

Commercial sexual exploitation of children: the health and psychosocial dimensions¹

1. INTRODUCTION

To understand the health and psychosocial implications of the commercial sexual exploitation of children (CSEC) requires an appreciation of the varying patterns of causality, circumstance and consequences in different countries and cultures. There are no single nor simple models or frameworks that fully explain or describe the varying patterns or consequences of CSEC. The behavioural patterns of causality in one setting, such as substance abuse, in another setting may be an instrument of entrapment and/or control - as in trafficking, and in another setting it may be perceived by the child victim as a means of escape and relief from suffering. In the developing world macro social and economic factor, such as poverty and social marginalization appear to be important background factors, while the more individual characteristics of the child and family affect resiliency or vulnerability. While poverty may be a contributing factor in the CSEC in some circumstances in the more industrialized countries, individual characteristics, the functional capacity of the family, and its experience maybe a more significant contributor to the occurrence of CSEC. Poverty of relationships, values and behaviours within families and communities may interfere with the child's ability to establish positive family and other social attachments that are among the essential elements of resiliency.²

The examination of the scope and nature of the health aspects of the commercial sexual exploitation of children has been placed in the context of the WHO definition of health, as well as two interlinked principles included in the Organization's Constitution, namely that:

- health is a state of complete physical, mental and social well-being and not merely the absence of disease...
- healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development... (and)
- governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures..."³

These principles reflect *inter-alia* the somatic, psychosocial and psychosexual maturation needs of children and adolescents. The health aspects of the commercial sexual exploitation of children (CSEC) needs to be examined in terms of:

- the impediments to the normal phases of reproductive maturation, including the closely related aspects of psychological, social and cognitive development of the child and adolescent;
- the resultant patterns of biomedical, psychological and social pathology and dysfunctioning; and,
- the health and other social costs of the underlying and direct causes of CSEC to the individual and the community.

Few doubt, although direct scientific data are very limited, that the sexual exploitation of children results in serious, often life-long, even life threatening, consequences for the physical, psychological and social health and development of the child. These children become social outcasts. Their future fertility and psychological capacity to establish healthy relationships and their own families is seriously compromised. At a community level the commercial sexual exploitation of children represents an erosion of human values and rights that threatens the health of society.

Despite the paucity of direct evidence, the indirect evidence of the health consequences of the CSEC is compelling. The evidence draws upon the increasing understanding of such emerging public health issues as sexual abuse in children; the phenomenon of street children; substance abuse by children and within families; and, domestic and extra-familial violence. The evidence will be presented in terms of several models and topologies of the health, growth and psychosocial development of children and adolescents, and an examination of the associated patterns of family dysfunction, and the well established understanding of the epidemiology of sexually transmitted diseases. There are the direct health effects of CSEC and there are the effects of the associated and contributing factors such as child abuse and neglect, sexual abuse and substance abuse. Intergenerational health and social effects must also be taken into account based on the well documented risk of intergenerational "transmission" of physical and sexual abuse pathologies to the children of its victims.

The issue of the health aspects of CSEC must also be seen both in terms of the biological, psychological and social capacity of the individual to engage in sexual activity, variations in the legal age of consent and of marriage in different countries and the definition of a child according to the Convention on the Rights of the Child (CRC).

II. METHODOLOGICAL CONSIDERATIONS

1. A Developmental Approach In Understanding The Vulnerability Of Children And To Define The Needs For Action

The concept of vulnerability of children has been a *sine quo non* of policies, programmes and advocacy efforts of community, national and international governmental and nongovernmental organizations and agencies that address the needs of children. What is not always appreciated is that vulnerability is a function of the biophysiological, cognitive, behavioural and social changes that are the defining features of the growth and maturation of infancy, childhood and adolescence. Developmental health encompasses all these dimensions, and is attained when the child is provided with an enabling environment for its development, i.e., sufficient nourishment, care and protection, including age appropriate psychosocial and cognitive stimulation. The interaction of these elements with the genetically preprogrammed endowment of the child will result in the healthy transition from one stage or phase of development to the next stage. While the potential for a child's development may be disadvantaged even before birth the human organism has built into it a high level of redundancy and resilience - if supported - to compensate for such difficulties.

Thus, four principles are essential in the understanding of human development. These are:

- development is a stepwise process;
- the elements of the maturational process develop in parallel and interactively; experiences in each stage affect how the individual will pass through succeeding stages; and,
- development is multifaceted, with the physiological, affective and cognitive elements determining and explaining observable behaviour.

A combination of models or frameworks is useful in understanding the impact of CSEC on the health and development of children. These include the framework of the biophysiological development of the reproductive system and organs, as well as several developmental health models which can be broadly used in examining the health consequences of CSEC. Among the latter would be adaptations of Erikson's human development model⁴ and the moral developmental model of Kohlberg.⁵ (Table 1) A behavioural model, the Modified Social Stress Model, which has been developed by the WHO Programme of Substance Abuse (PSA)⁶ based on the work of Rhodes and Jason⁷ as applied to drug use among children and adolescents, may also be useful in understanding the factors increasing vulnerability to and those

strengthening resiliency against the CSEC. Most of these developmental models include three developmental stages, often with substages. In general they accommodate the developmental stages of infancy and pre-school (or play age), school age and adolescents.

1.1. Pre-school or Play Age

The toddler and pre-school years are the key period for the child's development of self-awareness and a satisfying sense of self. (A summary of some of the characteristics of child development from infancy to school age are shown in Table 2.) While children of this age have little understanding of the workings of the human body, this period does serve as a period when gender identity and behaviour begin to be established. The child's external physical appearance prompts parents and other significant adults to respond to the child with rearing behaviour that reinforces and shapes the child's sex-role behaviour and gender identity. The child identifies with and follows the model of behaviour of the parent of the same sex. Learning at this stage includes what to expect and how to respond to members of the opposite sex. By five years of age, the child has established his/her gender identity. The toddler/pre-school age is also the stage of early moral development. Children at this stage tend to judge themselves or others as "good" or "bad" on the basis of the effects of a given action without taking into account the intent of the persons involved. It becomes very apparent that these stages of development may be adversely affected in circumstances of sexual abuse and through the practices of paedophilia.

Table 1. Child and Adolescent Development According to the Models of Erikson and Kohlberg

Stage in the life-span	Psychosocial Model of Erikson	Moral Development Model of Kohlberg
Infant	Basic trust vs basic mistrust: sameness and continuity of outer providers - self trust	<u>Preconventional</u> (premoral) ..punishment-obedience: egocentric, no moral concepts
Toddler	Autonomy vs. shame and doubt: self-control without loss of self esteem leading to good will and pride	..instrumental-relativistic: satisfaction of own needs
Preschool	Initiative vs. guilt: ready to become bigger ... moves toward the possible and tangible from dreams of childhood to goals of adult life..	<u>Conventional</u> (moral) ..“good boy” - “nice girl”: desire to please others
School age	Industry vs. inferiority: learns to gain recognition by producing things	..“law and order”: obligations to duty, respect for authority

Early Adolescence	Identity vs. role confusion: sameness and continuity prepared in the past are matched ... in one's meaning for others	<u>Postconventional</u> (principled) ..social contract, legalistic: relativism of personal values and opinions
Middle and late adolescence	moves from insistence on identity towards young adulthood with fusing identity with that of others and is ready for intimacy	..universal-ethical-principled: conscience dictates action in accord with self-chosen principles

Adapted from: Sahler and McAnarney, *The Child from Three to Eighteen*, 1981, The C. V. Mosby Co., St. Louis.

1.2 School Age

The development of the school age child is characterized by a slower rate of growth, greater coordination and motor development and a qualitative shift in cognitive development - particularly among those attending school. It is a period of considerable growth in thinking, imagination, and language - essential ingredients in understanding and relating to a wider world. Moral judgement and behaviour develop with increased social and cognitive sophistication, with a tendency to accept and follow a system of rules that regulate personal behaviour. There is a greater sense of cooperation among peers and within the family, and the locus of control, i.e., the perceived source of reinforcement for behaviour, is established. The child with an internal locus of control believes that events are caused by self, while the child with an external locus of control believes that events are caused by others or fate. Children at this age are particularly vulnerable to exploiters who appear to be sympathetic authority figures.

Table 2. Some Typical Stage-related Characteristics of the Child (as characterized in developed countries)

Age of child	Relate to World	Self-awareness	Adult relationship	Sexuality
1-2 years	sensory motor curiosity	says own name, recognizes self in mirror, need for praise and encouragement	separation problems	handles genitalia
2-3 years	symbolic thought, egocentric, animistic	gender identity, need for praise and encouragement	frequent help seeking	curious about sex differences
3-4 years	egocentric	development of initiative, pride in	separates easily	interested in where babies are

		accomplishments , verbalizes feelings		from
4-5 years	egocentric, distinguishes reality from fantasy	gender identification, evaluates self	mostly peer interaction, uses adults for help	sex play with other children

1.3 Adolescence

The biological changes of adolescence are somatic and hormonal, with marked individual variation in the timing and tempo of changes. During the period of adolescence the child experiences a growth spurt that affects both height and weight, which is closely linked to sexual maturation. Endocrinological changes govern the physiological changes which take place over a period of 1.5 to 6 years - with an average of 4 years. The physiological capacity of conception precedes the capacity to bear and care for an infant. There is a great deal of variation in the age of onset of puberty between children, and populations, the latter largely a function of differences in the nutritional status of children in different communities. The onset of menses is occurring at an earlier age. From 1860 to 1960 the age of menarche declined from 16.5 years to 12.2 in industrialized countries, largely as the nutritional status of girls has improved.

