



Creating a Healing Environment

Volume I: Proceedings

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



IPEC Trafficking in Children-South Asia (TICSA)

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



Creating a Healing Environment

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Kathmandu, Nepal**

Foreword

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

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

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the technical areas that this project focuses on is the intake, rehabilitation and reintegration process for children withdrawn from sexual exploitation as a result of a trafficking process. The project realized early on that some of the children who are withdrawn from engagement in prostitution indeed have needs that demand special attention from the moment of intake.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

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

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

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

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

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

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

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



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Introduction

Background

Today, tens of thousands of children and women across South Asia live in sexual servitude, victims of duplicity, coercion and illegal transportation. While trafficking and the abduction of persons for sexual purposes have existed on the sub-continent for millennia, concerted efforts at prevention have been made only in the last 15 years. Accompanying preventive interventions, in the last decade dozens of non-government organizations (NGOs) and government bodies with the support of donor organizations have been seeking ways to release children and women from the brothels and assist them in returning to their homes and communities, or in some cases starting new lives in South Asian society. Efforts at release are problematic, and at this time are primarily limited to ‘rescue raids’ on brothels to secure children presumed to be trafficking victims, and attempts at intercepting traffickers in the act of transporting people across national borders. At the same time, efforts to assist trafficking survivors to successfully re-enter society – most commonly termed ‘rehabilitation’ (or ‘recovery’) and ‘reintegration’ – are also problematic, and NGOs, governments and donors are now facing challenges that they have not faced before.

The challenges of rehabilitation are found in addressing the psychological and physical trauma frequently undergone by victims of trafficking. Children may be deeply affected by removal from their homes, incarceration, rape, physical abuse and repeated forced sexual intercourse, compounded by guilt and social stigmatization for being a prostitute. They may have physical problems resulting from rape and beatings, or communicable diseases such as tuberculosis or HIV/AIDS. While attending to physical trauma is within the experience and capacity of the existing medical system in South Asia,

attending to psychological trauma is a relatively new and limited field on the sub-continent. Psychiatrists, psychologists and professional counselors are in short supply for South Asia's immense population, and basic concepts of psychological and social care have yet to 'percolate down' to those caring for trafficking survivors.

The reintegration of trafficking survivors into mainstream society also has many challenges – primarily stemming from South Asia's socio-economic situation and from its culture, traditions and mores. Prejudice against sex workers – even those forced into the profession – is almost universal and is nearly impossible to eradicate. Extreme gender discrimination and patriarchal social rules not only make survivors subject to continued harassment and often rape, but restrict them from finding a place in the working world and from living independently from family or male protectors. In addition, the socio-economic situation of South Asia provides few opportunities for any young person, much less a trafficking survivor, to find adequately paid employment, particularly that which provides income comparable to prostitution.

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In the last five to seven years, NGOs and governments with donor support have established numerous facilities for the rehabilitation and reintegration of child trafficking survivors, as well as survivors of domestic violence, abandonment, rape and abusive labour situations. In some cases, these facilities were established almost overnight, in response to efforts that released children and women from brothel situations or forced the closure of established brothel communities, putting them on the streets. With the best of intentions, NGOs who had previously been working in women's economic empowerment, legal rights, agricultural development and other areas have established facilities while having limited knowledge and experience in psychosocial care of the abused. Similarly, supporting donors have initiated psychosocial care interventions and promoted government plans of action to address rehabilitation and reintegration while drawing on relatively limited experience in psychology, social work and the operation of care institutions for the abused.

In this short time, much important work has been accomplished: many physical facilities are in place; NGO workers, government persons and donors have increased knowledge and awareness of the complexities of rehabilitation and reintegration; and strong networks of concerned organizations have been established, facilitating rapid sharing of knowledge and experience. However, after these early years of enthusiastic effort, most working in the field are aware that the 'bottom line' of rehabilitation/reintegration efforts – the number of children who have been successfully reintegrated – is less than desired. The challenges remain and often appear insurmountable, and a re-thinking of concepts, challenges and strategies is needed both to refine the methods presently used and to develop new and more effective methods to assist the recovery and rehabilitation of trafficking survivors.

Objectives

In its role of strengthening the capacity of South Asian governments and organizations to provide rehabilitation and reintegration services to survivors of trafficking and other worst forms of child labour, the ILO-IPEC Trafficking in Children South Asia (TICSA) Sub-regional Programme held the South Asian Technical Meeting on Psychosocial Rehabilitation and Occupational Integration of Child Survivors of Trafficking from 11 to 14 June, 2002. Approximately 40 participants and 15 observers attended from Nepal, Bangladesh, Pakistan, India and Sri Lanka, as well as Thailand and the Philippines. In the selection of participants, ILO-IPEC recognized the need to create dialogue and understanding across the wide spectrum of roles that are integral to the rehabilitation and reintegration of survivors of trafficking and other worst forms of child labour. Participants thus included NGO managers and childcare workers, psychologists and social workers, all of whom work directly with children, and representatives from the government, labour and private sectors, who provide the legislative, advocacy and economic structures and policies by which countries can address the concerns of survivors.

The intention of the seminar was to stimulate a re-thinking of essential features of rehabilitation and reintegration, to acknowledge and address the limitations of present interventions, and to chart a path towards a more professional, child-centered and compassionate system of caring for and reintegrating trafficking survivors. Recommendations for a 'plan of action' were not sought from the participants; rather they were encouraged to reflect on their work, on the challenges to success, and on more effective means to address those challenges.

The objectives of the technical seminar were:

- a) to examine the present concepts and methodologies used in recovery and reintegration, acknowledge their advantages and limitations, and seek new paradigms for work with survivors of trafficking and other worst forms of child labour;
- b) to establish the groundwork for psychosocial care services that are based on professionalism, accountability and basic standards of quality care; and
- c) to address key issues of practical concern to those working with trafficking survivors.

The activities of the technical meeting were focused on practical applications in rehabilitation and reintegration. With due regard for their importance, issues regarding legal/court processes involving survivors and issues regarding legal instruments, prevention, release and cross-border repatriation were not included in the programme.

The paper presenters provided participants with focused, technical information, while avoiding the generalizations with which they were familiar. Subsequently, participants were given an opportunity to apply those ideas and methods to realistic settings through focused group work. Emphasis was placed on the applicability of existing and proposed activities, and through group feedback participants were encouraged to conduct 'reality checks', to assess whether a concept, method or strategy was genuinely applicable to the day-to-day reality of the caregiving facility.

Areas of Focus

To provide a working structure for the complex subjects of rehabilitation and reintegration, the meeting was designed to sequentially address the needs of participants in their work to strengthen care systems, whether as caregivers, programme designers or facilitators of government and private sector support. Prior to the technical meeting, the ILO-IPEC team identified eight interlinking areas of focus for input, reflection, discussion and debate. Beginning with identification of the survivor, the caregiver and their needs, the areas of focus progressed through stages of strengthening rehabilitation responses, and ended with methods for ensuring effective reintegration of survivors, as follows:

1. Understanding the abused child and the role of the caregiver
2. Establishing effective, professional systems of psychosocial response
3. Conducting interventions within the cultural setting of each country
4. Human resources development for caregiving facilities
5. Training in psychosocial counseling
6. Standards and guidelines for the operation of care facilities
7. Establishing systems for reintegrating survivors
8. Providing survivors with practical means of earning a living

For each area of focus, a technical paper was presented, followed by discussion and/or intensive group work in which the participants applied basic ideas to the care setting. The areas of focus, and the paper presenters were as follows:

The Child And The Caregiver

Dr Shekhar Seshadri, NIMHANS, India

Case Management For Abused Children

Atchara Chan-o-kul, CPRC, Thailand

Indigenizing The Caregiving Process

Dr Elizabeth Protacio-de Castro, University of the Philippines

Human Resources For Caregiving Facilities

John Frederick, ILO-IPEC Consultant

Training For Counseling The Abused Child

Mark Jordans, CVICT, Nepal

Quality Of Care Standards And Guidelines

John Frederick, ILO-IPEC Consultant

Strategies For Effective Reintegration

Alexander Krueger, ILO-IPEC Consultant

Occupational Reintegration And The Enabling Environment

Margot Lobbezoo, ILO-IPEC Consultant

Crosscutting Issues

While areas of focus for the technical meeting provided a sequential analysis of the caregiving process, a number of core issues were relevant to all stages of the process. These issues were initially presented either by the presenters or participants, and arose repeatedly in presentations, discussion and group work, to be ‘unpacked’, examined, questioned and clarified.

1. Understanding the child: how children feel, think, communicate and express their needs; the caregiver’s conception of the child and childhood.
2. Child participation: mechanisms to actualize participation; determining the areas in which children should participate; determining the parameters of participation.
3. The role of the caregiver and the adult: the role of ‘adult guidance’ in the healing process; the balance of child participation/freedom and adult guidance/authority.
4. Clarifying ‘rehabilitation’: children’s role in their own healing process; placing ‘counseling’ within a larger context of the ‘healing environment’; recognizing other important forms of intervention.
5. Clarifying ‘reintegration’: children’s rights to decide their future; community and family participation in reintegration; addressing the abusive home environment.
6. Professionalism and quality of care: professional responsibilities in caregiving; assessing and monitoring the level of care in a facility; resource limitations to providing quality care.
7. The caregiving facility: the functions of different kinds of facilities; the facility as a ‘healing environment’; ‘closed’ versus ‘open’ facilities.
8. The cultural and socio-economic challenges of South Asia: gender and caste/class discrimination; patriarchy and gender violence; discrimination against the sexually abused; problems for the working female; addressing the lack of opportunities and options.

The Technical Meeting

The Child and the Caregiver

Interventions on behalf of sexually abused children, including those who are survivors of trafficking for sexual purposes, must be based on a full understanding of the psychosocial dimensions of the effect of abuse on the child. Dr Shekhar Seshadri (National Institute of Mental Health and Neurosciences, Bangalore), in his paper “Addressing Sexual Abuse: Dimensions, Directions and Good Practice Parameters for the Care Setting”, presented a critique of the limited comprehension of the effects of trafficking into prostitution upon the child. “The trauma of child trafficking for commercial sex purposes goes beyond conventional impact mentioned in traditional models of trauma”, he explained. **Healing interventions must address a complex set of impacts, and are not limited to ‘counseling’ alone.** Understanding of these impacts is necessary for caregivers in order to provide a comprehensive set of responses to facilitate the healing process.

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The basis of understanding the impact of trafficking on children is the recognition of the personhood of children, and the effect of trafficking on their sense of selfhood and on their own affirmative sexuality. As with trafficking of children for other forms of abusive labour, trafficking for prostitution gives the child feelings of “dislocation, deprivation and the absence of nurturance and trust” that is normally provided by the family. The sexualization process that is a result of prostitution has particular effects on the child, affecting her/his sense of selfhood, distorting her/his sense of affirmative sexuality, and giving the child a feeling of loss of control over her/his life. This in particular is insufficiently addressed in most intervention models. **The individual caregiver’s lack of recognition and acceptance of affirmative sexuality can lead to subtle prejudices in**

treatment of the sexually abused. It is necessary, Dr Seshadri stated, for caregivers themselves to seek an understanding of their own selfhood as children – a personal understanding of what life is like ‘through children’s eyes’ – and to seek an understanding of their own sexuality.

The trafficking situation also disturbs the child’s confidence in relationships and affiliations, bringing about a sense of alienation and suspicion of others. The natural life processes of child – the simple acts of sleeping, waking, eating and playing – are distorted in the brothel situation. **The feelings of continuity, regularity and coherence which are so important for the young must be addressed first and foremost in the care setting, through providing a stable, secure environment, family-like experiences, play and personal interaction.**

Dr Seshadri presented the varying manifestations of the impact of sexual abuse on the child: “emotional reactions, negative self-perception, physical and somatic symptoms, sexual effects, interpersonal effects, and a negative sense of guilt”, while noting that these manifestations span a wide range of severity. Assessment of these levels of severity by those in everyday contact with the child, he emphasized, is an important role of the caregiver, because severe levels must be referred to trained professionals and should not be addressed by para-professionals.

// A para-professional working within the framework of a shelter or transit home plays the crucial role of identifying the more severely affected children and networking with trained professionals to make depth interventions available to these children. At the same time, a para-professional needs to be skilled in basic techniques that facilitate the healing process and give the child a sense of security, predictability and control. //

Paper, Dr Shekhar Seshadri, NIMHANS

In distinguishing rehabilitative tasks performed by para-professionals and others within the facility from the in-depth counseling tasks performed by professionals, Dr Seshadri presented an overview of the essential issues to be addressed in counseling. The healing process proceeds through five basic stages. The first three are activities which can be performed by para-professionals: 1) establishing rapport with the child and gaining her/his confidence; 2) identifying and addressing the immediate issues of the child's concern; and 3) containment techniques to address psychological discomfort, including relaxation, providing routine activities and acknowledging the child's needs and feelings. The latter two are generally the province of professional counselors, psychiatrists and psychologists: 4) memory work to identify the psychological problems the child may be facing; and 5) the internal healing process. The internal healing process provides the child with a reclamation of selfhood, bringing the child from the negative abuse cycle of confusion, self-estrangement, poor coping skills, entrapment and negative self-image to a positive healing cycle of clarity, self-awareness, good coping skills, empowerment and self-acceptance.

