials could not be reviewed because they were either not provided or were in draft form, and that many of the materials referred to in this paper are in the process of development and testing, and more will soon be developed.

Activities Covered in the Training Materials Reviewed, According to the Training Needs of Specific Caregivers

As stated in the '2. Purpose of This Document' above, the following chart indicates the general foci of available training programmes in terms of the training needs of the various participants in the caregiving process. The chart presents a list of primary activities involved in the intake, rehabilitation and reintegration processes, the primary target trainees for each activity, and the number of documents among the 32 reviewed that refer to each activity.

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In the following chart, the column 'number identified' refers to training programmes dedicated solely to a particular activity, or covered in a module or a significant section of a larger training programme. Training programmes which provide brief reference to an activity but do not provide substantial information or skills are not included in this number.

It should be noted that these materials (listed in Annex I. Reviewed Materials) represent those readily available and adaptable to facilities in South Asia. They do not include many developed for countries outside the region and some that are in the process of development in South Asia. A listing of zero for the number of materials applicable to an activity does not imply that materials do not exist. Worldwide, many materials and training courses are available and are adaptable to the South Asian situation. Further research and updating of this resource mapping should be conducted in the future.

**Chart 1. Activities Covered in the Training Materials Reviewed,
According to the Training Needs of Specific Caregivers**

No. = number of training materials among 32 reviewed that provide training in the designated activity
NR = materials on this activity were not reviewed

Activity	Caregivers	No.
GENERAL BACKGROUND		
background, needs of survivor population	all staff	12
psychosocial effects of CSA, trafficking	all staff	14
general care and support procedures	all staff	3
general counseling practices, orientation	all staff	20
principles and practices of reintegration	all staff	2
OPERATION OF CARE FACILITIES		
principles of care facility management (orientation)	managers	2
care facility operations (in depth)	managers	0
case management procedures	managers, case management team	4
minimum standards of care, and applications	managers	0
privacy and confidentiality policies and procedures	managers, case management team	1
child protection policies and procedures	managers, case management team	3
emergency policies and procedures - medical, psychological, violence, drug-related, theft, etc.	managers, case management team	4
care for caregivers	managers, all staff working with survivors	4
INTAKE		
intake orientation procedures	managers, case management team	3
crisis management, upon intake	para-counselors, counselors, psychologists, psychiatrists	8
medical, psychological, legal assessment	designated professionals	NR
family and situational assessment	social workers, para-social workers	3

REHABILITATION**activities conducted by support staff and others**

care and support activities includes recreational activities, sports, living procedures, rules, discipline, etc.	all support staff	3
communication and listening skills	all support staff	18
group facilitation skills	all support staff	7
conflict resolution skills	all support staff	0
emergency responses	all support staff	10
nutrition, hygiene, preventive health care	selected support staff, nurses, para-medical persons	NR
living/social skills for survivors	selected support staff	4
leadership skills for survivors	selected support staff	2
legal and rights awareness for survivors	selected support staff, para-legals	NR
life planning activities for survivors	selected support staff	1
play, dance and recreation activities	selected support staff	8
relaxation, de-stressing exercises	selected support staff	12
educational applications for survivor population	staff teachers	1
peer support activities	selected support staff, survivors para-counselors, counselors	3

activities conducted by para-professionals and professionals

counseling theory and applications for survivors of trafficking, CSA, CSEC	para-counselors, counselors, psychologists, psychiatrists	12
counseling for survivors - individual	para-counselors, counselors, psychologists, psychiatrists	10
counseling for survivors - group	para-counselors, counselors, psychologists, psychiatrists	7
counseling for survivors - family	para-counselors, counselors, psychologists, psychiatrists	2
art therapy	para-counselors, art therapists	1
dance/theatre/movement therapy	para-counselors, dance therapists	0
play therapy	para-counselors, play therapists	2
indigenous caring practices	para-counselors, counselors, support staff, indigenous healers	5
drug abuse counseling	para-counselors, counselors	NR
HIV/AIDS counseling	para-counselors, counselors	NR

PRE-REINTEGRATION ACTIVITIES

case management and planning for reintegration	case management team	3
occupational planning activities	selected support staff, para-counselors	NR
occupational training	selected support staff, occupational trainers	NR
business management	selected support staff, occupational trainers	NR
pilot business activities for survivors in facility	selected support staff, occupational trainers	NR
family and community assessment	para-social workers, social workers	3
parenting, conflict resolution, child-friendly support skills for families	social workers, para-social workers para-counselors, counselors	1
economic and social assistance for families	para-social workers, social workers	NR
assessment and preparation of foster family or alternative living situation	para-social workers, social workers	1
community support and preparation, including services and referral network	para-social workers, social workers	1

REINTEGRATION ACTIVITIES

family reunification activities	para-social workers, social workers	2
placement and monitoring in foster family or alternative living situation	para-social workers, social workers	2
post-reintegration outreach monitoring/support	para-social workers, social workers	0
post-reintegration outreach crisis management	para-social workers, social workers para-counselors, counselors	0

ADDITIONAL ACTIVITIES

training community lay counselors	community persons	2
telephone counseling	selected support staff, para-counselors	2

Analysis of Availability of Training Resources vis-à-vis Training Needs

7.1 General Background

Background and general orientation on the survivor population and on facility care procedures are necessary to ensure the collaborative efforts of all staff, from managers to cleaning persons, in creating a positive healing environment. The materials reviewed reflected a strong emphasis on ‘counseling’ and ‘problems’ in addressing the recovery of trafficking and abuse survivors. In materials specific to South Asia, practical information and/or skills on the operation of care facilities were not found. Materials were available from Southeast Asia, and could be adapted to a training programme on general care and support procedures.

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Throughout the materials reviewed, with a few exceptions in materials from Southeast Asia, social reintegration as well as interaction of the survivor with the community were absent. With those exceptions, materials reflected a strong ‘institutionalization’ approach to healing and recovery. It should be mentioned that while de-institutionalization and effective reintegration are promoted in many project planning documents, they were not reflected in the training materials reviewed.

7.2 Operation of Care Facilities

While ample training opportunities are available for facility managers on the background and counseling of trafficking and abuse survivors, few were available to assist managers in the operation of care facilities, to train persons in case management procedures, to ensure minimum standards of care, or to develop policies and procedures for confidentiality, child protection or emergency situations. Without these, facilities are necessarily run on an ad hoc basis, potentially leading to ineffective or inappropriate care of survivors.

A short note on case management procedures was found in only one set of training materials designated for South Asia. Although information on case management is available from Southeast Asia, a dedicated training module on the subject was not received. Information on the development and application of confidentiality policies and child protection policies for institutions were found in no materials directed at South Asia, although the latter are presently being developed in Sri Lanka. While the reviewed materials adequately covered responses to emotional and behavioral crises, none covered other issues such as drug-related emergencies or behaviors such as theft or violence, and few provided procedural guidelines on emergencies for facility managers. Training materials on care for caregivers were present and generally comprehensive.

7.3 Intake

Information and skills regarding the activities at the time of intake of a survivor into a care facility were primarily directed at the management of crises and acute psychological and medical problems. These materials were comprehensive, although they require placement within a case management framework, including the delegation of responsibilities and tasks of caregivers during the intake period.

The materials directed at South Asia, unlike those directed at Southeast Asia, gave little or no consideration to the work of para-social workers and social workers. Consequently, very little was available to train persons in family and situational assessment, necessary to initiating both the case management process and the legal process. Medical and psychological assessment by professionals was not reviewed for this paper, although materials have been and are being developed in Sri Lanka and elsewhere.

7.4 Rehabilitation

7.4.1 Activities Conducted by Support Staff and Others

Support staff, teachers and occupational trainers provide more than 80% of the day-to-day caregiving of survivors, the remainder being provided by

para-counselors, counselors and other professionals. The obvious necessity of training support staff in caregiving was not reflected in the training materials reviewed. While ‘counseling’ courses provide adequate to excellent training for support staff in basic communications, group facilitation and relaxation skills, materials to train support staff in many vital skills were notably absent. Very few materials were found that provided comprehensive training in conflict resolution, living/social skills, leadership skills or life planning activities.

While some materials from Southeast Asia presented a number of games and recreational activities, none of those reviewed provided adequate skills in everyday support activities such as living procedures, discipline and family visitation. Materials on emergency responses were directed at para-counselors, counselors and physicians. Only a few, from Southeast Asia, were directed at support staff, and very few included procedures for the assessment of problems and referral to para-professional or professional staff. Materials from one course, also from Southeast Asia, provided skills for teachers working with survivors. Notably absent from those directed at South Asia, considering the ‘child-rights’ framework proposed in the introductions to many training courses, were materials to train staff in promoting child-to-child and peer support activities.

7.4.2 Activities Conducted by Para-professionals and Professionals

The materials reviewed in general provided excellent background in counseling theory and applications for survivors of trafficking and sexual abuse. The materials ostensibly providing ‘counseling training’ offered generally excellent background information and communications skills for managers and support staff, as well as ‘skills upgrade’ on trafficking and abuse issues for already-trained para-professionals and professionals. One training course was found to be of sufficient duration with adequate clinical practice to train persons to be para-counselors, and to work directly with the trauma and emotional concerns of survivors. Several courses implied that they equipped persons to work with trauma, including PTSD, but lacked adequate provision of information and clinical experience.

While the reviewed materials provided some training on the use of art, movement and play for recreational purposes, and mentioned their applications in therapy, none provided comprehensive training in experiential therapy activities, such as the use of role play/theatre in the recovery of positive self-conception or art in the disclosure process. Some of the materials developed in South Asia referred to cultural sensitivity in the caregiving process, and one provided trainees with insight into the cultural context of the caregiver's role and presented culture-based applications to basic skills such as communication and interviewing. However, no reviewed materials developed for South Asia identified and utilized indigenous caregiving practices, although this was present in materials from Southeast Asia and Africa.

7.5 Pre-reintegration, Reintegration and Additional Activities

Although all training materials relevant to South Asia were not obtained for this resource mapping exercise, the absence of materials relating to reintegration was notable. No materials from South Asia under review covered case management for reintegration or planning with the child and family regarding the child's future after institutional residence. As mentioned above, the work of para-social workers and social workers was absent in the materials reviewed from South Asia. However, it should be noted that college and university-level training for social workers is present in South Asia, and there are considerable non-formal training materials for para-social workers and social workers available in Southeast Asia, particularly the Philippines. The latter were not obtained for this review.

Among additional materials reviewed, two from South Asia were focused on telephone counseling. It is known that a number of telephone counseling programmes exist in South Asia, particularly India, and although training materials for those programmes were not received, it is assumed that there are considerable resources for training in telephone counseling skills on the subcontinent. Several comprehensive sets of materials to train village persons as lay counselors were reviewed. Although these were directed

primarily at training lay counselors for general community support services or providing support to refugees or survivors of disaster, they could be adapted to developing community-level skills to support reintegrated survivors.

Activities Covered in Counseling Training Materials Reviewed

Chart 2 below presents a list of knowledge and skills generally recommended to be taught in training courses for managers, support staff, para-counselors, counselors and others working with survivors of trafficking and sexual abuse. (Much of this list is drawn from the study by E. Protacio-Marcelino and A. Camacho, 1998, *An Analysis of the Training Needs of Caregivers in Relation to the Provision of Biopsychosocial Help to Sexually Exploited Children in Nepal*, among other sources.) In Chart 2, the coverage, extensive coverage, or absence of these activities is noted among 10 sets of training materials obtained from South and Southeast Asia, presented in 8.1 below.

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8.1 Counseling Training Materials Reviewed

Materials specifically relating to counseling are presented here individually or in sets, when more than one manual was developed by a particular person or agency. While the materials varied widely in comprehensiveness, each contained certain features that are notable, and these are noted in the comments following the reference. The comments are followed by suggested applications to particular caregivers.

Reference No. 1

Centre for Victims of Torture. (2000). *CVICT Psychosocial Counseling Internship Program*. Kathmandu, Nepal: CVICT.

Centre for Victims of Torture. (2001). *Proceedings: CVICT Internship on Psychosocial Counseling for Trafficked Youth*. Kathmandu, Nepal: ILO-IPEC TICSA Nepal.

Jordans, M.J.D. (2001a). *A Guide for Psychosocial Interventions of Children in CWIN Counseling Centre and CVICT Manchari Clinic*. Kathmandu, Nepal: Centre for Victims of Torture, Child Workers in Nepal Concerned Centre.

Jordans, M.J.D. (2001b). *Internship on Psychosocial Counseling for Children*. Kathmandu, Nepal: UNICEF, Centre for Victims of Torture.

Jordans, M.J.D. (2001c). *Specialized Training Manual on Psychosocial Counseling for Trafficked Youth: Handling the Trauma of Sexual Exploitation*. Kathmandu, Nepal: ILO-IPEC TICSA Nepal.

Jordans, M.J.D. (editor). (2001d) *General Manual on Counseling for Children in Especially Difficult Circumstances, Second Edition*. Kathmandu, Nepal: UNICEF.

Jordans, M.J.D. (editor). (2001e). *Training Handbook on Psychosocial Counseling for Children in Especially Difficult Circumstances, Second Edition*. Kathmandu, Nepal: UNICEF.

Comments: These materials are distinguished from others reviewed in being utilized for a 4-month course with extensive clinical experience, intended to train para-counselors and to expand the skills of professionals. Due to the length and comprehensiveness of the course, the materials cover all relevant topics of psychosocial counseling with few exceptions. Emphasis is placed on assisting future counselors to understand their role in the healing process, on psychological assessment, on communications skills, and on problem-solving strategies, among others. Extensive background is provided on the psychosocial effects of trafficking and sexual abuse, and on recovery issues and practices. The materials are unique among those from South Asia in assisting counselors to recognize the cultural concerns in the counselor-survivor relationship.

Applications: Training of persons to be para-counselors, and upgrading the practical skills of counselors, psychologists, psychiatrists and other professionals through extensive clinical experience.

Reference No. 2

Delaney, S., Cotterill, C. (no date). *The Psychosocial Rehabilitation of Children who have been Commercially Sexually Exploited: A Training Guide*. Bangkok, Thailand: End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes (ECPAT).

Delaney, S., Cotterill, C. (no date). *The Psychosocial Rehabilitation of Children who have been Commercially Sexually Exploited: Self Study Materials for Carers*. Bangkok, Thailand: End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes (ECPAT).

Cotterill, C. (no date). *Ideas Bank of Creative Activities for Children at Drop-in or Residential Centers: Low Budget Activities for Non-literate Children*. Bangkok, Thailand: End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes (ECPAT).

Comments: The primary feature of these materials is that they assist managerial and support staff in the creation of a child-friendly 'healing environment'. Emphasis is placed upon creating a healthy, responsive, healing situation for children, rather than on assessing and attending to problems. The materials provide extensive background on CSA and CSEC, with emphasis on experiential healing strategies such as play, art, etc. The materials are realistic about the daily activities in a caregiving facility, and give attention to behavioral problems within the facility and to the necessity of providing adequate life skills and education. The materials are also attentive to the concerns of children outside the facility, such as peer influence and substance abuse. One manual includes a section on care for caregivers.

Applications: Facility managers and all support staff, including teachers. Applicable to para-counselors, counselors and psychologists for providing an understanding of the healing environment within which counseling is placed.

Reference No. 3

UN Economic and Social Council for Asia and the Pacific. (2002). *ESCAP HRD Course on Psychosocial and Medical Services for Sexually Abused and Sexually Exploited Children and Youth*. New York: United Nations.

Comments: This relatively sophisticated training course is particularly useful to project managers and planners, as well as case management team members and facility managers. The course is equally concerned with medical and psychosocial services for survivors of CSA and CSEC. The course provides a strong background in child health and the social context of CSA and CSEC, with functional applications to local cultural contexts. The materials emphasize skills for project planning and management rather than counseling or direct interventions. While lacking a full presentation of routine case management procedures, the training course provides comprehensive background with which to mobilize multi-disciplinary support networks essential to case management. The materials are unique among those reviewed in their extensive training in child and community needs assessment with which to plan interventions, establish facilities, mobilize support networks, etc. A comprehensive module on care for caregivers is provided.

Applications: Project managers and planners, government and other service providers at the managerial level, facility managers and case management team members. Valuable for providing background information for trained para-professionals and professionals.

Reference No. 4

National Child Protection Authority. (2002). *Working with Victims and Perpetrators of Child Sexual Abuse*. Sri Lanka: National Child Protection Authority.

Comments: These materials have been developed with particular reference to domestic child sexual abuse, and begin with a comprehensive examination of theories regarding the perpetrator. Directed primarily at professionals in the therapeutic setting, the materials extensively cover the detection and assessment of the psychological effects of sexual abuse, and include an extensive discussion of therapeutic theories and responses. Many useful tools for assessing psychological impact, relationships and self-perception are included.

Applications: Counselors, psychologists, psychiatrists, pediatricians and other professionals, with useful background information for facility managers and project managers.

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Reference No. 5

Sanyal, N. (2002). *Training Course to Enhance the Capacity of Counselors Working with Rescued Trafficked Children: Trainer's Manual on Basic Counseling*. Dhaka, Bangladesh: INCIDIN and ILO-IPEC TICSA Project.

Comments: This training course provides a fairly extensive overview of counseling theory and applications. In its discussion of child development, it is unique among the materials reviewed in distinguishing developmental features of the male and female child. It reviews counseling techniques in some detail, including response to PTSD and extreme trauma, although this short course does not teach the application of those techniques, or assessment and referral to trained para-counselors, counselors and psychologists. Includes extensive information on recovery strategies, and a section of care for caregivers.

Applications: Facility managers, support staff, with refresher background for previously trained para-counselors and counselors.

Reference No. 6

Seshadri, S. (2002). *A Training of Trainers Manual on Child Sexual Abuse*. Draft manuscript. Sri Lanka: National Child Protection Authority.

Comments: Although in draft form and not including many of the presentations of the original training programme, this manual is reviewed here as it contains subjects not found in other training materials. This manual is notable for emphasis placed on sexuality and gender considerations in working with children. Considerable attention is placed on assessment and disclosure of abuse, with a description of the responses to be followed by caretakers, police, etc. after affirmation of an abuse situation. Following a review of basic counseling techniques, the manual discusses various therapeutic techniques useful to the trained counselor and therapist, including mapping, imagery and containment techniques. Unlike many materials reviewed, the manual accompanies theories and concepts of abuse with theories and concepts of recovery.

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Applications: Diverse applications, both as background on abuse and response for those assessing possible abuse, such as police and child protection authority staff, and as a source of techniques for trained paracounselors, counselors and other professionals.

Reference No. 7

UNICEF. (1997). *Basic Training on Psychosocial Interventions for Street Children Service Providers: A Trainer's Manual*. Manila, the Philippines: UNICEF Manila, AusAID, National Project on Street Children.

Comments: While this training manual is directed at those working with street children, many features are applicable to those working with survivors of trafficking or sexual abuse. Notable are the manual's extensive activities to provide understanding of and empathy with the target care group (street children), with realistic applications to their lives and habits, including extensive coverage of drug abuse and extensive focus on working with children's groups and surrounding communities. Emphasis is placed on

helping caregivers understand their role. Unique to the materials reviewed, the multi-disciplinary process of case management is presented in a comprehensive and useful manner. The training materials are extensively adapted to the Filipino cultural context. Also notable, and unique in the materials reviewed, is a section on 'house parents' as key players in the healing process. Comprehensive information and techniques on care for caregivers are provided.

Applications: Specifically for street children service providers, but applicable to facility managers, support staff and para-professionals working with trafficking survivors.

Reference No. 8

UP CIDS Psychosocial Trauma and Human Rights Program and Department of Social Welfare and Development, Social Welfare and Development Institute. (2001a). *Helping Healing: Training Modules for Caregivers on Basic Bio-Psychosocial Help for Children in Need of Special Protection*. The Philippines: UNICEF, UP CIDS-PST, DWSD-SWADI.

UP CIDS Psychosocial Trauma and Human Rights Program and Department of Social Welfare and Development, Social Welfare and Development Institute. (2001b). *Training of Trainers on Basic Bio-Psychosocial Help for CNSP*. The Philippines: UNICEF, UP CIDS-PST, DWSD-SWADI.

Comments: These training modules present an approach to healing based on careful application of a child rights framework. The modules begin with extensive activities to help caregivers clarify their role in helping children heal, and to provide understanding of children and childhood in the Filipino cultural context, including seeking the point of view of the children. The training is based on the resiliency paradigm, utilizing children's capacity to assist in their own healing process, and provides extensive coverage of the mechanisms of child participation. Emphasis is placed on stress factors in children's lives and on providing culturally sensitive child-friendly healing

practices, such as storytelling and play. The skills taught are placed within a collaborative framework of the caregiver and other available services.

Applications: Facility managers, support staff, para-professionals and professionals.

Reference No. 9

Transcultural Psychosocial Organization. (1997). *Community Mental Health in Cambodia*. Phnom Penh, Cambodia: Transcultural Psychosocial Organization.

WHO. (1994). *Mental Health of Refugees*. Prepublication Version. Geneva: WHO.

Comments: These two manuals are reviewed together, as *Community Mental Health in Cambodia* is an adaptation, in part, of *Mental Health of Refugees*. Although developed for workers in refugee camps or community health workers in Cambodia without prior training in caregiving, these two manuals provide a rich source of information for caregivers working with the trafficked and sexually abused. Both provide extensive background and responses for working with stress and functional complaints. The manuals' discussion of identifying and managing major and minor mental disorders was not found in other materials, and provides a useful perspective in which to place the psychosocial effects of trafficking and sexual abuse. While child rearing practices were absent in most materials reviewed, both manuals provide useful information on supporting mothers in the care of their children. The manuals were unique among those reviewed in providing instruction on the utilization of traditional medicine and healers found in the community. *Community Mental Health in Cambodia* is notable for its careful application of indigenous child rearing practices, community support mechanisms and healing systems.

Applications: Community health workers, facility managers, support staff, para-professionals and professionals.

Reference No. 10

Sampa-Kamwendo, A., Syamujay, T., Brakarsh, J. (1999). *Trainers Manual for Psycho-Social Counseling of Children*. Zambia/Zimbabwe: Children in Need Network.