The completion of bone growth - both height and pelvic size and shape does not approximate adult status until two years after the onset of menses. The adolescent girl is thus capable of conception, but unlikely to deliver safely. In northern Nigeria pregnant adolescents under the age of 17 have a one in twenty chance of dying during pregnancy or childbirth. Those who survive have a high risk of serious, life long complications.⁸

The hormonal changes during adolescence confirm the gender identity and prepare the person for reproduction and parenthood. While the biological fact of puberty is unchanged from society to society, albeit its timing influenced by the health and nutritional status of the individual, the tasks and experiences of adolescents are particularly a function of the cultural structuring of adolescence as a period for the preparation for adulthood. While there has been a marked decline in the age of menarche there is little evidence that this is accompanied by a comparable marked shift in the cognitive, psychological and emotional capacity of children. The lack of synchrony in physical and emotional maturity will often put increased pressures on the adolescent who physically matures at a relatively younger age than his or her peers. Later maturation is generally associated with better affective adjustment. It must also be recognized that the adolescence follows childhood, retaining many child like characteristics, and only gradually achieving social and emotional maturity. The individual experiences physical changes and maturation, brain growth and cognitive development, and self perceptions.

There are both physical and mental health consequences that are associated with the physiological changes in hormonal and histological changes associated with the rapid physiologic changes of reproductive maturation and appearance of secondary sexual characteristics. During childhood and the transition to adulthood, the reproductive system of girls is particularly vulnerable to infection. The cells and secretions of the physiologically immature reproductive tract are much less able than in adults to resist invasion and damage by sexually transmitted microorganisms.⁹ The cervical epithelium goes through a process of transformation. The physiologic immaturity is characterized by particular cellular characteristics of columnar and metaplastic cells. These cells provide a poor barrier to invasion by a number of microorganisms, including those associated with pelvic inflammatory disease and its consequences of

infertility and ectopic pregnancy and those associated with cervical cancer, namely *C. Trachomatis* and human papilloma virus (HPV), two of the most common sexually transmitted diseases globally. The risks of these infections is associated with the proportion of the surface the ectocervix covered by these cells, the younger the age of sexual debut and the multiplicity of sexual partners. Under these circumstances, a later onset of menarche but an earlier onset of sexual activity greatly increases the immediate and long term consequences of the STDs in these young women. Because the presence of other STDs will also increase the likelihood of HIV infecting an individual, adolescent girls who have a later onset of menarche, but early onset of sexual activity will be at even greater increased risk of AIDS as well. Repeated *C. Trachomatis* which causes erosion of the normal cervical barriers, further increases the hazards of HPV infection and its subsequent risks of cervical carcinoma.⁷

Throughout adolescence self-esteem appears to be affected by their competence in certain valued domains - physical attractiveness, peer acceptance, and perceived support from peers, family or others. Identity is critical during adolescence. It reflects the formation of a stable, coherent picture of oneself that includes an integration of one's past and present experiences and a sense of where one is headed in the future. The process according to Erikson involves a series of selective narrowing of choices in the realms sexual, occupational and social roles and a progressive commitment to the choices one makes.

For the adolescent these developmental phases can be spoken of in terms of the need to attain or resolve a number of developmental tasks, *inter-alia*:

- adaptation to the physiological and anatomical changes associated with puberty and the integration of a mature sexuality into a personal model of behaviour;
- the progressive resolution of earlier forms of attachment to parents and family, and the development through peer relationships of an enhanced capacity for interpersonal intimacy;
- the establishment of an individual identity incorporating a sexual identity and adaptive social roles; ..."¹⁰

In meeting the health and development needs of adolescents it is important to recognize the interrelationship between the physiologic and psychosocial changes. Mood changes in adolescents are correlated with the hormonal changes that they are experiencing.

1.4 Developmental vulnerability and children as victims

Many individual and groups of children face major obstacles or destructive psychological or social circumstances that impede the attainment of the necessary developmental task or distort the development process essential to become a healthy, fully functioning adult. As in the case of the CSEC, the problems of children in other difficult circumstances are only seen in their social and economic context and not the context of their needs and vulnerability in attaining developmental health. Such children should be seen as being potential victims because of their vulnerability at a particular stage of psychosocial and/or cognitive development and their psychological, social, cultural and economic environment. Only recently are health professionals beginning to examine risk taking behaviours as a public health issue which, in the past, have been crises focused rather than developmentally oriented. For example, criminal and juvenile justice systems, as well as political authorities, see juvenile delinquency in terms of social and economic deprivation or the consequences of dysfunctional families. Yet Widom, Finkelhor and others suggest that a prime cause of delinquency may be the developmental stage of childhood victimization.^{11, 12} *Developmental victimology*", examines the developmental dimension of the risk of being a child victim, as well as the developmental aspect of the impact on the child victim.¹⁰

Athey and Ahearn¹³ in discussing refugee children make an observation that is equally applicable to CSEC. Children may be exposed to 'sociocultural risk' in which the environment of the child is lacking in the basic social and psychological necessities for life. Thus, risks can be related either to direct threats or insults to the child or to impoverishment, the absence of opportunities for development¹⁴ However, 'developmental

risk' is a statistical, epidemiological concept referring to increased risk of psychiatric morbidity, dysfunctional behaviour patterns (such as suicide, drug and alcohol abuse, or delinquency), or 'incompetence' in love, work or play. But 'risk' is not destiny, and children can and do overcome adversity.¹¹

Sexual abuse of children and the CSEC serve to illustrate the developmental aspects of risk which vary with age. The stage of sexual maturation is a determining factor in the nature of the targeting of child victims by the perpetrators.¹⁰ On the one hand pedophiles seek less mature children as their victims, whereas sexual violence is more likely in the physically mature, but not necessarily psychologically or socially mature child. Aside from intra familial sexual abuse, sexual violence to boys, as in instance involving girls, may be circumstantial, such as when children are institutionalized for care by child welfare or juvenile justice services in the absence of sufficient supervisory and monitoring systems.

The capacity for self-protection is also affected by the stage of development and maturation. The more extreme example of the developmental impact on victimization is seen among those individuals who have physical or intellectual limitations. They are unable to protect themselves and are particularly vulnerable to sexual abuse, and in some instances commercial sexual exploitation. Another group that would seem to be particularly vulnerable to both sexual abuse and exploitation would be girls who become physically mature at a young age but are socially and psychologically immature.

As Finkelhor points out, the developmental stages of a child interact with the characteristics of the environment they inhabit, affecting the risk of victimization. Children have limited autonomy over their own environments, and as they acquire greater control, "their risk of victimization appears to be less a matter of compulsory circumstances than of personal choices".¹⁰ He further notes that a "variety of developmental processes seem to affect these choices, including the formation of personal identities, acquisition of self/esteem, evolution of a personal style in interpersonal relationships, history of academic performance, and prior experience of violence and abuse"¹⁰

Based on this formulation, one can identify circumstances in which children are particularly vulnerable to sexual exploitation. For example, children whose developmental progress has been incomplete, yet sufficient for the child to continue striving for the accomplishment of developmental tasks, such as at the stages of pre-school and school age when there is a desire to please and a respect for authority. These children may be particularly vulnerable to pedophiles who initially appear to be supporting and caring. A second group that have been known to be seriously exploited sexually, and perhaps are among the most vulnerable, are children who are placed in residential or foster care because of domestic violence and/or abuse, or the parent(s) was unable to cope with or provide adequate care and protection of the child. The care facilities for such children attract potential pedophiles and organized sexually exploiting groups, particularly as there is often inadequate monitoring and supervision of such services nor is there sufficient screening or standards in selection of staff. In such settings, as in domestic abuse, and because of the developmental stage, the child is both threatened and made to feel guilty by the perpetrator. That guilt later becomes shame and the child is reluctant to discuss the abuse. Furthermore, they may perceive that their failure to speak out at the time made them accomplices.¹⁵

In discussing the developmental vulnerability of children special note must be made of children and adolescents exploited through sex rings and pornography. (see section 4.4)

2. Estimates Of The Extent and Inferring An Understanding Of The Circumstance Of CSEC In The Absence of Epidemiological Studies

Because CSEC represents an illegal or clandestine practice there has been a paucity of information on its health and developmental implications in the scientific literature. Only recently has there been a critical effort at assessing the methodologies for measuring the magnitude of the problem beyond the reporting that takes place within the criminal and juvenile justice systems. No reliable methods exist for the direct measurement of the magnitude of child prostitution, let alone the general area of CSEC. News reports

quote wide ranging estimates of the numbers of children affected, rarely with any reference to the methods used to derive these estimates. Over ten years ago, in a report commissioned by UNICEF, the weight of evidence was derived from either well documented case reports noted in the press, to judicial authorities or by advocacy groups, and population estimates with little in the way of documentation, apart from quotations from authoritative sources.¹⁶

Any effort to make an estimate of CSEC will have to be based on estimates of some indirect indicators which, at least within a given country and culture, are reasonably replicable and can be monitored over a period of time. Such an approach would allow for the use of the indicator as a measure for determining the impact of intervention programmes to reduce the magnitude of the problem. One such approach was described several years ago in Thailand.¹⁷ It involved applying known characteristics associated with child prostitution to derive an estimate of the population at risk of becoming child prostitutes based on the census data of 1990. At that time, the risk group was composed of migrant children, living in an urban setting, living apart from their family and not attending school. With nearly 4 million girls 11 - 17 years of age, only 1.7 percent have all four characteristics of high risk. Although not all of these girls can be considered as child prostitutes, girls having a lesser combination of characteristics could still be child prostitute. Another methodology was used by the Children's Rights Protection Center which based its estimates on the total population of commercial sex workers (CSW) and then estimating the proportion of the CSWs who were children.¹⁵ These methods provided a wide range of estimates of child prostitution in Thailand.