Dr Seshadri emphasized the importance of the broad caregiving setting – the 'healing environment' – in the healing process of the child. **“The generic purpose of intervention in shelters, transit homes and agencies is to provide experiences that counter the impact of the trafficking-sexualization-abuse process”**. He presented the following model.

ABUSE SITUATION

Unpredictable

Unstructured

Potential for violence

No opportunity for reflection

Child's needs not addressed

No organized recreation, discussion,
validation, ventilation

No activities that address growth.
creativity, imagination

Child not consulted

Child not in control

Mobility restricted

No scope for healing

INTERVENTION

Predictable
(including routine creative activities)

Structured

No potential for violence

Opportunity for reflection

Child's needs addressed

Present

Present

Consultation mandatory

Involvement in decision-making

Mobility provided – even if in the
freedom to share, think, imagine

Interventions based on child's right to
recovery and reclamation

In conclusion, Dr Seshadri reiterated the importance of organization and daily scheduling within the facility. This, combined with skills in communication and techniques of reassurance and with basic activities like art, theatre and yoga, can “provide the child with the structure and nurturance that was lacking in the trafficking situation.” In the discussion that followed, participants and the presenter discussed issues of preventing the child from relapsing into a prostitution situation, providing counseling for parents, governmental policies necessary to address rape, and providing counseling for offenders.

Case Management for Abused Children

Each child survivor enters the facility with a unique history, individual problems and needs, and a unique potential for recovery and reintegration.

Case management is an essential tool to address the individual needs of each child, to provide efficiency and order in the caregiving process, to monitor the progress of the child, and to clarify and harmonize the roles of all persons involved in the child’s recovery.

Ms Atchara Chan-o-kul of the Center for the Protection of Children’s Rights (CPCR) Foundation of Bangkok, Thailand, in the presentation of her paper “Case Management Guidelines for Child Protection and Care Services”, provided the participants with an outline of the case management system developed by CPCR over more than 20 years of experience working with trafficked and abused children. Ms Atchara’s paper presented the conceptual framework, practical approach and working methods of case management that can be applied to facilities in South Asia.

In her presentation, Ms Atchara repeatedly emphasized the necessity of addressing both rehabilitation and reintegration with a multi-disciplinary approach and methodology. Underlining the previous statements of Dr Seshadri, Ms Atchara stated that **case management is a collaborative process, involving the coordinated efforts of facility staff and outside professionals assigned to each case.** From entry into the facility to final reintegration, interventions are provided individually to each child through the decisions of the case management team, comprised of center staff, social

workers, psychologists, psychiatrists, physicians, lawyers and other professionals as needed.

Ms Atchara outlined the steps in the case management process, beginning from the intake of the child at the facility. At intake, the facility assigns a Case Officer, usually a social worker, to the child's case. The Case Officer then calls together members of the multi-disciplinary team for the first case conference. In this case conference, team members determine the child's immediate needs for protection and support, and delegate tasks for a collecting facts and evidence on the case and for assessing the physical, psychological and social impacts of the abuse.

It was noted that in most existing facilities in South Asia, the facilities' responses to the abused child do not include vital activities at the time of intake. Response is generally thought of as providing 'rehabilitation', without sufficient groundwork of evidence-gathering, protection, assessment or treatment planning. Ms Atchara outlined the essential stages of case management as follows:

Ms Atchara then reviewed the stages of case management, with reference to the treatment of trafficking survivors in the South Asian setting. While these stages are sequential, she noted that crisis intervention and treatment may be necessary immediately upon intake. **Special care for the well-being of the child must be provided during the intake stages of collecting evidence and conducting assessments, given the possible emotional fragility of the child.** Atchara emphasized that careful planning, as well as multi-disciplinary support, is essential in proper case management. Planning not only refers to the general Rehabilitation Plan for the child's recovery, but also includes, if the case management team finds it necessary, a Child Protection Plan to avoid possible negative responses from traffickers or the family, if they were involved in the trafficking. The Child Protection Plan also includes activities to support the child during the process of interacting with the legal system, including court appearances, testimonies, etc. The facts, evidence and needs assessment should also lead into a

THE STAGES OF CASE MANAGEMENT

INTAKE

- Collecting facts and evidence
- Protection and care during the intake period
- Intake assessment
- Needs assessment
- Formulation of treatment plans
 - Rehabilitation Plan
 - Child Protection Plan
 - Reintegration Plan

TREATMENT AND REHABILITATION

- Crisis intervention, immediate treatment
- Basic rehabilitation activities
- Specific rehabilitation activities
- Child development, incl. occupational
- Family development

REINTEGRATION

- Assessment of family and community
- Preparation of survivor and destination
- Monitoring and follow-up support

Paper, Atchara Chan-o-kul, CPRC, Thailand

preliminary Reintegration Plan for the child. **The Rehabilitation Plan should be developed in the early stages of care – reintegration, not rehabilitation, should be considered the goal of the process.** The Reintegration Plan is amended as the case management team learns more about the child, and as **the child and family participate in the planning of the child’s reintegration.**

Reiterating the statements of Dr Seshadri, Ms Atchara noted the importance of organization and daily scheduling within the facility. Drawing from two decades of experience, the CPCRF Foundation classifies treatment and rehabilitation activities into four categories: 1) crisis and preliminary interventions; 2) basic rehabilitation activities; 3) specific rehabilitation activities for certain signs and symptoms; and 4) activities for child and family development. Ms Atchara noted, along with Dr Seshadri, that certain interventions should only be conducted by experienced, trained professionals. Consequently, the use of a multi-disciplinary team is essential for determining, assigning and accomplishing tasks which may be performed by para-professional facility staff or by outside professionals. Tasks performed by the latter would usually include crisis interventions and rehabilitation activities for specific signs and symptoms of emotional difficulty.

Ms Atchara discussed the primary importance of basic rehabilitation activities in the recovery of the abused child. She noted that **basic rehabilitation activities – not counseling – comprise the majority of activities conducted with the abused child, and these can and should be conducted by para-professional and facility support staff.** Basic rehabilitation activities fulfill five essential purposes: to foster healthy relationships, to build confidence and trust, to encourage self-learning and self-discovery, to encourage positive behaviours, and to give happiness and enjoyment. To repeat the words of Dr Seshadri, these activities are meant to “provide experiences that *counter* the impact of the trafficking-sexualization-abuse process”.

//...counseling which delves into the child's traumatic history should only be conducted by professional, trained persons. //

Paper, Atchara Chan-o-kul, CPRC

In her presentation, Ms Atchara discussed many of the basic rehabilitation activities used by CPRC staff in their day-to-day work with abused children. These include, among others:

- child participatory activities, in which the children are given an opportunity to join in planning and running activities for themselves and other children;
- 'circle time', in which children talk together about themselves, and share feelings and concerns;
- art therapy, in which children express their imagination, dreams and aspirations through creative activities;
- cooking and agriculture classes, to give children a feeling of accomplishment, sharing with others, and caring for plants and animals;
- 'my favorite object', in which children have a toy or pet that they can love and care for;
- visits and excursions, in which children visit parks, shows and museums, to help them see a new and bright side of the world; and
- 'letter links', where children establish a relationship with a trusted volunteer or mentor, helping them build up healthy relationships, trust and attachment.

Specific rehabilitation activities may or may not be necessary to address the emotional trauma of the child's past experiences. While most children removed from an abusive situation, particularly one of sexual abuse, require general counseling during the rehabilitation period, some may require more intensive counseling to address feelings of despair, hopelessness, fear or anxiety, or to address post traumatic stress disorder, negative symptoms of sexualization or anti-social behavior. As Dr Seshadri stated in his presentation, it is the role of para-professionals and others in the facility to note such signs and symptoms and refer the child to members of the case management team trained in therapy.

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

Paper, Atchara Chan-o-kul, CPRC

Ms Atchara emphasized that **rehabilitation activities with a child should be conducted with the child's eventual reintegration in mind**. This begins at the intake stage, when a preliminary Reintegration Plan is drawn up. During the rehabilitation phase, Ms Atchara noted, activities should be included that strengthen and prepare the child for life outside the facility. At present in South Asia, the primary focus of such preparatory activities is skills training for recreational purposes, and relatively little emphasis is placed on the child's intellectual, emotional or social development. The planning of intellectual development activities is based on assessment of the child's intellectual capacity, followed by placement in an appropriate educational setting, whether formal or non-formal. Often, children may need educational counseling and special help in a non-formal situation before being enrolled in a regular school programme. In formal school, counselors from the facility should coordinate closely with school officials in monitoring and stimulating the proper development of the child survivor.

Activities which strengthen emotional development reinforce counseling and regular rehabilitation activities. These include providing role models for children, often from among sensitive facility staff members, and the creation of self-esteem by providing regularized situations and tasks in which the children contribute to the welfare of others and learn to share responsibilities.

Social development activities prepare the child for the everyday interactions with society when they leave the facility. Many abuse survivors lack

socializing skills, which may be interpreted by society as undisciplined or anti-social behavior. Group participatory activities in particular are important for helping children learn to work and play with both adults and their peers. Life-skills training is also an important preparation for reintegration, teaching the children, for example, how to manage their money, how to shop, and how to travel. As well, life skills training should teach children to protect themselves from possible future abuse, such as how to communicate with strangers and how to seek help if needed.

Occupational training is an important part of the child's preparation for reintegration. Ms Atchara emphasized that **prior to vocational training, a vocational needs assessment of the child must be conducted, and the child her/himself should participate in the process.** Given the limited job opportunities in South Asia, "the focus should be on helping them find employment of their own choice and capacity."

Family development activities are vital to the successful reintegration of the child survivor and should be conducted before the child returns to the family. Often, as Ms Atchara said in her paper, families of abused children have emotional problems, economic problems and lack appropriate parenting skills. Family development activities also address the reluctance of the family to accept a child who has been a prostitute. Members of the facility and case management team work with the family to help them learn basic child rearing skills, how to work with emotional problems and crises, and how to create a child-friendly environment in the home. In cases in which abuse has occurred in the family, family counseling and therapy may be required.

The reintegration process begins soon after the child's entry into the facility, with the development of a preliminary Reintegration Plan. After a child has completed the rehabilitation process, the first task is an assessment of the child's community to identify the presence of risk factors by which the child might be abused or trafficked again, or conditions in the family, school or community that could cause problems for the child. Following this, **the**

Reintegration Plan is developed with the participation of the child and family members.

The reintegration process involves not only facility staff and members of the case management team, but also members of a community support network that is established to facilitate the child's reintegration and provide support after the child returns to her/his family or an alternative situation, which may be living with relatives or a foster family, or in a new shelter situation. This network is composed of school teachers, local health care workers, village leaders, community volunteers, neighbors and members of the child's family. The child is prepared for entry into her/his family or new living situation by providing her/him with counseling regarding her/his goals and aspirations for the future, and with information regarding the new situation. If possible, a pre-reintegration visit to the family or new situation is conducted, to make the child gradually feel safe and secure. Families, relatives or foster families are provided with information about the child, her/his background, and ways in which they can support the reintegration of the child. The caregiving facility continues to provide follow-up and support for some time after the child has returned to the family or entered the new situation. Most importantly, concluded Ms Atchara, **regular ongoing dialogue sessions should be held between representatives of the original facility, the child and the new caregivers until there is assurance that the reintegration process has been successful.**

// Preparation for reintegration includes fostering proper relations between the child and members of the family, providing basic material necessities if the family is economically incapable of supporting the child, providing counseling on parenting, and providing capacity-building for family members, such as problem-solving skills and communication skills. Social workers play an important role in this process, and can help a great deal in soliciting both material and non-material assistance for the family. //

Paper, Atchara Chan-o-kul, CPRC

A panel discussion on case management followed Ms Atchara's presentation. Panelists included Ms Atchara, Dr Bogendra Sharma (CVICT, Nepal), Dr Shekhar Seshadri, and Ms Zebunessa Rahman (BNWLA, Sri Lanka), with Mr John Frederick moderating. Mr Frederick asked Dr Sharma, whose training organization CVICT is developing a course for facility managers, what managers need to know about counselors' and para-counselors' work for better management of the centers. Dr Sharma replied that he has observed that in some facilities children are being provided with adequate support, whereas in others the psychosocial support was not up to standards, perhaps even harming the children. He referred to a case in which insufficiently trained teachers gave group counseling to girls, resulting in increased problems for the girls. In many cases, he said, management does not recognize the fact that counseling truly helps survivors. He said that the energy and resources of donors could not properly be utilized if they don't work together with both facility managers and those providing counseling services. Mr Frederick asked Ms Atchara to tell about everyday activities in her centers that are not counseling, but are concerned with developing the positive feelings and happiness of the survivors. Ms Atchara emphasized that daily activities are very important and effective in helping children. **Many problems can be resolved in a simple, friendly manner through activities such as gardening or going to the movies, activities that just make the children happier.**

In the following question and answer session, Mr Masud Hasan Siddique (NPC, ILO-IPEC, Bangladesh) asked how to address the situation where female survivors aren't accepted back into their communities and are re-victimized. Ms Rahman replied that her organization addresses this by going into the community repeatedly to make them understand that the child belongs to the community and thus the community bears some responsibility. She referred to a situation in which a girl ran away from her family after rehabilitation and had suffered injury in an accident. The community then realized their responsibility and provided material assistance to the family and the girl. She said **reintegration is possible only if the community is motivated.** Dr Seshadri added that **to promote**

community acceptance, there also must be a larger discourse in the media and the public that survivors are not dirty, different or damaged, but are normal people trying to adjust to a very abnormal situation. Ms Kiran Bhatia (UNICEF ROSA) said that in Afghanistan hundreds of boys undergo abuse, and the social construction there allows much greater opportunities of reintegration for boys than for girls. She said that the issue of gender needs to be addressed throughout the process, and it is important to identify the different needs of boys and girls.