Comments: Although from Africa, these materials are included because they contain issues and skills not found in materials received from South and Southeast Asia. Considerable focus is placed on the family as a key stakeholder in the psychosocial health of children. Unlike other materials received, the manual contains an adequate discussion of gender issues in caregiving. The importance of children's play is emphasized, including ways to encourage play activities within the family. The materials include an extensive coverage of traditional methods of counseling, seeking to integrate both 'contemporary' and traditional counseling methods in the helping framework.

Applications: Facility managers and support staff, with useful background on indigenous counseling methods for para-counselors and counselors.

8.2 Knowledge and/or Skills Provided, by Materials Reviewed

In Chart 2 below, the numbers 1 through 10 refer to the reference numbers of the training materials in 8.1 above. 'X' indicates provision of knowledge and/or skills on a particular activity. No 'X' indicates either no mention of the activity, or mention of the activity without comprehensive provision of knowledge and/or skills. 'XX' indicates extensive coverage of the activity.

It should be noted that the courses reviewed are of varying lengths and differing foci. Consequently, a course's lack of coverage of an activity (no 'X') may reflect this, and does not suggest that those materials were inadequately developed. As mentioned before, this review has been limited to training materials alone, and supplementary coverage of activities by lectures and additional materials are not included. Further, some materials received were in draft or prepublication form, and are awaiting revision and expansion.

Chart 2. Knowledge and/or Skills Provided in Counseling Training Materials Reviewed

- 1 Centre for Victims of Torture, Jordans et al. (for ILO-IPEC TICSA Nepal, UNICEF Nepal)
- 2 Delaney, Cotterill et al. (for ECPAT International)
- 3 ESCAP, Uppsala University
- 4 National Child Protection Authority, Sri Lanka
- 5 Sanyal (for ILO-IPEC TICSA, Bangladesh)
- 6 Seshadri (for NCPA, Sri Lanka)
- 7 UNICEF Manila, National Project on Street Children et al.
- 8 UP CIDS, DWSD-SWADI
- 9 Transcultural Psychosocial Organization and WHO
- 10 Sampa-Kamwendo et al. (for Children in Need Network)

BACKGROUND	1	2	3	4	5	6	7	8	9	10
child health and development	X		XX		X		X	XX	X	
child and adolescent sexuality	X					X		X		
family issues, child rearing, parenting				X			X		X	XX
case management			X				XX	X		
social context of trafficking, CSA and CSEC	X	XX	XX	XX	X		XX			
psychosocial effects of trafficking, CSA and CSEC	X	X	X	XX	X	X	X	X	X	X
physical effects of abuse			X	X						
psychological effects of abuse	X		X	X	X	X	X		X	X
child abuse - assessment, detection, disclosure	X		X	XX		XX	X		XX	
clarification of counselor's role in caregiving	XX				X		X	XX	X	X
abuse and recovery theories and issues	X		X	X	XX	X		X		
overview of healing responses	X	X	X	X	XX	X		X		
resiliency, coping and child participation in healing	X			X			X	XX		
cultural considerations in rehab/reintegration	X		X				XX	XX	XX	X
utilizing indigenous healing practices			X				XX	XX	XX	XX
experiential healing practices (art, drama, play)	X	XX	X			X		XX		X
child-to-child and peer support approaches	X						X	X		
gender issues in caregiving					X	X				X
children's rights, incl. confidentiality, participation			X					XX	X	

GENERAL THEORY AND SKILLS	1	2	3	4	5	6	7	8	9	10
basic communication skills	XX	X	X		X	X	X	X	X	X
stress and relaxation	XX		XX				XX	XX	XX	X
individual counseling - theory	XX	X	X	XX	X	X	X	X	X	X
individual counseling - basic skills	XX	X	X	X	X	X	X	X	X	X
group counseling - theory	X	X			X		X	X		
group counseling - basic skills	XX	X					X	X		
family counseling - theory	X				X					
family counseling - basic skills	X									

SPECIFIC PROBLEMS AND RESPONSES	1	2	3	4	5	6	7	8	9	10
behavioral problems - background	XX	XX		X	X		X			
behavioral problems - responses	XX	XX					X			
developmental problems - background	X				X			X	X	
developmental problems - responses	X								X	
trauma - background	XX		XX	X	X	X	X	X	X	
trauma - responses	XX		X	X		X	X	X	X	
emotional problems - background	XX	X	X	X	X	X	X	X	X	X
emotional problems - responses	XX	X	X	X	X	X	X	X	X	X
social problems - background							X			
social problems - responses										
functional/somatic problems - background	XX				X				XX	
functional/somatic problems - responses	XX								X	
sexualized behaviors - background	X			X		X		X		
sexualized behaviors - responses										
crisis response - suicide, self-abuse, etc.	X						X		X	
substance use		X	XX				XX		X	
HIV/AIDS	X	X	XX		X					
care for caregivers		X	X				X		X	

Analysis of Reviewed Materials on Counseling, by Knowledge and/or Skills Provided

9.1 Background

Overall, the training materials were comprehensive in their coverage of the social context and the general psychosocial effects of trafficking and child sexual abuse. Essential tools for the para-counselor and counselor, including the particular psychological effects of abuse and the assessment of abuse, were also adequately covered in almost all materials reviewed. However, in the majority of the reviewed training materials some key background elements of the psychosocial context were lacking: child and adolescent sexuality, and family dynamics and parenting practices.

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Regarding the specific tasks of caregiving, the materials provided an adequate background of abuse and recovery theories and issues, as well as a generally comprehensive overview of healing responses. However, the materials were in large part focused on standard counseling practices, with relatively little reference to other forms of healing. As mentioned before, case management considerations were lacking, particularly in materials developed for South Asia. Experiential healing practices such as art, drama and play were covered, although primarily as recreational rather than therapeutic activities. In the materials developed for South Asia, cultural considerations significant to the subcontinent – such as caste/class, gender and patriarchy issues – were notably absent, with the exception of one training programme. No materials developed for South Asia gave more than passing consideration to indigenous healing practices, although these were extensively covered in materials developed for Southeast Asia.

The materials reviewed were at variance with several central issues which underlie programme development for children based on the Convention on the Rights of the Child and other documents. Training in child-to-child approaches, gender issues and the actualization of children's rights (including confidentiality and participation) was absent in the majority of reviewed materials.

9.2 General Theory and Skills

The reviewed materials as a whole provided excellent training for managers and support staff in the basic mechanisms of the counseling process. The materials provided substantial resources for training in basic skills such as communication, listening and stress reduction that are necessary for those working daily with trafficking and abuse survivors. As well, the materials provided excellent background in individual counseling by which managers and support staff can understand the work of para-counselors and counselors. However, background and basic skills on group counseling were limited, and background and skills on family counseling were virtually absent. The latter, with the previously-noted absence of background on child rearing and parenting, indicates a need to place the child's recovery within the framework of family and community.

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9.3 Specific Problems and Responses

'Specific Problems and Responses' refer to training activities applicable to either the training of para-counselors, in the case of one training course, or the 'upgrading' of skills of previously trained para-professionals and professionals. As Chart 2 indicates, the reviewed training materials provided an incomplete coverage of the psychosocial problems generally presented by survivors of trafficking and abuse. Materials generally focused on more obvious and immediate problems, such as trauma, including PTSD, and other psychological concerns such as depression, anxiety, alienation, fear, etc. It should be noted that many training materials were unclear as to the qualifications of those who should provide depth counseling interventions, leading to possible misapplication of interventions by inadequately trained persons.

The materials, with the exception of one long-term training course, provided insufficient coverage of much of the spectrum of problems to be addressed for successful rehabilitation and reintegration of the abused. While caregivers were provided some background on behavioral problems (about which many caregivers have expressed concern, particularly with young people returned from brothel situations), few courses offered training in responses. Physical, intellectual and emotional development are frequently affected by prolonged sexual abuse or the exposure of a child to a brothel environment. While attendance to developmental problems is essential for the child's long-term health, emotional stability and ability to work and study, neither background nor skills regarding developmental problems were adequately provided in most of the reviewed materials.

Training on addressing social problems such as peer pressure, gender aggression and negative influences in the community are necessary for children's effective reintegration. However, this training was not found in the reviewed materials, and perhaps reflects a general focus on 'institutionalization' rather than social reintegration in working with trafficking survivors. Reflecting the previously-mentioned lack of background provided in child and adolescent sexuality, there was insignificant coverage of sexualized behaviors in the reviewed materials. Considering that the primary target group are children who have been in prostitution or have been sexually abused, training on sexuality and sexualized behaviors can be considered necessary. Attempted suicide, self-mutilation, violence and similar acts are not infrequent among the survivor target population, although there was lack of training in crisis response in the majority of reviewed training materials. Notably, some of the materials provided good to excellent training in care for caregivers.

Recommendations

10.1 Recommendations Regarding the Training Needs of Specific Caregivers

Recommendations regarding needs in individual subjects for training courses can be deduced from Chart 1. The following recommendations are general.

- As a first step in strengthening human resources for caregiving, general care and support procedures for caregiving facilities need be clarified, including a delineation of the roles and responsibilities of specific caregivers. These procedures need to be formulated into a preliminary short training course which is provided to senior facility managers as well as funding partners who will support the human resources development of the facility. With basic knowledge of care and support procedures, facility managers and staff can effectively participate in training needs assessment leading to the application of appropriate training programmes. This should be followed by comprehensive training for managers in care facility operations applicable to the individual facility.
- Short, focused, 'one-topic' training courses need to be developed. It should be understood by training programme developers that facility staff are frequently under a number of pressures in their daily work, and consideration should be given to the ability of staff to put their learning into practice. 'All-inclusive' training courses may provide adequate theoretical background, but often contain the teaching of more skills than trainees can actualize in the workplace. All training courses should be accompanied by on-site follow-up training to help the trainees apply their learning in their actual surroundings.
- Facility managers should be seen as a specific trainee target group with specific needs. Keeping in mind that the caregiving facilities of a nation

should operate according to uniform minimum standards of care, training courses directed at facility managers should be uniform throughout each country. Training of managers from different organizations in one course would not only provide a strong foundation of uniform caregiving practices, but would allow managers to share and address management concerns.

- It should be recognized that adequate capacity building in some core subjects (including case management procedures, applications of minimum care standards and care facility operations) cannot be provided by 'short courses'. While orientation is beneficial, effective application requires sufficient training time, on-site instruction, and follow-up over weeks or months.
- Intake should be recognized as a discreet and vital process in rehabilitation and reintegration. Proper procedures during intake ensure the immediate protection and the emotional and physical well-being of the survivor, and lay essential groundwork for case management, legal proceedings and eventual reintegration.
- With the exception of basic orientations in caregiving, survivors' needs, etc., specific target trainees should be carefully identified in the development of training courses. Applicants for participation in training courses should be screened, and only those who will directly apply the designated skills and knowledge should be included.
- Support staff should be recognized as a vital resource in caregiving, and not considered to be 'subsidiary' personnel who only support the work of managers, para-professionals and professionals. Activities provided to survivors by support staff should be clearly delineated by training programme developers and distinguished from activities to be conducted by para-professionals and professionals. Courses developed for general support staff, which may include semi-literate persons, should give consideration to the trainees' educational background, language skills and learning abilities. As mentioned above, information and skills should be provided in small units followed by on-site training to allow staff to actualize their learning.

- In South Asia, managers, supporting partners and training programme developers need to recognize a broader spectrum of caregiving activities than counseling and job training, and training programmes need to be developed to address those activities. The lack of focus on experiential therapies and, in particular, on social work applications needs to be addressed.
- In South Asia, trained para-social workers and social workers need to be integrated into the intake, rehabilitation and reintegration processes. Managers should be trained to understand the purpose of social work in these processes.
- Focus needs to be redirected from institutionalization and rehabilitation to family and community reintegration. For this, there is a need to train staff to teach survivors living/social, life-planning and leadership skills, to apply case management planning to reintegration activities, and to work with families and communities.
- Children's rights need to be actualized in the healing process. Staff need to be provided with functional skills to promote participation in healing processes and facility operations, ensure privacy and confidentiality, promote survivors' interaction with peers, family and community, and facilitate survivors' planning and choice in future occupations and living situations.

10.2 Recommendations Regarding Training in Counseling

Recommendations regarding needs of coverage for individual subjects in counseling training courses can be deduced from Chart 2. The following recommendations are general.

- Counseling training programmes need to address a wider spectrum of psychosocial issues than 'emotional problems', including sexuality, developmental problems, family issues, gender, cultural considerations, peer support, and the child's social environment.
- Programmes that provide orientation to counseling should be clearly distinguished from programmes that train persons to counsel survivors. Because of potential harmful effects on survivors, courses which might

lead insufficiently trained persons to counsel survivors should be discouraged. Training for managerial and support staff in assessment and referral of problems to para-professionals and professionals should be imperative.

- Consideration should be given to children's participation in the healing process, and to healing practices which reinforce children's natural resiliency and ability to cope with problems.
- Counseling training programmes need to be placed in national and local cultural contexts. The 'indigenizing' of caregiving and the use of indigenous care practices should be preceded by research to identify values, practices and resources in the existing culture. In South Asia, the multiplicity of castes, classes, religions and ethnic groups within individual countries should be taken into consideration in the indigenizing process.

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Training of Psychosocial Counselors in a Non-Western Context

The CVICT Approach

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Abstract

In non-western countries, few counseling training approaches incorporate sustained, supervised clinical experience in their methodology. This paper describes a model approach for training psychosocial counselors conducted by the Centre for Victims of Torture, Nepal (CVICT). The objective of the training approach is to incorporate extensive clinical experience in order to ensure that para-professional counselors are well equipped to assist persons with psychosocial problems, such as problems among trafficked youth. The approach combines minimal classroom teaching with extensive supervised practice. The four-month training program described here starts with a two-week core training, followed by approximately four cycles of alternating practical placements and training sessions. This methodology has been developed because it appears that only through substantial supervision can learning be transferred into counseling skills. The content of the course can be adapted for the training of counselors of different target groups.

Introduction

More and more attention is being given to the psychosocial component of development (Bracken al., 1995). Recent publications of books and research on psychosocial care and public mental health in the non-west, and research on care of refugees and trauma survivors bear witness to this development (e.g., de Jong, 2002; Mollica al., 1993; Van Ommeren al., 2001). Although a psychosocial component is often seen to play a vital role in the stabilisation and development of a country, few systematic efforts to implement sustainable psychosocial care have been realised.

This paper serves two functions. First, it describes the approach taken by CVICT for the training of psychosocial counselors in Nepal in order to stimulate systematic thinking on sustainable psychosocial training in non-western contexts. Second, the paper attempts to provide a framework for future developments in training psychosocial counselors in the developing world.

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1.1 Mental Health in Nepal

The formal mental health system in Nepal is centralised in the capital of the country and is understaffed. There are small psychiatric units in general and military hospitals in the capital and there is a state mental health hospital with 20 beds for male and 20 beds for female patients. Together with other psychiatric units they account for a total of 174 beds (Robertson, 2001). Outside the valley in which the capital is situated psychiatric patients are seen in three other urban centres in the east, mid-west and west of the country (Kaplan, 1999). Following current estimates, there are 25 psychiatrists, with an average of three psychiatrists being trained every year. Nepal has a population of 24 million. Eight to ten psychiatric nurses, mainly

trained in India, are currently employed within the public mental health system and the training of clinical psychologists has just started (Robertson, 2001; Jensen, 2001).

Although the formal mental health system is non-existent in most places, the indigenous healing system, including Dhama, Jhankri, Baidya, Jharphuke and Mata, are available to help most Nepalese deal with their mental (and physical) health. It is estimated that between 400,000 and 800,000 faith healers are currently active in Nepal (Shrestha al. cited in Kaplan, 1999). Problems with mental health and problems in the community are usually presented to the faith healer before consultation of the formal mental health system because of the costs involved in reaching the urban centres where this system is concentrated (Kaplan, 1999). Almost all cases go to a faith healer whether or not they seek help in the modern system. Only those who do not find relief from seeing faith healers tend to seek help from allopathic services.

Besides non-formal healers or a formal mental health system a number of non-governmental organisations (NGOs) are active in the field of mental health (some of them currently united within the Kathmandu Psychosocial Forum, or KPF). Their activities are mainly directed towards the prevention of trafficking of girls, rehabilitation of girls who have been trafficked and psychosocial interventions with street children, child workers and substance abusers. Although these NGOs provide very useful services, their staff have until recently, as will be described later, not been thoroughly trained in counseling. Especially outside the capital a judgemental and uninformed implementation has often led to basic misunderstandings of the process of counseling, sometimes resulting in wrong practice. The state of counseling in Nepal is further complicated because of people working in the area of family planning who apply the word 'counseling' for the purpose of persuasion to use temporary and permanent methods of birth control. This may not be a central policy of the Nepal Family Planning Association, but this practice occurs all over the country.

1.2 Training Rationale

To assist people in reducing their emotional distress, including those who suffer from the consequences of traumatic experiences, psychosocial counseling can be an integral component of rehabilitation programs. The assistance that psychosocial counselors can offer includes providing a mere listening ear, providing emotional support and assisting in dealing with a problem. This, in turn, is applicable for a variety of problems, from psychiatric disorders such as depression, anxiety disorders, substance abuse, post traumatic stress disorder symptoms, and somatoform disorder to social emotional problems (possibly related to the previously named) such as fear of persecution, other realistic and unrealistic fears, losses, interpersonal conflicts, loneliness, social stigmatisation, disabilities, self doubts, and, occasionally, existential questions.

CVICT first started training mental health workers to provide psychosocial counseling for victims of torture in 1991. During its first 10 years, CVICT came to realise that short training courses of psychosocial counselors are often inadequate (for a review, see Van Ommeren al., 2002). CVICT organised at least two dozen short training programs during its first nine years of existence at the request of various organisations. There were several lessons learned. First, training was mostly provided by visiting psychologists who had very little or no knowledge of the local context. Second, there was little knowledge and sensitiveness among managers of organisations concerning counseling of clients with severe psychosocial problems and similarly among donors within the country towards uplifting counseling skills. This led to more or less haphazard, inefficient counseling training, which typically was not evaluated or followed up. Third, training usually consisted of short (one to two weeks) training without supervision and practical learning of skills, and often took a training of trainers (TOT) structure, which typically entailed that trainees who have just superficially learned skills themselves are responsible for training others, without having the chance to first build their own clinical experience. Fourth, training programs structurally lacked the inclusion of after-training activities, such as follow-up, refresher training and supervision.

Besides the training of counselors in the above fashion through the NGO-based mental health program, no practical learning concerning counseling was available in Nepal in the 1990s. At that time, the curriculum of university courses in psychology, nursing and social work lacked the training in counseling skills. One exception to such training practices was provided by Psychosocial Transcultural Organisation (TPO), whose experts, materials (e.g., de Jong and Clarke, 1996) and programs played an important role at the early stage of the development of the training approach described in this paper.

In 2000, to be able to build up higher quality rehabilitation programs, CVICT, in collaboration with TPO, initiated a training approach to educate mental health workers and NGO workers in psychosocial counseling, with key elements being the length of the program and ongoing supervised practice (Poudyal and Van Ommeren, 2000).

1.3 Theoretical Background

The approach to training psychosocial counseling, as outlined in this paper, is based on different theoretical influences as well as extensive practical experience of providing psychosocial counseling to torture survivors within CVICT. The core idea behind the training approach is that it needs to fulfil an emerging need for psychosocial counseling in contexts where such intervention are not yet available or operational and therefore focuses on both paraprofessionals (commonly NGO service providers) and professionals (university graduate psychologist) who have had no previous clinical training. For similar reasons, the training approach is mainly skill-based. The approach combines aspects from different theoretical frameworks, integrating components that appear culturally suitable.

The integrative approach builds on the following theoretical framework. First and most importantly, it teaches the participants counseling skills, with communication skills as their fundament. This idea corresponds with the micro-skills approach to counseling as designed by Ivey and Ivey (1999). Micro-skills are communication skill units of the interview that help the counselor to develop the ability to interact more intentionally with the client

(Ivey and Ivey, 1999). Counseling is then based on a hierarchy of communication skills, which includes attending behaviour, reflection of feeling, confrontation, reflection of meaning, and influencing skills among others. This theory underlies the approach in two ways: first in the emphasis on individual skills as the essence of counseling, and second in the way the different skills are explained and structured in relation to each other. There exist many counseling books that describe some of the communication skills, though they all describe them somewhat differently. The CVICT approach, in large part, follows Ivey and Ivey's explanation and classification, because Ivey and Ivey write from a multicultural perspective and in easy, comprehensible English (e.g. in contrast to most western textbooks, Ivey and Ivey's writings minimise metaphors and examples that are not always understandable or suitable in non-western contexts).

Another influential theory for this training approach is the problem management approach as described by Egan (1998), which emphasises the flexible implementation of the following overlapping and interacting tasks: (a) helping clients identify, explore and clarify their problem situations; (b) helping clients identify what they want in terms of realistic goals that are based on an understanding of the problem situation and opportunities within the socio-cultural context; (c) helping clients develop strategies for accomplishing realistic goals; and (d) helping clients act on what they learn throughout the helping process through goal-accomplishing activities. This structure and some counseling skills that are specific for this approach (e.g. goal setting, brainstorming) are included in this training approach. We acknowledge (Van Ommeren al., 2002) that this type of pragmatic framework has a distinct North American flavour, especially when implemented in a linear manner. The framework is based on two assumptions that are widespread in modern western psychotherapy, namely: (a) that systematic approaches to helping (e.g. therapy protocols) are beneficial, and (b) that helping is most efficient if the helper aids the client in identifying and implementing ways of problem solving and coping. Even though these assumptions are western, both Nepalese counselors and clients appear comfortable with this approach.²

The third theoretical starting point is the incorporation of cultural comprehension. It is clear that interventions devised in the west, based on western principles regarding the nature of psychopathology and rehabilitation, cannot be implemented in other cultural settings without thorough reconsideration of their components. The standpoint of this training approach in this area is mainly influenced by the thinking of Arthur Kleinman (e.g. Kleinman, 1988; Kleinman and Good, 1985). The two most important aspects of his thinking regarding the training of counselors in a non-western context are specific explanatory models and illness experience (Kleinman, Eisenberg, and Good, 1978). Illness experience is the client's view of his problem as opposed to the doctor's view of the problem, which has been termed disease. Paying attention to the illness experience ensures that culturally specific information about the onset and the continuation of the presented problem is not overlooked or deemed unimportant. This results in better agreement on the counseling priorities and better motivation on both the client's and the counselor's side. CVICT's staff comprehension of culture benefited from CVICT's research into local idioms of distress and local ways of coping in the 1990s (see Sharma and Van Ommeren, 1998).