As a result of the lack of epidemiological data it is necessary to derive an understanding of the health and psychosocial aspects of CSEC from an analysis by analogy, drawing upon the scientific literature and studies of:

- intra-familial sexual abuse of children, which is noted to occur in both developed¹⁸ and developing countries.^{19,20}
- the consequences of early sexual activity of adolescents, including sexually transmitted diseases, pregnancy, abortion and unwanted births;
- clinical and epidemiological data on sexually transmitted diseases and their consequences;
- substance abuse among children and adolescents; and,
- street children.

III. Definitions of the commercial sexual exploitation of children

Commercial sexual exploitation of children is the use of a child for sexual purposes in exchange for cash or in-kind favours between customer, intermediary or agent and others who profit from the trade in children for these purposes.

The three forms of CSEC that the Congress will address have been defined by the United Nations as follows:

Child prostitution:

"Child prostitution is the act of engaging or offering the services of a child to perform sexual acts for money or other consideration with that person or any other person".²¹

Trafficking and sale of children across borders and within countries for sexual purposes:

The 1956 Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery defines the sale of children as "the transfer of a child from one party to another for whatever purposes in exchange for financial or other reward compensation."

Sexual trafficking is the profitable business of transporting children for commercial sexual purposes. It can be across borders or within countries, across State lines, from city to city, or from rural to urban centre.

An international conference on traffic in persons noted that "force", whether actually committed, threatened, or implicit in the abuse of authority or deception, was an important feature, though not a defining characteristic of trafficking.²²

Child Pornography:

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

The issue of CSEC is compounded by the varying definitions of childhood and adolescence, and their application in different cultural, social, religious and legal contexts in different countries. From the health and human development perspective it is important to distinguish sexual exploitation that occurs before, during or after puberty.

Article 1 of the Convention on the Rights of the Child states that, "For the purposes of the present Convention, a child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier". Since marriage confers on the individual the age of majority, the articles of the Convention are no longer applicable to such an individual.

While Article 5 recognizes the responsibilities of parents and care givers in providing guidance and direction to the child, it acknowledges that such guidance is exercised in the context of the evolving capacities of the child.²³ Such a distinction is particularly relevant in addressing the issues of CSEC because adolescence, for convenience and inclusiveness defined by WHO as being from the age of 10 through 19, represents the developmental stage between childhood and adulthood. It is characterized as a period of uneven and non-synchronous transition "characterized by biological development from the onset of puberty to full sexual and reproductive maturity; psychological development from the cognitive and emotional patterns of childhood to adulthood; and, the emergence from the childhood state of total socioeconomic dependence to one of relative independence."²⁴ The discordance of the age at which adolescents attain maturity has implication for their vulnerability to sexual exploitation, particularly with menarche in girls occurring at a younger age, and the age of marriage increasing. The earlier biological maturation, i.e., more mature appearance, of a young female adolescent may lead people to have social expectations of her that she may be neither capable nor ready to fulfil. Ennew²⁴ notes that although the age of consent for heterosexual acts in England was set at 16 in 1885 after the pressure of child prostitution scandals, yet the legal age of marriage in England was not changed from 12 years to 16 years until 1929. In the realm of sexuality, different interpretations of evolving capacity is reflected in the variation in the legal age of consent in those countries that have such legislation. In both heterosexual and homosexual relationships the age of consent, may fall within the age definition of a child within the Convention.

Both from the perspective of child marriage and any form of sexual activities involving children, by combining the biomedical and developmental definitions of sexual competence it is possible to define the circumstances that will result in ill health, impaired or damaged emotional, social and moral development of children resulting from inappropriate sexual activity. It is this framework that will provide the basis for discussing the health aspects of CSEC.

IV. ILLUSTRATIVE SCENARIOS OF THE COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN

A general understanding and reasonable mapping of the major pathways and circumstances characterizing CSEC is important in order to:

- develop policies and programmes to prevent the CSEC,
- humanely and effectively care for its victims, and
- to create a viable, satisfying future for its victims by facilitating their reintegration into the community.

For policy and programme development purposes it may not be necessary to obtain a precise epidemiological description of the problem. Through reasonable estimate procedures, adapting techniques used, for example, to estimate street children, substance abuse and other clandestine behaviours, gross estimates and ranges of the extent of the different patterns of CSEC may be possible. It is important to have at least some semi-quantitative feeling of the patterns and pathways into CSEC through the use of a mixture of epidemiological, anthropological, behavioural and social science, and modeling methodologies and techniques. Such a "mapping" and characterization exercise is useful if scarce resources are to be wisely allocated, and policies and programmes are to be appropriately directed at the overall problem, its antecedents and its health consequences.

The interrelationship of the different forms of CSEC was recognized over ten years ago by Hermann¹¹ who noted that "children who are involved in the production of pornographic materials are usually involved in prostitution, are frequently moved within and between nations for this victimization, are exploited to meet the pathological needs of pedophiles." His report, in large part derived from case studies, news accounts or police reports, documented the different forms in which the CSEC is expressed in both developed and developing countries.

The following scenarios are presented as examples of the different patterns and pathways by which children become victims of commercial sexual exploitation. The presentation of these scenarios does not imply that one scenario is more significant or tends to characterize CSEC more than another. Great care should be taken to avoid generalizations that may be too wide for the available limited information. For example, although childhood sexual abuse may not be an uncommon event among commercial sex workers, it is also not uncommon in population based studies, with 10 and 15 percent of adults in many developed countries having claimed to have been sexually abused as children.²⁵ In one sense the scenarios reflect the variation in the availability of information. Other scenarios may exist, or existing scenarios may be far more wide spread than is reflected in the scientific literature or the media. The pathways and expression of the CSEC remain undocumented and unmentioned in numbers of communities. Too often unseen is translated to absence and no need for action. Nor should lack of documentation be used as an excuse for excessive zealotry in the application of inadequately validated methods for documenting the problem on a clinical or community basis. Many of the antecedents of CSEC probably exist in most countries to a greater or lesser extent, although the form and level of CSEC of expression will be highly variable.

1. Street children, substance abuse and sexual exploitation

The street child has been defined as "any girl or boy ...for whom the street (in the widest sense of the word, including unoccupied dwellings, wasteland, etc) has become his or her abode and/or source of livelihood; and who is inadequately protected, supervised, or directed by responsible adults."²⁶ The Modified Social Stress Model which was developed by the WHO Programme of Substance Abuse⁴ and based on the work of Rhodes and Jason⁵ model of risk for drug use may in part be applicable, and in part adaptable to understanding and identifying priorities for action to eliminate the commercial sexual exploitation of children. In the PSA model stress (or distress), normalization of drug use and drug effect increase the risk of drug use. Elements that decrease the risk of drug use are the presence of strong attachments, coping strategies and resources. In the same way that the model may explain why not all street children become

substance abusers, it might also be applicable to explaining why only a portion of street children end up being sexually exploited for commercial purposes.

The stress factors cited by Rhodes and Jason⁵ are unfortunately all too common in the lives of large numbers of children and adolescents. These include: major life events, such as parental death or abandonment, natural or man-made disasters; everyday problems such as conflicts over finding shelter, clothing and food; enduring life strains as related to poverty, life transitions and the developmental changes of adolescence. In situations of hopelessness the only perceived models of success may be those of criminality or through commercial sex work. Among those who can be considered most vulnerable are the adolescent who is suddenly thrust into a world of adult responsibility, by choice or misfortune, and who has not had sufficient time to gradually complete the developmental tasks of adolescence. Countering the effects of stress are the factors of attachment - if positive - such as with family, school and peer group, and coping strategies and skills. The role of attachment, for example, is illustrated in the street child literature which describes a phenomenon in which girls from large families "enter the world of the street child" somewhat later than boys. This is often attributed to the girl assuming a protective, caring role for the younger children in an abusive or stressed household, until such time as the younger child is in a position to fend for itself.

1.1. Street Children And Runaways In Developed Countries

The scientific literature from developed countries shows a strong association of street children with intra-familial violence, substance abuse and sexual abuse. These children are characterized as "runaways, walk aways or throw aways". Often the perpetrators of violent and abuse behaviour is a male member of the family, himself a substance abuser. The maternal figure in the household is often a victim as well, frequently characterized as being weak and ineffective in her caring functions. The intrafamilial environment is characterized as lacking security and affection. The child's response is to seek and meet these needs in the "society and family" of street children and to treat his or her own wounds in substance abuse ranging from alcohol, glue or other chemical sniffing and the range of narcotics.