Sierra Tamang (SCF UK, Nepal) said that she had seen shelters which were operated for trafficked girls with the best of intentions, but were detrimentally affecting the girls' psychological well-being. For example, she has known cases in which facility staff blame the girls for having been trafficked or do not let them leave the center, telling them that they would attract unwanted attention. She asked what could be done to make workers in the center more aware of the girls' situation. Dr Seshadri replied that for most people, sexuality is associated with marriage and procreation, and they readily consider the sexualization of girls involved in prostitution to be aberrant behavior that is the girls' own fault, despite their coercion. In his training experience, he said, **counselors and all facility workers should be helped to examine their own notions of childhood and sexuality before working with survivors.**

Ms Sita Ghimire (Redd Barna, Nepal) asked Dr Seshadri and Dr Sharma whether survivors could be effective counselors. Dr Seshadri replied with a yes and a no. There can be a negative effect, he said, if the counselor who is a survivor has not resolved all of her/his own issues. That is why there should be a rigorous screening process for applicants to training programmes. At the same time, people who have healed have powerful stories to tell, and that can hold a great validation. However, he said, one does not need to be an alcoholic to treat alcoholism. Dr Bogendra remarked that he would prefer not to train survivors to become counselors, as they have found survivors to be very vulnerable despite treatment. He said that CVICT has had such experiences and would not like to continue such training.

Ms Sony Pradhan (WOREC, Nepal) asked how reintegration with a family can be addressed if the child has previously been abused by the family. Dr Seshadri said that incest abuse is more difficult to handle here in South Asia than in countries such as the United States, where they have means of prosecuting families and putting children in foster care. Here, because those alternatives aren't available, they try to seek an ally for the child in the family, minimize the child's contact with the perpetrator and provide supporting activities to the family. Ms Atchara said that it is very difficult to send children back to such families. It was important to access supporting members of the family and remove the perpetrator. CPCR, she said, has been successful in only about 25% of these cases. Mr Krueger (ILO-IPEC Consultant) said that he did not see much child participation in the case management process as presented by Khun Atchara. He said that children's participation in the recovery and reintegration process can help us avoid a lot of mistakes. Dr Seshadri agreed, saying that in the area in which he works, they always take "one step down" and make sure that they know the child better. Ms Atchara also agreed, saying that participation was particularly important in the needs assessment of the child and determining areas to support her/his development.

Indigenizing the Caregiving Process

While caregiving for the abused child is most effectively conducted within the multi-disciplinary framework of case management, the needs of the child must be addressed within the context of her/his culture.¹ Strengthening the capacity of caregivers to provide effective rehabilitation and reintegration not only requires the establishment of structures and protocols applicable to caregiving facilities worldwide, but also requires a process of integrating local knowledge and practices into the caregiving setting. Dr Elizabeth Protacio-de Castro of the University of the Philippines Psychosocial Trauma and Human Rights Program, in her paper presentation "Integrating Indigenous Knowledge and Practices into Psychosocial Help and Support for Child Survivors of Commercial Sexual Exploitation", discussed the

¹ Here, 'culture' includes the language, customs, beliefs, social structure, communication patterns, etc. specific to the ethnicity of the child.

process of 'contextualizing' our conceptions of the child, childhood and rehabilitation to the Asian setting.

Dr de Castro first presented the working perspectives in psychosocial care, presenting a case for a paradigm shift towards a perspective that more fully recognizes the capacity and rights of the child. In many countries, she said, treatment of the child survivor follows the 'bio-medical perspective'. In this perspective, the sexually abused child is considered 'damaged', and in need of 'repair' or 'cure', for both physical and psychological injury. This perspective, drawn from medical practice, is clinical in its diagnosis and treatment, is more attentive to physical than psychological concerns, and tends to apply prescriptive interventions to remove or eliminate the 'problem'.

The social welfare perspective, said Dr de Castro, has developed from social work and community development, and is the perspective most commonly used today by NGOs, governments and donor agencies. It places the child in the framework of her/his social environment, and seeks to modify factors in the environment for the benefit of the child. The social welfare perspective goes beyond 'treatment of the problem' as in the bio-medical perspective, taking into consideration the child's physical, intellectual and social development and factors in the environment that affect that development. This perspective adds the concepts of recovery and reintegration to the concept of treatment, and includes caregivers and facilitators in the healing environment with physicians and psychologists. It addresses making adjustments in the child's surroundings, including family and community, as an integral part of the healing and recovery process.

Dr de Castro's critique of these two perspectives is based on what is termed the 'vulnerability paradigm'. This paradigm includes assumptions, which in Dr de Castro's opinion insufficiently address the reality of the child and her/his view of the world. One assumption is that children are 'small adults', and what works for adults can be applied to children without major adjustment. Another is that the child survivor is powerless and incapable of helping her/himself. A third is the assumption that all children who are

abused are by definition damaged, and will develop certain symptoms and behaviors reflecting that damage. These assumptions lead to the strategy that in order to help the child, the problems and causes must be identified, the problems must be addressed and the causes must be contained.

What is missing in the vulnerability paradigm, said Dr de Castro, is a recognition of the child's inherent capacity to respond to difficulties, adjust to circumstances, make decisions, and facilitate their own healing and recovery. **Not all children who are raised in 'difficult circumstances' or are faced with difficulties as severe as sexual abuse become dysfunctional.** Contrarily, children have an immense capacity to respond to difficult situations, and beyond simply coping or surviving, children are capable of learning and growing from the experience. This view, said Dr de Castro, is the competency paradigm.

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Dr de Castro explained that the competency paradigm does not ignore the risks and vulnerabilities present in the child's surroundings, which can include the family, school and community. Rather it adds an additional agent to the healing process: the child. **Children can become actors in their own healing, and participants in their own development.** With this paradigm, rehabilitation and reintegration are genuinely conducted in the child's rights perspective, which not only recognizes the rights of children to care and protection, but children's inherent dignity as human beings, and their rights to express themselves, access information, state their opinions, and participate in matters that affect them.

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

Paper, Dr Elizabeth Protacio-de Castro, University of the Philippines

From this perspective, said Dr de Castro, the process of ‘contextualizing’ or ‘indigenizing’ caregiving practices can be undertaken. As an example, Dr de Castro reviewed the history of psychology in the Philippines over the last several decades, beginning from its advent in which western models, theories and methods were applied to the Philippine experience, with limited success. “The Philippine experience has proven that approaching psychology using these **(western) models cannot fully capture the subtleties and nuances of Asian culture and realities**”. Psychologists in the Philippines then attempted to create a ‘Philippine psychology’, primarily by translating materials into local languages and modifying concepts to apply to the local context. This, said Dr de Castro, could be termed ‘indigenization from without’, that is, making indigenous versions of foreign models.

After this attempt showed limited success, Filipino psychologists embarked on a process which can be called ‘indigenization from within’. Here, key indigenous methods of communication, identification of problems and healing were identified, and elaborated in the context of Filipino semantics, “with the source of knowledge coming from within the culture as experienced and articulated by the culture bearers themselves”. Basic elements of psychology were not rejected, although originating in the west – rather they were redefined and re-formed according to the Filipino context. For example, counseling interview methods in the west are based on westerners’ cultural conditioning to communicate directly and forcefully, and to freely share personal thoughts and opinions. In the Philippine context, the communication style is more indirect, personal opinions are expressed only after preliminary levels of interaction are achieved, and the level of intimacy is very dependent on the speaker’s personal familiarity with the listener. Thus, the Philippine methodology included, among others, more elaborate and careful preliminary trust-building activities and less direct methods of questioning.

The process of indigenization must be predicated upon an understanding of cultural conceptions of children and childhood. As with psychosocial theories and methods, western theories of childhood

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

	Vulnerability Paradigm	Competency Paradigm
Nature/ Character of Response	Output-oriented Rigid Formal Statistical Predetermined	Process-oriented Flexible Informal Descriptive Evocative
	Preconceived Clinical/diagnostic Detached Compartmentalized Palliative/immediate relief	Consultative Participatory Grounded Integrated Holistic/enriched helping relationship
Method	Curative Dole-out Drug therapy	Participatory Empowering Uses creative arts, play, indigenous methods
Key players	Only professionals	Child and the environment
Relationship	Authoritarian/paternalistic Vertical relationship Individualistic	Democratic, as equal human beings with rights Child as a human being with the same value as adult Shared meaning
Results	Learned helplessness Dependence Immediate relief Stigmatization/alienation	Self-trust, self-esteem Social participation Long-term solutions Shared meaning

predominate in the discussion of ‘who is the child.’ Among these is the implication that all children in all cultures go through the same stages of development, and that children who do not conform to those patterns are potentially at risk, or even abnormal. Coupled with this are the ideas that children a *tabula rasa*, a blank page on which their identity is constructed by the influences of parents and society, and that childhood is an extended period of dependence in which the children are prepared – not preparing themselves – for adulthood. This contradicts the reality of children in the developing world, many of whom perform caregiving activities for siblings at a very young age or accept responsibilities undertaken only by adults in the west. However, said Dr de Castro, eastern ideas of the child and childhood also need to be challenged – for example, the notion that children are the property of their parents, who can use them as they wish, or that the girl child requires a substantially different upbringing than a boy child.

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Dr de Castro reviewed some of the sources of indigenous knowledge and practices (IKP) that can be utilized, including stories, folklore, traditional healing, dances, religion and traditional wisdom. She provided further examples of the application of indigenous knowledge to case management and counseling, including the intake interview, observation, problem identification, data gathering and assessment.

In conclusion, Dr de Castro reiterated the statements of Dr Seshadri, stating that it is most important for caregivers to seek an understanding of the ‘real child’. Caregivers cannot project their ideas upon children, rather **caregivers must actively explore who children are, how they think and how they communicate. ‘Child-centered’ means acting on the**

// ...it is important to underscore the use of indigenous languages in communicating with children, as well as adults. We can not afford to ignore such a rich resource because herein lies the solution to understanding many pieces of the puzzle in indigenous ways of coping and healing. //

Paper, Dr Elizabeth Protacio-de Castro, University of the Philippines

children's behalf with knowledge of how they perceive their own needs, their own options, and their own futures.

In the brief question and answer period that followed, Tine Staermose (CTA, ILO-IPEC TICSА Programme), remarked that some activities were sometimes not successful, despite their apparent cohesion with indigenous practices. For example, although in South Asia sense of identify is generally placed on the group rather than the individual, as in the west, in Pakistan and Nepal group cooperatives have not been successful. Dr de Castro responded that in South Asia 'group' does not necessarily imply sharing among all, but group identity is also family-oriented and caste-oriented. In any culture, she said, certain sub-cultures and identities are dominant, and would take precedence, thus providing limitations to 'sharing' among people of different families and castes.

Following Dr de Castro's presentation, the participants divided into groups for an activity to help them understand the process of integrating indigenous knowledge and practices into the caregiving setting.

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After group deliberations, Mr Kazi Abul Kashem (Ministry of Women and Children Affairs Bangladesh) on behalf of Group One said that his group concluded that the girl could resort to bursting into tears; she could isolate herself in a room or under a tree in the village; or she could pray to feel better without telling anyone what happened. She would also try to meet a trustworthy or dependable person such as (first) her maternal grandmother, (second) a close friend, or (third) her mother, to be with them for mental relief. Group One said that a former child prostitute in a care setting could resort to sharing her/his pain with a close inmate. Peer counseling was recommended in the care setting, as the child would open up easier with a friend than with a counselor in the caregiving environment.

On behalf of Group Two, Fr. Anthony H. Pinto Nalawattage (Don Bosco, Sri Lanka) said that the girl could engage in a cleansing ritual such as a bath and scented applications, perform rituals such as speaking to a power

Group Work: Integrating Indigenous Knowledge and Practices

FEELING BETTER

A 17-year-old village girl has been molested (not physically forced but psychologically coerced into having physical contact) by an unmarried man. They didn't have intercourse, but everything except intercourse. The man leaves for elsewhere and is out of the picture.