Finally, general psychotherapeutic aspects are emphasised within the approach presented in this paper. Basic elements of counseling are the relationship between client and counselor and reflection on the counseling process. An important aspect of the relation between a client and a counselor is the attitude of the counselor to the client's presentation of problems and general lifestyle. In Nepal this concretely means that a counseling relationship has to involve basic respect and complete acceptance with the aim to break through barriers such as caste, ethnicity, language and religion. Besides these, attention is given to other general psychotherapeutic aspects such as self-awareness as a helper, documentation, feedback, handling reluctance, group dynamics, coping and ethics.

Description of Training Model

The training model described below has been implemented for a variety of direct and indirect beneficiaries. It aims at training psychologists or para-professionals to manage a broad range of psychosocial problems (e.g. dealing with emotional issues related to having HIV/AIDS; dealing with consequences of trauma experiences; dealing with distress regarding the reintegration into mainstream society; and reducing group tensions and dissatisfaction in centre-based programs). The training program does not intend to be equivalent to graduate-level university courses nor does it prepare for some specific counseling applications (such as marital, family, or substance abuse counseling).

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2.1 Structure

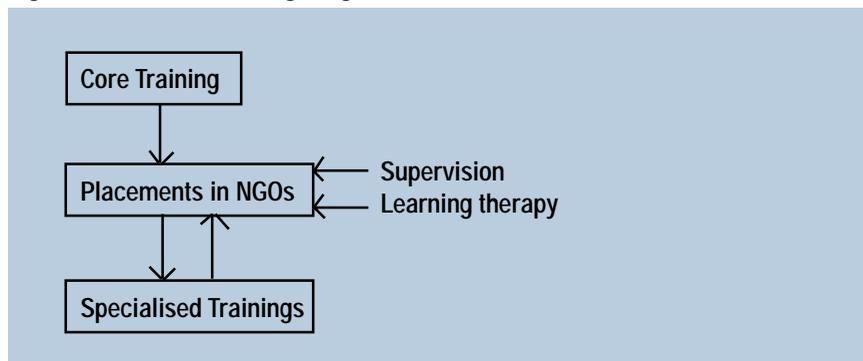
As mentioned above, this training approach is based on an integrative theoretical framework, from which was developed a training program with the following components: (a) providing clients with emotional support; and (b) a counseling process that focuses on assisting clients with coping and problem solving. Emotional support, as we define it, involves giving complete attention, encouragement, acceptance and comfort to the client as well as communicating understanding of the client's feelings and perspective. This is put into practice through a variety of skills, such as paraphrasing, reflection of feeling, summarising, non-verbal communication, and advanced empathy. The counseling process that focuses on assisting clients with problem management entails that the client and the counselor work together to find and implement strategies to either reduce or resolve the problem situation or to manage the impact of the problem situation (see Van Ommeren al., 2002). In this training approach, Egan's (western-oriented) problem management approach is not straightforwardly taught. Instead the Nepalese situation asks for more emphasis on process steps such

as the introduction of the intervention and identification of the necessity of psychosocial counseling (based on criteria such as presentation of problem or dissatisfaction, an expressed need for such assistance or emotional imbalance) and exploration of the perceived causes and perspectives of the client. This process is put into practice mainly through skills such as open questioning, brainstorming, setting goals, working with coping strategies, advanced communication skills (e.g. challenging, psycho-education, giving feedback) and alternative strategies (e.g. relaxation techniques, role-plays, and, among children, play).

2.2 Procedure

Two core ideas of this training approach are the length of the program and the regular interchange between training sessions and supervised placements with relevant target groups. The four-month internship generally consists of a two-week psychosocial counseling core training, four two-week placements at local NGOs including daily two-hour supervision meetings at CVICT, and four one-week sessions for further training. Simultaneously, learning therapy is conducted to provide trainees more insight into the experience, structure and functioning of the intervention. These components are described below and an overview is given in Figure 1. After the training, which includes 90 hours of supervision, 140 hours of placements and 10 hours of learning therapy, the participants receives a psychosocial counselor certificate.

Fig. 1: Overview of Training Program



Selection

On the basis of applications, the most talented and qualified candidates are selected through a transparent and competitive selection process. Interviews last a full day. First, candidates go through short interviews with the training management and clinical staff. Each candidate receives a numerical rating from each interviewer, which reflect (a) background and experience, and (b) motivation. Second, each candidate engages in several role-plays with a CVICT counselor, who pretends she/he is a person in distress with one or more problems, while the candidate pretends she/he is a helper. Candidates are then rated for (c) potential³, and (d) attitude.

Training Sessions

As mentioned above, the training program generally includes five training periods, which are structured from basic counseling skills in the first (core) training period to more specialised sessions that increase in degree of difficulty, still mainly aimed at learning skills. The training sessions entail mostly focused lectures, minimal readings, extensive role-plays, group-work, exercises and case discussions. Furthermore, main concepts and skills are reviewed, because repeated presentation, especially with growing knowledge and experience, increases clarification of these concepts and skills, and the interrelation between them. The reading and teaching materials are almost all developed either specifically for the course and for the level of training.

The core training session focuses on the situation of the target group, explanation of psychosocial counseling and its process, communication skills, self awareness, the functions and ethics of a counselor, Nepali feeling words, documentation, and general psychosocial issues such as stress, coping, assessment and understanding of various social and emotional problems.

The following specialised training sessions teach the participants alternative techniques for counseling (such as role-plays or relaxation), using play and drawings for counseling children, handling reluctance, resolving medically unexplained pain, focusing on core-problems and brainstorming. Moreover,

the participants are trained in major mental disorders (such as psychosis, anxiety, depression), suicide, and trauma reactions, as well as in important psychosocial issues such as sense of self-worth, sexuality and assertiveness. Finally, participants learn specific techniques on how to provide assistance to groups of help-seekers or to different types of populations, such as torture survivors, survivors of trafficking or HIV/AIDS patients (Jordans, 2001b; Jordans al., 2001a, 2001c). Interwoven between these sessions the participants are made aware of means to adapt the intervention to the existing culture (see below).

Placements and Supervisions

As described above, the training periods are alternated with placements. Placements entail that the participants go to a local organisation that works for people who are prone to different types of psychosocial problems (e.g. trafficked girls and women, street children or children at risk, leprosy patients) and conduct interviews with the residents, thereby practicing skills and process in a real life setting. A cycle of placements at different organisations provides the participants with a diversity of client groups and maximises experience and learning. Subsequent placements are structured such that the participants practice and focus on certain specific skills or parts of the counseling process that they have learned in the preceding training session (e.g. during the first placement participants focus on identification, assessment and communication skills). Towards the end of the training program they are expected to integrate all such components in the placement setting.

Supervision refers to the daily meetings at CVICT during the placement periods, in which the participants share their placement experience and receive support through feedback and shared concerns. This time is mostly used to assist participants in dealing with experienced difficulties or concerns, which can be either case-related or process-related issues, or may involve the feelings of the participants themselves. Furthermore, during the daily supervision, learned skills and concepts are reviewed from a practical

perspective while trainers give constant feedback on their implementation. During the supervision, skills are further practiced through exercises or role-plays. Similarly, group members are encouraged to give feedback to each other and discuss case-related difficulties together. Finally, this meeting is used to give short training sessions on new topics, mostly related to an ongoing case discussion. Different supervision methods are used, such as exploratory questions, overview of skills, case discussion format and agendas, all of which are based on principles of supervision as described by Poudyal and Van Ommeren (2000). At times, the trainers visit the placements and occasionally videotape sessions, for later use as feedback and evaluation material.

Learning Therapy

In learning therapy, once a week the participants receive a counseling session from a CVICT counselor, aiming at providing a model intervention for the participant as well as to create some personal change, self-reflection, or both. As counseling is about a process of change, the participants are encouraged to enter the learning therapy with an idea of what they would like to change in their life (e.g. workplace, family situation, conflicts, personality). At the same time, self-reflection can be a central theme throughout the process. Each participant has approximately one session per week during the placement periods, until the end of the training program or until the desired changes have been reached. Ultimately, this gives the possibility of understanding the practice of the intervention as well as understanding themselves within the intervention and the counseling relationship.

Once a week, during the placement periods, a one-hour group discussion is held in which the participants can reflect on and express their experiences within the learning therapy (process-related instead of content-related) and integrate these observations into the other activities of the internship (training sessions and placements) and vice versa if necessary.

As mentioned above, the learning therapy may stop when the desired changes or self-reflection is achieved. If this is before the end of the training program a group is formed, within the same time frame, involving group-learning therapy. These are theme-centred group counseling sessions with similar objectives as the individual sessions, mainly serving as an example or model of group counseling as well as a reflection of oneself within group relations.

Evaluation

Evaluation is conducted repeatedly and at different levels throughout the program to ensure the quality and effectiveness of the ongoing training activities. Participants answer a questionnaire with 23 dichotomous questions regarding psychosocial counseling on the first day of training (pre-test) and the last day (post test) (this methodology is adopted from TPO Uganda). For example, across participants, the mean score of 48% correct answers in the first training improved to a mean score of 87% in the last training. Other methods of evaluation include daily training feedback forms and mid-term and final feedback sessions. Finally, at the end of the program, as a last proof of capability, each participant role-plays a full counseling session.

Future Implementation in Different Contexts

As we realise there is a need for the implementation of a psychosocial counseling training program in other countries and/or settings as well, this section of the paper serves as a kind of guide for future implementation. The steps through which a training program can be implemented are assessment of preconditions, raising awareness, preparation, implementation, evaluation and employment.

3.1 Assessment of Preconditions

Assessment of preconditions involves numerous considerations that are beyond the scope of this paper. We will touch nevertheless on a few points.

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First, one needs to take a critical look at the situation in which the training program is to be implemented. Counseling can, in our opinion, almost never be directly implemented, but has to be adapted to the cultural setting. Cultural adaptation of training and clinical activities can be structured according to three levels. The first level concerns adaptations related to the structure of Nepalese society. This entails that counseling conforms to issues such as the significance of the family and the importance of respect for hierarchy and prestige. A second level of adaptations concerns the counselor's skills and inputs. A competent counselor in a Nepalese setting will generally ask questions more indirectly, will understand local taboos (e.g. sexuality of unmarried women), and will minimise use of directly challenging the client, all aiming at respecting the client's zone of comfort. The third level entails adaptation that can be characterised by the input of the client. For example, clients in Nepal, compared to clients in western countries, appear to be more inhibited in showing negative emotions openly, attributing problems externally and reflect on their own psychological processes. Other adaptation issues that this approach takes into account

are the status of traditional healers (counseling is seen as a parallel form of assistance) and the need for elaborate rapport building. Additionally, extra attention must be given to explanation of the way counseling works, because it is a new treatment modality (Jordans al., 2002a). In some settings, counseling might prove to be a very difficult intervention as it might lack cultural appropriateness.

Second, one needs to take a critical look at the strength of the implementing organisation. A training program as described here takes a substantial amount of time and resources that may be allocated otherwise, depending on priorities. Careful consideration needs to be given to the importance of the training program as a whole in the context of the organisation's general objectives.

Third, to be able to organize the practical placements, one needs to identify whether there are sufficient relevant NGOs that are willing to cooperate. Further, one needs to identify whether within these organizations there are sufficient potential clients with psychosocial issues who are willing to collaborate. We have experienced, however, that various organizations are happy to facilitate placements as they lack quality psychosocial services and see the need. Nevertheless, it has not always been easy to find organizations, because participation in the program requires effort.

3.2 Awareness Raising

Before training can be conducted or an intervention initiated, the particular setting needs to be favorable. This entails that the organization, donor agencies and even the society at large within which the training program or the intervention is planned need to be made aware of the necessity and potential positive impact of such an intervention.

3.3 Preparation

When preconditions have been met, the training program needs to be carefully prepared. Working in settings within the developing world generally means that donors for funding have to be sought. This has to be

done simultaneously with finding the target group for the training program. As donors generally have specific demands regarding the population that is to benefit from their funds, it is necessary to identify the group for which training is intended. Once financial sources are secured, a month's time is needed for the development, adaptation or refinement of training materials to the specific target group. Every target group has its own specific demands and for every training cycle editing, changing and updating the training materials are a necessity. During this month, selection of candidates needs to be organised and the planning of the placements should also be done.

3.4 Implementation

When training materials are ready and funds have been allocated, the training program can be implemented. Six to 12 participants are recommended for one training program. Ideally, the selection pool should be at least three times as large.

Preferably, the participant's age should be over 20, because a certain amount of life experience appears to be prerequisite to grasp the basics of counseling and to understand psychosocial problems. Moreover, participants should be available for the entire period of training on a full-time basis. Some working experience in a NGO or having a social work background is generally beneficial, because it appears to increase the participant's ability to learn the elements of the training program. In the CVICT training program, it is required that NGOs providing a participant or the involved donor agency guarantee employment of the participant within the NGO or another program after completing the training. This is to ensure sustained implementation of the taught skills.

Selection of trainers has to be done hand-in-hand with the selection of participants. In the CVICT program, local trainers who are extensively trained counselors are used. They are experienced in counseling and have been trained extensively in their homeland with additional short-term training abroad. These trainers are assisted by TPO expatriate psychologists. A detailed description of training of trainers does not fit the scope of this

paper, although it is a crucial part of the implementation of a training program. We do emphasize, however, that being a good trainer requires more than being a good counselor. Training skills differ from counseling skills, and both need to be instilled over time before a four-month training program is conducted.

3.5 Evaluation

An often-overlooked part of creating a training program is its evaluation (Weine al., 2002). Evaluation serves two purposes. In the first place, it checks the effectiveness of communicating the elements of the training program. Second, evaluation serves to identify and modify the elements that were deemed uninteresting, difficult, culturally inappropriate, or irrelevant regarding the target group. Evaluation is the key tool to establishing a link between the interest of the trainer and that of the participant. Details of some aspects of evaluation have been covered in section 2.2.

3.6 Employment

Ultimately, the goal of training programs on psychosocial counseling is that newly trained counselors assist people to reduce their problems or distress by putting into practice the learned skills. It is therefore crucial, for all parties involved, to ensure adequate subsequent employment for the psychosocial counselors, which includes defining the specific functions of the psychosocial counselor within organisations. This entails developing a set of guidelines for activities to be conducted by the counselors-to-be. Depending on an organisation's target group, such guidelines could be as follows: availability of regular counseling sessions for people with a diversity of psychosocial problems; conducting the intake and psychosocial assessment of new residents; being part of an interdisciplinary case management team which is responsible for rehabilitation and treatment plans; and finally providing training or sensitisation programs on psychosocial issues to other staff.

3.7 Follow-up

As mentioned earlier, an often-overlooked part of training programs, both by implementing and donor parties, is the after-training activities. Such activities entail that the organisation that is going to implement psychosocial counseling needs to be prepared for such. That includes the above-mentioned guidelines for practice but also setting up a case management system (e.g. referral network, case responsibility system), and establishing of a counseling room or center, with all the necessary forms and materials. A clinical supervisor or mentor should be responsible for professional supervision meetings that focus on quality of care for clients and the care for the counselors themselves. Finally, routine, thorough refresher-training courses need to be planned, in which main concepts and skills are reviewed and reinforced.

Conclusion

Attention to psychosocial components within rehabilitation as a whole or to specifically address individual problems is relatively new in Nepal. At the same time, Nepal shelters many target groups that are particularly prone to psychosocial problems (as a result of the structurally experienced traumata as well as socio-cultural factors).

Even more so, in Nepal the conception of a mental health approach as a component of the overall health approach is not prevalent, even though it has been shown that mental health problems are very present and the availability of interventions is warranted (Tol, 2002; Robertson, 2001; Van Ommeren al., 2001). Therefore adequate attention should be given to mental health as a whole and integrated with local or traditional ways of dealing with mental health problems.

The comprehensive, thorough training of psychosocial counselors is part of that development. Comprehensive and thorough training suitable for fully addressing the needs of trafficking survivors, among others, is not possible within the limited scope of short training-of-trainers courses. Consequently, this approach has been developed based on four months of rigorous training that is mainly skill-based and structurally combines both theory and supervised practice.

This training program has been conducted five times, both for professionals (psychologists) and para-professionals (NGO workers). It has been shown to be effective in that it has converted motivated, yet inexperienced, service providers into self-confident helpers. The program itself has developed over time and has been adapted after the experiences of each program

conducted. In the beginning, the development and implementation of the training program were largely dependant on the TPO expatriate psychologist, but over time this assistance has been reduced because of the development of training capacities of Nepalese trainers, who have now conducted the program several times. This corresponds with the desired goal of the expatriate expert slowly fading out of such a program.

Even though the training program has proven effective so far, there still seems much potential for development of the psychosocial field in Nepal and elsewhere. First, it entails expanding awareness of the benefits of psychosocial counseling at the local, national and regional levels. Second, to professionalise the services of counselors as well as to ensure qualitative interventions, a supervision and referral system needs to be set up. This means that all newly-trained counselors have the possibility to share cases and professional concerns with colleagues and to know whom they can refer to for particular cases. For any practicing counselor, continued supervision is essential to provide adequate assistance. Third, collaboration between existing mental health and psychosocial workers will be highly beneficial for the development of the field and can be done through networking or an association (e.g. the Kathmandu Psychosocial Forum).

Fourth, the education of psychosocial counselors itself needs to develop, both by improving and expanding. One possibility for the creation of a (post-graduate) one-year diploma course on psychosocial interventions to raise practical and theoretical capacity on a higher level, creating a core group of professionals for future implementation and education. This can take place nationally or regionally. CVICT is currently developing such a course.

Finally, it is essential that after-training activities are structurally included in the overall program. Besides continued supervision and a referral system, as mentioned earlier, it should also include refresher training and care-for-caregivers, among others.

From the above points it can be concluded that improvement lies in the institutionalisation and professionalisation of the psychosocial field of work. The long-term goal is the involvement of the Nepalese government in this field to ensure that sustainable interventions are carried out within existing sustainable structures. Additionally, development of this field should include research on the cost-effectiveness of psychosocial interventions, as well as identifying how such interventions can maximally complement and collaborate with traditional healing practices. As a final comment, we feel it is important to emphasize cultural appropriateness in counseling skills and concepts. Basic communication skills and emotional support does not appear to be incompatible with forms of interpersonal relationships and problem management found already in the culture.

Annex I. CVICT Training Approach – Psychosocial Counseling: An Overview⁴

Aim: to identify and implement strategies to resolve or reduce a problem situation or to reduce the impact of that situation.

Emotional Support	Problem-solving	Counseling Process
<ul style="list-style-type: none"> - Giving attention and encouragement - Provide acceptance - Being with the client, <i>attending</i> 	<ul style="list-style-type: none"> - Identify and explore [Problems, situation, causes, perspectives, goals, etc.] <p>Leads to:</p>	<ul style="list-style-type: none"> - Introduction and rapport building - Getting at the problem, <i>assessment, gaining understanding of illness experience</i> - Questioning - Repeating key words
<p>Non-verbal Communication</p> <ul style="list-style-type: none"> - Giving comfort - Communicate understanding, <i>empathy</i> <p>Reflecting feelings Paraphrasing Advanced empathy Reflection of meaning Summarizing</p>	<ul style="list-style-type: none"> - Understanding the problem situation and reflecting that to achieve awareness <p>Prepares for:</p> <ul style="list-style-type: none"> - Achievable steps towards change [plan of action, alternatives, solutions, disadvantages, etc.] <p>Results in:</p> <ul style="list-style-type: none"> - Increased level of preparedness in order to implement changes - Brainstorming - Goal setting - Working with coping strategies 	<ul style="list-style-type: none"> - Counseling goals - Implementation <p>Alternative tools (e.g. relaxation techniques, play, drawings, writing, role-plays)</p> <p>Focusing Advanced Communication skills</p> <ul style="list-style-type: none"> - Termination, generalizing - Follow-up

Annex II. Example of Training Program

Program & Duration	Topics
<p>Training 1. 2.5 weeks</p>	<ul style="list-style-type: none"> - Core knowledge and skills for psychosocial counseling for children (<i>see below for schedule</i>)
<p>Placement 1. 2 weeks</p> <p><u>Ongoing:</u> Learning therapy Case analysis</p>	<ul style="list-style-type: none"> - Assessment and identification - Case study - Basic communication skills
<p>Training 2. 6 days</p> <p><u>Ongoing:</u> Literature review Relaxation practice Role-plays</p>	<ul style="list-style-type: none"> - [Sharing and Feedback (<i>role-play on case studies</i>)] - Alternative tools for counseling - Culture and counseling - Psychosocial theory - Eliciting explanatory models (use of EMIC tool) - Focusing on the core problem - Goal setting - Brainstorming - Coping - Discussion on problem-solving approach - [REVIEW: communication skills]
<p>Placement 2. 2.5 weeks</p> <p><u>Ongoing:</u> Learning therapy Case analysis</p> <p>Filmed at placements/ Trainers visits</p>	<ul style="list-style-type: none"> - Communications skills - Alternative tools (mainly draw, play, journal writing and role-play) - Focus on coping strategies, goal setting and brainstorming
<p>Training 3. 1 week</p>	<ul style="list-style-type: none"> - [Sharing and feedback] - Group counseling - Trauma

Ongoing:

Literature review
Relaxation practice
Role-plays

- Advanced communication skills
- Functional complaints
- Handling reluctance
- Mid-term feedback
- [REVIEW: alternative tools]

Placement 3. 3 weeksOngoing:

Learning therapy
Case analysis

- Working with groups
- Advanced communication skills
- Trauma, functional complaints and reluctance, if applicable
- [REVIEW: all concepts and skills (prepared and conducted by participants)]

In-between Training

2 days

- Trauma treatment
- Psychopathology (child and adult)

Training 4. 1 weekOngoing:

Literature review
Relaxation practice
Role-plays

- [Sharing and feedback]
- HIV/AIDS
- Suicide and depression
- Anger management
- Task-oriented counseling
- Crisis intervention counseling
- Cultural psychopathology

Placement 4. 2 weeksOngoing:

Learning therapy
Case analysis

- Counseling integrative
- [REVIEW: All concepts and skills (prepared and conducted by participants)]

Filmed at placements/ Trainers visits

Training 5. 1 weekOngoing:

Literature review

Relaxation practice

Role-plays

- [Sharing and feedback]
- Assertiveness, conflict resolution
- Substance abuse
- Care for caregivers, secondary trauma
- Role-play one full session by each participant (30 minutes each); participants give feedback on each other
- Legal basis (*Lawyer*)
- Sexuality
- Self esteem
- Video analysis of counseling sessions
- Case management system, referral

Evaluation

- Final feedback on training course

Closing

- Post-test, exam
 - Meeting with donor and participating organisations about implementation of counseling within existing programs
 - Closing ceremony, certificates
- Official end of the program*

Annex III. Core Training Schedule

The core training is the initial 2½-week training on the most basic skills and concepts of counseling. In later training sessions more advanced topics are discussed. The training below is based on the following structure: (1) general child issues; (2) theory of counseling; (3) main skills of counseling; and (4) specialized skills and topics. Practice is integrated at all times, through role-plays, discussions, brainstorming, etc.