While prostitution has not been a particularly common consequence of childhood sexual abuse, among prostitutes studied in some developed countries, childhood sexual abuse was common.²⁷ Widom, in a matched cohort of children who had been abused or neglected, found that there was a 27 fold increase in the odds sexually abused child being arrested for prostitution in later life, although the overall rate of such an arrest among the sexually abused children was only 3.3%.²⁸ Widom and Seng conclude that sexual and other forms of abuse *per se* do not lead to prostitution, but that it leads to runaway behaviour which is more directly associated with prostitution.^{24, 29} In one review of research in the field, between 11 and 23 percent of runaway children became involved in prostitution, which in turn also made them more vulnerable to rape and pornography. It is also reported that most of the children under 16 years of age recruited for pornography in the U.S. are runaways.³⁰

The relevance of the sexual abuse literature as a source of analysis and understanding of the health and developmental consequences of and approaches to addressing the CSEC has been underlined by the in depth studies by Silbert on the effects on juveniles of being used for prostitution and pornography.³¹ She studied 200 women street prostitutes from four cities in the United States. Seventy-eight percent of the women started prostitution as juveniles and 61% were sexually abused as children or juveniles. At least in an North American setting, her observations challenge some of the causal assumptions that have focused on macro social and economic deprivation, but failed to take into account psychosocial, intrafamilial relationships and resiliency (or lack thereof). The majority of juvenile prostitutes described family structures that had the outward appearance of stability. For example, over three-fourths described a religious upbringing, with regular church attendance. However within the dynamics of the family the situation was quite different. Common features included excessive drinking and violence directed by the father at the mother. Over 60% of the subjects were beaten while growing up, and a similar proportion were sexually abused, usually by father figures - with half the victims blaming themselves for the abuse. A

sense of isolation, and serious attempts of suicide frequently followed such abuse. The backgrounds of the male juveniles engaged in prostitution is similar to the females in Silbert's studies.

Silbert notes that "while a number of juveniles were recruited for prostitution by pimps and other prostitutes, many reported that they were recruited by middle-aged women, *nurturing in style and appearance*[emphasis added]." Silber terms these women "house-mother", noting that they would take the girls to cafeteria, provide them with a meal and listen sympathetically to their stories. These women would slowly encourage the girls into prostitution by a continuous process of nurturing, concern and an offer to care for all their needs.

While the purpose of the Silbert studies was not explicitly focused on pornography, she noted in the analysis that there was a strong relationship between violent pornography and sexual abuse. She noted that of the 193 cases of rape studied, the women/girls spontaneously commented that the rapist alluded to pornographic material. Pornographic material was also noted to be widely used by the adults in sex rings to "show, teach or induce the children into the sexual activity or pornographic modeling."³² Silbert describes the use of such material being used for sexual arousal before intrafamilial sexual abuse of children. Nearly 40% of the women prostitutes spontaneously reported that sexually explicit photographs had been taken of them when they were children for commercial purposes.²⁸

1.2 Street Children In Developing Countries

In addition to family breakdown, physical and sexual abuse, other factors are important contributors to the phenomenon of street children in the developing world. These include severe poverty, armed conflict, famine, natural and man-made disasters, migration and urbanization with severe overcrowding and acculturation.

A variety of methods have been used for estimating the prevalence of street children. A National Joint Project on Street Children in the Philippines³³ estimated the number of street children at between 1 and 3 percent of the children in the 10 major cities in the country. Poverty, while an underlying factor in the phenomenon of street children in many settings, cannot be considered as a sufficient explanation of the phenomenon. A number of studies support the hypothesis that weak or disorganized family structures is a key factor in the problem. One report from Honduras among the children served by a health, education and social services programme, *Proyecto Alternativos*, contrasts the family circumstances and behavioural patterns of two groups of street children, those who are *in* and those who are *of* the street - the former being characterized as market children, the latter as street children, and both of which are associated with poverty.³⁴ Substance abuse, criminality, sexual activity and prostitution are common events among these children.(Table 3)

The proportion of street children engaging in overt prostitution may vary markedly from setting to setting. Sexual activity begins at an early age among street children, many of whom turn to prostitution as a means of survival. With their needs for affection and a sense of security, these children are easy prey for pimps, purveyors of pornography or traffickers. The initial pattern of sexual exploitation of street children is more likely to be one of an "exchange of sexual services" for protection and support within the community of street children. Initiation into sexual activity occurs at a young age - with a mean age around 11 years for girls, but not infrequently as a result of coercion according to a study of street children in Brazil.³⁵ In the same study, not only does the incidence of sexual activity among street children increase with age, but the nature of that activity is also a function of their changing developmental and survival needs. At a younger age sex with peers was both more common than with adults and described in terms of pleasure, protection or behavioural control by the peer group. Sexual activity with adults by girls and same-sex partners by boys increased in incidence with age and was in exchange for money, material objects or leisure resources.

In the Honduras setting one in five street children engaged in prostitution, whereas in studies among street children in Mwanza, Tanzania, 5 % of the girls were described as earning income through "informal sex work", although only one case was engaged in prostitution. Nine of 122 street children, at a minimum had

acquired an STD in the year previous to the study. However, virtually all the girls in the latter setting were drawn into relationships in which they were exploited sexually.

Street children of both sexes are at increased risk of HIV infection. In the studies from Brazil risk behaviour included nearly half of the children having sex while using alcohol or drugs, 20 percent of the girls and over 15 percent of the boys engaging in sex for money, high levels of previous STDs and low and inconsistent use of condoms.³²

AIDS is not only a hazard among street children engaging in prostitution, but increasingly at least in some areas of Africa, an important factor in becoming a street child. In the Tanzanian studies nearly 30% of the children cited being an “orphan” or “abandoned” because of AIDS as one of their reasons for being on the street, often when extended families did not accept them or failed to provide adequate care after the death of a parent.³³

Table 3. Criminality, substance abuse and sexual activity of Honduran street children (percent of children)

	Market Children N=900	Street Children N=108
Living with one or both parents	82.1%	28.4
Poor to fair relationship to family	22.4%	67.8%
Attends school	48.3%	10.1%
Ever been arrested	0.6%	47.7%
Substance abuse:		
glue sniffing	0.9%	56.3%
alcohol	4.0%	42.5%
tobacco	4.8%	57.4%
marijuana	0.1%	19.4%
Sexually active of whom treatment	5.2%	43.5%

received sexually transmitted disease for	40.0%	85.1%
Engaged in prostitution	5.4%	21.9%

2. Early Age Of Marriage And Other Traditional Practices In Traditional Society Subject To Rapid Change And Urbanization

In most traditional societies sexual activity of girls is normally initiated within marriage, albeit in many before or soon after the onset of menses - at times as young as 10 or 11 years of age. In an adolescent clinic population in Ethiopia, premenarche sexual initiation was noted to occur in 40% of the girls.³⁶ The hazards of sexual activity and child bearing before biological and social maturation have been well documented. In some settings, particularly when the man engages in sexual activity with other women, including prostitutes, outside of the marriage, the girls in such marriages have an increased risk of acquiring sexually transmitted diseases on two counts: the increased likelihood of acquiring such infections from their husbands; and their vulnerability to the consequences of such infections due to the relative lack of resistance of the immature reproductive tract. Data from several countries in Africa, for example have shown higher levels of infertility the earlier the age of onset of sexual activity. Marital discord is also more common with a younger age of marriage, and both circumstances are associated with child prostitution, often as a consequence of the child-wife running away and having no other means than prostitution for supporting herself.

Studies in Ethiopia³⁴ have shown that 42 % of prostitutes as compared to 9% of those still married to their first husbands had been married before the age of 13. Furthermore, nearly 70% of the women engaged in prostitution were sexually active before menarche compared half that number among a control group. Noting that half of all prostitutes were married for less than 5 years, a large number began prostitution as children.³⁷ Despite very high rates of child marriage, particularly in rural areas, the first coitus was at the time of or after marriage. In a study of the social-cultural background of early child marriage in Ethiopia, Dagne notes four major factors that have historically and continue to sustain the tradition, namely the “urgency to utilize the immediate capacity of parents to establish a family for their children; ...to enlarge kinship relations for protection and economic security; ... to conform to the norms of age old compelling tradition; patriarchal subordination of women placing high value on virginity.”³⁸ In other countries in primary infertility is a significant reason for divorce and an underlying factor in prostitution.³⁹

In some countries aspects of child prostitution have their roots in historical social and religious traditions. In India adolescent girls may be wedded to the temple goddess and spend their lives as *devadasis* - "god's servant". Priests and other men sleep with the *devadasi* to appease the goddess's desires. Young *devadasis* are highly regarded by some as deities, and then discarded when they grow old. One estimate suggests that 5,000 to 10,000 girls a year may be condemned to a life of sexual servitude and subsequently into prostitution.⁴⁰ A similar practice, referred to as the *Deuki* system, is found in regions of Nepal. The Nepalese authorities note that “a girl becomes a *Deuki* when she is brought from a poor family to be offered to the gods...she cannot marry and often engages in prostitution for economic support. Their children, known as *Devis*, are accepted in the society, but find it difficult to get married because of a traditional belief that some disaster will strike the husband’s family.”⁴¹ In part based on these traditions and an awareness of other traditions in which poor families sent their daughters to be prostitutes for Kathmandu’s ruling elite, traffickers have found it easy to lure large numbers girls to brothels in India, even with the collusion of their parents who see the wealth that these daughters bring back.