Nobody in the village except the girl knows of the occurrence. She doesn't want to tell anyone. However, she feels guilty, 'dirty', 'unclean'.

What traditional practices could the girl conduct, or what person could she go to, in order to feel better about herself – without telling anyone what happened?

Describe three options for the girl.

Now, choose one of the points above. Describe two ways that this particular method or person used for 'feeling better' can be applied to a former child prostitute living in a care setting.

(God) to seek absolution and cleansing, or talk to someone in her family with whom she feels secure. In the case of a child prostitute in the care setting, Group Two suggested that caregivers could provide a 'ritual of self care' that focuses on appearance, interests and skills, encouraging a sense of self-nurturance that symbolically does away with 'dirtiness'.

Deepa Dhital (CWIN, Nepal), speaking on behalf of Group Three, said that the girl might pretend she is sick and isolate herself, or she might seek out a person who has had similar experiences. In application to the care setting, the most important support to provide the girl would be a child-friendly environment.

Speaking for Group Four, Sony Pradhan (WOREC, Nepal) said that some of the traditional practices she could conduct would be going to the temple for prayer, becoming a *Jogini*, fasting, waiting for the man to return, or accepting the situation as ‘destiny’. In the case of a girl in the care setting, Group Four thought that the girl could pray to god and visit a ritual place for *bhajans* (devotional music) in order to feel better.

In the discussion that followed, participants shared ideas that arose from the group work on communication and confidentiality in the care setting. The general consensus of the participants was that a girl in a village setting would seek out friends and sisters before older relatives. Similarly, a girl in a care setting would seek support from a peer before a counselor or teacher. The participants commented on the importance of developing peer support activities in the centers, and on the need for facility personnel to establish closer, less hierarchical relationships with the residents.

Human Resources for Caregiving

In South Asia, facilities and programmes for the care of survivors of sexual abuse and exploitation are rapidly growing in number. With this growth, there is a growing need to develop and mobilize human resources of a variety of forms. The last five years in South and Southeast Asia have seen the development of a number of training programmes, with manuals, trainers’ guides, resource materials and activities, to respond to that need.

Mr John Frederick (ILO-IPEC consultant) presented a brief overview of a paper in progress, “Human Resources Development for the Care of the Sexually Abused and Sexually Exploited”, a resource mapping of training programmes directed at the personnel of caregiving facilities. The primary purposes of the mapping, he said, were to clarify the goals and applications of training, support quality development of training programmes, and identify gaps in the present collection of training programmes now available to organizations in South Asia. The training programmes reviewed in the paper ranged from short orientations to extensive trainings and were primarily directed at professionals without clinical experience, para-

professionals and support staff. These included training in counseling skills, experiential therapies, case management, social work and family assessment, operation of care institutions and others. College and university courses were not included.

After review of documents and materials, Mr Frederick said, it was possible to give some preliminary observations. Notably, **the majority of training materials focused on counseling, with limited training opportunities offered for the range of other activities within the caregiving spectrum, including para-social work, art or recreational therapy, life skills development, guidance and life planning, family interventions or peer activities.** Training courses generally provided comprehensive information on the concepts and issues of child abuse, and most provided trainees with empathetic learning experiences to deepen their understanding of abuse. However, many provided a limited background of child development and few gave comprehensive information on the healing process of the abused child or on the sexualization of the child in the abuse experience. **There is a potential concern that ‘counseling training’ courses may give the impression that trainees are thus equipped to provide in-depth counseling to the abused.** Most of the courses available may better be termed ‘orientations’ than ‘training’, and should not be thought to equip the trainee for working with serious levels of trauma. As was underlined in the presentations of Dr Seshadri and Ms Atchara, this should only be undertaken by professionals with clinical experience.

Regarding teaching methodologies, virtually all included lectures, reading materials, role-plays and group discussions. The programmes ranged widely in the use of experiential teaching methodologies, such as art work, mini-drama, visualizations and empathy-creating activities. Almost no programmes, including those that taught ‘counseling methods’, included clinical, hands-on experience as part of the course. Almost none included field observation to give the trainee a view of the child’s situation, such as street living or prostitution.

Mr Frederick commented on some of the limitations in the training courses available to organizations working in South Asia. Reiterating that the available courses focused almost entirely on counseling as opposed to other facets of caregiving, he noted that **very few courses placed counseling in the context of a case management system**. Of these, even fewer provided training on case management processes, including intake procedures, assessment, case planning and referral. Overall, among the programmes there was relatively light emphasis on the caregiver and their psychological involvement in caregiving. Only a few had a module on care-for-caregivers.

In most programmes, the focus of the healing process was the generalized 'child'. Relatively few made clear distinctions between male and female children, or pre-pubescent, pubescent and adolescent children and their sexuality, behaviors and needs. In general, family systems, parenting practices, family reunification and the issues of child attachment received little or no emphasis. With some notable exceptions, the use of indigenous knowledge and practices in the healing process was covered lightly or not at all. Mr Frederick concluded his presentation with the statement that overall, the training programmes reviewed provided excellent general knowledge and orientation on child abuse, trauma and counseling. His **primary recommendations were to encourage the development of training programmes for other actors in the caregiving setting, apply the skills within the context of case management, and develop focused training programmes for specific needs in the care setting, including child participation, crisis management and care-for-caregivers**.

// Almost all training programmes claimed to take a 'child-centered' approach. However, in most there was little explanation of the practice of child participation. While mentioned in the conceptual framework of almost all courses, there was little training on how to promote the participation of a child and how to utilize the child's own views and intentions in the healing setting. //

Paper, John Frederick, ILO-IPEC Consultant

Training for Counseling the Abused Child

In the presentations by Dr Seshadri, Ms Atchara and Mr Frederick, all noted the importance of case management in the care of the abused child, and the need to clarify the roles of support staff, para-professionals and professionals in addressing the psychological condition of the child. **While severely affected children and crisis situations must be referred to professionals, para-professional counselors provide the majority of counseling interventions to children within a facility.** As well, there is the need to clarify the roles of the para-professional counselor and the other staff within a caregiving facility, as counseling which directly addresses fears, anxieties, anger and other manifestations of the abuse experience should be performed by specifically trained persons.

Mark Jordans, of the Center for Victims of Torture (CVICT), Nepal, in his presentation of the paper “Training of Psychosocial Counselors in a Non-Western Context: The CVICT Approach”, stated that **there is an important distinction between general ‘orientations’ on counseling and the needs of survivors, and specific training programmes which equip a para-counselor to provide psychosocial interventions.** As an example of the latter, Mr Jordans presented the approach of CVICT’s intensive four-month training programme for para-counselors in Nepal. Mr Jordans began his presentation with a review of the human resources for psychosocial intervention presently available in the country, noting the limited number of trained professionals and the growing number of NGOs that are now seeking to provide support to victims of trafficking, other worst forms of child labour, and domestic abuse.

Mr Jordans discussed the limitations of many training programmes previously conducted in Nepal, including early programmes conducted by CVICT, and the lessons which CVICT has learned and applied in the development of its current programme. First, Mr Jordans said, the necessity of utilizing local Nepali trainers became evident, as expatriate psychologists had limited knowledge of local idioms of distress, coping styles,

communication styles and socio-cultural factors related to abuse and healing. As stated by Dr de Castro, **counseling – and thus training in counseling – must be undertaken within the context of the resident culture.** Second, until recently there has been limited knowledge of facility directors or of donors who support training programmes about counseling of survivors with severe psychosocial problems, leading to inappropriate training and inadequate evaluation. Third, most training programmes were short and did not provide adequate supervised skills development. Moreover, programmes often were conducted with a training-of-trainers (TOT) structure, in which persons without clinical, hands-on experience were responsible for training others. Finally, after-training activities were lacking in training programmes, including refresher training and follow-up supervision of the trainees. While these programmes provided adequate orientation on counseling and the needs of survivors, they did not equip trainees to provide quality counseling to the abused.

Mr Jordans then discussed the theoretical background for the present CVICT training programme. The programme is directed towards the training of para-professionals and of professionals, such as university graduate psychologists, who have no clinical experience. The programme approach has been integrated from several theoretical backgrounds so that it can be applied in a non-western setting. The core of the approach involves training in 'micro-skills', primarily communication skills such as attending behavior, reflection of feeling and reflection of meaning, among others. These are applied within a problem-management framework in which the counselor helps survivors to identify and clarify their problem situation, identify realistic goals within the cultural context, and develop strategies and activities to achieve those goals. In addition, the training provides counselors with an ability to place their activities within the cultural context of the survivor. Counselors become aware of modes of communication and response specific to the Nepali context, and learn to address concerns from the survivor's perspective, in the survivor's terms. **Considerable emphasis is placed on helping the counselor become aware of the complex**

// Counseling can...almost never be directly implemented, but has to be adapted to the cultural setting. This entails that counseling conforms to issues such as the significance of the family and the importance of respect and prestige. The counselor in a Nepalese setting will generally ask questions more indirectly, avoid culturally inappropriate issues (e.g. sexuality) and the use of challenging the client will be less common, all aiming at respecting the client's intimacy. Extra attention must given to explanation of the way counseling works, because it is such a new treatment modality. In some settings, counseling might prove to be a very difficult intervention as it might lack cultural appropriateness. //

Paper, Mark Jordans, CVICT, Nepal

social barriers of caste, ethnicity, language and religion in Nepal, reflect on their role, and achieve respect and acceptance of the survivor's worldview, attitudes and lifestyle.

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The distinguishing features of the CVICT training model are its length and intensity, the provision of clinical experience, and the focused supervision and guidance of trainees' development as counselors. Following core training, trainees are provided with approximately 140 hours of placement in organizations in which they can practice their skills with those prone to psychosocial problems, including trafficking survivors, children at risk and street children. **Clinical learning experience distinguishes a 'training' course from an 'orientation'**. Placements in different settings are alternated with specialized training sessions which teach the participants specific skills, such as counseling techniques, experiential therapies, and working with specific mental disorders. Following each specialized training session, the trainee is provided an opportunity to practice her/his skills in the placement setting. In the CVICT model, supervision is intensive, and is conducted through daily meetings, supervisory visits to the placement settings and videotaped sessions. In addition, trainees participate in weekly 'learning therapy' sessions, in which the trainees are helped to undergo a process of self-reflection and personal change as they enter the role of counselor.

In concluding his presentation, Mr Jordans discussed the responsibilities of facility directors and donor organizations to ensure procedures and physical support necessary to conduct effective counseling activities.

In the question and answer session that followed, Fr. Anthony H. Pinto Nalawattage (Don Bosco, Sri Lanka) said that during his work in rehabilitation for the last 16 years, he has observed that in theory much emphasis is placed on healing, but in practice there has been little investment in personnel and training. As well, **while counseling is important, establishing a ‘healing environment’ is perhaps more important, and this should be reflected in our investment.**

Sierra Tamang (SCF UK, Nepal) asked how words such as ‘gender’ were translated from English to Nepali, and asked Mr Jordans to elucidate on the issue of transmitting basic concepts in translation. Mr Jordans replied that translation has been a key issue in developing training courses, and the words and translations used have evolved considerably. There is, he said, an important issue regarding the problems of concepts that might be rooted in the western context and have no counterpart in the local context. He provided examples of concepts of sexuality, goal setting and psychosomatic problems. Dr Sharma (CVICT, Nepal) added that rather than seeking literal translations, counselors should try to go by the essence of meaning in the words.

// ...the organisation that is going to implement psychosocial counselling needs to be prepared for such. That includes... (developing) guidelines for practice...setting up a case management system, and establishing of a counseling room or center, with all the necessary forms and materials. A clinical supervisor or mentor should be responsible for professional supervision meetings that focus on quality of care for clients and the care for the counselors themselves. //

Paper, Mark Jordans, CVICT, Nepal

Dr Seshadri remarked that one of the best experiences for participants to take home would be Mr Frederick's suggestion to make rehabilitation programmes more comprehensive, rather than focus only on counseling. Mr Krueger expressed his agreement, and stated that it was necessary to focus also on family issues. Without family-directed interventions, he said, facilities will not be able to reintegrate the children.

Dr de Castro, on the topic of integrating indigenous concepts, said that she would prefer to use the term 'contextualizing' to 'indigenizing'. There are various applications of the process, she said, but the basic idea was to promote local healing resources. The entire procedure of 'contextualization' is a learning process, and is still not articulated very much. In essence, she said, there is nothing wrong with importing concepts as long as they are able to grow organically in the new culture. One should take what is good and then give it a life of its own. Ms Kiran Bhatia (UNICEF ROSA) commented that it is the culture of the language that must be adopted and not the words themselves. She added that people's personal feelings on gender and similar issues were evident even in trainings, and consideration must be given in the training process to the different ways men and women view certain issues.