SESSIONS

1. Introduction, expectations, objectives
2. Situation of trafficked youth
3. What is counseling?
Principles of counseling
4. Why counseling?
5. Child/adolescence development
6. Needs of an adolescent
Hierarchy of needs
7. Self awareness
8. Methodology
9. Nepali words for feelings and concepts
10. Communication skills I
11. Social and emotional problems related to trafficked youth
12. Assessment
13. Communication skills II
14. Stress and relaxation
15. Functions and roles of a counselor
Ethics of counseling
16. Counseling process

Annex IV. Acknowledgements

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Endnotes

1. Correspondence or requests for materials to Center for Victims of Torture (CVICT), Bansbari 3, PO. Box 5839, Kathmandu, Nepal. Email: cvict@cvict.org.np.
2. Some have argued that counseling is a fundamental western exercise that should have no priority in non-western settings. For a discussion of this view point, please see Bracken and colleagues (1995).
3. The potential scale is a combination of observed qualities, such as warmth, genuineness, self-confidence and social skills.
4. This page does not pretend to include all skills, concepts and ideas of psychosocial counseling. It just aims to give an overview of some main components and to get an idea how these are related to each other. Furthermore it should be noted that information in the three columns is overlapping and/or interchangeable. Finally, all relevant skills are put in boxes near the concepts or in the columns that they are most related to, though these as well are interchangeable. Taken from Jordans (2002b).

Standards and Guidelines for the Care of the Sexually Abused and Sexually Exploited

Some Applications for South Asia

John Frederick

Ray of Hope
Kathmandu, Nepal

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Abstract

There is general agreement that there is a need to strengthen the capacity of childcare facilities in South Asia, and lay the foundations of a formal psychosocial care system along the same lines of professionalism, transparency and accountability as the medical care system. One of the starting points of this process is the development and application of routine minimum standards for the operation of facilities, in order to ensure the quality of care for children who are survivors of sexual abuse and exploitation. This paper presents basic features of quality of care standards and discusses their application to the South Asian setting. The paper discusses the range, purpose, development and application of quality of care standards and reviews existing standards in use throughout the world. It provides a model of care standards to be used as a 'discussion point', by which governments, NGO leaders and workers, child care experts and children can undertake the process of developing and applying quality of care standards to the institutions of their individual countries.

The Purpose and Scope of This Document

1.1 Purpose

The purpose of this document is to stimulate a process of discussion and development among NGOs, governments, experts and supporting partners that will lead toward the adoption of uniform minimum standards of care, or 'quality of care' standards, for facilities and government institutions that work with survivors of sexual abuse and exploitation, specifically survivors of trafficking for sexual purposes.

There is a wide range of standards and guidelines that are applicable to providing care for survivors of sexual abuse and exploitation. This paper will focus on general 'minimum standards' for the operation of facilities and the care of survivors. Others are explained briefly below, and examples are provided in the bibliography.

Quality of care standards can only be developed by the caregivers themselves in the context of their governments' National Plans of Action, their own cultures and the needs of their own children. This document is intended to facilitate that process.

This document presents some of the basic issues around the development and application of quality of care standards, provides examples of guidelines and standards regarding the general operation of care organizations, and presents a preliminary model for discussion summarized from those examples. This model can be used for a 'starting point' for the development and adaptation of child-centered 'quality of care' standards by care organizations, and by governments as prescribed in their National Plans of Action.

1.2 Definitions

Target Groups

The activities of care organizations and auxiliary caregiving tasks described in this document apply in particular to child survivors of trafficking for sexual abuse and sexual exploitation, and in general to child survivors of trafficking for the 'worst forms of child labour' as defined in ILO Convention No. 182.

However, within some parameters, these activities are also applicable to adults, and to persons who are survivors of other forms of abuse and traumatic events, including domestic sexual abuse, physical violence, forced prostitution, war and natural disasters. In this document, primary reference will be made to child survivors of sexual abuse and exploitation, both trafficked and non-trafficked, and both commercial and non-commercial.

Caregiving Situations

The terms generally applied in South Asia to the 'helping stages' provided to survivors of trafficking for sexual abuse and exploitation are Rescue (Release), Repatriation, Rehabilitation (Recovery), and Reintegration. While there is considerable overlap between these activities, this paper will confine itself primarily to caregiving situations providing rehabilitation and reintegration.

Within the rehabilitation stage (particularly the intake phase), this paper will not be directed at caregiving during legal and judicial procedures, including the protection of child witnesses, and forensic medical and psychological assessment. Those complex and vital facets are beyond the scope of this paper, and are covered adequately in other documents.

Caregiving Facilities

The physical facilities for providing care to survivors of sexual abuse and exploitation in South Asia vary widely. These facilities are at present rapidly evolving as care organizations learn more about the needs of survivors and the most optimal physical situations for providing those needs.

In general in South Asia at the time of writing, most physical facilities are 'institutional', allow minimal interaction of residents with the surrounding community, provide care for 20 or more survivors per facility, and are 'caregiver-centered' rather than client or child-centered. In South Asia, there is some terminological confusion regarding the terms 'center-based' and 'community-based' – the former generally held to mean urban, and the latter rural or town. These terms should be used to indicate the function, rather than the locality, of the facility.

For clarification, this paper will use the following terms:

Center-based Facilities. These are facilities (in both urban and rural locations) in which most services, including counseling, recreation and training, are provided within the facility and the survivors' interaction with the surrounding community is restricted. Functionally, center-based facilities would usually include, among others, emergency or crisis shelters, intake facilities, and facilities for survivors needing intensive psychological support.

Community-based Facilities. These are facilities (in both urban and rural locations), including family and foster-family care, in which services are also sought from the surrounding community, and where survivors interact more extensively with that community. Functionally, community-based facilities primarily refer to residences for survivors who no longer have need of the more 'intensive' services of center-based facilities, have responded successfully to critical psychosocial and medical treatment interventions, and are in the process of reintegration into the community. These facilities can range from small residential 'shelters', care in the homes of family or relatives, care in the homes of foster families, and small group homes, both with and without live-in supporting staff.

Drop-in. These are facilities which provide services, including counseling, medical care, recreation, etc., but do not provide long-term residency.

Outreach. These refer to services provided by caregivers outside the physical facility. These services include, among others, crisis intervention, home medical and psychological support, and guidance/support following reintegration. These also include community 'barefoot' counselors and social workers who respond to community needs and provide referral to facilities and professional services as needed, and telephone and email 'hotlines' to provide non-direct assistance to those in need.

Crisis Intervention Units (CIUs). These include both physical facilities and outreach crisis intervention teams which deal with emergency situations of trauma, abuse, attempted suicide, family conflict, etc.

Counseling and Support Units. These include counselors, social workers, and para-professionals attached to hospitals, health posts and center-based facilities which provide support to community members in times of crisis, domestic violence, abuse, etc.

Transit Homes. The term 'transit home' is frequently misapplied in South Asia at present, often leading to inappropriate placement and treatment of survivors. Functionally, the term 'transit home' should be applied to a short-term-stay shelter for a survivor during the process of repatriation. Residence in 'transit homes' should be followed immediately by entry into a facility which can address the needs and trauma of those just coming out of a situation of abuse. An added confusion comes from the use of the term 'transit home' for a facility for survivors at the reintegration level who are 'in transition to' living in the community. The term 'community-based facility' is more applicable to this situation, and will be used in this paper for pre-reintegration facilities. It is suggested that the term 'transit home' be only used to designate short-term-stay shelters for survivors during the process of repatriation.

Throughout this paper, the term 'facilities' will be used as a catch-all term encompassing all of the above.

Caregiving Personnel

In the case management process, a wide range of personnel is required to provide adequate care and support for the survivor of sexual abuse and exploitation from the time of intake to their reintegration into the community. In the whole caregiving process, 'caregivers' range from highly-trained professionals and experienced para-professionals to the vitally important roles of non-professional facility staff, peers and family members.

Caregivers include:

Physicians, psychiatrists, psychologists

Counselors, para-counselors, 'barefoot' counselors, peer counselors

Social workers, para-social workers, 'barefoot' social workers

Art/recreation therapists, art/recreation workers

Guidance/occupational counselors and trainers

House 'mothers' and 'sisters'

Facility management

Facility support staff

Other case management team members, including: lawyers, police, immigration, and court officials

An important purpose of quality of care standards and case management guidelines is to clarify the roles of individual caregivers and indicate ways in which they work as a team to heal and reintegrate the survivor. The limitations of this paper have not allowed a full presentation of the role of every form of caregiver.

Range of Standards and Guidelines

Standards and guidelines are applied to many purposes. Some are sets of ethical and practical principles, some are applied to broad-range activities, such as the operation of care facilities, and others are applied to specific tasks and personnel. There are no hard-and-fast distinctions between them, as specific tasks related, for example, to counseling a child can and should be based on essential principles such as right to confidentiality. Thus, the descriptions below overlap.

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Human Rights Standards. These encompass a wide range, from principles and ideological standards applying to a human situation to specific recommendations for action. Essentially, the UN Convention on the Rights of the Child is a set of human rights standards. Some are specifically applied to trafficked persons, such as the document “Human Rights Standards for the Treatment of Trafficked Persons”. This provides basic ideological standards to a human situation, include clarifying definitions of terms, and also prescribes specific actions (particularly legal actions) to be taken on the persons’ behalf.

Quality of Care Standards for Childcare Facilities. These are the standards/guidelines with which this paper is concerned. These can include in-house ‘operation manuals’, codes of good practice, general guidelines for care, and government regulatory guidelines. Comprehensive ‘minimum standards’ for facilities encompass all, including human rights standards. They contain both standards of rights and ethics on the treatment of a child, specific obligations of a facility regarding the child’s well-being (such as having a Crisis Response System in place), minimum requirements for physical well-being, and guidelines for caregiving activities, among others.

Case Management Guidelines. These are, as indicated, guidelines on the case management of survivors, including the composition of case management teams, the operation of case conferences, intake, assessment, referral, treatment, crisis response, reintegration, etc. These can include in-house manuals/guidelines, class/training materials regarding case management, case management ‘models’, and guidelines used by governmental or other regulatory agencies. They may or may not include guidelines for family counseling or outreach social work, and may or may not include guidelines for the reintegration process.

Standards/Guidelines for Training. These are essential to ensure that the needs of survivors are adequately met by appropriately-trained caregivers. They include national, training organization or in-house training standards and competency levels, training assessment guidelines and checklists, and guidelines for the assessment of personnel.

Standards for the Legal Treatment of Survivors. The purpose of these are to ensure that the survivor, particularly the child, is protected and supported during the process of legal action on her/his behalf, while at the same time ensuring that the necessary legal procedures are correctly undergone to ensure prosecution of the perpetrator. These include standards for legal persons, guidelines for those caring for the child, and child-friendly materials, films, etc. for the survivor.

Other Specific Standards and Guidelines include guidelines for family/survivor assessment by social workers, psychologists, etc.; guidelines for forensic examination of survivors by physicians; guidelines for the operation of Crisis Intervention Units; guidelines to protect the child against abuse within the facility; guidelines of response to psychological crisis or medical emergency; and others. All are useful and vital, and should complement the ‘minimum standards’ guidelines for facilities in their care for the abused.

Quality of Care Standards

3.1 The Purpose of Quality of Care Standards

Why do we develop and use quality of care standards? Because quality care, whether medical or psychosocial, is a basic right. We use care standards for psychosocial care for the same reason that we use standards for medical care – persons who enter a hospital with a fractured arm have the right to receive the same quality care wherever they are. The same applies to the ‘fractured life’ of an abused child. To be very simple, the core purpose of standards are:

- a) to provide the most effective and compassionate care to survivors;
- b) to develop and maintain professional, transparent and accountable care practices; and
- c) to help and support caregivers in their difficult task.

To Provide the Most Effective and Compassionate Care to Survivors. Standards should not be looked at as ‘rules and regulations’ imposed from outside, but rather as a ‘tool’ which is created by those who care for children, and which is based on principles that ensure the best interests of the child. Too often, in institutional situations, children are given inferior treatment or facilities because they are too helpless to assert their rights, because they are considered ‘victims’ who don’t really know what they need, or because they (especially if they have been prostitutes) are subtly considered ‘bad children’ who should be ‘corrected’. Care standards provide instructions and guidelines to ensure that caregiving is child-focused, that the child is allowed to participate in her/his healing processes, and that the child and her/his family are given full respect as human beings.

To Develop and Maintain Professional, Transparent and Accountable Care Practices. Quality of care standards also function as a ‘watchdog’.

Just as standards in medical practice ensure the sterility of immunization needles and the proper dosage of medicines, standards in caregiving ensure that children are cared for in responsible and professional ways. This is of particular importance with children who have been in prostitution or have been sexually abused in the home. Such children, by their history, remain at extremely high risk of subsequent abuse. On one hand, their 'bad history' and perhaps their sexualized behaviors make them easy victims of sexual predators. On the other hand, their 'bad history', their helplessness and their 'victim' status make them easy victims of casual or abusive care. Minimum care standards provide clear strategies, guidelines and responses to ensure that care practice is professional, safe and accountable. Among other things, they ensure the placement of systems to prevent additional sexual abuse; they provide methods of response to the psychological, medical and social crises which often accompany caring for the abused; and they protect children from the possibilities of poor or inappropriate practices, which for the traumatized can have very severe consequences.

To Help and Support Caregivers in Their Difficult Task. Standards are tools which help caregivers do the work they have to do – and caregivers need as much help and support as possible. As all know who have worked with children who are abused, trafficked, physically/mentally challenged or in conflict with the law, caregiving work is very difficult, very demanding and all too often not 'rewarding'. Try as we might, we won't always 'succeed'. Some children will return to prostitution, some will go on to lead difficult lives, and some will die. That is the reality of this work, and it takes a heavy toll on the caregiver. That is a core reason why care standards include processes for taking care of the caregiver as well as taking care of the child.

3.2 Care Standards and National Plans of Action

Four countries in the South Asian region have National Plans of Action (NPAs) regarding trafficking of children. Pakistan's responses have been included in their plan of action against child labour, and are for that reason not included here. These vary in their explicit mention that minimum

standards should be applied to the operation of caregiving facilities. However, all NPAs include provisions for establishing mechanisms to monitor caregiving practices, from which the establishment of standards and guidelines may be inferred.

The *National Plan of Action (to Combat the Trafficking of Children for Exploitative Employment in Sri Lanka)* of Sri Lanka specifically states (IV, Goal 2) that “All ‘Homes’ conform to uniform minimum standards”, followed by the Strategies “Establish Protocol guiding the administration of Homes” and “Encourage achievement of standards of excellence among staff in Homes”. This NPA also states a basic standard (among others) within the caregiving framework (IV. Goal 3): “New Rehabilitation concept (individual needs-based) integrated into all rehabilitation programmes”, followed by the Strategies “Ensure Individual Assessment preferably by a multi-disciplinary team involving family if and when necessary”, “change from custodial to therapeutic environment in institutions”, and “Strengthen mechanisms for multi-disciplinary cooperation in rehabilitation”. In Sri Lanka, the formulation of minimum care standards is already in process.

The *National Plan of Action against the Sexual Abuse and Exploitation of Children including Trafficking* (Bangladesh) in (B. Protection, 3.), in the Objective “To create safe havens to strengthen the capacity of children at risk/child victims of sexual abuse/exploitation or trafficking.....”, clearly states in Strategy 7: “Develop monitoring system for day facilities and night/residential shelters/homes”. In the other Strategies under this Objective are clear directions for the establishment of minimum physical facilities and staff training, among others. In Part C (Recovery and Reintegration), the Bangladesh NPA comprehensively lists many elements of child-friendly support services. Notably, in Objective 1 of this part, the document ensures the rights of children to have “an opportunity to play a part in their own recovery, and to identify the most appropriate recovery and reintegration options in consultation with them”. Also of note, in the first part (A. Prevention), the document states the Objective (6) “To protect children from

sexual abuse by staff working in institutions, facilities or organizations serving them”. While not explicitly stating the establishment of minimum standards, the Bangladesh NPA provides all the ‘ingredients’, including the essential participatory rights of the child.

The *National Plan of Action for Combating Against Trafficking in Women and Children, Revised Version* (Nepal) is in process and may be elaborated before its finalization. In the section applying to the rehabilitation of trafficking survivors (6. Area: Rescue and Reintegration), in the second Objective “To prepare victims and society for reintegration and enable for normal life”, under the first Strategy “Delivery of improved services”, the Nepal NPA states the Activity “establish and consolidate the service of transit home, shelter house/training centers and hospices”. The second, third and fourth Activities provide some basic elements of rehabilitation (viz. counseling, vocational training and community preparation for reintegration). The fourth Activity (under the Strategy “Update information system”) reads “set up regular monitoring and evaluation systems without victimizing the victims”. This could perhaps be interpreted beyond “information system” to imply monitoring and evaluation of caregiving facilities, and thus imply the use of standards and guidelines. However, an adjustment of wording in the final version of this NPA would add to clarification.

The *Plan of Action to Combat Trafficking and Commercial Sexual Exploitation of Women and Children* (India) is primarily directed at the establishment and strengthening of governmental caregiving institutions, although there is significant mention of NGOs, women development corporations and women’s organizations. Regarding guidelines per se, the India NPA states in Section II (Trafficking, part 7) “Comprehensive guidelines will be formulated for dealing with the return and rehabilitation of women and children of foreign origin”. In Section VI (Housing, Shelter and Civic Amenities, part 4) the NPA states that “Girls and women subjected to violence will be provided well funded shelters and relief support as well as medical, psychological and other counseling services....”

More directly applicable to the use of minimum care standards is in this NPA's provision to establish Task Forces which "...will be set up in major cities to effectively coordinate activities for the prevention, suppression, rescue, rehabilitation and reintegration in cases of commercial sexual exploitation and to coordinate among the various agencies involved". These Task Forces would be comprised of, as well as government officers, "...educational experts, psychologists, social workers and representatives of NGOs..." In the following section (IX. Rescue and Rehabilitation, part 3) India's NPA specifically states "The Task Forces would coordinate among the various agencies involved and public spirited citizens to see that the child victims are properly protected, medically and psychologically treated, education imparted and successfully reintegrated with their families or elsewhere. This would require upgrading the services in homes, including providing special training to the personnel in the homes, provision of medical and psychiatric care, etc." Part 7 further states "Women's organizations should be involved in monitoring of remand, protective and other homes." It may be implied that Task Forces would operate under certain parameters for assessment and 'upgrading', thus involving the use of minimum standards of operation and care for survivors.

3.3 The Development of Quality of Care Standards

In considering how quality of care standards are to be developed for the countries of South Asia, the immediate question is: How applicable are quality of care standards to the South Asian setting? This question requires a double answer: a) 'core' quality of care standards are entirely applicable and entirely imperative; b) however, certain aspects of quality of care standards can and should be adapted to the South Asian setting through careful discourse, research and testing.

In other words, quality of care standards are *adaptable* to individual cultural settings, but basic standards *cannot be compromised*. For example, all children need a clean, relaxed place to take their meals. In England, a facility may interpret that standard to mean that children should sit at a table and eat with a knife and fork. In Bangladesh or Nepal, a facility may decide

that children are happiest sitting together on the floor and eating with their hands. Thus, cultural adaptation is the prerogative of the culture, but the core standards are inviolable.

The process of developing care standards begins with presenting a model, such as this paper intends to do. The model should be a distillation or compilation of individual standards taken from different documents, because no single document is entirely appropriate for, say, Nepal or Bangladesh, and very few documents adequately cover all aspects of caregiving as we now understand it in the year 2002.

Some quality of care, or minimum standards, documents carefully outline the minimum requirements of physical facilities and caregiving practices, but do not include basic issues such as child participation, or the child's rights of access to her/his family. Others are focused primarily on the rights of the child, but do not clarify the 'nuts and bolts' of everyday childcare. Still others focus on procedures such as protection from subsequent abuse or response to crisis situations, but say little about physical facilities, such as the child's need for a safe place to play or a 'personal space to call their own'.

Consequently, a model 'starting point', as is presented in this paper, should be as comprehensive a blending as possible – all the better to provide 'fuel' for the next process, which is *discussion*.

Quality of care standards are developed with the input of everyone concerned with the care of the child: the government; funding organizations; NGO facility leaders and managers; on-the-ground caregivers; experts in psychology, counseling, medicine, law and social work; and of course children themselves. It is a process that takes time, care, expertise and a constant reminder that the well-being of the child is the focus.

Because the process of developing standards is collaborative, the process itself is a valuable means of building and strengthening the perceptions as

well as the practices of caregiving for the abused. The process naturally brings up some 'hot questions'. For example, how should a child be disciplined? How can a child have access to their family, if their family has contributed to their abuse? What does 'child participation' mean in prescribing treatment for an extremely traumatized child? These and others are questions which must be confronted and agreed upon – and consequently the process of developing standards is a growing and educational process for the entire community of caregivers.