The practice of families placating gods by giving virginal daughters to traditional priests is not limited to Asia. Among the Ewe people of west Africa, a virgin daughter may be given to the shrine of the war god to atone for an ancestral crime. These girls, known as “fetish slaves” or female Trokosi serve life sentences at the shrines of traditional West African war gods. They are “condemned to a lifetime of hard labour, sexual servitude and perpetual childbearing at the service of the village priest... At some shrines when the woman dies, the family is expected to replace her with another female virgin... Fetish slavery is still common in the rural east (of Ghana, as well as areas of Togo and Benin), affecting an estimated 10,000 women and girls...”⁴²

3. Poverty And The Exploitation Of Children

In many areas of the world, increasing rural poverty, limited educational opportunities, lack of work and a pattern of bonded labour draw children into the labour market. The pathways of poverty to child prostitution are many and varied, affected to a large extent to cultural traditions of submission authority and powerlessness. Kaime-Atterhog et al describe a number of factors contributing to the sexual exploitation of children through prostitution in Thailand.⁴³ Selling children into prostitution had had an historical precedent in Thailand during the era of slavery when slaves, mistresses and concubines could be traded as goods and children, and could be used as collateral for loans. The complexity of relationships and responses by the children themselves is illustrated by the observation that, having entered prostitution against their will, many of the children nonetheless felt that they had fulfilled their obligations for the care and protection given them by their parents in raising them - thus gaining merit according to Buddhist principles. Despite the risks of disease and physical abuse, girls who had been sold into prostitution returned home with honour because they had brought money, goods and security to their families.

At times poverty, the aspirations of parents for their children and the naivete of the parents conspires to push children, particularly girls into highly exploitative and abusive situations with the CSEC being the end result. Research on the patterns of child labour in Kenya by Onyanga and her colleagues documented a scenario in which girls from rural areas have been sent by their families to relatives or others in urban areas in order to attend school in exchange for “some” domestic service on the part of the child. A large number of these girls are grossly exploited and not infrequently subject to physical and sexual abuse. If they become pregnant they are turned out of the household, often unable to return to their families, and ending up by surviving on the street, through prostitution or both.

There are many other ways in which children are drawn into CSEC: deception in offering families job opportunities for their children; bonded labour where children may be physically and sexually exploited and abused; and, even child sponsorship organizations have been used for the CSEC. In the latter instance, Hermann¹⁴ cites confidential reports of the use of well-known charitable organizations by pedophiles to gain access to and to sexually abuse their “foster child.”

4. Sex Rings And Pornography

While newspaper, magazines and the electronic media provide episodic and anecdotal accounts of sex rings and pornography¹⁴ only in the last decade has there been a systematic collection and analysis of the scope and impact of this form of sexual exploitation of children and adolescents. Burgess and her colleagues²⁹ have characterized this type of adult-child sexual involvement and undertaken a follow-up of victims initially identified by law enforcement agents. They define sex rings according to the number and use to which they put children in such groups. A solo ring involves one adult who is sexually involved with a small group of children. There is neither “transfer” of children nor are photographs provided to other adults. On the other end of the spectrum they describe the “syndicated” ring which involves several adults in a well structured organization which engages in the recruitment of additional children, often younger siblings of those already involved, the production of pornography, the delivery of direct sexual services, and

the establishment of an extensive network of customers. A transitional form exists which may involve more than one adult but without the structure of the syndicated ring.²⁹

The adult perpetrators of sex rings prey on the developmental needs and vulnerability of young children who seek to be praised and gain recognition by pleasing others, and tend to respect authority and obligations. (see Table 1) "Entrance into a sex ring introduces children to an elaborate socialization process that not only binds them to the ring but locks them into patterns of learned behavior. The maintenance of children in the ring is through a distortion of a belief system that convinces the child the activities are "normal"... The leader uses a peer network that forces a pattern of adaptation ...the adult acts benevolently and pits the group members against one another... The modeling activities of the adult, who poses, teaches and acts as mentor, further strengthen the group cohesion by appealing to the child's needs for attention, approval and affection. The use of alcohol and drugs, together with promises of extra money for the photographs, plays a key role in enticing the child. Thus, the child is bound by seemingly good forces as well as fearful, negative ones."²⁹ In the studies reported by Burgess et al "the adults were 'legitimate' in the lives of the children, and included a neighbor, a school bus driver, a coach, a scout leader, a grandfather, a teacher and an apartment manager."

IV. SPECIFIC HEALTH EFFECTS OF CSEC

The health aspects of commercial sexual exploitation of children should be seen both in terms of the clinical-pathological effects on the individuals as well as the psychosocial and psychosexual effects and its impact on public health and social development. The analysis would also need to take into account the interrelationship of CSEC with substance abuse, the phenomenon of street children and violence to children. Unfortunately, only limited information is available, leaving the picture of the health consequences of CSEC incomplete, and probably highly variable according to the different pathways and circumstances.

The health effects of the CSEC arise as a consequence of either the direct effects of sexual experiences or the circumstances that have led to the child's sexual exploitation. The effects relate to the consequences of infection, physical violence and/or sexual abuse, the toxic effects of substance abuse, pregnancy and the psychosocial impact of the experience according to the vulnerability and subsequent expression of psychological, emotional or mental development of the individual.

1. Health Effects Of Causal Or Co-factors Arising In The "Pathways To CSEC" And/Or Which Become Behavioural Outcomes

Other than the obvious consequences of sexually transmitted diseases, including HIV/AIDS, the health consequences of the CSEC among street children is in large part a function of their "street child" status and/or the antecedents of being on the street. Street children - whether being sexually exploited or not - often suffer from a variety of infectious diseases as a result of the unsanitary conditions of their environment, drinking water, food and eating arrangements and being unable to maintain their personal hygiene. Skin infections may be common, and infected wounds or other injuries not uncommon. They suffer from scabies and lice and are frequently malnourished, and stunted in growth. Among the street children of Mwanza in Tanzania, violence or neglect at home was cited among nearly 90% of the children as a reason for living on the street.³³ Street life adds to the hazards of physical injury and wounds among these children, as well as sexual attacks by adults and older children.

Substance abuse, whether as a primary entry point, as part of the behavioural pattern of street children or as a component of the CSEC *per se*, has very specific associated health consequences depending on the substances being abused, the route of administration and in the instance of intravenous substance abuse, cleanliness and sharing of needles. Intoxication increases the hazards of overdose, accidents, injuries, violence, rape, and unsafe sex. Some of the abusing substances, particularly solvents and other volatile

organic compounds produce liver, kidney or brain damage that can be permanent and life threatening. Needle sharing has been well documented as a risk for hepatitis, HIV infection and other blood borne infections.

Violence whether physical and/or sexual, and coming from many different sources, creates an aura of fear and insecurity. Whether originating in the family and as a causal factor in being a street child, or whether used as an expression of power and an instrument control by police or peers, violence in its many forms and health consequences, is part of the abusive environment of the street child. Violence, including psychological abuse, sometimes coupled with the use of toxic substances, alcohol or psychotropic drugs, also serves as an instrument of control of sexually exploited children and in trafficking of children.

Sexual abuse of children can be seen as both a pathway to commercial sexual exploitation and as an example of the possible health and developmental impact of the CSEC. To understand the impact of sexual abuse, and possibly CSEC, it is necessary to go beyond the usual approach in classifying sexual abuse in terms of intra familial or extra familial, and whether or not force and penetration took place.(see section 5.2.4)

2. Direct health and developmental consequences of CSEC

2.1. Infections Other Than HIV/AIDS

Sexually transmitted infections are the most common direct medical consequences of child prostitution, with HIV/AIDS the most serious of these infections, both for the child and public health. At present at least a dozen different microorganisms have been identified as being sexually transmitted and capable of producing disease in either sexual partner, the fetus or the newborn infant. The effects may either be immediately apparent or delayed and not manifest until years later. In the instance of infertility the effects are not apparent until failure of a conception in a planned pregnancy. From both the clinical and epidemiological perspective, one of the major problems in getting both health authorities and the public to take seriously the problem of sexually transmitted diseases is that in most instances initial infection is either asymptomatic or simply associated with annoying but not worrying local symptoms.

The immediate and long-term consequences of STDs span the clinical spectrum from localized genital tract infection, pelvic inflammatory disease(PID), ectopic pregnancy and infertility in the woman; genital tract, urethral stricture and infertility in the man; and, ophthalmia neonatorum, sepsis and meningo-encephalitis in the infant born of an infected mother. For those able to reintegrate into their communities and expecting to have a normal family life, infertility may be associated with a high level of social stress, marital instability and divorce.³⁷

Although rarely death-threatening, PID is one of the serious consequences of STDs. The definitive community-based study on the clinical and epidemiological pattern of PID has been conducted over a 17 year period in Sweden.⁴⁴ Throughout the entire study period, the incidence of first episodes of PID was highest in the teen-age group, thereafter decreasing with age. The risk of acquiring salpingitis in sexually active 15-year-old girls was calculated to be 1:8, and in girls aged 16 years, 1:10. The incidence then rapidly declined, and in women aged 24 years the risk was estimated to be 1:80. A correlation between early sexual debut and promiscuous sexual relations might explain the very high salpingitis incidence in the sexually active teen-age girls, although the biological immaturity of the younger adolescent's cervix may also contribute to the increased rates in the younger group. Similar associations of early onset of sexual activity with infertility have been shown in studies from other countries.