Quality of Care Standards and Guidelines

The elements of strengthening the caregiving process so far discussed in the technical meeting – including training, case management, child participation, creating a 'healing environment' and cultural appropriateness, among many others – are all meant to ensure that high quality, professional care is provided for the survivor of trafficking and other worst forms of child labour. These diverse elements find cohesion in another basic tool required for caregiving facilities: operational standards and guidelines to ensure the quality of care. John Frederick, in the presentation of his paper "Standards and Guidelines for the Care of the Sexually Abused and Sexually Exploited: Some Applications for South Asia", discussed the range of standards and guidelines utilized in caregiving, elucidated how quality of care standards can be developed and applied to the South Asian setting,

and provided a model of care standards which the countries and the region of South Asia can use as a starting point for their own process of developing appropriate standards.

Mr Frederick began with a description of the different forms of standards and guidelines. These include: 'basic minimum' standards for the operation of childcare facilities; human rights standards, such as the Convention on the Rights of the Child; case management guidelines, such as were presented by Ms Atchara; standards and guidelines for training; standards for the legal treatment of survivors; and specific standards and guidelines such as those for forensic medical assessment of sexual abuse, family assessment guidelines for social workers, and guidelines to prevent abuse within the facility. Mr Frederick explained that the focus of his presentation was on the first form: basic minimum standards for the operation of care facilities. He stated that **quality of care standards should not be considered 'rules and regulations', but rather a tool to help caregivers conduct effective interventions.**

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As quality of care minimum standards have been developed in the west, the question arises as to how applicable care standards are to South Asia. Mr Frederick provided a two-part answer to the question. First, he said, 'core standards' are both applicable and imperative. Such include: the right of an abused child to protection from further abuse, to be given confidentiality in personal matters and to have contact with her/his family; the responsibility of the facility to ensure case management procedures and to provide adequately trained personnel for appropriate tasks; and the rights of caregivers to be given support in their work and to have a clear understanding of their roles and responsibilities. Second, Mr Frederick said, certain aspects of care standards can and should be adapted to the South Asian setting. For example, all children have the right to take their meals in a clean and pleasant environment. However, in England caregivers may interpret that to mean that children are provided chairs, tables and cutlery, whereas in Nepal or Bangladesh, caregivers may interpret that to mean that children are allowed to sit together on the floor and eat with their hands.

// Quality care is a basic right of all who enter a caregiving facility, whether it is for medical treatment or psychosocial treatment. Quality of care standards are developed and used for three basic purposes: to provide the most effective and responsive care for survivors; to maintain professional, transparent and accountable care practices; and to support caregivers in their work. **//**

Paper, John Frederick, ILO-IPEC Consultant

In short, Mr Frederick said, **quality of care standards are adaptable to individual cultural settings, but basic standards cannot be compromised. The indigenization of caregiving practices should not justify harmful practices, such as physical discipline or denial of the rights of the child.**

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The development of quality of care standards, Mr Frederick explained, is an important process which each country must undertake for itself. It is a lengthy process that must be conducted with care and sensitivity. The process starts with using a basic model which includes the entire range of considerations in care, including minimum requirements for physical facilities, procedures for caregiving practices, personnel requirements, responses for special situations such as crisis and abuse in the facility, children's rights and participation, and guidelines for supporting the caregiver, among others. **Standards are developed through discussion and collaboration with all of those concerned with the care of the child, including NGO facility directors, caregivers, experts in psychology, medicine, law and social work, government representatives, donor representatives and the children themselves.**

Mr Frederick then discussed the application of care standards on a national scale. "For individual facilities to develop the necessary quality of care, human resources must be available. Quality care," said Mr Frederick, "depends on quality caregivers, and quality caregivers depend on quality training." And this in turn, depends on the availability of monetary resources and training expertise. Training and educational institutions must be

strengthened, courses must be developed and human resources expanded. Mr Frederick then presented some basic principles of care standards, which are summarized below.

Following these principles, quality of care standards are developed according to a number of basic ‘ingredients’. Mr Frederick presented a model outline for a care standards document, noting that fully functional care standards are detailed and comprehensive. He provided the example of “Care Homes for Younger Adults: National Minimum Standards” from the U.K., which is a document of 100 pages. The headings of the model outline included: children’s rights, child protection, discipline, staff, physical surroundings, health care and nutrition, education, recreation and culture, case management, psychosocial interventions and reintegration.

Mr Frederick then discussed how minimum care standards can be applied to individual facilities. For most caregiving facilities, fulfilling all the ‘requirements’ of quality of care standards is a challenge in terms of funding, physical facilities and human resources. **Donors and recipient institutions will have to work together to make the most effective use of funding and reduce the cost of operations while improving the quality of care.** It is important, he emphasized, not to ‘cut corners’, such as saving money on training by using TOT methods instead of experienced trainers. Mr Frederick outlined **three strategies for lowering costs while improving quality of care; 1) move from larger ‘institutions’ towards smaller, family-style caregiving situations; 2) expand the potential and abilities of support staff within the facility; and 3) develop networks of supporting human resources.** He outlined the process which includes: a) creating an individual ‘Quality of Care Development Plan’ for each organization, based on a collaborative needs assessment of the facility; b) providing ‘quality of care’ training for the management, to help them understand and support the process; c) providing the necessary staff training, support and materials; and d) providing assistance in developing a network of supporting expertise.

Some Basic Principles of Care Standards

Principles for the Child

- Basic human rights (genuine participation privacy and confidentiality right to family, and many others)
- Facilities and interventions are child-centered
- Each child is provided individual case management
- Children have access to the outside world
- Interventions are culturally appropriate

Principles Guiding Care

- Systems are in place for case management, abuse prevention, crisis management, confidentiality, referral, etc.
- Operations are transparent, monitored and open to all members of the case management team
- Roles and responsibilities of the staff are clarified
- Care is provided for caregivers

Principles Guiding Basic Activities of the Rehabilitation Process

- Facilities have a designated function in the case management process (intake, intensive care, general care, pre-reintegration)
- Facilities strive towards a personal, humanistic family-like environment
- Case management planning leads towards 'de-institutionalization', and effective and rapid reintegration.

Paper, John Frederick, ILO-IPEC Consultant

Mr Frederick concluded his presentation by discussing the monitoring of quality of care standards within facilities. A monitoring body is necessary both to monitor quality of care and to provide helpful and supporting feedback to the facilities. This should be an independent body similar to the body which developed care standards: that is, including all involved in the caregiving process, including children.

In the following question and answer session, Mr Shyam Shrestha (Ministry of Women, Children and Social Welfare, Nepal) said that standards and guidelines should also specify the quality of staff and provide a time frame for reintegration. He asked if a legal framework should be involved, and if the government should be involved in the monitoring process. Mr Manzoor Khan (Ministry of Interior, Pakistan) said that in Pakistan there weren't many NGOs working in the field. The primary foundation caring for children in Pakistan, he said, is "working as a parallel government" and has refused any government help. He expressed his feelings that the government should set some guidelines. Ms Tine Staermose responded that from the ILO side the concern has been that homes run by both governments and NGOs are not up to minimum standards. She said the reason for tabling this topic during the meeting was that **all should recognize the need to have independent, consensual guidelines, rather than saying "the government needs to do this" or "the NGOs need to do that"**. Through consultations, both governments and NGOs have expressed the need for minimum care standards.

Mr Kazi Abul Kashem (Ministry of Women and Children Affairs, Bangladesh) said that the pertinent issue to him and his government was the financial concern, which had been highlighted in the paper. Mr Salahuddin Kasem Khan (Bangladesh Employers' Federation, Bangladesh) said that Mr Frederick had made important points in presenting cost-effective strategies for the achievement of minimum standards. ILO-IPEC, he said, has been involved in establishing minimum standards for workers in the garment factories in Bangladesh, and they have felt that there are areas where private institutions and NGOs could create linkages. He highlighted the work of

UCEP, adding that among cost-effective strategies, existing setups such as UCEP could be replicated in other countries.

Deepa Dhital (CWIN, Nepal) underlined the importance of minimum standards for protecting children's rights, and stated that shelters should provide justice to the children entering their doors, and ensure that they are not re-victimized by the shelter. Mr Frederick concluded the question and answer session and provided the participants with group work which, he said, would give them a brief experience of the process involved in creating standards and guidelines for their countries. He repeated that **the development of standards and guidelines must be a careful, collaborative process that is conducted with the best interests of the child always in mind.**

Following group discussions, participants reconvened to discuss the development of standards regarding discipline. The four groups expressed a consensus of opinion regarding the standards for discipline in the facility. They stated that physical violence and abusive language should not be used by staff in disciplining, the problems of the child should be listened to, positive behaviors should be reinforced, and counseling provided if necessary.

Regarding monitoring mechanisms, Group One decided that both internal and external monitoring mechanisms were valuable. An internal monitoring body should include children, staff and NGO management, whereas an external monitoring body should include government, NGOs and professionals. Ms Ghimire added that monitoring should take place twice a year, and as and when needed. Group Two reaffirmed that there should be monitoring in all centers, including monitoring of the counselor, house mother and social worker. If an organization refuses to be monitored, Group Two decided that there should first be an informal discussion, then an attempt of persuasion and a reminder of the rules; following this the organization should be called for a meeting to address the issue, then asked to show cause. Arbitration should be conducted if possible, and following that, action as per the rules. Ms Muzaffar added that there should be a

Group Work: Developing Quality of Care Standards

The purpose of this exercise is to 'give a taste' of the process of developing Quality of Care Standards.

First Activity

Practice in the development of standards, using the topic: Discipline of Children in Care Settings.

A 17-year-old girl returned from a prostitution situation is causing trouble in the facility. She argues with other girls, has frequent outbreaks of temper, and has recently gotten in a fight with another girl.

List five standards that would guide the staff in working effectively with this child.

Second Activity

Developing a monitoring mechanism to ensure quality of care in facilities.

Answer the questions:

1. Describe who should be on a monitoring body.
2. How often should an individual facility be monitored?
3. Example: a facility refuses to allow monitoring of their activities. What should the monitoring body do?

specific mechanism in the monitoring process to correct and support basic problems such as this.

Group Three's conclusions regarding the composition of a monitoring body included; doctors, psychiatrists, psychologists, lawyers, NGOs, INGOs, children and local government representatives. Monitoring times should include: surprise visits when deemed necessary, monthly reports from the facility, and regular quarterly visits. Group Four decided that a monitoring body should be selected through a participatory process and include government, NGOs, children and professionals. Institutions should be visited once a year or as necessary to ensure compliance. If any criteria remain unfulfilled, an investigation should start. A warning system should be established so that the facility has a chance to improve their activities. Ms Gautam said that necessary action in the case of non-compliance depends on the seriousness of the problem, and added that there should be a reward system for those facilities who are maintaining quality standards. Regarding compliance with standards, Mr Khan stated that Group Three felt that children should be transferred to another facility. Ms Staermose said that in the consideration of Group Four, a gradual warning system could be established to indicate to the organization firstly that improvements are necessary and then if no improvements are noted after a given time and depending on the kind of violations, then the warning becomes serious. If improvement still does not take place, then serious investigation has to be carried out. She emphasized that in order to improve the general standard of care there must be the option of closure as a last resort. Dr Seshadri said there should be a legal system attached to the procedure.

Concluding the group work, Ms Soni Pradhan (WOREC) said that Mr Frederick's presentation was very interesting regarding the reintegration of children into their own homes. However, she asked, as the children would be getting so many facilities in the centers, how could a child cope with the poorer environment in the home? Mr Frederick replied that there are two responses. First, there must still be minimum standards provided for children, no matter how poor their home environment is, and second,

rehabilitation includes strengthening the family prior to children's unification with their families. The children must given an improved family environment when they return.

Strategies for Effective Reintegration

Reintegration of survivors of trafficking and the worst forms of child labour cannot be separated from the activities of rehabilitation. As was mentioned in Ms Atchara's presentation on case management, planning for the child's reintegration begins at the initial intake stage of the rehabilitation process. And as was illustrated in Mr Frederick's model quality of care guidelines, minimum standards apply to careful and effective reintegration as well as rehabilitation. Today, most NGOs and government institutions working with survivors admit that the **reintegration is a considerable challenge in the South Asian context, given extensive gender discrimination, the absence of women in the workplace or living independently, the reluctance of families and communities to accept girls and women who have a history of prostitution, and the absence of employment opportunities.** In consequence, to date most NGOs, governments and supporting partners in South Asia have conducted limited exploration of the issues surrounding reintegration, primarily focusing on the development of skills, many of which have proven unfeasible for providing sufficient income to the reintegrated child.

Mr Alexander Krueger (ILO-IPEC Consultant) in the presentation of his paper "A New Approach to Community-Based Reintegration: The International Rescue Committee's Experience in Rwanda" addressed many of the concerns of the South Asian participants regarding the challenge of reintegration. Reflecting Mr Krueger's earlier work with the International Rescue Committee (IRC) in Rwanda, the paper reviewed IRC's development of strategies and methodologies for community-based reintegration.