3.4 The Application of Quality of Care Standards on the National Scale

Following the development of care standards, the application of those standards present significant challenges in South Asia. For individual facilities to develop necessary quality of care, the 'raw materials' must be available: human resources. Quality care depends on quality caregivers, and quality caregivers depend on quality training. And, of course, quality training depends on the availability of monetary resources and training expertise.

This is the responsibility of governments, educational and training institutions and funders. Today, many NGOs are strongly requesting both training for their staff and new well-trained persons. As well, effective case management of the abused depends on multi-disciplinary teams which include well-trained and *experienced* psychologists, counselors, social workers, paediatricians, psychiatrists and legal professionals. By 'experienced', it is meant professionals who are not just trained in the classroom and have 'degrees', but people who have had extensive clinical, hands-on experience working with the trafficked and sexually abused.

This takes both resources and time. Training and educational institutions must be strengthened, courses must be developed, and human resources expanded. Training in the caregiving for the abused also needs to be provided to working physicians, nurses, psychologists and legal professionals, among others, because this is a specialized field with which few in South Asia yet have significant experience. Again, this is a matter

not of just theoretical training, but of experiential training as well. Psychosocial care, like medical care, is practical, not theoretical. Counseling or social work can only be learned through extensive, supervised practice in real life situations. Caregiving for the sexually abused can involve working with extreme trauma, violence, suicide, dysfunctional families and children dying of HIV/AIDS. Caregivers who are only 'book-educated', even if they have high university degrees, can possibly endanger the health, and even the lives, of the children they are meant to care for.

3.5 The Application of Quality of Care Standards for Individual Facilities

In the last ten years there has been a rapid growth of 'caregiving facilities' in South Asia, particularly directed at child survivors of trafficking for prostitution. These facilities have developed through rather ad hoc means, through the efforts of NGO workers who have struggled – with limited funding, few models and little guidance – to develop care programmes sometimes almost overnight (as in the case of the 120+ rescued girls returned from India to Nepal in the late 1990s). In more recent years, many other NGOs have followed suit, starting up caregiving facilities in response to the growth of international concern (and funding) for survivors of commercial sexual exploitation.

Today, many of these caregiving facilities – with the very best of intentions – cannot overnight fulfill all the 'requirements' of quality of care standards. This is a challenge for the organization, in terms of funding, physical facilities and human resources.

Funding is the most immediate consideration. To improve quality of care, facilities must train existing staff, perhaps hire additional staff (some of whom might be more-expensive professionals), repair and upgrade facilities, provide time/costs for the development of policies and procedures, add on activities such as family assessment, recreation therapy or reintegration support, provide materials and equipment for improving occupational training, and more.

Funders and recipient institutions will have to work together to make the most effective use of funding and to reduce costs of future operations while improving the quality of care. It is important, however, not to compromise quality by 'cutting corners'. For example, money would be saved by training by TOT methods instead of direct training. However, this would generally result in a great diminishment in the quality of staff, because, as mentioned above, training for caregivers of the abused requires skills-based, hands-on, supervised methods taught only by those with experience working directly with the abused. TOT has frequently shown non-optimal results in training other, less-critical skills and would not be recommended for teaching caregiving for children who may have extreme trauma or other emotional problems.

A central strategy for reducing the costs of improving care standards is, fortunately, also a strategy for creating more personal child-centered care facilities: move from larger 'institutions' towards smaller, family-style caregiving situations. Smaller facilities are less expensive to run, and provide a more therapeutic and less custodial environment for the child. In these – which include small shelters, foster homes and group living situations, among others – the child is closer to her/his 'community', has greater opportunities for interaction with the 'outside world', and is moved more effectively towards reintegration.

Another cost-effective strategy is also a strategy which directly benefits the child: expand the potential and abilities of non-professional caregivers. Certainly, counseling for traumatic situations should only be done by trained professional counselors and psychologists, and not by para-professionals, let alone regular facility staff, however earnest. The same applies to medical and legal care. However, perhaps 90% of the 'every-day' care of the child – vital care in which the child is nurtured, protected, loved and supported – is conducted by para-counselors, 'house mothers', art/dance teachers, recreation therapists, and other para-professional and non-professional staff. With training, these important human resources can be developed at low cost from existing staff in the organization as well as solicited as volunteers.

A third strategy to reduce costs is as well a strategy for improving quality of care: develop networks of supporting human resources. It is a basic principle of caring for the trafficked and sexually abused that *the facility cannot do it alone*. Effective and careful case management is a bottom line for quality care, and case management is a multi-disciplinary process, involving not only the varied staff of the facility, but outside expertise as well. No facility is expected to employ physicians, social workers, psychologists, psychiatrists, lawyers and all of the ‘team’ necessary to provide the comprehensive case management necessary for each individual child. Supporting networks are necessary, and costs for expert and professional support can be shared among facilities and organizations.

As each organization strengthens its care practices, it adapts those practices to its own ‘personality’, its own culture, the inspirations of its staff, and the needs of its children. In this process organizations also require technical input to help them develop the procedures, guidelines and practices which are the basis of quality of care standards – for example, on developing procedures to prevent subsequent abuse of the children in its care, or to respond to crisis situations.

Every organization is different in its needs, and as it works to develop high-quality care, each organization requires:

- a) an individual ‘Quality of Care Development Plan’, based on a collaborative needs assessment of each individual facility;
- b) ‘quality of care’ training for the management, to help them understand and facilitate the process;
- c) the necessary staff training, support and materials, as well as directed monetary input; and
- d) assistance in developing a network of supporting expertise, such as psychologists and social workers, to complement the total case management process.

In turn, this process is guided by:

- e) an independent, assisting mechanism to ensure that standards are adequately met and maintained.

3.6 The Monitoring of Quality of Care Standards

As mentioned above, quality of care standards are adaptable to individual cultural settings, but basic standards cannot be compromised. As each country works to develop minimum care standards for its facilities, it must develop an equitable and transparent system of maintaining those standards through independent assessment and monitoring of facilities. Because the process of developing care standards is a collaborative process between the government, caregivers, experts and children, it may be appropriate that the monitoring institution be similarly composed. The drawback to a single body – whether governments, caregivers or experts – being in charge of monitoring is a drawback familiar in the developing world: corruption and influence may interfere with objective reasonable monitoring, or may be used to benefit certain facilities at the expense of others. Either would be a direct challenge to providing optimal care to trafficked or sexually abused children. Each country, as it develops minimum standards, must establish an independent, collaborative institution which not only monitors the care processes, but provides helpful and supportive feedback to the facilities who are caring for children.

Some Basic Principles of Quality of Care Standards

Quality of care standards are based on essential principles, which we can think of as 'universal'. These principles apply to center-based, community-based, outreach and all caregiving facilities and caregivers. And they apply to facilities in every country, whether Nepal, Brazil or Canada. They serve not only to support and protect survivors, but also to support and develop the caregivers themselves.

Following are some principles – though not all – on which specific standards are developed:

- a) Children are guaranteed all basic human rights, as expressed in the United Nations Convention on the Rights of the Child.
- b) Activities, interventions and attitudes of the facility are 'child-centered', each child is treated individually and personally, and all 'healing processes' on the child's behalf are conducted with the child's full participation and agreement.
- c) Children are given access to the 'greater world' outside the facility (with all consideration for their protection), including family, community and friends, and are provided opportunities to interact, learn from and recreate in the outside world.
- d) All interventions, activities and facilities are appropriate to the child's culture, age, sex, language, ethnicity, class and religion.
- e) All staff of a facility are oriented on and responsive to the circumstances of the child residents, particularly sexual abuse. However, trafficked/abused children are not 'labeled' as such, treated in discriminatory ways, or separated from children with other histories.
- f) All facilities have established procedures and available trained staff to respond to situations of special concern to survivors of sexual exploitation and abuse, including: crisis management, abuse or

harassment by staff, confidentiality, emergency psychological or medical situations, and protection from outside persons, among others.

- g) All operations of care facilities are transparent, monitored and open to the routine presence of outside professionals, including psychologists and doctors.
- h) The operations and interventions of facilities are consistent and standardized, and conducted according to documented protocols and procedures. These include case management, abuse prevention, crisis intervention, confidentiality, documentation and referral, among others.
- i) Each child is provided individual case management from the time of entry into the facility to the time of departure. Case management is conducted by an interdisciplinary team, and includes routine case conferences. The case management team has decision-making precedence regarding all medical or psychological interventions.
- j) The roles and responsibilities of all staff members, including case management team members and non-facility personnel, will be clearly established and shared with all staff. Each role will be filled based on defined standards/competencies of training and experience.
- k) Due to the stressful, demanding work of caring for children who have been abused and exploited, staff who are working directly with children are provided support, counseling and means to express their concerns.
- l) Different kinds of facilities are designated according to their function for different needs of survivors of sexual abuse and exploitation (intake/assessment, emergency/intensive care, general rehabilitation, pre-reintegration, etc.). With the exception of 'intensive care' facilities, existing and new facilities will be developed in the direction of smaller, 'non-institutional' community-based, family-size homes and family/foster care.
- m) Case management planning for children will be based on comprehensive professional care leading towards rapid 'de-institutionalization' and effective reintegration. Reintegration plans will be included as part of each child's Case Management Plan, and caregiving organizations will themselves and with others, ensure support/follow-up to the child during the reintegration process.

Documents Used for this Paper

These documents are representative of those used for this paper, but does not include all. These documents were selected because of the broad range of standards included throughout, from essential human rights standards to detailed standards for operational management. The basic standards drawn from these documents and others, including the Convention on the Rights of the Child, are ‘international’ and do not represent the ideas or standards of any particular country.

- S1. *Draft Standards for Quality Institutional Childcare.* Bangladesh.
A short, careful outline of basic standards for childcare based on developmental needs. Emphasis is placed on the establishment of child-centered approaches to caregiving, in response to custodial, institutional approaches.
- S2. *Human Rights Standards for the Treatment of Trafficked Persons.* International. Standards are drawn from international human rights instruments and formally recognized international legal norms. The primary focus is on State responsibilities, with emphasis on legal protection, release, repatriation and reintegration.
- S3. *Guidelines on the Operation of Crisis Intervention Units.* The Philippines.
Description of the rationale, legal basis, objectives and services of governmental crisis intervention units, with description of basic procedures for walk-in and referred clients.

S4. *Residential Special Schools: National Minimum Standards Consultation Document.* Wales, U.K.

Extensive, detailed standards of care for the operation of special schools, based on a rights framework. A valuable document illustrating thorough and comprehensive minimum standards applied to a particular setting.

S5. *Sexual Violence in Refugee Crisis: A Synopsis of the UNHCR Guidelines for Prevention and Response.* International.

A brief summary/guidelines to response to sexual violence of women and children in a refugee situation. Includes basic guidelines on prevention, psychosocial support in response to the trauma of a refugee situation generally, medical care, legal support and psychosocial support in case of sexual violence upon refugees.

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S6. *Care Homes for Younger Adults: Adult Placements. National Minimum Standards Care Homes Regulations.* U.K.

As above, extensive, detailed standards of care for the operation of care homes, based on a rights framework. A valuable document illustrating thorough and comprehensive minimum standards applied to a particular setting.

S7. *Human Rights in Practice: A Guide to Assist Trafficked Women and Children.* Thailand.

A simple but comprehensive manual for NGO persons, primarily focused on rescue, legal procedures, shelter operation and reintegration. Very clearly outlined, and valuable as a training document.

S8. *Standards of Care Task Force Guidelines: Mental Health Care for Child Crime Victims.* U.S.

Comprehensive guidelines for the child protection professional, covering standard case management, documentation and government procedures.

S9. *Caregivers of Young Children: Preventing and Responding to Child Maltreatment.* U.S.

A discussion of basic procedures of working with cases of child abuse and neglect, from both a social work and a counseling perspective. Valuable chapter on minimizing the risk of maltreatment in early childhood programmes.

S10. *Draft script for Orientation Video: Ban Kred Trakarn.* Thailand.

A brief outline of a video script to orient recently-rescued children to a community-based intake shelter. Includes the basic elements and processes of intake shelters, and is directed at children of different languages and nationalities.

S11. *The Role of Mental Health Professionals in the Prevention and Treatment of Child Abuse and Neglect.* U.S.

A detailed document for professionals describing their role in the general caregiving process, particularly their role in case management. Includes guidelines for caregiving from the point of view of professionals on case management teams.

S12. *Guidelines for Public Child Welfare Agencies Serving Children and Families Experiencing Domestic Violence.* U.S.

Directed at welfare administrators. A short, valuable overview of basic and essential guidelines for caregiving operations, including training, intake/screening, assessment, case planning and cultural diversity, among others.

Quality of Care Standards: A Model for Discussion

Following is a ‘model’ of quality of care standards compiled from individual standards taken from different documents. This model is intended to serve a starting-point for discussion leading to the development of standards appropriate for countries as a whole, and for individual facilities. The points listed below are ‘basic features’ for standards which encompass the rights of the child survivor, functional operational guidelines, ethical principles of practice, responsible management, effective case management including reintegration, and care and consideration for staff.

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This model has no pretensions of being complete, and final comprehensive standards require much expansion on individual points during each country’s process of developing its own standards. It should be noted, for example, that many important standards regarding the legal rights, privacy, special medical treatment, etc. of survivors are not included here.

A. Children’s Rights

- a) Children and their families are asked their opinions and participate in decisions about the children’s lives and their future.
- b) On intake, children receive orientation on the purpose and operation of the facility, the roles of the staff, and the conditions of their residence. This is presented in child-friendly versions, in appropriate languages and explained to children who cannot read.
- c) The privacy and confidentiality of the child are ensured in all matters, and each facility has written policies on privacy and confidentiality. All staff are instructed in these policies, and they are made available to children. Areas of privacy and confidentiality include, among others:

- 1) access to case records or other personal records
 - 2) sharing personal background, including names, with other than designated staff
 - 3) interviews, photographs or 'observation' of activities by press persons or others
 - 4) unrequested entry into children's 'private space' and access to their personal possessions
 - 5) personal matters, including hygiene and bathing facilities
 - 6) meetings and conversations with parents and family
- d) Children have the right of complaint according to written policy and guidelines. Their complaints shall be attended to without delay, and they may take complaints for representation to a person, such as a counselor, outside the facility.
 - e) Children are allowed physical assets of personal identity and belongings. They may wear personal clothing on certain recreational occasions, secure their own requisites, have no interference in personal possessions, and are helped to look after their own money.
 - f) Children have the right to maintain regular and personal contact with parents, family, friends and community (unless there are welfare considerations). Staff assist children in contacting and writing to their family.
 - g) Children have the right to keep and use their given names, and to keep possession of or have access to personal legal documents.
 - h) Residents, including legal children, have the right of access to and (unless there are welfare considerations) the right to care for their own children.
 - i) Children are provided access to spiritual services, books, objects, teachers and religious holidays of their own religious conviction, and are free from obligation to engage in religious practices that are not their own.
 - j) Support is available to enable disabled children to enjoy a range of activities, including recreation, education and occupational training.

B. Child Protection

- a) Facilities shall ensure a system to protect children from sexual abuse within the facility, including operational policies to prevent sexual abuse, and vetting of staff and visitors to prevent exposure to potential abusers.
- b) Facilities shall have guidelines and procedures to protect children from neglect, physical abuse from staff or other children, and self harm.
- c) Facilities shall provide immediate notification to authorities of significant events in the facility, including death, staff misconduct, illness, accident or communicable disease.
- d) Facilities shall have guidelines and procedures to follow in the case of a child's absence without authority, including notification of families and authorities, and appropriate action.
- e) Facilities shall have procedures, referral and notification systems for emergency situations. Facilities shall provide sufficient trained staff and accessible outside persons to attend to children's needs and emergency medical and psychological situations at any time of day or night. All core staff shall be trained in responding to emergency medical or psychological situations.

C. Discipline

- a) Through positive responses, staff shall support the acceptable behavior of children, and in cases where behavior is unacceptable, staff shall provide constructive, acceptable and known discipline according to clear written procedures.
- b) Written procedures for discipline shall be openly available to staff, children and parents.
- c) Staff shall receive training in disciplinary procedures, including the safety/containment of children with violent or other unacceptable behavior.
- d) Hitting, slapping, or any form of corporal discipline is prohibited.
- e) Children may not be punished or disciplined in a manner that demeans or degrades them, including verbal abuse or embarrassment in front of other children.

- f) Children may not be locked in small confined areas, or denied food, warmth, bathing, toilet or sleeping facilities.

D. Staff

- a) Staff shall be selected according to, among other criteria, their capacity to relate to and interact with children.
- b) Staff shall be provided clearly defined job descriptions and understand their own and others' roles and responsibilities. Staff shall be provided clear, written guidelines on procedures and practice.
- c) The facility shall receive training in 'care-for-caregivers' and shall provide routine counseling and support for staff who are engaged in tasks directly related to children with psychosocial problems. Staff shall have access to a staff care scheme which they can access independently of line management, to discuss personal concerns and receive advice and counseling.
- d) Hiring and staff supervision practices shall include procedures to minimize possible abusers.
- e) Specific tasks (such as psychological assessment, trauma counseling, nursing, medical care, etc.) shall be undertaken only by persons with appropriate training and experience, as clarified in a general training standards/competencies document applicable to all facilities. The facility shall utilize outside persons for those tasks for which staff have insufficient training.
- f) All staff working directly with children shall receive training in child development, appropriate responses to sexualized behavior, de-escalation of anger, and group dynamics.
- g) All staff of each facility, including drivers, guards, etc., shall receive orientation on child abuse and exploitation, on confidentiality, and on supportive modes of interaction with the children.
- h) Staff are prohibited from any type of sexual, romantic or closely personal behavior with residents or former residents.
- i) The facility shall maintain a ratio of one staff person for every ____ children, and a ratio of caregivers (para-counselors, 'house mothers', recreational persons, etc.) of one caregiver to every ____ children.

- j) Good faith efforts shall be made to provide each child with a volunteer mentor who shall visit the child at least weekly. Mentors shall be permitted to take the child on trips away from the facility unless there is legitimate and documented concern about the child's absconding or safety for the child or the mentor.

E. Physical Surroundings

- a) The capacity of a facility shall be based on function of the facility, the size of the facility and the number of staff.
- b) No facility shall have a capacity of more than ____ children.
- c) Each child shall be ensured a space of ____ square feet of the total indoor 'child-active' area of the facility (including sleeping rooms, recreation rooms, dining rooms, educational rooms, hallways, toilets, visitation rooms, medical rooms and counseling rooms). Offices, staff quarters, storage rooms, kitchen areas and other non-child-active areas will not be included in this calculation.
- d) Adequate space shall be provided for both group and individual play both indoors (at least ____ square feet per child) and outdoors (at least ____ square feet per child).
- e) The physical plant shall be kept clean, well-maintained, free of debris, well-ventilated and well-lighted.
- f) The facility shall have appropriate protection and mechanisms in case of fire and earthquake, and staff shall be trained on safety responses in case of natural disaster.
- g) All rooms shall be decorated in bright colors pleasing to children and provided with suitable and homelike decoration to make them comfortable.
- h) Security shall be provided by personnel, and bars and other prison-like forms of physical security shall not be permitted.
- i) Children shall be provided with a designated place to take meals, and shall not take meals in their sleeping area.
- j) Each child shall be provided with her/his own bed.
- k) Each child shall be provided with a sleeping/personal area of a minimum of ____ square feet.

- l) Each child shall be provided with secure, private storage space for clothing and other personal items.
- m) Children shall be allowed to personalize their personal living area with photographs, decorations, etc. within reason.

F. Health Care and Nutrition

- a) All children shall receive a medical and a dental examination within 5 days of admission.
- b) HIV/AIDS and STD testing shall be conducted only by request, and all results shall be kept within the confidentiality of selected members of the staff.
- c) All necessary medical and dental care shall be provided, including special care for the disabled.
- d) Each facility shall be open to access by and shall provide for the routine presence of a professional medical person from outside the facility.
- e) Immunizations shall be kept current.
- f) Health records shall be maintained and current. A copy of the health record shall accompany the child when she/he is discharged.
- g) Any specific therapeutic technique, diet, medication, etc. shall be used only upon a physician's recommendation, and only as part of the established Case Management Plan of the child.
- h) Children shall be provided varied and nutritious foods, including adequate amounts of protein and vitamin-rich foods.
- i) Children shall be provided with adequate physical exercise and adequate time for rest and sleep.

G. Education

- a) All children shall be provided with formal education to the level of their ability and according to their wishes.
- b) Children who cannot read or write shall be provided with non-formal literacy education to the level necessary for enrolling in formal education. Attention shall be given to the parent language of each child.
- c) School records shall be formally kept, and proper documents shall be provided to the child when she/he leaves the facility.

- d) Children shall be provided space, privacy and time to pursue studies, assistance by staff outside classroom time, and relevant and sufficient library materials, news materials, etc.
- e) In addition to the routine curriculum, all children are to be taught health, hygiene, reproductive health, age-appropriate expressions of sexuality, and appropriate ways of relating to men and to women.
- f) In addition, all children shall be provided with functional Life Skills Training, which will include basic living skills, managing money, caring for a home, and corresponding with family and friends, among others.

H. Recreation and Culture

- a) Children shall be provided with adequate time for leisure, recreation and cultural pursuits.
- b) All children shall be taught the songs, dances, stories, and other expressions of their own culture.
- c) All children, including the disabled, shall have opportunities to participate in organized games and play activity, under the direction of the staff.
- d) All children shall have opportunities for child-directed individual or group play, without the intervention of staff except for safety purposes.
- e) Each facility shall have a recreational policy, developed in consultation with children, and shall have a full or part-time staff member dedicated to providing varied and interesting recreation for the children.
- f) The interests and abilities of individual children shall be assessed, and each child will be encouraged to engage in creative expression according to her/his own wishes.
- g) All children, including the disabled, shall have opportunity to participate in crafts, art, and other creative expression.
- h) Individual children shall be supported to celebrate personal occasions such as birthdays, name days, and cultural and religious festivals.
- i) All children shall have opportunities for excursions, picnics, etc. outside the facility in healthy recreational environments.
- j) Toys, games and other playthings appropriate to the age of the child in care shall be provided and available for use by the children. Safe and age-appropriate outside play equipment shall be provided.