Infertility is a common consequence of STDs, and is both a consequence of prostitution as well as a factor forcing women into prostitution. Even in settings with well developed, appropriately used diagnostic and therapeutic services for STDs, non-gonococcal salpingitis, despite early and prolonged therapy, is associated a rate of tubal occlusion of over 15%. Following gonococcal infection in such settings the rate is 5.5%.⁴⁵ The risk of infertility following a single episode of salpingitis is increased five fold over the risk in women

who have never had salpingitis⁴⁶. In the African setting where many women are defined in terms of their capacity to bear children, divorce is a common consequence of childlessness and "one child sterility",^{47, 37} with women bearing its burden, even in instances when male infertility may be the cause. Such women - including those married as children, divorced from their husbands and unable to return to their family of origin, frequently turn to prostitution as a means of survival. Those married as children are particularly vulnerable on biological grounds, particularly in settings with the dual standards of virginity for the women, and where the urethral discharge of an STD in the man is considered confirmation of his coming of age.

Post-partum and post-abortion sepsis, in addition to being common causes of maternal mortality are associated with high rates of pelvic inflammatory disease and place high demands on the health services.⁴⁸ The frequency with which these infections occur are a function of the standards of maternal care, the extent to which women become aware of and seek care for such infections and the adequacy of the therapy provided. The problem is particularly acute among adolescent women who terminate an unwanted pregnancy, especially by unsafe, unskilled abortion procedures.

2.2. HIV/AIDS

Whether child prostitutes provide sexual services in an "organized" system or as a consequence of "street child survival", they are probably at much greater risk of acquiring HIV infection than older individuals in similar circumstances.⁴⁹ First, they are less likely to have been reached with accurate information on the risks and consequences of HIV infection. They are also less likely than older individuals to have access to information on and the means to prevent infection - including condoms, in large part due to their social marginalization. Even if they had such access, their powerlessness - whether due to their exploited position, social or economic circumstances or position of psychological dependency - and lack of skills to negotiate safe sexual practices would nullify the usefulness of the information.

Fear of AIDS has also been seen to be a factor in procurers and traffickers recruiting younger children into the system of commercial sexual exploitation on the assumption that they are less likely to be infected with HIV. There are also anecdotal accounts in eastern and southern Africa of an increase in the "sugar daddy" phenomenon, with older men establishing younger school girls as their mistresses on the assumption that they are more likely to be HIV negative. Unfortunately for all concerned the reverse is as likely to be true. There is already a higher risk of infection in the young adolescent with an immature reproductive tract. Furthermore, due to her age and power relationships, she is less able to negotiate safe sexual practices, once again raising her chances of HIV infection. There is another dimension of the relationship of HIV/AIDS and the CSEC which can be characterized in terms of social economic causality. The risk of children becoming infected with HIV may arise from the devastating social and economic consequences of AIDS wiping out or totally incapacitating the adult members of the family, forcing, as in the instance of street children into CSE situations as a means of self and family survival.

2.3. Other Sexually Transmitted Diseases And Their Consequences

Besides HIV infection the other three most significant viral sexually transmitted diseases are human papilloma virus (HPV), herpes simplex virus type 2 (HSV-2) and hepatitis B virus. HPV in its acute form causes genital warts, it may cause laryngeal papillomatosis in the infant born of an infected mother, and in its chronic form is among the causes of genital tract cancer. In some settings it is the most common STD among adolescents and is strongly associated with early age of onset of sexual activity and multiplicity of partners.^{7, 50} HSV-2 in its acute form causes genital ulcers, increases the risk of prematurity and may result in disseminated disease in the newborn, and, in its chronic form, is thought to be another of the microorganism associated with cervical cancer.

HBV will cause an acute hepatitis which is particularly fulminant among pregnant women in some parts of the world, and a significant cause of maternal mortality in some countries. HBV is even more likely than the other sexually transmitted viral infections to infect the newborn who is likely to become a chronic

carrier. In its chronic form it produces chronic hepatitis, cirrhosis of the liver, and cancer of the liver. While there is no specific documentation in the recent medical literature, one would expect higher risks of morbidity and mortality from HBV infection in individual with an already damaged liver, as from abuse through inhalation of organic substances.

2.4. Psychosocial And Developmental Consequences

Aside from the obvious consequences of sexually transmitted infections, psychological problems are the most widely discussed manifestations of the health effects of CSEC, or its antecedents. Few systematic or reasonably controlled studies exist on the psychological consequences of the commercial sexual exploitation of children. There is a well-developed scientific literature on the immediate and long-term consequences of sexual abuse which has been reviewed and analyzed by Kendell-Tackett et al⁵¹, but most of the remaining reports on the psychosocial consequences of CSEC have been limited to small series of case reports with no comparisons of unaffected children from the same or similar circumstances. Furthermore, the extent, depth and permanency of psychosocial damage is likely to be greatly influenced by the pathway that has led the child to a situation of commercial sexual exploitation, the manner in which the child is maintained in those circumstances and the degree to which the child is cut off from family and circumstances that would allow for the child's normal development.

The underlying assumption in the CSEC is that children in such circumstances are objects not individual human beings, and that sex serves as a commodity. Insofar as the child is a "late victim" of CSEC, some aspects of the child's developmental tasks may have been achieved to a greater or lesser extent. To the extent that CSEC is the end stage of psychopathology within a dysfunctional family, the depth, nature and likely duration of damage to the child is that much greater.

Post-traumatic stress disorder, as an acute response, is among the psychosocial consequences of child sexual abuse, violence and pornography, and may be found in other instances of the CSEC. It is defined as a psychological response to an event threatening death or injury that entails: 1) a sense of re-experiencing the trauma and the intrusion of memories or feelings; 2) a pattern of avoidance, a numbing of responsiveness, or reduced involvement in the external world; and 3) a persistent state of physiological arousal, reflected by such problems as difficulty sleeping, startle responses, and angry outbursts. The suitability of PTSD model to fully reflect the impact of CSEC can be questioned in relation to the degree to which force, violence or the perceived threat thereof enters into the sequences leading up to or maintaining the child in situations of CSEC.

Finkelhor¹⁰, in describing the developmental aspects of the victimization of children, distinguishes two types of effects, namely those that are explicitly developmental because they result in a disturbance of the developmental process, and those that are specific to the trauma experience, but without developmental implications. He refers to the latter as localized effects, many of which have the attributes of PTSD. The former effects can be characterized in terms of impairment of attachment, self-esteem, and interpersonal relationships; and, failure to acquire competence in peer relations, adoption of highly sexualized or highly aggressive behaviour or the use of drugs, dissociation, self-injury, or other dysfunctional ways of dealing with anxiety. The interference with the developmental process may impair both current and future developmental tasks.

In examining the impact on child sexual abuse Finkelhor and Browne⁵² undertook an extensive review of the published literature and analyzed the outcomes in terms of four trauma-causing factors: traumatic sexualization; betrayal; powerlessness; and, stigmatization. They noted that many of the trauma-causing dynamics are present in other traumatic circumstances, the "conjunction of these four dynamics in one set of circumstances is what makes the trauma of sexual abuse unique." Some of their observations appear relevant to the CSEC and are summarized in terms of the characterization of the trauma-causing dynamics, factors modifying the effects and the short and long-term consequences (Table 4, adapted from Finkelhor and Browne). By using this framework, and to the extent that the same trauma-causing dynamics are

present in the CSEC, it is possible to obtain a better overview of the short-term and long-term health and developmental effects of the CSEC.