Following the civil war in Rwanda, thousands of children were separated from their families and placed in centers across the country. After a number of years, the government, acting according to a 'one child-one family' policy,

decided to significantly reduce the numbers of institutionalized children and close many centers within a very short time period. IRC took on the responsibility of coordinating this activity for selected centers in the country. The primary focus of IRC's efforts was to facilitate the return of children to their families, understanding as well that many could not return to family situations.

In his discussion of IRC's work, Mr Krueger placed emphasis on organizational development in creating mechanisms for reintegrating children to their families, the core challenge being the need to mobilize 'reintegration teams' in rural areas while maintaining a core administrative structure. The organizational structure which IRC developed was based on decentralized teams operating with localized decision-making capabilities and networked with the core administration by processes that insured proper flow of information and support. Through a restructuring of the existing reintegration system, IRC arrived at a new community-based reintegration methodology based on community and family participation. A specific tool was designed to assess family willingness and suitability to receive the child, in order to avoid returning children to an inappropriate situation which might expose them to exploitation or abuse. It is important to note, said Mr Krueger, that **children's participation – specifically children's own opinions on the suitability of their families – play a key role in determining whether children should be reunited with their families.**

Children's participation was central to the reintegration activities of IRC. In the case of adolescents who had spent years in the centers, many had no desire to return to their families, and preferred to live in the cities. The

// The basic guiding principles of the activity were: to work in the best interests of the child; place emphasis on family and community responsibility for the children's well-being; to respect communities' living standards; and to emphasize child participation.

Paper, Alexander Krueger, ILO-IPEC Consultant

centers were generally 'open' centers, in which the children had opportunities to interact with the surrounding community, which was often urban. Mr Krueger discussed the problems of keeping children in 'closed' centers, and noted the difficulties of reintegration children who had spent a long time in the centers. **Prolonged institutionalization can 'handicap' children, making it difficult for them to readjust to the outside world and its requirements of work, responsibility and social interaction.** To prepare adolescents for re-entry into the world as independent persons, the youth were provided with life skills training, to equip them with skills of communication, handling money, seeking employment and finding accommodations.

For younger children, reunification with their families was actively sought. In the cases in which families appear suitable and willing to accept the child, Mr Krueger said, the majority of families faced socio-economic problems. For these cases, identification and analysis of potentially supporting social networks and resources in the community were undertaken. This assessment was conducted with specifically-designed tools to determine the poverty level of the family and to indicate the primary actors in the family and community who could support the reintegration process. These data were then presented for feedback to the children, family, neighbors and other community members at a community round table. Following this, the IRC local community team conducted a case review meeting, in which all information was considered and **a Reintegration Action Plan was developed for each individual child, with clearly defined responsibilities, activities and timing. This plan was presented for final approval to the child, the family and the community.**

As in the case management strategy of CPR in Thailand, the IRC strategy was to provide assistance to the family in case it failed to live at the socio-economic level of the surrounding community. As with CPR, IRC's policy was to strengthen the family prior to the reintegration of the child. If preliminary assessment indicated that assistance was necessary, a more in-depth economic assessment was conducted with family participation to help

the family identify the kind of support which IRC could provide to improve their condition. IRC's economic strategy provided two basic kinds of assistance. The first was the identification with the family of a suitable income-generating project, with assistance provided in training and referral to micro-credit programmes. The second, in response to specific difficult situations, was one-time assistance in kind, including assistance for shelter, health, school or psychological problems, and legal advocacy to provide the family with pensions, inheritance, etc. that might be coming to them.

When assessment indicated that the family was economically able to satisfy of the child's needs, case workers proceeded to prepare the child and the family for reunification. **Pre-reintegration activities included making the child aware of the situation that awaited her/him, including the likelihood of having to work and perhaps live in a poorer situation than was provided by the institution, and making the family and neighbors aware of the potential problems and misunderstandings that can occur with a child who has been living away from the family for a long period of time.** The programme provided follow-up for up to six months after reunification. Case closure was dependent on the same criteria which guided the willingness and suitability assessment.

In the conclusion to his presentation, Mr Krueger reviewed **some of the lessons learned in the process of developing community-based reintegration activities: the need for preliminary screening of families for willingness and suitability; the need for strong family and community involvement; creating an 'exit strategy' for the child at the beginning of the rehabilitation process; and providing favorable conditions prior to reunification.**

In the following question and answer session, Fr. Nalawattage (Don Bosco, Sri Lanka) asked the presenter to clarify his statement that IRC does not take responsibility for the child despite being a facilitating agency in the process of reintegration. Mr Krueger replied that a facilitating agency can only take responsibility for the process, not ultimately for the child –

responsibility belongs with the child, the family and the community. The agency must ensure that the process is done properly and that options are given to the child, family and community. Responsibility is there, but not the responsibility to make decisions for the child or family. Even regarding the community, the case is placed before them right at the beginning, and they can reject the child if they want to.

Ms Deepa Dhital (CWIN, Nepal) asked if the agency had any problem with children returning despite the long-term follow-up in the community. The situation may appear satisfactory as long as the agency is present, then deteriorate after the agency withdraws. Mr Krueger agreed that the follow-up time of six months appears short, but it is sufficient if it can be ensured that the family is economically stable prior to reintegration. The most common problem, he said, is interpersonal conflict and such conflict usually occurs within the first three months. In addition, he said, local NGOs and authorities are made responsible to ensure that the reintegration works out.

Dr Elizabeth de Castro (University of the Philippines) commented that Mr Krueger made an important statement saying that **children could become 'handicapped' if they stay for a long time at a center**. She asked if the group or child-to-child approach of young people living and growing together, as has been used in Southeast Asia and Latin America, had been tried as an alternative to a case-by-case reintegration strategy. Mr Krueger agreed that the centers in Rwanda had many 'socially handicapped' children,

// The basic criteria for case closure are the same as those checked at the first family willingness and suitability assessment. When, at the end of the reintegration process, the child is happy in the family, eats at least two times per day, is treated in the same way as the other children in the family, goes to school (primary school), is integrated into the community (has friends, plays, participates in group activities), has no protection concerns, and at least one member of the family has a regular income, the case can be closed. //

Paper, Alexander Krueger, ILO-IPEC Consultant

particularly girls who were there due to rape or sexual abuse. Referring to Mr Khadka's question about open versus closed centers, he said that **in terms of life skills, girls from closed centers were three or four years behind girls of the same age who lived in open centers, and had a difficult time establishing normal relationships.** Referring to the group living approach mentioned by Dr de Castro, Mr Krueger said that the group approach could certainly be an alternative in certain situations. The case-by-case approach is most applicable to younger children, and the group approach is most applicable as the children reach adolescence. He said that the case-by-case approach has also been applied to reintegrate children to independent living, not with their families, and in Rwanda there have been pilot approaches with group living, such as group homes. Those pilot approaches haven't been very successful, which does not mean they are bad approaches. In Rwanda, he said, they are now trying to organize family-like units dispersed in villages, which are group living situations of children and social workers connected to the local community.

In the concluding comment, Mr Frederick noted Mr Krueger's statement that adolescents frequently didn't want to return to their families and villages, but preferred to stay back in the cities. This is an issue which we have not confronted sufficiently in South Asia, he said. **Many women and girls who have been trafficked to the cities don't want to go back to the village. We have to consider what has to be done if they don't want to return to prostitution, but want to live independently in the cities.**

In the following group work, four groups were each given a different set of questions. Group One was provided with the following two questions regarding rehabilitation centers:

- Should the center be open to the surrounding community, or is it better to keep it closed?
- Are actual centers really transitional?

On behalf of Group One, Ms Lara Perera (National Child Protection Authority, Sri Lanka) discussed the advantages and disadvantages of open centers, concluding that in open centers there should be standard behavioral guidelines created with the best interests of the children in mind, the children should be under supervision not only of the center but of the community in the area, 'red zones' of protection should be created around open centers, and children should be informed about risk.

Group Two was provided with the following question about the government and reintegration.

- What should the role of the government be?
- What can the government do to create favorable conditions for sustainable reintegration?

Ms Manju Kanchuli (Tiwari) of ABC Nepal spoke on behalf of Group Two. She said that the role of government includes, among other things: creation and support of infrastructure, and capacity building; resource allocation; and collaboration with NGOs. Regarding creating favorable conditions for reintegration, Group Two concluded that government can: appoint a special authority; establish infrastructure to ensure training and monitoring of staff in government homes; provide employment opportunities; and strengthen government institutions that can support reintegration activities.

The following questions about the community-based approach were given to Group Three:

- With highly stigmatized children, is it worth adopting a community-based approach?
- Why?

Mr Douglas MacLagan (Child Welfare Scheme, Nepal) said that Group Three concluded that community-based approach is appropriate because such an approach creates ownership of the problem, leading to community responsibility, and the community can protect the children. As well, the community-based approach makes reintegration more sustainable. On the

negative side, the child her/himself might not want to be placed in a local community situation, the stigmatization might be too strong to overcome in the community, and the needs of the individual might not be met by the community.

Group Four was provided with the following questions about child participation:

- What is the role of child/family in reintegration?
- How could the child influence the process?

On behalf of Group Four, Mr Acharya (FNCCI, Nepal) said that the roles of both the child and the family in reintegration are making basic decisions about the future of the child. The family, in addition, can provide assistance and leadership in the reintegration process.

Occupational Reintegration and the Enabling Environment

Whether children are reunited with their family and community or whether they are reintegrated into society as independent, working persons, occupational training is an essential part of the rehabilitation and preparation process conducted by the facility. Throughout the technical meeting, there was repeated reference to the challenges of finding appropriate employment for recovered survivors of trafficking and the worst forms of child labour. Ms Staermose introduced the topic of the session, entitled “Economic Empowerment: Occupational Reintegration and the Enabling Environment”. She noted the challenges to occupational reintegration, observing that successful occupational placement depends not only on the training facility, but also on the coordinated efforts of government and the private sector.

Following Ms Staermose’s introduction, Ms Margot Lobbezoo, ILO-IPEC consultant, gave a presentation on ILO’s occupational preparation model SIYB (Start and Improve Your Own Business). This model provides a means to apply small enterprise development tools to the needs of disadvantaged youth. Ms Lobbezoo first placed occupational reintegration in the context

of special characteristics of sexually abused children, including low self-esteem, vulnerability to relapse, lack of trust, lack of a family support system and, notably, having a strong will to survive. In making the choice of a future occupation, there are two options: self-employment or employment by others. The focus of the presentation, said Ms Lobbezoo, was on self-employment, particularly through micro-enterprise development.

The starting point for young people who are interested in self-employment is to help them understand what business is all about. This first module of the SIYB programme, called Know About Business, is designed to help young people understand what a business is, what kind of person is best suited for business and what needs to be done to operate a business. This foundation training helps young people explore business as a career opportunity. Following this, the facility provides the youth training in a marketable skill. Ms Lobbezoo noted that **the purpose of vocational training is not treatment but providing a useful skill to be used upon reintegration**. Training can often be provided at low cost through local artisans and business people. Ms Lobbezoo recommended that traditional female skills such as tailoring and embroidery should be avoided unless the market need is clearly indicated, and encouraged facilities to explore new options for business, particularly for females. It must be emphasized, she said, that **'marketable skills' can only be determined through a careful assessment of market needs in the location where the youth are to be reintegrated**. She suggested that many appropriate skills are related to service enterprises, such as restaurants and shops.

Following a young person's selection of an occupation among the options identified as being suitable and marketable, the SIYB model provides basic

// Preparation for occupational reintegration within the facility not only requires training, but planning to ascertain job markets and providing activities so that the children can practice their occupations before reintegration. //

Presentation, Margot Lobbezoo, ILO-IPEC Consultant

training in conducting a business. It teaches young people the basic principles and skills of entrepreneurship, and helps them develop a business plan. The training includes interpersonal skills necessary for operating a business, including how to deal with customers, with traders that buy or sell goods, and with issues such as sexual harassment in the workplace. This part of the training uses role plays and other methods to illustrate the everyday interactions of the business world, and aims at increasing the youth's self-confidence in working with others.

The significant feature of the SIYB model is the concept of 'incubators', that is, providing a protective, supporting environment for the nascent businesses, in which young people can practice their business skills with security and confidence for an initial period of time. This is particularly important to survivors of sexual abuse, who need extra protection and support. The 'incubator' for the growing business can be a space and facilities in or near the facility and also in the vicinity of the market. The incubator can be an independent business operated by young people or a business started by the facility in which young people learn skills under the supervision of a counselor or skills trainer. The primary purpose of the incubator is to help young people create a viable, operating business which attempts to earn a profit while teaching them functional business management and giving them the confidence to go out on their own.

During this process, **the young people are provided with ongoing business counseling, which encourages the young entrepreneurs to seek solutions to common business problems, and strengthens their ability to make responsible business decisions. This is accompanied by psychosocial counseling, which helps the young people address natural fears of risk in business, and assists them in working with adverse social situations that may arise.** To support the incubation of the small businesses, the facility assists the young entrepreneurs in gaining access to supporting services, such as finance, accounting services and computer services. As in the assessment of markets for skills and services, the facility must identify whether such services are readily available and

accessible, and must develop strategies for helping the young entrepreneurs access those services.