I. Case Management

- a) Individual case management shall be conducted on standardized case management guidelines for each child, beginning at intake and ending upon completed reintegration.
- b) Written policies and standards shall be established regarding intake and evaluation procedures, treatment goals and plans, record-keeping requirements, client confidentiality and release of information, and maintenance of records.
- c) Individual case management, including regular case review and case planning, shall be conducted by a multidisciplinary case management team, which will be comprised of persons from both inside and outside the facility.
- d) The primary caregiving staff of each facility shall receive training on case management, and all caregiving staff shall receive orientation on the case management process.
- e) In the case management process, only professionally trained persons may authorize decisions/plans regarding medical care, psychological care and legal representation.
- f) The case management team, which will include a minimum of one professional psychologist, counselor or social worker from outside the facility, shall review the case of each child within 15 days after intake and each 60 days or less thereafter for as long as the child is in the facility. A Case Management Plan shall be developed with full participation of the child and, if possible, her/his family.
- g) The Case Management Plan shall include a Reintegration Plan (see below). This plan shall be developed with full participation of the child and, if possible, her/his family. The Reintegration Plan shall be developed within 60 days after admission and reviewed every 60 days thereafter.
- h) A Child Protection Plan, if needed for the welfare of the child, shall be developed within 15 days after admission, and reviewed every 30 days until the time that the child no longer needs special protection.
- i) Good faith and diligent efforts are to be made to locate parents within 30 days of admission and, unless there are overwhelming reasons to

the contrary, to encourage parental involvement with the child. Any reasons for discouraging or not permitting parental involvement shall be discussed with both parents and the child, noted in writing in the child's records, and approved by the case management team.

J. Psychosocial Interventions

- a) Staff shall receive orientation on psychosocial care, and the specific roles and responsibilities of staff members and outside persons shall be clearly defined.
- b) Use of psychosocial interventions is to be decided only by a professional psychologist or fully-trained counselor of the case management team. With the exception of emergency and crisis situations, the child shall participate in all decisions regarding psychosocial interventions on their behalf.
- c) Psychosocial interventions addressing trauma, PTSD, extreme emotional states, suicide, etc. shall be conducted only by professionally trained counselors, psychologists and psychiatrists, and in accordance with the case management process.
- d) Each facility shall make efforts to train staff and hire additional staff to provide psychosocial supportive activities, including para-counseling, play therapy, art therapy, confidence-building activities, and life-direction activities.
- e) Interaction, counseling, or 'helping' activities which involve discussion with a child of her/his history and experiences of abuse and exploitation shall be conducted only as prescribed in her/his Case Management Plan, and shall be conducted only by appropriately-trained and designated staff members.
- f) Psychosocial interventions shall be conducted in a private and confidential setting, and will take into account the child's language, culture, age, sex, ethnicity, class and religion.
- g) The facility shall make all efforts to provide caregivers who are of similar language, caste, class and ethnicity to the children.

K. Reintegration

- a) Each child's Reintegration Plan (mentioned above as part of their Case Management Plan), shall be created with participation of the child, and will be based on an assessment of the child's skills and inclinations conducted by a trained counselor or guidance specialist,
- b) The child and, if possible, the child's family shall participate in all decisions regarding reintegration activities conducted on her/his behalf.
- c) The Reintegration Plan for each child shall include life planning activities, occupational development, and pre-reintegration orientation.
- d) In developing the Reintegration Plan, the case management team shall conduct assessment of the target community/family situation, and the Reintegration Plan shall be reviewed by the case management team prior to the child's discharge.
- e) Life planning activities shall be conducted to assist the child in determining goals, wishes and strategies for their future life. These shall be integrated into the child's Reintegration Plan.
- f) Occupational development shall include: career planning with the participation of the child and, if possible, her/his family; training the child in occupations clearly shown to provide adequate employment; assistance in finding on-site apprenticeship training, if appropriate; and assistance in job placement or in establishing self-employment.
- g) Each facility shall provide training only in occupations which are suitable for proper, protected and viable employment of the child.
- h) Occupational training shall be accompanied by education in basic business management, household savings and fiscal management, and networking with community banking and other monetary institutions.
- i) Facilities shall not use children's labour for its own monetary purposes, and children shall not conduct labour by name of training unless it is appropriate to their future employment.
- j) Occupational training shall not interfere with children's basic education, recreation or free time.
- k) If the facility receives proceeds from the sale of products or labour from training activities, children shall have access to an equable part of the

proceeds for their individual use, will have control over those proceeds, and those proceeds will be protected by the facility.

- l) Prior to reintegration, the facility shall provide pre-reintegration orientation to each child, whether the child returns to her/his family, or enters a foster family or alternative living situation.
- m) Pre-reintegration orientation shall include awareness of social and economic opportunities and challenges to be faced, appropriate living skills, contacts with 'helping' persons and organizations outside the facility, and explanation of the facility's outreach/support mechanisms.
- n) Upon reintegration, the facility shall conduct outreach/support activities, or shall oversee the delegation of those activities to other organizations or individuals in accordance with the Reintegration Plan. Outreach/support activities shall be conducted only with permission of the child.
- o) Outreach/support activities shall include: counseling support visits to assist in psychosocial reintegration; occupational support visits to assist in economic reintegration and assist the child in developing self-employment, etc.; and crisis intervention in the case of abuse, trauma, etc.
- p) Upon discharge, each child shall be provided with school records, medical records, legal documents, savings and all personal belongings.
- q) Facilities shall make all efforts to ensure the dignity, self-confidence and well-being of the child at time of reintegration. If lacking, each child shall be provided new and appropriate clothing, shoes and luggage.

Case management records retained by the facility shall be filed in a confidential and protected manner. The facility shall ensure the privacy, confidentiality and legal rights of all former residents regarding their past history, their residency in the facility, or their future situations.

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A New Approach to Community-based Reintegration

The International Rescue Committee's Experience in Rwanda

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Abstract

The International Rescue Committee's (IRC's) Unaccompanied Children Program has successfully experimented with a new approach to community-based reintegration. The encouraging results and the lessons learned lead us to believe that the implications of this program could go far beyond the Rwandan situation. The proposed methodology could be useful for different kinds of children living and growing up in centers. The paper presents the community-based reintegration experience, the methodology, and the related tools developed by IRC staff within the Rwandan context. Starting with lessons learned in the field, the author explains the development of a new approach aimed at sustainable community reintegration by working both in centers for unaccompanied children and in the community. The Rwandan experience demonstrates the necessity and the possibility of going beyond standard reunification activities. Readers will learn how IRC has been able to adopt guiding principles such as *participation*, *a community-based approach*, and *the best interests of the child* in its field operations. In addition, the paper presents how IRC decentralized its teams for more effective implementation of the reintegration program over a wide territory with geographically dispersed cases. Finally, key statistics and strategic considerations are provided to support the value of the new approach and its potential replication.

Background

1.1 Rwanda: The Post-conflict Situation of Unaccompanied Children

It is estimated that in any civil conflict, one to five percent of all children will be separated from their parents or orphaned. The 1994 Rwanda genocide, however, resulted in unprecedented numbers of unaccompanied children (UACs). The government reported in 1996 that between 200,000 and 400,000 Rwandan children were living without their parents, while hundreds of thousands more lived outside the country in temporary care situations. Although the majority of in-country UACs lived with community members, a significant number of 'untraceable' children (over 10,000) was in institutional care. Considered by child welfare experts to be among the most vulnerable of children, the international community and Rwandan authorities focused their efforts on searching for family members and promoting the fostering of untraceable children. Through these efforts, the number of children in centers significantly declined.

In the year 2000, despite this success, over 3,591 UACs were still living in institutional care away from their families, relatives, neighbors and friends. Many had been deemed untraceable; others were unable to return due to socio-economic reasons. Furthermore, with the high HIV prevalence rate of 11% and communities already overstretched in caring for orphaned children, there was a risk that the number of children placed in centers would grow if immediate and coordinated action was not taken. Many of the children still in centers were among the most difficult cases, having been traumatized from the conflict, abused during the war or in the centers, exploited, or rejected. Some had psychological and behavioral problems.

The Government of Rwanda (GOR) continues to be committed to its policy of 'one child – one family'. This is rooted in the knowledge that a family provides love, affection and social protection crucial to a child's development, while centers often leave children developmentally and socially handicapped, and should only be considered as a last resort. Although international resources and activities to reunify children have dramatically decreased in the past several years, the Ministry of Local Governance and Social Affairs (MINALOC) recognizes that many of the 'untraceable' children and socio-economic cases living in centers can still benefit from tracing, reintegration and fostering services. IRC's experience in the Fred Rwigema Unaccompanied Children's Center proved a case in point. In 1998, after revising its strategy for finding solutions for children who were declared untraceable by the International Committee for the Red Cross (ICRC) and Save the Children UK, the IRC children's team was able to find solutions for all 144 children still residing in the center. A case-by-case approach was adopted, allowing tracing of families for 30% of the children already classified as closed cases. In August 1999, the center officially closed, with all children successfully reunified and/or reintegrated. Based on this success, the Ministry requested IRC to expand its work to six additional centers and assist in developing implementation strategies and policies for the reintegration of UACs across the country.

1.2 IRC's Unaccompanied Children Program

Currently IRC is the only agency in Rwanda dealing with different categories of children in centers, including the most difficult of the residual caseload, the adolescents. This new program was designed in 2000 with the support of USAID's Displaced Children and Orphans Fund, and different foundations. The project works in four government-selected centers. Initially, the project employed an innovative five-fold strategy to reduce the unaccompanied children caseload. First, new and personalized tracing techniques were adopted (including photo distribution, radio broadcasts and field visits) for hard-to-trace families. Second, the project addressed socio-economic cases as well (children who know where their family is but are unable to go back for social and economic reasons). Third, new strategies to support the reintegration of adolescents and young adults into

communities were developed. Fourth, the project worked closely with other agencies to provide alternative solutions, such as foster families or longer-term proper center care, for children who were ‘untraceable’ and hard to reintegrate. Finally, the project adopted a time-limited follow-up program to ensure the successful reintegration of children into their families.

To reinforce the community involvement and sense of responsibility built during the five-step process, lessons from the field helped the program evolve into an eleven-step process. The new approach is more systematic at integrating community and family involvement with children’s participation from the time the case is first activated. The entire process takes an average of four to six months from activation in the community until case closure.

The project continues to develop new methodologies, tools, and strategies to trace UACs and to reintegrate the most difficult-to-place children. Starting from a more personalized approach and taking child’s participation and the role of the family into greater consideration, the program continues to move forward.

1.3 Guiding Principles

Four practical principles specific to the Rwandan context guide IRC’s Unaccompanied Children’s Program.

The Best Interests of the Child

In support of the GOR’s policy of ‘one child – one family’, IRC adopted a more comprehensive child rights-based approach as the foundation of the program. The key guiding principle to the new approach is that long-term solution must be based on *the best interests of the child*. Hence, the program viewed centers as the very last solution for the child, to be considered only after the family, the community and the child have failed to find a sustainable living situation. This focus is critical in the Rwandan context, particularly after the massive, post-emergency reunification. IRC emphasizes the importance of understanding a child’s willingness to reintegrate and

assessing the actual socio-economic situation of the family and the surrounding community. When this assessment has not been done, cases of failed or abusive situations have occurred. Although no definitive study has been conducted, the Centre Carrefour in Kigali estimates that at least 10% of children reunified after the emergency ended up in the streets. Based on experiences to date, IRC proposes a revised national policy: 'one child – one suitable family'.

The Responsibility of the Community and the Family for the Child

IRC does not have direct responsibility for the children. Rather, IRC plays the role of facilitator in the reintegration process and the prevention of children's placement in centers. In recognizing that families alone cannot, and, in some cases, should not always be expected to support a child, IRC adopted a community-based approach to promote *the assumption of responsibility at different levels: family, community and authorities*.

The Respect of Community Standards During any Intervention with Children and Families

Any intervention to support a family's reintegration of children must *respect the cultural and living standards of the surrounding community*. In order to avoid the isolation of families and children, IRC ensures that its economic support strategies include community participation throughout the process of reintegration.

Respect and Promotion of the Child's Right to Participation

The UAC Program makes efforts at every step of reintegration to promote and guarantee child *participation* in all decisions about his/her current and future life. In institutional care the child is the center of IRC activities, and his/her point of view guides IRC caseworkers. Furthermore, during work in the community, the child's perspective is given consideration in any initiative proposed by the family and the community.

IRC'S Experience with Community-based Reintegration

2.1 A New Entry Strategy in the Centers

During the first seven months of the project, the UAC program encountered significant resistance in at least three of the five centers initially selected by the government. Entry strategies for selected centers focused primarily on conducting protocol visits with Ministry officials and organizing orientation sessions for center staff and children on program activities. This strategy, however, was not effective with 'private' centers, so IRC developed a new approach with a greater involvement of Ministry officials and center directors from the beginning. To avoid the perception of invasion and imposition of reintegration activities at the center level, it was important to ensure the broad participation of all actors in regular meetings from the initial assessment through the planning sessions. Through this process, IRC was able to develop a joint plan of action with each center and to create a stronger sense of ownership and partnership between all key actors (government, center, community and the project).

The new strategy and methodology used in center activities were refined, adapted and systematized according to a standard model. This was done through two key activities: participatory center assessment and a joint planning exercise. Using standard Participatory Learning and Action (PLA) tools, the assessment explored the center's history, its organization and management, children's profiles, internal and external relationships, and the staff's, children's and communities' perspectives on the center and the children's future. Then, a joint center-Ministry-project planning session was organized. During this session, expectations were clarified, roles and responsibilities outlined, means of ensuring good communication identified, and material contributions specified.

In the new strategy, the IRC staff, in collaboration with center staff, implemented three groups of activities: *general psychosocial activities*, *staff reintegration activities* and *standard reintegration activities*. The first two answered organizational reinforcement needs. Generally in Rwandan centers, psychosocial activities, like basic life-skills training, games and entertainment, are neglected. Staff reintegration activities were planned, as some or all of the staff would lose their jobs at the end of the reintegration process. With small income-generating projects, IRC helped to overcome the obstruction of center staff brought on by the fear of becoming unemployed.

The main activities focused on the reintegration of children, starting with an introduction and presentation of the program to the children together with the center workers. Following this, case assessment began with the analysis of all existing documentation on children, verification of cases according to the ICRC list of UACs, and, finally, a new classification and prioritization. With the new approach, and as part of the center assessment and planning exercise, the center Team Leader developed a limited 'open' (or non-difficult) cases list based on the following criteria:

- Least complicated cases (based on center workers and project staff evaluation)
- High percentage of sibling groups
- Origin of children within prefectures where there is an IRC team

Once the caseload decreased, a second stage began, during which the difficult cases were examined and involved in the reintegration program. The case classification system identifies different categories of children within the same center. Among the tracing cases there is a further distinction between *sans address* (without address) tracing cases and normal tracing cases. To gather important information for locating the families, new tools were introduced and adapted to the situation (mobility map, memory jogger, and others)¹, and, in all cases of tracing, a radio announcement about the child was prepared and broadcast on national radio. If the radio message did not produce results after three transmissions, field research

was requested. For hard-to-trace families, a specific Team was organized during the weekends to attend the major community gathering occasions, such as local markets, health centers and churches. Most often, the community caseworker implemented the standard field tracing activities. After three visits without progress, the case was reconsidered at the center level, the child was informed and alternative solutions were discussed with him/her, such as foster family or longer center care. If the family was located, a family assessment was conducted to determine if the case was socio-economic or if the child could be reunified through a faster procedure.

For socio-economic cases, tracing the family did not present a problem; rather, it was important to know exactly why the child was in the center and not with his/her relatives. To this end, documentation was produced and completed through interviews at the center level. Then the case was handed over to the community worker. At this stage it was crucial to ensure on-going communication between the community and the child in the center – who was the focus of the reintegration action plan designed by the family, the community and him/herself. Before reintegration, the staff prepared the child to understand his/her new life back in the family, the expected changes in behavior, and his/her and the family's expectations. When the family and the community were ready and the child was prepared, a leaving ceremony was organized to stress the passage and to allow the child to bid farewell in an appropriate way to his/her friends in the center.

Through the classification process, other cases were identified.² These included *adolescents*, who were among the most difficult group to deal with in the reintegration process. In several centers, the difficulty of managing the changing needs of growing boys and girls, as well as the absence of clear understanding of rising conflicts, led center directors to expel them. In response, IRC put in place a pilot program to reintegrate adolescents into the community as independently living persons. In this case the personal case-by-case approach was even more pronounced, due to the intensive follow-up conducted by IRC staff and community leaders. For the transition from the center to an independent living situation, adolescents

went through intensive training (mainly life skills) and transitional living in a foster family designated by him/herself. After three months of transition, an income-generating project was developed with the adolescent while housing was provided or built with the participation of the community.

It should be noted that all the work based in the center required careful attention to detail in order to avoid missing precious information which could be useful to finding families or to solving difficult reintegration cases. Attention to the child and his/her aspirations and willingness was crucial, given the problems of inducing the child to accept already-made decisions. Every step had to be documented and all information had to be shared among the child, center staff and community workers.

2.2 Lessons Learned from the Field

Important lessons from the field have been learned, especially about the socio-economic cases about whom minimal literature has been produced so far. Under the new program, the intensive work done in the centers with staff and children and in the communities with families and local leaders showed some gaps in the system. While IRC's first and most productive experience was developed in its own center, the work in the four new centers requested by the Ministry was in practice different and more difficult. Following are some the key lessons learned.

The government's mandate to reunify/reintegrate children from these centers shows practical limits when the cooperation with the staff became difficult, unclear, and, in some cases, turned into open opposition. Center staff had enormous influence on the children. Often they discouraged children from cooperating with project staff. Staff threatened children who expressed an interest in returning home, and center management forbade documentation activities. One reason for this reaction was that only one of the four centers was managed by government authorities, and all of the others were private or church-led services. In light of this reaction, it was recognized that reintegration work was often perceived by centers as a threat, that the relationship between caretakers

and reintegration staff was inherently delicate, that center staff had the tendency to consider children as their own, and that reducing the number of people assisted by the institution meant unemployment for some of the staff. Unfortunately, the government's formal mandate did not do enough to build up collaboration with centers and did not guarantee a substantial change in childcare models.

The danger in the reunification/reintegration activity was that the process did not reduce numbers; rather it opened more space for new children. Each center had its history, policy, vision and a singular way of dealing with the communities around them. Often they were still open to receiving new socio-economic cases, including children who were abandoned or came from destitute or mother-orphaned families. Some children came to the center as the only opportunity to continue their education. Two main problems arose from such a situation. First, there was a progressive reduction of responsibility among families and communities in taking care of children in difficult situations. Second, despite the guiding principle of 'one child – one family' at a policy level, there was no other indication of who had the right to be in a center, how a center should be run, what essential services were to be provided by these institutions, and what perspective they should work with for the long term.

The relationship with the families was a key aspect of the reintegration program and required a professional approach so as not to jeopardize any follow-up efforts. The recent history of Rwanda, with its massive humanitarian assistance, created the habit of giving assistance to the poor even among international NGO staff. Although social workers were trained to explore the possibility for an economic support project for each family, initially this translated into 'one child – one project'. Conducting a socio-economic study of the families was helpful in identifying family resources and needs, but the tool was too broad and formal, and often created expectations through implicit promises. In addition, the families often withheld information in anticipation of receiving more assistance. Hence, staff recommended finding new and more creative ways

to assess each family situation with a stronger emphasis on social considerations.

A stronger community involvement was recommended throughout all steps of the reintegration process, not only in the follow-up activity. Earlier and stronger community participation was proposed to reinforce and stimulate a greater sense of responsibility for returning children, and to prevent future separation in the longer term.

The experience of the past two years of reintegration activities indicated the necessity of conducting an accurate screening of the families. The policy of ‘one child – one family’ could sometimes be problematic. In several cases just after reunification or foster placement, conflict arose in the family. Finding a solution after the child was already involved in the family dynamic was extremely difficult and harmful, obliging caseworkers to follow cases for more than one year. Careful screening was proposed to detect potential problems or incapacity of families, in order to avoid starting a reintegration process without a clear vision of the exit strategy.

It was essential to have a clear vision of how and when a case should be closed and to try to refer cases to local direct service providers. As a result, IRC worked in the community bearing in mind that they were not the only actor in the field. The local Teams regularly updated an inventory of other interventions at the prefecture level. The guiding principle was that IRC cannot do everything and should not attempt to be a substitute for local initiatives that could guarantee a longer-term action and follow-up. IRC followed an integrated networking approach to working with the communities. Through knowing who was doing what, how and where, it was possible to refer specific cases to local ‘safety networks’ or to the programs of other NGOs. This was useful mainly for economic interventions and for medical care. In some cases, when the family was destitute, the economic support strategy of IRC was not able to change the situation and ensure proper follow-up in a reasonable time. In these cases,

it was preferable to facilitate the family's participation with different local development initiatives.