Table 4. The traumatic impact of child sexual abuse

Trauma-causing dynamics	Characterization	Modifying elements	Consequences
Traumatic sexualization	child's sexuality shaped in developmental inappropriate interpersonally dysfunctional manner - may use sexual behaviour for manipulating others for meeting developmentally appropriate needs -misconceptions and confusion about sexual behaviour and morality	understanding of sexual implications may be less at younger developmental age	sexual preoccupation with knowledge and interest inappropriate to age - become sexually aggressive and victimize peers or younger children - risk entering prostitution - risk of sexual assault - inappropriate sexualization of own children leading to sexual or physical abuse - confusion in sexual identity - aversion to sex, negative attitudes to sexuality
Betrayal	trusted person has manipulated child through lies or misrepresentation about moral standard - realization that child treated with callous disregard by someone whose affection was important or family member unable/unwilling to protect or believe child after disclosure of abuse	extent to which child feels taken in by the offender - family's response to the disclosure extent to which	grief and depression over loss of trusted figure - need to regain trust and security, with extreme clinging and dependency - vulnerability of female victims to relationships in which they are physically, psychologically and sexually abused - aversion to intimate relationships and problems in successful heterosexual relationships or marriage - anger, hostile and aggressive - antisocial behaviour and delinquency
Powerlessness	a child's territory and body space are repeatedly invaded against the child's will - attempts to halt the abuse are frustrated - child feels trapped because of dependency	exacerbated by elements of coercion and manipulation imposed by the offender - increases if unable to make adults understand or believe what is happening -	Fear and anxiety common - nightmares, phobias, hypervigilance, clinging, somatic complaints - impaired efficacy and coping skills - expectation of revictimization - despair, depression and suicidal behaviour - compensation by unusual and dysfunctional need to control or dominate, particularly male victims - become bullies and offenders

Stigmatization	negative connotations of badness, shame, guilt are communicated to child by abuser and/or others with child being blamed - sense of being different	age and awareness of social attitudes - existence of strong religious or cultural taboos	feelings of isolation - gravitate to stigmatized levels of society - drug, alcohol abuse, criminal activity and prostitution - extreme effects in self-destructive behaviour and suicide attempts - low self-esteem
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Kendall-Tackett et al⁴⁹ have extended their analysis of the consequences of child abuse and organized the results of their review of the literature according to three age groupings which correspond approximately to the developmental stages (Table 1) of Erikson, Kohlberg and others. Aggregating the data from a large number of studies which presented quantitative data and in which comparisons were made comparing sexually abused and non-sexually abused children, they demonstrate the clustering of symptoms by developmental stage, as reflected in the three age groups. (Table 5)

Table 5. Effects of Sexual Abuse: Percentage of Children with Symptoms by Age Group

SYMPTOMS	Preschool	School	Adolescent
Anxiety	61	23	8
PTSD: Nightmares	55	47	0
Depression: Depressed	33	31	46
Withdrawn	10	36	45
Suicidal	0	-	41
Inappropriate sexual behaviour	35	6	0
Promiscuity	-	-	38
Substance abuse	-	-	53
Self-injurious behaviour	-	-	71
Composite symptoms: internalizing	48	-	-

externalizing	38	-	-
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Source: an adaptation of a table by Kendall-Tackett et al.⁴⁹

Long-term follow-up of sexual abuse victims has indicated that the psychopathological consequences vary according to the developmental stage at the time of victimization. (Table 5) Among preschoolers the most common symptoms associated with sexual abuse are anxiety, nightmares, general PTSD, internalizing and externalizing disorders and inappropriate sexual behaviour. For school-age children the common symptoms included fear, neurotic and general mental illness, aggression school problems, hyperactivity and regressive behaviour. Adolescents experience depression, withdrawal, suicidal or self-injurious behaviours, somatic complaints, illegal acts, running away and substance abuse. Changes in symptomatology are noted over time. In one study 65 % of preschool age children improved over one year. However, a number of studies also suggest that as many as 10 - 24 % show a deterioration over time.

The role of pornography and sexual violence and abuse has been widely debated, and not infrequently caught up in a broader social and political debate. There have been a wide range of methodologies applied in an attempt to prove or disprove the relationship. In many of the published studies the scope of the analysis lacks sufficient precision to test the hypothesis relating sexual violence and pornography or when a statistical correlation is established there is sometimes an uncritical assumption of causality. By the nature of the subject matter methodological rigour may not always be possible, and well controlled experimental studies entail assumption that may not be borne out in reality.

The health and behavioural science literature from developed countries notes that the sexual experience of children portrayed in pornography is accompanied by a sense of betrayal, guilt, feelings of worthlessness and rage. A number of studies indicate that sexually exploited children are at high risk of becoming sexual exploiters of children as adults.²⁵ Children involved in “sex rings” show a variety of somatic and psychosocial symptoms during the exploitation, at the time of disclosure and in the posttraumatic stages. Somatic complaints include urinary infections, headaches and stomach aches. Behavioural problems at the time of exploitation include difficulty in school, acting-out behaviours and sudden changes in behaviour. At the time of disclosure children display signs of post-traumatic stress, including re-experiencing the traumatic events, diminished responsiveness to the environment.

Burgess et al²⁹, in their analysis of the consequences of sex rings and pornography provide another useful framework with broad implications for the immediate and long-term needs of children who are sexually exploited, whether or not for commercial purposes. She and her colleagues characterized the response of 62 children two years after the sex rings in which they were involved were reported to the criminal justice system in the U.S. They characterized the responses in terms of the ability of the child to relate to participation in the ring’s activities; belief patterns - statements by the child about sexual involvement with the adult; symptoms of distress; and, bio-psychosocial performance - health and adjustment to school or work and to family, classmates, peers and authority figures. Based on the child’s responses in each of these areas, the investigators categorized the children according to one of four groups: *integration of the event; avoidance of the event; repetition of symptoms; or, identification with the exploiter.*^{29, 53}

Equal numbers of the children were characterized as falling into one of the four groups. Factors associated with the characterization are noted in Table 6. In the integration of the event the child has mastered the anxiety about the exploitation and believes the adult was not only wrong but was responsible for initiating the behaviour. These children were future oriented, and had reestablished friendships with a new peer groups. They showed evidence of making age-appropriate adjustments with peers, family and school. The event remained sealed off, consciously or unconsciously in those characterized as avoiding the events. The child is afraid of the offender, and so long as he or she is not under stress, is able to manage life as if nothing happened. The child does not have a sense of right and wrong, and in situations of stress depression and self-destructive behaviours appear. Relations in the family remain strained, school difficulties occur and persist, and minor antisocial behaviour appears. The child is very present oriented. In those characterized as showing signs of repetition of symptoms, with acute posttraumatic stress disorder

becoming chronic, the child's role and anxiety over being powerless are increased - the child being unable to master or control that anxiety. The child feels guilty and blames himself or herself. The family relationships are considered unstable, peer relationships are not reestablished, nor is the child successful in socializing with children of the same age but instead relates to younger children. The child continues sexually explicit behaviours, or may be repeatedly victimized. The child is described as being past oriented and may be hopeless about the future. In child that identifies with the exploiter assimilates his or her anxiety through impersonating the aggressor. The child exploits others and adopts an antisocial position toward peers, school and family. This child minimizes the exploitation and pornography, maintains emotional, social and economic ties with the offender, and use of drugs and alcohol continues and increases. The child's belief system has shifted to support antisocial behaviour, often serious and violent.

Table 6 Patterns of Stress Response of 62 Children Exploited in Sex Rings
by Sex, Participation in Pornography, and Length of Time in Ring

Characteristic	Integration of event	Avoidance of event	Repetition of event	Identification with exploiter
Sex				
Male	13	13	8	11
Female	3	4	8	2
Participation in Pornography				
Yes	6	7	9	12
No	10	10	7	1
Time in Ring				
< one year	10	11	3	0
> one year	6	6	13	13

Silbert reported that involvement with pornography was among the most difficult experiences for children and juveniles to cope with. These children experienced a long-term deep humiliation, with feelings of unworthiness and dirtiness pervading all images of themselves. The problems became compounded over time, partly out of an inability to disclose the exploitation or to resolve it in any healthy fashion. As juveniles and adults, they have an overwhelming sense of being out of control in their lives, even despite long and intense supportive care. Silbert describes the situation as being one of psychological paralysis arising from extended and repeated situations which lead to "learned helplessness".

Some of the observations on the mental health of street children may also fill some of the gap in the knowledge of the mental health impact of the CSEC. In the Tanzanian studies previously cited, many of the street children show some of the signs of PTSD. They wet themselves at night, wake up screaming, exhibit signs of mental “breakdown” and draw pictures that depict tremendous pain and confusion.²⁸

2.5. Intergenerational Effects

The intergenerational health and human development effects of CSEC may be physiological, psychological or a function of the social context of the sexual exploitation or its precursors. Whether pregnancy is intended or not, if continued to term, the effect on the newborn are very much a function of the life styles and circumstances before and during pregnancy and at the time of delivery. One would expect a high rate of prematurity, intrauterine growth retardation and low birth weight among the infants of girls caught up in commercial sexual exploitation, in large part due to the poor nutrition, micronutrient deficiencies, high levels of smoking and alcohol use, as well as the specific effects of psychotropic drugs and other substance abuse patterns. Substance abusing girls, particularly those using alcohol or solvent sniffing, have a very high risk of giving birth to children with congenital defects that damage the growth, psychosocial and cognitive development of their infants. The majority of such infants are born premature, exhibit postnatal growth deficiency, microcephaly and developmental delays in infancy and childhood; they have a high risk of perinatal mortality.⁵⁴ High levels of alcohol use during pregnancy greatly increases the risk of fetal alcohol syndrome which is associated with impaired motor and cognitive development and attention span defects which affects the child’s learning capacity and performance in school.

Although no precise data are available on the outcome of pregnancy among sexually exploited girls, because of the well documented high rates of STDs and their effect on inducing premature onset of labour, one would expect a high rate of prematurity among such births. These infants would be expected to have higher rates of neonatal mortality and morbidity because of the expected poor health of the girls, their very young and the likelihood that births to such girls would not be well attended, thus subjecting the infants to higher rates of birth trauma and other complications. Aside from the specific toxic effects of substance abuse, since smoking may also be common and intense among some populations of children being sexually exploited, the infants are likely to suffer from intrauterine growth retardation, clinically manifested as being small for the gestational age of the newborn. These children, while not suffering excessively high rates of neonatal mortality, are likely to bear the impact of an inadequate intrauterine environment in terms of learning capacity and learning disorders, attention span difficulties and other neurological sequelae. These morbidities are all the more likely if the infants are not provided a strong caring and stimulating environment for meeting their developmental needs. Infants born of girls who are substance abuse may go into withdrawal symptoms, suffer seizures and possibly die.