In concluding her presentation, Ms Lobbezoo discussed potential problems which, in addition to the problems faced by all entrepreneurs, are particularly faced by survivors of trafficking. Sexual harassment is a concern, not only for survivors but for all female entrepreneurs in South Asia. Customers might avoid the shop or restaurant because of the young person's background. The psychological status of the young entrepreneurs, particularly low self-confidence and distrust of others, is an important consideration. **The business should generate sufficient income to prevent discouragement and the possibility of youth leaving the activity.** The youth might become discouraged if their business activities do not elevate their status in the village or community. **The SIYB 'incubator' model provides an open yet protected situation in which young people can learn to conduct business in the outside world, while providing monitoring, support and counseling to address problems that may occur.**

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In the question and answer session that followed, Fr. Nalawattage stated that he found the presentation practical for the process of healing, as vocational training provides more opportunities for the young when they return to the home environment. At the same time, he said, vocational training can be an important part of treatment. Ms Lobbezoo replied that the matter depends on the kind of vocational training provided. Most of the training given, she said, is based on treatment rather than on the needs of the job market and is thus therapeutic not occupational. As well, most training is not directed towards those who may want to start a business. She stated that **vocational training for treatment and training for actual income generation should be differentiated.**

Ms Staermose of ILO-IPEC recalled Dr de Castro's statements that children must make the final choices in their lives, even with guidance, support and help to find one's potential. When Ms Lobbezoo talks about career

counseling, she said, it is important to identify what a child's potential might be, so that a child can be motivated to be an entrepreneur or not. **Once the child's interest is identified and the child is motivated, at that time the reintegration process can properly begin.**

Ms Shanti Chadda (WEAN, Nepal) agreed that it was very valuable to share experiences in starting up businesses for women. WEAN has conducted a lot of research on consumer needs and import/export markets, and this has been central to choosing the type of training given. However, she said, as well as market assessment, there are many considerations to be taken into account in creating products for sale, such as packaging, labeling, costing and so on. Without these considerations, there is a much higher chance of a micro-business failing. After training women, WEAN helps them find access to micro-credit financing. The government of Nepal has also determined some sectors which the banks should give financing priority, such as handicrafts. However, the banks are reluctant to take on the task of supporting new businesses. There are some important areas in financing women entrepreneurs that need to be worked on, she said.

Following Ms Lobbezoo's presentation, four groups were designated and provided with individual questions. Group One deliberated on the following questions:

Imagine you are a girl just rescued from a brothel. You have received counseling and are ready to take your first steps in the world. During your counseling you received training about owning your own business. You are interested in starting your own business, but you still have many questions.

- What questions would you have if you were starting your own business?
- What uncertainties would you feel?
- How can a programme address these uncertainties?

Mr Manzoor Khan (Ministry of Interior, Pakistan) presented the responses of Group One, which had consolidated their answers into general guidelines for the survivor seeking to be an entrepreneur. First, the rehabilitated girl

should select a business, which is less competitive and requires less investment. She should seek information regarding capital, technology or marketing from someone with success and experience in the same field and from market surveys. Credit would have to be provided by micro-credit banks and cooperatives because of her lack of experience. In the beginning, she should be careful to ensure herself a regular income.

Group Two was provided with the following questions:

Just training girls and boys to start up a business is not enough. These businesses have to become profitable and there must be a market for their product or services, otherwise they will easily relapse into their former profession.

- How can you find out what products are needed at the local level?
- What additional support do these youth need to enable them to make a living being an entrepreneur?
- In the beginning, an enterprise never makes much profit. How can youth be motivated to keep going?

Speaking on behalf of Group Two, Mr Mahamud Un-Nabi of the Association for Community Development, Bangladesh, said that the ways to determine what products are needed is to look at existing research materials and to conduct a market survey, particularly using observation and interviewing key informants such as shopkeepers, businesses, households and offices. One should address considerations like rental of shop space, cost of raw materials and infrastructure requirements, as well as duplication of existing services and competition from bigger businesses. It would be helpful to link with cooperatives, he said. Regarding training, qualified trainers can be found among local experts, families with a traditional vocation, university departments of Home Science, NGOs, training institutes and women's cooperatives. Motivating youth at the beginning of their enterprise can be accomplished by providing business counseling, sharing experiences among peers, budget planning to deal with losses, frequent monitoring of the activity, and advocacy to strategic partners on behalf of the children.

Following are the questions provided Group Three:

There are many development projects to stimulate micro-enterprise development.

- Do you know any of these projects in your region?
- Can you think of any modalities with which you can work together with these projects?
- What knowledge and skills are you lacking to support activities like these?

Mr Khan (Bangladesh Employers Federation), speaking for Group Three, provided a list of micro-enterprise development projects in Bangladesh, Nepal and Sri Lanka. He said that working with these projects could be accomplished by replicating the most appropriate programme models in the region, transferring technical expertise, networking between organizations, and working closely with the private sector to establish marketable products and ensure job placements. The primary knowledge and skills that are lacking include the identification of viable business prospects, counseling on business, marketing skills and monitoring skills.

Group Four was provided with the following questions:

In a normal situation, entrepreneurs often get support from their family, but they also get demands.

- How can families support the youth?
- How can you learn to deal with the demands from the family and separate business from family?

Responding for Group Four, Mr Binod Koirala (FNCCI, Nepal) said that families can support youth in micro-enterprise development through providing moral and emotional support, manpower, finances, supplementary skills, protection, counseling and legal support.

Concluding Activities

Dr Seshadri remarked on the wide range of issues, concepts and ideas which had been presented in the technical meeting and emphasized the importance of reconnecting those with the “voices of the children whom we want to serve.” Dr de Castro underlined his statement, saying that all of the activities presented in the meeting must first and foremost be undertaken with full awareness of children’s full humanity and their ability to make decisions, understand ideas and create their own responses to adverse situations. To fully activate child participation, she said, we need to develop ‘drawing out’ mechanisms, by which we reach out to the child, seek to understand the child’s point of view, and give the child confidence in ourselves as ‘listeners’. We cannot, she said, expect the child to reach our level of communication – we must reach theirs. In the discussion that followed her statements, participants commented on the parameters of child participation, specifically the question: **how can we balance children’s rights to decision-making on their own behalf with our ‘parental’ role as adults of providing guidance and direction to the young?** Dr de Castro responded that we must clarify which decisions children can make and which decisions we can make. However, we should be aware of our feelings in the matter, for we could sometimes think that children participating in some areas, such as the operation of a facility, challenges our power as caregivers. It is important for all concerned to be very clear what decision-making roles children can and should play.

Dr de Castro presented the participants with a final group work activity, the question:

What options/alternatives (e.g. ideas, activities, projects) can young people in the community do together and come together for?

For the conclusions of Group One, Dr Seshadri presented a process for caregivers in working with children in the facility. This process, he explained,

has multiple uses, including facilitating the ability of a group of children to decide options and alternatives for their own activities: the creation of anticipation through curiosity, bonding exercises, introductions to know each other better, exercises to free the imagination, introducing the content of the proposed activity, role play or group work, evaluation, application, debriefing and finally bonding to unify the group of children. Mr K.K.M. Mustaque Ali (INCIDIN, Bangladesh), on behalf of Group Two, suggested an activity in which children create their own space for their recreational activities, using an unutilized location in the neighborhood for cultural activities, sports, and “activities only children can understand”. The children, he said, can elect their own representative to look after the space, and amenities can be collected from the local neighborhood. Youth clubs, mothers’ clubs and children’s clubs can work together for the purpose. Group Three, presented by Mr MacLagen (CWS, Nepal) said that drama, debates and sports are three major activities that children can do together. He encouraged children’s involvement in social, cultural and environmental issues that gave them a positive attitude towards society. The conclusions of Group Four, presented by Mr Shrestha (MWCSW, Nepal), generally agreed with those of Group Three. His group placed particular emphasis on sports activities, and included making children aware of their rights and of the concerns of the underprivileged.

Summary and Analysis

Rehabilitation is a complex process which must address a multiplicity of factors generally not addressed in current interventions. The effects on the child from trafficking for sexual purposes are broader than 'psychological damage' which is to be 'repaired' by counseling. Central are those which effect the personhood of the child: her/his sense of who they are, who they can trust, and how they expect the world to respond to them. Interventions to help children reconfirm a positive identity go beyond counseling, to the creation of 'healing environment' in which children find order, coherence, positive response, friendship and security. While severe emotional complications can occur, these should be addressed only by properly trained and experienced counselors. The majority of interventions, however, involve providing the child an environment which counteracts the effects of the trafficking situation, and provides family-like experiences, play, enjoyment, personal interaction, participation and the freedom to respond to a safe world in a child-like way.

Case management provides an operational structure by which caregivers can determine the needs, wishes and abilities of the child, plan the most appropriate ways to help the child recover and reintegrate, and conduct interventions using the most effective methods. It provides the caretaking facility with a wide range of multi-disciplinary expertise, and ensures 'back-up', support and monitoring for all activities. Through case management, caregivers are provided with an ongoing 'picture' of the child as she/he progresses through her/his recovery and reintegration, and are given the ability to adjust and develop mechanisms to protect, support and strengthen the child. The process allows children to participate in their healing process, while taking into account their individual capacities and liabilities. By addressing the child's eventual reintegration during the rehabilitation

process, case management not only ensures the child's immediate psychosocial well-being, but also facilitates her/his successful re-entry into society.

Successful rehabilitation of child survivors of trafficking can only be accomplished with an understanding of the characteristics of childhood and by placing interventions within a localized cultural context. Rehabilitation interventions conducted by caregivers are most effective if they recognize, reinforce and foster the child's natural processes of self-recovery. Reaffirmation of selfhood and the strength to be active in society are developed through flexible, participatory interventions based on recognition of the child's capabilities and affirmation of their inherent value and respect as human beings. Interventions must be appropriate to the cultural setting in which the survivor thinks, communicates and seeks her/his means of self-recovery. The integration of indigenous knowledge and practices into counseling and caregiving recognizes behaviors, social relationships, communication patterns and healing options that are of great value in the rehabilitation process

Training programmes for the development of human resources for the caregiving of trafficking and abuse survivors in South Asia are primarily focused on counseling. These programmes in general provide comprehensive information on the concepts and issues of child abuse and excellent 'empathetic' learning experiences to help caregivers understand the trauma of commercial sexual exploitation. The approaches of almost all programmes examined were 'child-centered' approaches. Among the counseling courses, there is a need to place counseling within the context of a case management system, to provide more comprehensive information on the healing process, and to include clinical experience in the training. Few programmes were found to offer training opportunities on other aspects of caregiving for the abused, such as para-social work, experiential therapies, life skills development, peer activities or family interventions.

Central to the design of training and orientation courses for those addressing the psychosocial concerns of the abused child is a clear indication of what role the trainee will play in the caregiving process upon completion of the course. Courses which provide background and orientation on trafficking and abuse processes must be distinguished from courses which train persons to directly intervene in children's psychological concerns. The latter courses, in which persons are trained to be 'para-counselors', require: comprehensive clinical experience; supervised applications of theory in a practical setting; training in conducting counseling interventions in the cultural context of the survivor; counseling for trainees to help them clarify their self-conceptions and role as a counselor; and comprehensive post-training activities, including placement, monitoring and refresher training. Training for facility directors and managers is needed to help them understand the role of para-counselors and counselors, establish facilities to assist the counseling process, and develop a case management system in which counseling is integrated into a comprehensive caregiving strategy for survivors.

Quality of care standards and guidelines provide an operational framework by which facilities provide routine effective care for survivors, maintain professional, transparent and accountable care practices, and optimize the abilities and performance of caregivers. Care standards clarify human rights principles guiding the care of the survivors, the physical requirements and operation of facilities, specific responses to the needs of survivors, roles and responsibilities of staff, and basic procedures of protection, rehabilitation and reintegration. While core standards are universal and applicable to all institutions conducting rehabilitative interventions, they must be adapted to the cultural context of each society. The development of quality of care standards is most effectively conducted through the collaboration of all of those concerned with the caregiving process, including children. Facilities' achievement and maintenance of care standards require monitoring, which is best conducted by an independent, multi-disciplinary body.

Rehabilitation planning and activities are conducted both to facilitate the recovery of the survivor and to prepare the survivor for reintegration into society. Activities which lead towards reintegration are based on ongoing assessment of the survivors needs, capacity and wishes, and are planned with the participation of the child and the family. Reintegration of the survivor into the family setting necessitates careful assessment of the family and community for risk factors, mobilizing family and community involvement, and, if necessary, providing material and psychosocial support to the family prior to reintegration, so that it can provide a safe and adequate home for the child. Due to the child's wishes, family unsuitability or challenges caused by long-term institutionalization, alternative living situations may be more suitable for the survivor, and should be considered in planning reintegration strategies. Constraints to reintegration in South Asia, including discrimination due to gender or past abuse, and lack of occupational and residential options, must be carefully considered in the reintegration planning process.