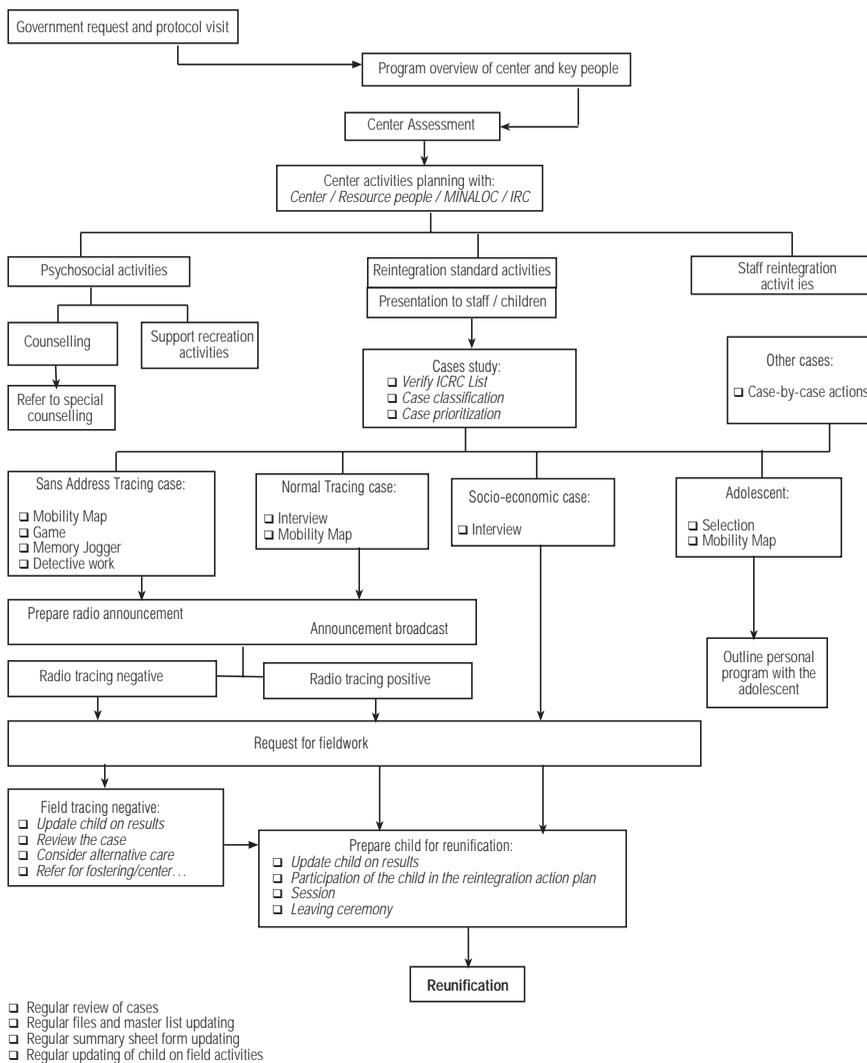
Economic support to the family should be provided prior to the reunification of the child in order to ensure a more favorable environment for the reintegration. The IRC experience demonstrated that implementing an income-generation project after reunification often led to the child being caught between the NGO and the family. In these cases, IRC was often obliged to give emergency support (food and non-food items) to stabilize the reunification. With the new approach, the economic intervention was realized before child's return to the community. In this way it was easier to confirm family and community commitment to overcome eventual obstacles to the reunification. Furthermore, the reunification was realized in an improved situation favorable to the social reintegration.

It was necessary to work with an objective that went beyond the actual reunification and ensured proper social reintegration against strict closure criteria. Reunification was simply one step in the more complex process of social reintegration. The 'standard' reunification methodology relied on basic criteria such as the location of the family and their refusal or non-refusal to accept the child. But when the child, the family and the community had lived different experiences for years, it was no longer possible to simply reunify the child. It was fundamental to go beyond this and take into account the willingness of the child, the capacity of the family and the existing social networks. The reintegration process can be considered successful only when the child participates in community activities, is not excluded or exploited, and has access to the same basic services as other children in the community.

It was necessary to restructure staff and program responsibilities in order to ensure stronger supervision, monitoring and effectiveness at the centers and the community level. At the beginning, program teams were divided between two geographic areas, Kigali and Gisenyi. Within this

structure, a national coordinator and two regional team leaders supervised all reintegration activities, including center-based and community-based work. This organizational structure proved heavy, bureaucratic and tended to spread expertise too thin. As a result, the reintegration program adopted a decentralized and networking organizational approach in order to better respond to its objectives.

The pre-reunification activities of the community-based reintegration program are outlined in the following chart.



2.3 A New Community-based Reintegration Methodology

As *participation* is the key principle in community-based reintegration, caseworkers in the community were required to work as facilitators rather than solution providers. The IRC experience showed how difficult it was for social workers to avoid giving solutions and instead assist the child, family and community in designing their own solutions. With a more rigorously designed methodology and related tools, social workers found it easier to proceed toward the resolution of each case. Following is the community-based reintegration process currently used by the IRC program.

2.3.1 The Process

The complete documentation file of a case is passed to the community worker from the center while the child remains under center care. The community caseworker, like the center caseworker, has to assess and analyze the situation and inform and prepare the participants before proceeding with the reunification. With the new approach, the first group of activities in the community, including the assessment of the family and the community, is crucial for the development of the following steps. Good assessment and good facilitation at the community level allow the child to be reintegrated with minimal problems, and allows case closure in a reasonable amount of time and in a more sustainable way.

Once the family is located, the first contact is generally dedicated to assessment of *family willingness and suitability* to receive the child. A specific tool has been designed to gather more objective information for caseworkers who otherwise would have to make a decision based on their own judgment. This preliminary assessment is of fundamental importance to avoid placing children in inappropriate situations and eventually exposing them to exploitation, abuse and reintegration failure. At this stage an important decision must be made about whether the child can be reunified with the family. From the analysis of documentation from the center, the social worker already has the child's perspective of his/her family, what he/she really thinks about them, and if he/she would like to join them. To the child's perspective, the caseworker adds the family's and the community's perceptions about

possible reunification. This is gained from the family through interviews on the reasons for separation as well as their awareness of the changes which are bound to come with reunification. Other children of the family and the surrounding community are involved as well. On the basis of the collected information, the caseworker proposes either continuing with the process or finding different solutions. The child shares the findings from the community, and in the latter case he/she contributes to identifying the right direction to be taken.

Through the family willingness and suitability assessment, one of three different possible scenarios are identified. In the worst case, where the family does not want or is not suitable to accept the child, mediation is tried according to the seriousness of the problem. If the family is still unable to reintegrate the child, the file will be sent back to the center for alternative solutions. In the second scenario, when the family is willing to take the child back and has no social or economic problems, the procedure for preparing and reunifying the family and the child is rather fast. A short-term follow-up (up to three months) is conducted to monitor the stability of the reunification. At the end of this time, if all criteria are met the case is officially closed with the child, family and community.

In the third and most common scenario, the family would welcome the child back but must first deal with problems, typically socio-economic. At this stage, a thorough family assessment is conducted with the help of several adapted tools. For cases with socio-economic problems, it is fundamental to start the analysis by identifying the *social network and resources* around the family. Through exercises such as mobility maps and flow diagrams, the family is able to identify its own social resources and weaknesses. This process often signals a turning point in the relationship with the family. As a result, the family's awareness of available resources grows stronger, allowing family members to gain self-esteem and strength. The *social network analysis* helps to identify the main actors in the family's life, including potential leaders who can accompany families in the process of reintegration, and local links such as churches, solidarity groups and local associations that can be key players in solving identified problems.

Equally important is an evaluation of the economic situation of the family in order to understand specifically how the child will be supported in his/her development. In the Rwandan context, where 69% of the families live below the poverty line, it is not easy to determine if a family really needs an economic intervention or not. For this reason, a specific tool has been designed to give measurable parameters for *assessing the poverty level*. This tool eliminates the bias of social workers who tend to consider all families to be poor and incapable. This bias can create disparities and conflict inside communities. To avoid this, economic support is limited to putting the family in the position of at least satisfying the basic needs of the child¹. For these reasons, both the social and the economic evaluations require information collected from neighbors, the community and local authorities.

The community caseworker analyzes the information to produce a complete synthesis of the family, and also provides some suggestions. This information is shared with the child, the family and the community for feedback, and is then presented at a *community round table* meeting. The meeting should include local authorities, the family, neighbors and the reference people identified during the social network assessment. The caseworker limits himself/herself to facilitating and to sharing the analysis in order to help the assembly design a shared reintegration action plan. Everybody is well aware of the problems the family is facing and the resources that are available, and it is up to the community to find sustainable solutions. The results of the community round tables have been remarkable, showing an unexpected capacity (even in poorer groups) for the community to take the lead and responsibility in offering mutual help to allow the child regain his/her place in the family.

A *case review meeting* is regularly held at the IRC local community team level to review all the active cases in the community, and their progress and problems. At this technical meeting the caseworkers exchange ideas on cases and methodological approach. This also is the occasion to refine each caseworker's time estimation for case closure. More specifically, the case review meeting is strategic in reviewing the results of the community

round table, the proposed reintegration action plan, the level of community and family commitment, and at the end, if and by what means IRC should support the plan. The *reintegration action plan* is then finalized with clearly defined responsibilities, activities and timing, and is offered for final approval to the child, the family and the community.

Where *external assistance* is needed to support the reintegration of a child, an economic outreach worker from the IRC team conducts a more in-depth participatory economic assessment through which the family identifies the kind of support that IRC can guarantee to improve their living conditions. By using the *poverty assessment tool*, the family is placed into one of three categories: poor family, very poor family, and destitute family. In the latter situation, IRC will refer the case to local initiatives because the rehabilitation process would be too extreme and lengthy for the IRC program. For the first two categories, if the community itself is not able to overcome all the obstacles, IRC will complement the local effort.

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IRC's economic strategy offers two different – but not exclusive – kinds of assistance. A more structured intervention is the identification with the family of an income-generating project where there are already some economic, human and social resources to build upon. When the family has an asset or an on-going activity that guarantees even low earnings, the IRC contribution is likely to be expressed in training and referral to micro-credit programs. The economic outreach worker is responsible for the identification of the intervention in a participatory way, accompanying its implementation and following up the project. In the case of specific situations (returnees, homeless, widows, etc.), if a thorough socio-economic analysis reveals that the assistance would be useful, then immediate, one-time assistance is considered. This includes material assistance (shelter, health), school assistance or advocacy (pension, inheritance).

Once the family's economic activity is stable and the family is assessed to have enough supporting resources, it is now considered to have enough means to guarantee the satisfaction of the child's basic needs. As a result,

the supporting project is declared closed and the case is referred to the community caseworkers for the reunification.

At the same time, the center caseworker and the community caseworker *prepare the child and the family* for the reunification according to the timetable in the reintegration action plan (often the most intense period of reunification is during school holidays, so that procedures for school transfer can be done without losing educational opportunities). Preparation activities consist of discussing with the family the most common problems and misunderstandings that can be encountered with a child who has been living separately from his/her family in a center for a long time. In this exchange, the neighbors are also involved, in order to facilitate a better understanding of how to overcome foreseeable interpersonal conflicts.

Usually the family welcomes the child back with a party, which is a recognition that reunification is a delicate passage for the child and for the family. In socio-economic cases, the program provides *follow-up* which can last for six months after reunification. The frequency of the visits depends on the types of problems met by the child/family after reunification. Experience has shown that the better the initial assessment, the fewer the problems that occur after reunification, translating into shorter follow-up and more rapid case closure.

The basic *criteria for case closure* are the same as those checked at the first family willingness and suitability assessment. When, at the end of the reintegration process, the child is happy in the family, eats at least two times per day, is treated in the same way as the other children in the family, goes to school (primary school), is integrated into the community (has friends, plays, participates in group activities), has no protection concerns, and at least one member of the family has a regular income, the case can be closed. If these criteria are not met at the first follow-up contact with the family, the process has to produce substantial changes in order to allow IRC, the child, the family, the neighbors and the local authorities to sign a case closure protocol. If the reintegration is characterized by a 'child-headed

household' or involves an ailing child, the existence of a support person (from the neighbors, church or a local association, etc.) is necessary in addition to the above-cited criteria for closing the case.

2.3.2 Observations and Comments

The shift of the program from its beginning until the time when step-by-step guidelines were defined and implemented has been remarkable. Every step of the process was achieved in collaboration with the staff, with whom IRC was able to critique the methodology and identify and monitor its strong and weak points. Yet, perhaps the greatest change was in the staff's approach and attitude towards *participation* and *community-based action*.

For the majority of the staff, *child participation* had been a guiding principle only in project documents. In a culture where the child is not properly considered a person, it is hard to train social workers to adopt a participatory approach. It takes a long time to change attitudes and behaviors because this affects not only their way of working, but puts into question their way of living. That is why in several sections of the methodology and within the tools, there is repetition of the necessity to inform, consult and involve children, families and community. With practice and close supervision, a remarkable shift was recorded as the social workers properly informed the child and started to consult him/her on decisions of concern.

For staff that are used to dealing with single cases in a traditional process of reunification, shifting to a community-based approach is even more difficult. The first obstacle is community identification: *What is community?* In the extremely organized and hierarchical Rwandan society, talking about community often brings some misunderstanding. The first concept of community is authority, so at the beginning of the program much attention was given to informing and involving local authorities. Yet, the involvement of local administrators can backfire too, if the authorities push the people to work and the neighborhood to reintegrate a child. In this case, the community feels obliged to act but will not take any other responsibility to facilitate and stabilize the reunification. With the adoption of the *mobility*

map and *flow diagram* during the family assessment, the family itself identifies the key players in the community in relationship to them. In this way it becomes easier for the caseworker to clarify the concept of community. In fact, in the IRC reintegration program, community is not seen as all the inhabitants of a certain geographic area who belong to the same unit, but rather as the part of the community affected by the problem or able to help solve it².

Even more difficult to change was the bias of approaching social problems through a strictly *economic lens*. IRC staff, ministry officials, authorities and local leaders commonly identified the sole cause of separation as being poverty. This may be because it seems easier to deal with economic issues than social issues and social conflict. Hence, the easy answer for reunification in a poor country would be to systematically help families with money or small pre-determined projects (not tailored to the situation). This approach is ineffective and dangerous. In the eyes of those who have a salary, the living conditions in the poor countryside always appear terrible and unacceptable. By proposing a project or a bright new shelter to a family who does not want or need it could result in the worst case in altering that family's social links with the rest of the community, or at least would be a waste of money. Social problems and poverty are strictly linked and cannot be addressed separately. The introduction of specific tools for assessing the social and the economic aspects allows the caseworker to have measurable indicators with which to declare a family in need of help or not. Without these references, his/her judgment would be extremely subjective, too often opting for an economic project. This risk is easily avoided by letting people participate and lead their change process without proposing external solutions.

The following chart outlines the community-based reintegration methodology.

2.4 Tools Developed to Support the New Methodology¹

To support the new approach, three specific tools have been designed, tested and adopted. They are inspired by other methodologies used in different fields, and adapted, refined and introduced as key instruments to help social workers in the reintegration process. These include the following:

2.4.1 *The Family Willingness and Suitability Tool*

Although centers are deemed a last resort for separated children, in some cases it is not in the best interests of the child to reunify him or her with identified family members. In the past, this decision has been left to the individual caseworker. To help caseworkers in this decision, a new tool was developed *ex-novo*, studying past experience and linking elements from center life and community life in the Rwandan context. Using simple indicators, a scoring system has been developed to rank families' suitability and willingness. The tool is used as an entry assessment for any case activated in the community. The Family Willingness and Suitability Assessment Tool is composed of three main sections:

An introductory general section of basic information about the case and the visited family is at the top of the tool. This part includes the main possible relationships between the family interviewed and the child to whom the case is referred. This is necessary because the more distant the family relationship, the harder the reintegration and acceptance of the child by all the family members could be. In some cases, such as the maternal aunt and maternal grandmother, possible problems of inheritance can be foreseen². Thus, it is important to take family relationships into serious consideration in order to have a complete picture.

The *second section is specifically dedicated to assessing the family's willingness* to reintegrate the child and is used exclusively with the family. The survey focuses on three main elements, including the relationship, the motivation and the changes, each one detailed by indicators. Regarding the *relationship*, the aims are to: a) understand whether there are any strong links between the child and family, as in most socio-economic cases the family knows the

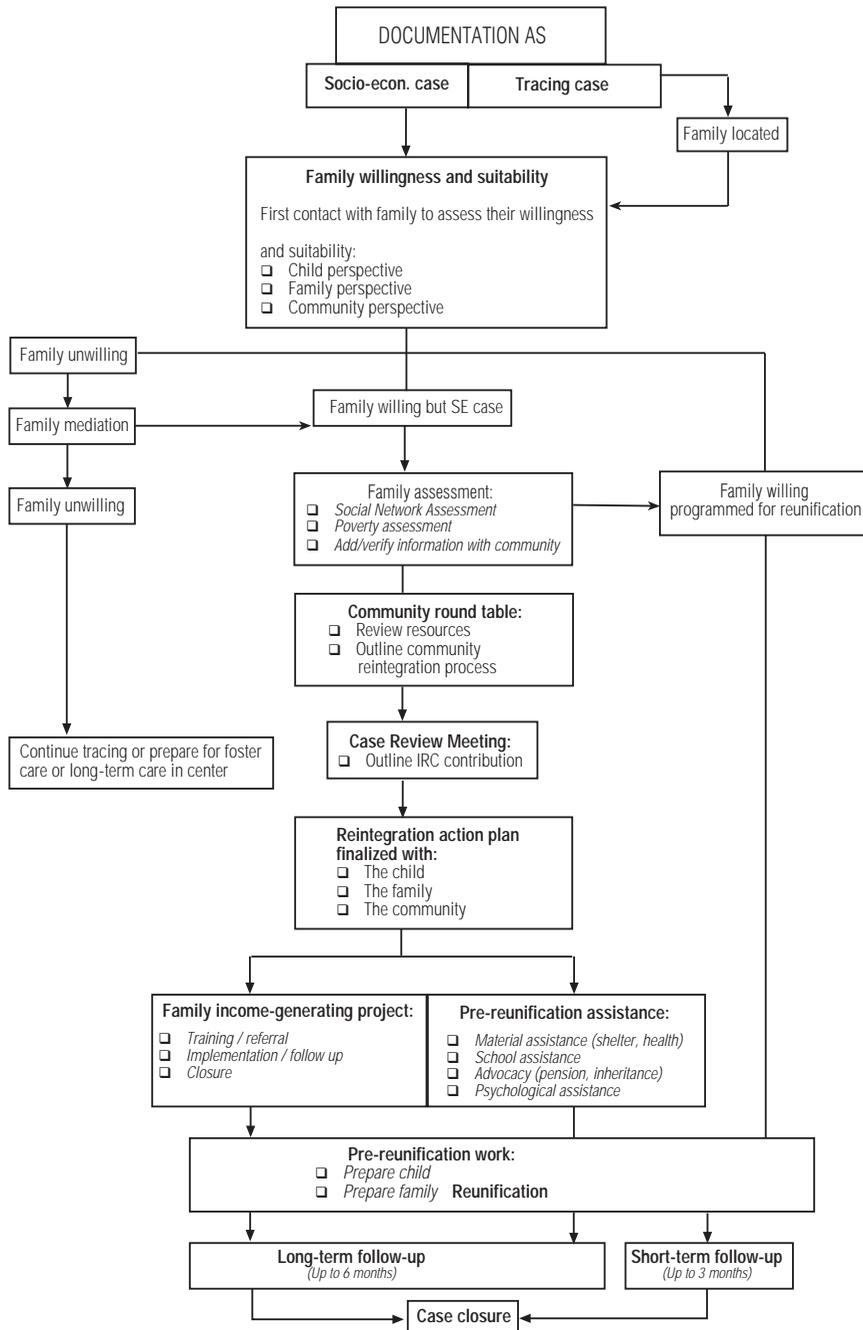
exact location of the child, and the frequency of their visits tell much about the strength of the relationship; b) understand the reasons for separation from the family's point of view (this information could be compared with the child's explanation); and c) detect their attitudes towards the reintegration.

The *motivation section* is more difficult to grasp and requires good interviewing skills by the caseworker. The tool cannot be used directly in front of the family, and the interviewer must be well prepared beforehand in order to guide the conversation to touch each indicator more than once. This portion is specific to a postwar situation since it takes into consideration the emotional dynamics of substitution/compensation of the loss. In good interviews, the family reveals the real motivation behind their declared willingness to accept the child's reintegration.

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A next step is the *changes awareness study*, a tool that gives crucial indications of how deeply the family is concerned with the return of the child and how much it takes into consideration his/her future. The scoring system is not standardized, to allow the tool to be adaptable to different social and geographical settings where the teams work. Based on experience, each team fixes a score in order to clearly identify the level of willingness of the family. The lower the score, the less chance the child has to be happily reintegrated. Generally, a score of 9 or below is considered negative or very problematic, and a score of 14 and above indicates a good willingness.

The *third section is addressed to the other children of the family and to the surrounding community (neighbors and lower level authorities)*, who are interviewed separately from the family. In this part of the tool, the caseworker studies the capacity and the suitability of the family to reintegrate and keep the child in the future. Specifically with the children of the family, the criteria (same as those used for case closure) are checked, mainly to understand which changes should occur to allow closure of the case. The community adds information from a point of view that is external,



but close enough to warn of relevant conflicts or inabilities. These indications considered together should exclude the exposure of children to abuse, violence or exploitation, which are reasons not to continue in the process with this family unit.

2.4.2 The Family Assessment Tool

In the past, family assessments were conducted using the Socio-Economic Study Form. Although an innovation in reunification practices, this 'survey-like' methodology had clear shortcomings (i.e., implicit promises). To address this, a combination of two new assessment tools was designed and tested: the *mobility map* and the *flow diagram*³. Using a visual map, the purpose of these tools is to document a family's social support network and economic activities, and to begin identifying community-based strategies for reintegration. These tools allow field staff to concretely illustrate the informal and formal relationships between family members and community members. Mobility maps are conducted with family members (including children) and discussed with neighbors and local leaders. As a result, the family assessment is less extractive and more inclusive in nature.

2.4.3 The Poverty Assessment Tool

In Rwanda, 69% of the population lives below the poverty line, and it is estimated that the majority of children in centers are there for socio-economic reasons. The program is faced with the dilemma of resolving economic obstacles for reunification, but at the same time respecting community standards. Using a basic scoring system adapted from the 'Trickle-Up' model, a basic poverty assessment tool was designed and developed to help case workers determine which families are eligible for direct project assistance and which families should be referred to alternative credit sources and economic support services. The tool was developed first in a rural context and then refined and adapted for cases in urban areas.

Beside the general information box, the tool is comprised of two main sections: *poverty criteria* and *description of living conditions*. The first is essentially used for an initial gross selection based on criteria adapted to

the average Rwandan family's economic situation (for the rural areas as well as for the urban areas). The criteria take into consideration nutrition, land ownership, earnings, school attendance and social status of the head of the household. The worse the situation, the higher the score. Beyond 4, the family is selected for intervention; where the result is 7, the family is referred to other longer-term accompanying initiatives.

The description of living conditions gives a wider and more detailed picture of the family to better understand at which level an eventual intervention would be needed. In this portion the following elements are considered: dwelling, assets, education, sanitation, health/nutrition and social status. In each category, specific indicators are expressed from the worst to the best living conditions. The final score helps the caseworker to classify the family according a categorization chart.