The psychological state of the mother will greatly affect the survival and development of the infant born into such circumstances. Dependent in part on the degree of control that the child-mother has, the experience of pregnancy and bearing a child may be translated into one of two forms: the girls self-esteem may be enhanced - which if reinforced with the support and transfer of caring skills, may offer one avenue of rehabilitation, or her lack of self-esteem and self-loathing may be reinforced, leading to post-partum depression, neglect or abuse of the infant, and/or further self-destructive behaviour by the girl. In the latter circumstances, unless decisive action is taken to ensure a consistent and supportive caring environment for the infant, it will start life with a lack of attachment and a legacy of mistrust, doubt, compensated either by aggressive behaviour or withdrawal - a poor candidate for later care and schooling.

Those children who have been caught up in the web of CSEC as a consequence of physical, emotional or sexual abuse, particularly when they come from substance abusing dysfunctional families, are unlikely to have suitable adult models of parenting and caring to draw upon in their own roles as mothers. Under these conditions they will be at great risk of perpetuating the behavioural cycle of physical, emotional or sexual abuse to their off-spring.

3. Public health consequences of CSEC: the special circumstances of HIV/AIDS and STDs

As has been the case of STDs and despite a long period of denial by many governments and cultures, the advent of HIV/AIDS has catapulted a range of social health and behavioural issues to the forefront of the global public health agenda. No longer is it possible for STDs to be dismissed as signs of the rites of passage of young men. Nor is it any longer possible to ignore commercial sexual exploitation, particularly of children. While there are no precise quantitative figures on the extent to which the CSEC contributes to the spread of HIV/AIDS, it is not unreasonable to speculate that CSEC is significant and an important public health problem in the context of AIDS. This assessment is based on our knowledge of the patterns of child trafficking - including cross-border, the role of commercial sex workers in the HIV/AIDS epidemic, the timing and initiation of children into commercial sexual exploitation through various pathways, and the enormous rate at which the epidemic has swept different areas of the world.

There are two dimensions to the public health aspects of the CSEC. The most obvious and immediate is the possible role of CSEC in the spread of HIV/AIDS. While there is no clear evidence, the involvement of children in the commercial sex work could possibly increase the rate of transmission of HIV - first because of their increased biological vulnerability to STDs, and second, because of the lack of power in negotiating safe sexual behaviour. It is also reasonable to hypothesize that wherever trafficking of commercial sex workers takes place the spread of HIV transmission from one local to another is also facilitated. Trafficking in such children within country and between countries would probably be quite high. Furthermore, when such children "burn out", whether due to AIDS or other infectious, nutritional or psychological causes, they may be sent or shipped back to their places of origin, or left to fend for themselves. In such circumstances they may be more vulnerable to further sexual violence. In addition, not wishing to become pregnant, and unable to negotiate safe sexual behaviour, the child sex worker may resort to contraceptive methods, such as the intrauterine device (IUD) or the oral contraceptive pills, that do not depend on the partner's behaviour. The IUD increases the risk of acquiring STDs by causing erosion of the cervical mucosa and providing a means for ascending infection. PID is one of the major and frequent complications of IUD use among those with a multiplicity of sexual partners. The oral contraceptive pill is associated with increased rates of cervical ectropion which exposes the transformation zone and endocervical epithelium to bacterial and viral agents. It is thought that this might explain the increasing rates of cervical cancer, and could contribute to HIV transmission.

Having been girls or young adolescents at the time of initiation into CSEC, even if these children are aware that they have treatable conditions other than HIV, they are likely to have less knowledge, confidence and negotiating skills in seeking and obtaining medical care, thus increasing their risks of progression of such conditions and the acquisition of HIV, if they are not already infected. They are less likely, unless they have established some form of information and support networks, to draw upon the resources of other programmes such as training and education, housing, etc.

VI. EXPERIENCES IN HEALTH CARE AND REHABILITATION OF VICTIMS OF CSEC, WITH PARTICULAR REFERENCE TO THEIR HEALTH AND PSYCHOSOCIAL DEVELOPMENTAL NEEDS

There are few published reports on specific health care and rehabilitation of victims of CSEC. Much of what is known in the field has been drawn by analogy from HIV/AIDS control work among commercial sex workers, street children and the principles of community development work among the networks of nongovernmental organizations. Despite the lack of specific experience there are a number of principles that appear to work reasonably well for a variety of circumstances. These include ensuring the involvement - and preferably the sense of ownership - of the "beneficiaries" of programmes in setting the priorities, approaches and content of programmes, and in the managing and evaluation of such programmes. Health may or may not be their first priority. More often than not the first choice of these children will be in terms of personal security and skills for immediate daily living and personal appearance. While they may

seek care for painful conditions and symptomatic illness, once care is provided other immediate needs are likely to take precedence. A major principle in such programmes is flexibility. In the literature on street children, and by implication, including some victims of the CSEC, there has been an extensive discussion of the merits of open versus protected residential facilities. The rationale for the latter has been to protect the child from those who have sexually exploited him or her. On the other hand, the price paid for “protected” residential facilities is the confidence building of “choice to stay or choice to leave.” Many in the field have expressed the view that the process of choice is such an important part of the rehabilitation process, that it is worth the risks except under the most extreme situations of threatened violence.

On the whole the health system and health workers are ill-prepared to address the health and psychosocial needs of victims of CSEC. Most health services and care providers are somatic disease oriented, and, except for those who have been seriously engaged in the efforts to prevent, treat and care for those with HIV/AIDS, they are very uncomfortable dealing with any issues related to human sexuality in any form. Health workers, being inadequately trained in human sexuality and all of its health and psychosocial dimensions, carry their own biases and judgements when dealing with such problems. Furthermore, public services for health care are rarely designed to take the needs for dignity and confidentiality into account in health care practice. The organization of health care, particularly in large urban centres, removes the continuity of care provided by the consistent and sympathetic laying on of hands, so important in reinforcing the child’s sense of human worth.

1. Existing Judicial And Social Response To CSEC

The mapping of the social and judicial responses to CSEC is an essential component in establishing policies and programmes to address the health and child development consequences and in preventing further damage to the health and development of its victims and to protect their rights. Such a mapping exercise of pathways must include an examination of the systems to deal with the victims of CSEC not only from the perspective of protecting their rights, but by adapting their processes and procedures so as to take into account the developmental and health needs of the child at different ages and stages, where possible facilitating that development, but above all, doing no further harm. It is the parallel adage of the Oath of Hypocrites, “physician, do no harm.”

VII. An agenda for action of the health and developmental needs: Filling the gaps for policy and programme development and implementation

The lack of direct and specific information on the health and human development implications should not be an obstacle to effective action. However, action without evaluation is a waste of human resources and energy, depriving others of the lessons learned and denying community, national and international solidarity essential to mobilize all relevant disciplines and parties with those most affected. There is a great deal of analytic work that could be done on existing analogous data to refine the hypothesis and provide guidance on programme development and design that could then be subject to evaluation/operational research. Much of the existing information remains inaccessible to other interested parties and groups. And those currently providing care and services frequently do not have access to methodological developments that would facilitate the analysis and understanding of their own experiences and data. Similarly, there are a number of participatory methods that have been developed for other aspects of health development that could be adapted and applied to CSEC.

One of the major challenges is to build action coalitions involving affected children, community groups, academic institutions and governmental bodies which cut across the spectrum of disciplines such as health, education, child and social welfare, the judiciary and the private sector. The broad issues should define “what are the needs?” and “what works?” Among the issues that might be addressed are:

- what simple methods exist and can be readily adapted to defining the needs of CSEC in different settings and circumstances?

- what kind of counselling, care and support services are appropriate to meet the needs of these children in their different settings?
- how can existing services be adapted, improved or otherwise modified to better meet the needs of such children? What alternative forms of care and organization of care might be more effective and efficient?
- how suitable to the needs of these children are the existing health care structures and facilities?
- what are the most effective participatory modalities to ensure the confidence and sense of ownership of programmes by those most affected?
- can effective preventive programmes be developed in collaboration with families, community institutions and other bodies in the areas from which children are drawn for CSE?

The commercial sexual exploitation of children represents one of the most important challenges to modern and developing society. Just as HIV/AIDS is now understood to be a societal priority that goes beyond the traditional bounds of medical care and public health, the commercial sexual exploitation of children must similarly be understood. CSEC is an issue of health care and it is a concern for public health. But above all it is about fundamental and universal human values and individuals with faces, names and aspirations. In one sense, the issue of the CSEC has become a lightning rod for the seriousness with which governments, representing well over 95% of the world's children, take and will give effect to the Convention on the Rights of the Child. It is also a test of the degree to which such governments trust and share responsibility for action with their own people. The last thirty years of health care development in support of women, children, families and communities has taught us that all sustainable programmes derive from negotiated processes among equal partners.

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