The chart below illustrates the basic elements of the Poverty Assessment Tool.

Poor family	Very poor family	Destitute family
Section 1: between 3 and 6	Section 1: between 4 and 7	Section 1: between 4 and 7
Section 2: between 14 and 19	Section 2: between 8 and 13	Section 2: under 9
Material resources	Limited material resources	No material resources
Human resources: practical competencies	Limited human resources : some practical competencies	No human resources
Social resources: member of association or mutual	Limited social resources: member of association or mutual Existing productive capacity	Really weak social resources
Strong productive capacity Satisfying the majority of children needs	Satisfying the minimum of children needs	No existing nor potential to be productive Managing to survive

Organizational Development

3.1 Structural Changes to Serve the New Approach

The vertical organizational chart reflects a fast and efficient but static way of structuring program staff. Consequently, a horizontal organizational structure was designed. Based on the program belief that progressively growing responsibilities of the staff are a precondition to program development and success, the majority of staff were encouraged to perform different tasks that were not directly inherent to their position. Over time, this flexibility has become the rule rather than an exception, as extending the program to embrace other objectives has required methodology adaptation, training and accompaniment of local partners. As a result, several roles have crosscutting functions through different teams. Moreover, the program has remained committed to drawing methodological contributions from field workers, thus necessitating the development of a more participatory organizational structure.

To accommodate the new approach, a more streamlined structure was proposed. This involved replacing the two regional teams with technical, objective-based teams. These are comprised of: a) Team Leaders (focused on activity implementation, team organization and supervision, monitoring, and methodology development); b) Decentralized or ‘community-focused’ Teams (which implement activities at the community level and provide analysis of methodology); c) Center Teams (crosscutting teams created by regrouping center case workers, focused on the refinement/adaptation of center methodology); and d) an Economic Outreach Team (a transversal team created by regrouping economic outreach workers, focused on developing, improving and adapting economic support methodologies).

A National Community Team Leader and a Center Team Leader supervise these teams. In addition, the community team is divided among four smaller regional teams, each with its own team leader (community teams include a team leader, two social case workers and an economic outreach worker). A core staff of technical advisors, including a psychologist, an economist and an adolescent advisor, reinforces the teams. Through this restructuring, all activities can be focused closer to the areas of intervention, allowing each caseworker to better understand the local context, thus becoming more effective. This new decentralized organizational structure aims to accomplish four main goals: staff are more specialized in their tasks (a more defined division of labor between center case workers, community case workers and economic outreach agents); more efficient decision-making within a decentralized framework; better use of resources; and better supervision due to smaller team structures.

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The reintegration program adopted its decentralized and networking organizational approach in order to better respond to its objectives. The objective-based and team-based organizational chart guarantees that the program has the needed flexibility and mobility. Increased participation and clarification of responsibilities bring about a general growth of professionalism and efficiency. The crosscutting functions allow a deeper specialization and improvement of strategy and methods. A horizontal, objective-based organizational structure is more suitable to the current context, keeping in mind that it requires attention to information flow, respect for terms of reference, and good planning.

Strategic Issues for a CBR Methodology

4.1 Case-by-case Processes and National Policy

The proposed new community-based reintegration methodology is rather complex and demands the same intensive case-by-case work already existing at the center level. Working for social reintegration means much more than only family reunification. It means creating the conditions within which the child can find a place in his/her original community as an active participant.

Adopting the *best interests of the child*, the *responsibility of the family and the community for their children* and the *respect for community standards* as principles of a reintegration program does not make the work easier. A strategic factor is the geographic dispersion of cases over a certain area, obliging the program to organize and communicate efficiently. In the same country, living conditions, solidarity and participation change according to the location and the target group. This demands flexible and adaptable instruments which are managed by skilled caseworkers who are able to understand and propose revisions to the methodology and its tools.

Ongoing training, on-the-job training, and close supervision are also necessary, considering that this is not a 'traditional' way of working, as the caseworker is also asked to play the role of facilitator. The Local Team dimension is the most effective way to monitor activities and to support the staff in a decision-making process which involves local input and exchange. Working with children (often traumatized, abused or rejected), families and communities requires differing skills and backgrounds. Caseworkers should be specialized and their tasks must be made clear in order to enable everyone to contribute their best in the process.

Work that is focused on a case-by-case praxis should not forget the wider context and fundamental collaboration with other agencies (international or local) and with the government. The government to some extent is responsible for those children and clear policies are needed to tackle the problem. Working towards reintegration without an effective legal framework that prevents and regulates the access of children to the centers is in the long term not useful for the country. The authorities should be involved at all stages of the process, and if necessary help in developing adequate social policies, as well as enforcing the law. Child reintegration has a certain impact on the communities and could be used as a community promotional opportunity, but not without a parallel change at the policy level. The relationship with partners and government should be frank, open and collaborative, respecting everyone's responsibility while sharing a common objective and vision.

4.2 Key Issues in Applying the Experience to South Asia

4.2.1 General Considerations

Survivors of trafficking and sexual exploitation are considered difficult cases for social reintegration. This does not mean that reintegration is not possible, but that it is necessary to be extremely careful. More than for other 'categories' of children, it is important to understand how and why the child was involved in trafficking. This information can make all the difference in determining the manner of approaching the case and in identifying possible solutions with the child. A child who has been kidnapped to be trafficked will see his/her future differently from a child who has been sold or has been abused by their family. It is very probable that some children will not be interested in returning to their original family, and some families may be considered unsuitable following the family assessment. In this situation alternative solutions should be studied with the child, such as reunification with other relatives, reunification with a foster family who is respected and chosen by the child or, for adolescents in particular, social reintegration into independent living.

It is true that working with victims of trafficking and sexual exploitation requires specific competencies; however, an overly narrow approach could result in further exclusion and stigmatization of the child. Centers should be open to the surrounding community, which should be encouraged to participate in the center's activities. In this way, children are helped to develop relationships in a 'normal' social environment that opens up future solutions. Supporting children to have a healthy interaction with the community facilitates the reintegration process, should it be with the original family or in a different situation.

South Asian internal and international conflicts, community tensions and natural disasters are negatively impacting the coping capacity of the most vulnerable groups. An increasing number of children will be exposed to abuse, exploitation and trafficking as the number of 'internally displaced persons' grows in areas such as Afghanistan, Kashmir and Nepal. A stronger reintegration effort will be necessary to deal with such a large number of separated children. Working with children who are unaccompanied for a variety of reasons could be an advantage in reducing issues of community stigmatization of trafficking and abuse survivors. If the reintegration is undertaken in response to an emergency, it is imperative to remember the importance of basing efforts on participatory approaches with children and communities. Successful reintegrations have positive effects beyond the return of the child to the community.

4.2.2 Child Participation

In South Asia, many basic problems are the same as are found in other parts of the developing world. To address them, the first major questions could be: What do we mean by participation? How much have children really been the owners of the choices made for their past/present/future lives? Particularly in the case of sexual exploitation survivors, how much did the 'educator' influence and induce the child to make the 'right' decision?

The choices offered to children are often already filtered by the social worker or the organization. However, the child has the right to a say even if he/she is traumatized, and it is up to the supporting structures (agencies or governments) to create the necessary conditions to express this right. In South Asia, even reputed actors risk being too invasive with children, depriving them of the ownership of the problem and making decisions in their place, thereby creating other potential conflicts. It should be questioned whether the centers in South Asia provide an environment which enable children to express their rights, and whether those fostering structures are genuinely thought of as transitional solutions.

4.2.3 Centers

Children under center care have few links with their family and the community, and they develop relationships mainly inside the structures. It is thus important for an institution to be open to the 'outside world', enabling the community to participate and understand the children's problems, and enabling the children to build up 'normal' relationships with people living in the community.

Protection concerns, often raised by directors of centers, should not allow the transformation of what is meant to be a temporary solution into a long term 'detention' structure where children have no right to the outside world. Protection is of concern, but any structure is part of the community and the problems of 'outside' are equally reflected inside the center. Children should be aware of what they are going to do while in a center, how long they will remain there, and what plans for social reintegration are made for them. NGOs and governments should look much further than a 'center-based' solution to the problems of survivors of trafficking and sexual abuse. This requires a strong engagement of authorities and different actors, as well as a commitment to find solutions in the best interests of the child while preventing new cases. As a core question, it must be asked if it is possible to shift from center-based interventions to integrated community-based interventions in South Asia, involving all stakeholders including children.

4.2.4 Community

After the family, the community has responsibility for its children and it is at the community level that much work needs to be done to prevent trafficking. Legal enforcement is insufficient to prevent the phenomenon. The community itself must be helped to address the problem, to understand the reasons, to find alternatives and change behaviours. In this process, reintegration can play a key role in raising awareness at the community level. Once the community accepts the responsibility to face the difficulties of taking care and reintegrating a child, the dynamics start to change. In the South Asian context, with strong caste segregation and stigmatization of sex workers and the abused, the approach should be even more community based, and the time spent to prepare communities must be even longer than elsewhere. A first community meeting to present the problem in general terms is useful, followed by more selective meetings with individuals who are more concerned with specific cases. It is important to note that communities cannot be stimulated by *ad hoc* means, as awareness and sensitivity must be gradually built up, starting from the local authorities. Some key questions to ask in developing community-based reintegration methodologies include: What is 'community' for a South Asian social worker? How much are women a part of that 'community'? Is the family considered to be the main actor with the child in the reunification? How much do social workers try to force the family to take back the child? How much do authorities try to impose the reunification? And do we really know at this stage what the reasons for trafficking are? And of this knowledge, how much have we shared with the communities concerned?

4.2.5 Government

Complimentary to the case-by-case approach developed by IRC, governments play a fundamental role in guaranteeing a clear policy commitment at all levels as well as legal enforcement. The formal support as seen in the Rwandan experience is simply not enough. Governments face challenges in having the best interests of the child as a guiding principle, because this generates debate on adult/parental control versus child participation. Community reintegration is only one aspect of a wider intervention in the

protection of vulnerable children and communities. It takes time and governments, NGOs and other actors need to be realistic about the expected results. In order for governments to progress in their support of reintegration activities, it is important to clarify how coherent the policies addressing trafficking are in the region, how difficult the collaboration would be among different countries, and how committed the local authorities are to fighting this phenomena and allowing the reintegration of survivors.

Endnotes

- ¹ The most important tools are explained in detail in Section 2.4.
- ² There are other children who did not belong to any of the main categories, such as those who were in the center for studying opportunities, or for care of specific health or psychological problems. These cases were not involved in the IRC reunification/reintegration program.
- ³ For IRC, the basic needs of the child are identical to the criteria for case closure.
- ⁴ The involvement of the community in a wider sense is necessary in dealing with highly stigmatized children (street children, sexually abused children, prostitutes). The process would be slightly different, involving advocacy for the general community, and, little by little, reducing the circle of responsibility to the section of the community interested in the individual child's reintegration process.
- ⁵ For an illustration of the tools, refer to Annex I.
- ⁶ Rwandan law does not ensure the right to inheritance for women, causing serious problems after the genocide that left a huge number of widows.
- ⁷ These tools are adapted from PLA methodology.

Annex

Family Willingness and Suitability Assessment Tool

Family:

Date:

IRC n°:

Prefecture:

Commune:

Secteur:

Parental relationship:

own parents uncle/aunt (father) brothers/sisters (adult) other
 own parent (1) uncle/aunt (mother) brothers/sisters (CHH) remarried father
 remarried mother grandparents

Willingness Criteria

I. RELATIONSHIP

indicator : **family/child contacts** (s/e cases)

0. never
1. seldom (once/year)
2. often (once/three months)
3. really often (once/month)

indicator : **separation**

1. relationship reasons
2. economic reasons
3. lost (tracing cases)

indicator : **feeling toward reunification**

1. reject reunification
2. would like reunification but ...
3. absolutely want the reunification

TOTAL:

II. MOTIVATION

indicator : **Interest for reunification**

1. for family support
2. for affective compensation
3. for the right to be in a family

III. CHANGES

indicator : **changes awareness**

1. no change foreseen
2. some changes foreseen
3. awareness of all consequent changes

indicator : **life project for the child**

1. no project for the child
2. life project different from other children
3. life project same as for other children (study, heritage...)

Capacity and suitability

Capacity (*with children*)

Yes = 1

No = 0

1. children are happy
2. all children are treated the same
3. children of school age attend school
4. children are involved in social activities
5. children eat twice a day (or more)
6. no protection concern

Total =

Suitability (*nyumbakumi/neighbors*)

Yes = 0

No = 1

1. family shows relational and physical instability
2. family is violent
3. family is isolated/excluded
4. family is depressed
5. children of family are exposed to different exploitations

Total =

Poverty Assessment Tool

Family:	Date:	IRC n°:	
N° members:			
Prefecture:	Commune:	Secteur:	
Poverty Criteria		Yes	No
1. <u>The family eats more than once per day</u> (2 points)		<u>0</u>	<u>2</u>
2. <u>Have 250x250 steps (400m²) of land per person at least</u>		<u>0</u>	<u>1</u>
3. <u>Have an income 1600 frw/month per person or more</u>		<u>0</u>	<u>1</u>
4. <u>There are visible malnourishment cases</u>		<u>1</u>	<u>0</u>
5. <u>Children of school age go to school</u>		<u>0</u>	<u>1</u>
6. <u>The head of the household is vulnerable (elderly, ailing, handicapped, child)</u>		<u>1</u>	<u>0</u>

Total =

Description of living conditions

I. DWELLING	IV. SANITATION
indicator : roof type	indicator : clothes changesments
1. <u>blindé/shitting</u>	1. <u>seldom/never</u>
2. <u>banana leaves/herbs</u>	2. <u>once in a week</u>
3. <u>tiles/iron sheets</u>	3. <u>more than once in a week</u>
II. ASSETS	V. HEALTH/NUTRITION
indicator : cooking utensils	indicator : access to medical services
1. <u>pot/ aluminum box</u>	1. <u>treat maladies as they can</u>
2. <u>one saucepan</u>	2. <u>through traditional medicin</u>
3. <u>saucepans/plates</u>	3. <u>through health center</u>
III. EDUCATION	VI. SOCIAL STATUS
indicator : head of household education level	indicator : head of household status
1. <u>absolutely illiterate</u>	1. <u>elderly</u>
2. <u>illiterate with numbering skills</u>	2. <u>young (16-22)</u>
3. <u>literate and numerate</u>	3. <u>adult</u>
	4. <u>elderly/young/adult</u>
	- 4 <u>problematic adult (alcoholic, violent)</u>

TOTAL:

Poverty Assessment Tool (urban area)

Poverty Criteria	Yes	No
1. <u>The family eats more than once per day</u> (2 points)	<u>0</u>	<u>2</u>
2. <u>There are more than three people per room</u>	<u>1</u>	<u>0</u>
3. <u>Have an income 1600 frw/month per person or more</u>	<u>0</u>	<u>1</u>
4. <u>There are visible malnourishment cases</u>	<u>1</u>	<u>0</u>
5. <u>Children of school age go to school</u>	<u>0</u>	<u>1</u>
6. <u>The head of the household is vulnerable (elderly, ailing, handicapped, child)</u>	<u>1</u>	<u>0</u>

Total =

Family selected between 4 and 7

Description of living conditions

I. DWELLING

indicator : **house property**

1. occupy the house/hosted
2. rent the house
3. own the house

II. ASSETS

indicator : **cooking utensils**

1. pot/ aluminum box
2. one saucepan
3. saucepans/plates

III. EDUCATION

indicator : **head of household education level**

1. absolutely illiterate
2. illiterate with numbering skills
3. literate and numerate

IV. SANITATION

indicator : **soap consumption per week**

1. 1 soap or less
2. up to 3 soaps
3. more than 3 soaps and different

V. HEALTH/NUTRITION

indicator : **access to medical services**

1. treat maladies as they can
2. through traditional medicine
3. through health center

VI. SOCIAL STATUS

indicator : **head of household status**

1. elderly
2. young (16-22)
3. adult
4. elderly/young/adult
- 4 problematic adult (alcoholic, violent)

TOTAL:

Mobility Map

The mobility map is a visual record of a person's social network as well as an excellent tool to explore social and economic activities. In a map-like fashion, family members/children draw places and people frequently visited and then discuss the specific relationship that exists with each site/person.

- Begin by explaining the purpose of the exercise: To learn more about the family/child so that we know who they are.
- Introduce the map, telling them that this tool will be a good way to “meet” the family/child.
- Provide paper and pencil. Draw a circle in the middle of the page. Write the name of the family OR, in the case of adolescents, the name of the Center. Explain that this is their/his/her home and that you would like them/him/her to draw all the places/friends that they visit. This is not limited to the immediate vicinity, and can include other towns. (For families, this should be done with as many members of the family as possible and should, at minimum, include the persons responsible for the family and another child from the family. Family members can draw maps at the same time.)
- Once the drawing is complete, ask each member to tell you all the sites on the map. Write down the names next to the sites. (If the members of the family/child are/is literate, ask them to write them.) Now ask them if they have not forgotten any other places.
- Once the map is complete, provide the family with two colors of stickers. Gray and Green. Ask the family/child to place the green stickers in the places that they most like to be/are most important to them. Explain that the gray stickers are for the places that they least like/are least important to them. (Verify that they understand the use of the stickers.)
- Now distribute the red and yellow stickers. Ask the family/child to place the red stickers in the places they go to the most and the yellow in the places they visit the least.

- Once the map is complete, begin the interview. Ask the family/child to explain each place/site. Ask the family permission to take notes. The interview will follow the below guidelines:
 - i. Tell me about this place and what it means to you
 - ii. What activities do you do there?
 - iii. Which people do you visit there and what is your relationship with that person?
 - iv. How often do you go? (number of times per week/month)
 - v. Has the relationship/your involvement with this place always been the same?
 - vi. Why do you dislike this place? (for green and gray)
(NB: The above questions are only a guide. Remember to ask probing questions and following interesting leads.)
- Once you have completed this exercise, ask if they have forgotten any sites/places. Add when appropriate.
- Once the exercise is complete, share with the family/child what you have learned/points of interest.

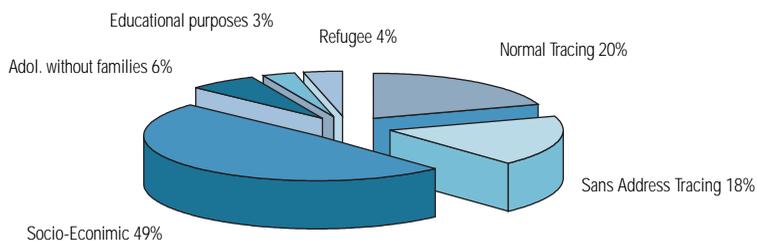
Flow Diagram

The flow diagram is a simple exercise that explores the social safety network of a family/child. It outlines the resources of each family/child by asking who they seek help from when they have a problem. Three problem areas are explored with families; four with adolescents.

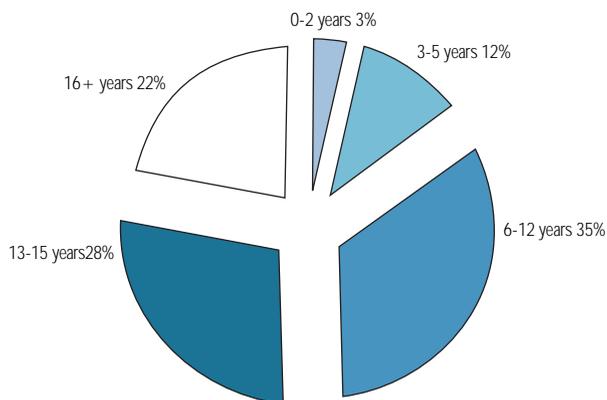
- 1) Begin by asking the family/child when they have a health problem who they approach. If that person/organization does not help, who do they then approach. Again, if that person/organization is not able to help, who do they approach...exhaust this list. Record responses as follows:
Money Problems: Justin ? Constance ? Liz ? Andre
(Note the exact relationship between the family/child and the person cited.)
- 2) Next follow the same questions regarding problems concerning money and morale/sadness. For adolescents, also do a flow diagram for advice concerning love.

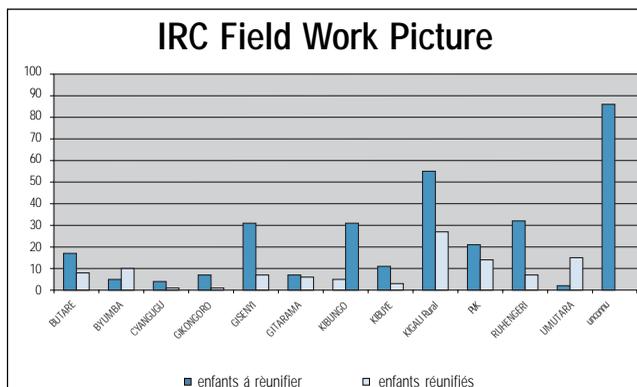
Annex II. Program Statistics

Cases Features



Age Range of Children in Centers





Rwamagana Center (*closed*)

- Number of children in the center: 144 children
- Date center closed: July 1999
- 62% percent of the children were reunited with family, which includes 52% originally destined for fostering.
- Of the socio-economic cases, 36% percent were able to be reunited with only mediation efforts, and 42% were re-traced to other relatives.
- Of the 19% originally categorized as adolescents assumed to live independently, over 40% percent of those were reunited with family members.

Musha Center (*closed through the new approach*)

- Number of children in the center: 120 children
- Date center closed: December 2000
- 56% were reunited with family members, 9% fostered, 5% placed in independent living programs, 30% transferred to specialized care facilities for handicapped children.
- Of the 70 "closed tracing cases" that were reopened for tracing, 30 (43%) were reunited with family: 33% of these children were reunited with at least one parent and an additional 60% with close family members (i.e., older sisters, grandparents).

Number of Children Reunited	202
Number of Children Fostered	11
Number of Adolescents in Independent Living	06
Number of Children Transferred to Life Care Facilities	29
Number of Children under Process	142
Children of Closed Cases	73
TOTAL CHILDREN COMPLETED	248



Trafficking in Children - South Asia (TICSA)

**International Programme on the
Elimination of Child Labour (IPEC)
International Labour Organization**

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