Occupational training in preparation for employment or income-generation should be distinguished from therapeutic work activities which are a part of the rehabilitation process. Careful assessment of markets for jobs, goods and services in the survivor's destination community provides the basis for determining the selection of skills in which the survivor can be trained. The survivor, with assistance from occupational counselors and her/his family, has the right to choose which suitable area of work she/he wishes to pursue. If the child chooses to undertake a micro-enterprise, facilities can assist the child to establish a trial business through a micro-enterprise training programme such as ILO-IPEC's Start and Improve Your Own Business (SIYB) programme. With the SIYB 'incubator' model, young people are provided training in business management as well as appropriate skills, assisted to start a trial business, and given ongoing business and psychological counseling to help them address the challenges and opportunities of engaging in micro-enterprise. The model promotes a successful income-generating experience by providing a protective, supporting environment in which young people can practice their business skills with security and confidence.

Lessons Learned

The South Asian Technical Meeting on Psychosocial Rehabilitation and Occupational Integration of Child Survivors of Trafficking differed from many previous seminars and conferences in that its primary intention was not to provide information, establish consensus on issues, or directly solicit recommendations for 'plans of action'. Instead, the meeting sought to critically examine certain aspects of caregiving practices in South Asia, and to question, 'unpack' and reformulate existing operational paradigms relating to rehabilitation and reintegration, in order to provide a clearer conceptual framework which will lead to the planning of more effective and successful interventions.

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For this purpose, participants were chosen from a wide spectrum of disciplines – from caregivers to policy makers to labour organizers – and were encouraged to contribute ideas from their often very divergent standpoints. In addition, the meeting discouraged repetition of the facts and formulae of the trafficking discourse with which participants were familiar, and encouraged participants to 'explore new ground', test new ideas, and re-think the trafficking discourse. Consequently, presentations were technical and intellectually challenging, participants were encouraged to challenge their own preconceptions and provide critical, imaginative responses, and group work was focused on determining practical applications to the care setting rather than making theoretical or generalized conclusions.

While the consensus of the participants was that the activity was successful and provided experiences, ideas and tools beyond expectation, lessons were learned which may be applied to similar activities in the future:

- Few of the participants had previously joined in such an exercise, and most expected to play a more passive, input-oriented role as in the seminars and conferences with which they were familiar. Recommendations: prior to such meetings and during the introductory part of the meeting, participants should be carefully oriented on the strategy of the meeting and the roles of the participants.
- The complexity and detail of some of the subjects were unfamiliar to some of the participants. For example, some government and private sector persons were unfamiliar with the practices of caregiving, and some caregivers were unfamiliar with business and marketing activities. Recommendations: prior to the meeting, participants should be provided with a comprehensive written 'briefing' of the issues to be addressed, in addition to the papers to be presented.
- As the meeting was sub-regional, it was conducted in English. Some participants had little or no English language proficiency and consequently limited comprehension of the activities. Recommendations: in sub-regional activities, in which English or another single language is used throughout, participants should be screened for their language proficiency. At the national level, activities should be conducted in local languages if possible. In both cases, translators should be available to assist participants when they have difficulty in following the proceedings.
- As in many seminars and conferences, there was a low level of participation among a few participants. In this form of meeting, however, extensive participation of all participants is necessary. Recommendations: mechanisms must be built into the meeting to ensure participation, including communication activities, ice-breaking activities, means of promoting individual responses, means of 'equalizing' the input of voluble and reticent persons, and means to provide comfortable situations in which individuals can express their personal ideas and opinions without concern for group opinion.

- The meeting not only challenged people's ideas and conceptions, but confronted them with the need to change existing ways of doing things. While all participants in this meeting were open to reflection on their own work, it is thought that mechanisms to encourage change should be integrated into such meetings in the future. **Recommendations:** pre-meeting orientation should make participants aware that the meeting will be an environment for the analysis, testing and criticism of existing ideas and methods. Within the meeting, mechanisms should be in place to prevent critical analysis directed at the activities of individual organizations, and to help participants understand the direct benefits of improving practices.
- Children were not participants in this meeting, and the complexity and detail of the topics would be difficult for children to comprehend. **Recommendations:** children should be invited as participants, although care should be taken to select children who represent the 'common ground', rather than extremely advantaged, English-speaking children, or extremely disadvantaged children. Simplified, 'child-friendly' versions of both orientation materials and papers should be provided to the children. A 'child participation strategy' should be developed, to ensure genuine, not token, participation. This can include preliminary communication activities which help adults listen to and respect the children's input, and providing 'child participation assistants', who attend the meeting with the children and work with them to ensure their comprehension of the issues and their equal participation with adults.

Recommendations and Next Steps

At the end of the meeting, areas of greatest concern and recommendations for further action were solicited from the participants.² Those are presented here in the order of importance to the participants, as determined by the volume of comments on a particular area. Suggestions for 'next steps' are included with each recommendation.

Developing Quality of Care Standards and Guidelines

The majority of participants underlined the necessity of developing and applying minimum care standards to the operation of caregiving facilities. They recognized the necessity of guidelines to help them coordinate the components of their work, and to facilitate the reintegration of survivors into their families and communities. Many of the NGO representatives noted that they had begun to establish in-house operational guidelines, and welcomed a collaborative, focused process to assist them in the task. Most of the participants who recommended the development of care standards emphasized the need for an external, independent mechanism to monitor quality of care in the facilities.

// I would like to incorporate in my work the idea of having standards and guidelines. I think we should have national and sub-national consultations to develop a matrix of what the minimum standards should be. I hope the ILO-IPEC supports my country in developing minimum standards and guidelines for rehabilitation centers. //

²The participants were given one hour to reflect and evaluate in writing their impressions from the seminar.

Next steps:

- Conduct follow-up meetings in each country on quality of care standards, and identify and mobilize stakeholders.
- Clarify the process of developing standards, and develop tools to assist those working to develop standards.
- Establish a multi-disciplinary 'standards development working group' in each country, and provide support to the group during the standards development process.
- Provide linkages for collaboration of country working groups to facilitate a sub-regional consensus on basic standards.

Family and Community Participation in Reintegration

Many participants remarked that they gained a realization of the importance of the family and community in the reintegration of the child survivor, and understood the value of community-based activities. They felt that they could mobilize their existing skills and activities in particular towards community awareness and support. While they understood the importance of family interventions, responses were equivocal as throughout the meeting, expressing their inexperience with working in the family setting. Participants understood the linkage between rehabilitation and reintegration, and repeatedly recommended community-based facilities as the best preparation for the survivors' reintegration. In general, participants were eager to learn modalities and strategies for applying their work in the community setting.

Next steps:

- Conduct research in families and communities, and examine existing good practices to identify the modalities of providing community-based rehabilitation and rehabilitation interventions.
- Assess the existing capacity of organizations to expand or adapt existing community-based efforts to rehabilitation and reintegration.
- Support organizations to develop pilot community-based programmes.

// One has to start the reintegration plan for a child having the context in mind that 'I can not possibly provide the best options for the child'. //

// In a country like Nepal, where the exploitation goes on in a vicious circle, looking at a larger perspective, at the family/community level, is very necessary. It is not only about a single child being reintegrated. //

// There were certain issues about center-based reintegration that opened up my mind, like keeping youth and children in centers too long could handicap them, and therefore, create actual relapses. //

Actualizing Child Participation

In their recommendations and throughout the meeting, participants expressed their concerns regarding child participation. They clearly recognized the importance of the child's participation in her/his rehabilitation and the necessity for the child to make the leading decisions regarding her/his reintegration. However, there were general questions as to what 'child participation' means, how adults can and should 'listen' to children, how to promote full participation, and how to balance the child's 'empowerment' with the adult 'parental' responsibilities of providing guidance and direction to young people inexperienced in the world. Recommendations sought increased child participation, while emphasizing the development of new mechanisms to strengthen that participation.

// We should not impose our life-skill ideas on children, rather talk to them to find out her/his area of interest and then assist the child to take her decision. //

// If we bring up the matter of child participants and then do not include them in the planning and designing from the start, it seems a wee bit of a contradiction. //

// Children should be involved in decision-making which ultimately effects their lives. Children may come up with solutions for problems which adults may not be able to comprehend. //

Next steps:

- Hold meetings in each country focused directly on child participation to analyze, re-think and critique existing paradigms of participation, and to seek new and more effective ways to include children in the different processes of rehabilitation and reintegration.
- Conduct studies with children and review existing studies and best practice documents regarding child communication, interaction, decision-making and participation.
- With children, develop pilot activities for their participation in specific tasks related to rehabilitation and reintegration.
- With children, develop pilot activities directed at adults to assist them in understanding, respecting and utilizing the input of children.

Redefining Caregiving

Participants expressed that they learned from the meeting that caregiving for the trafficking survivor involves more than counseling. However, they felt that they still did not have adequate knowledge of what the ‘full spectrum’ of caregiving implies. For the majority of participants, the primary activity in caregiving for survivors was providing counseling, although they expressed a need for facilities to provide a safe and supportive environment for the abused, as well as activities such as sports and recreation. In their comments and recommendations, many asked for clarification of the roles of various forms of caregivers and assistance in developing those human resources.

// The abused child is a wounded child and a wound is a cavity. Rehabilitation necessarily involves positively giving the victim a chance to fill himself or herself. It may be in the field of acquiring a skill, developing an inherent talent, or sports and games. //

// Developing human resources involves making of the whole staff (e.g. cook, security guard, driver) feel that they too are directly involved the process of healing. //

// We want to develop manpower but are not sure what to do, we need guidance. //

Next steps:

- Provide NGO managers and staff with a comprehensive orientation programme on the spectrum of caregiving and the healing environment.
- Conduct collaborative assessments of individual facilities to determine human resource needs.
- Develop training programmes for caregivers in other forms of interventions as well as counseling, including para-social work, experiential therapies, recreation, 'house mother' activities, and others.
- Provide training for facility staff on non-counseling interventions, and orientations for facility managers on how to develop the facility into a healing environment.

Establishing Case Management Procedures

Participants were very responsive to the concept of case management, and many stated that such would ease their work and make it more effective. The majority of participants saw case management as a way to facilitate the planning of interventions, particularly recognizing the importance of early planning for the child's reintegration. For many, the discussion of case management clarified the sequential processes of rehabilitation, particularly the importance and specific requirements of the intake stage. However, while most recognized the value of utilizing a case management system, they generally did not feel they had sufficient knowledge to develop and utilize such a system, and were uncertain about the sharing of roles with a multi-disciplinary team in case management.

// The rehabilitation and reintegration process needs to be planned in detail with the long term follow-up in mind. //

// Case management proves to be very important in how to cover all aspects of each individual case, to follow the 'case file' from a stage before the 'student' actually becomes center-based, and to follow the case file through to longer than the 'youth' is with the center. //

// This gives us a step by step approach, rather than jumping from A to B and forgetting about A1, A2, A3, etc. //

Next steps:

- Provide orientations for facility staff and managers on the case management process, as applicable to their present interventions.
- Assist facilities in establishing a multi-disciplinary network which can comprise the case management team while providing specialized assistance to the facility in the rehabilitation process.
- Develop and provide a comprehensive training programme in case management practices for facility managers, staff and all potential members of a case management team.
- Provide ongoing assistance and guidance to new case management teams.

Indigenizing Caregiving Practices

Throughout the meeting and in the final recommendations, there was a very positive response to the concept of indigenizing caregiving practices to the local setting. Participants rapidly acquired an understanding of the value of applying indigenous knowledge and practices in their healing interventions. Most participants understood 'indigenization' to mean adaptation in terms of language and vocabulary, and recognition of survivors' own perceptions and attitudes towards the reintegration process. Notably, a number of participants linked the indigenization process with the child participation process. In general, participants were unclear about the range of indigenous knowledge and practices that could be applicable to their caregiving settings, and sought ways to actualize indigenization in their work.

Next steps:

- Conduct a review of existing activities in indigenizing care practices.
- Develop a general procedure for the process of indigenizing caregiving, applicable to any country setting.
- Mobilize and support country working groups and networks to contribute applications of indigenous knowledge and practices (IKP), conduct participatory research, examine existing studies on IKP, and recommend practical applications of IKP for specific caregiving tasks.
- Develop methodologies by which caregivers can mobilize the participation of survivors, local healers and others in the indigenization process.

// An idea that I had when I first attended this seminar was that it is most often better to tap into foreign expertise when it comes to training programmes, etc. I felt that a foreign expert would have more up-to-date training materials and would in general be more effective. However, I learnt that sometimes it is much more beneficial to use my own local expertise. Such people would be able to apply the training directly to the culture and there would be no language barriers. In addition, it would be a method of developing national capacity of the country. //

// While developing strategies we should be very careful about the indigenous knowledge they (the survivors) are dealing with, also we should not ignore their perception, attitudes towards the reintegration process. It should be in a very participatory way. //

Providing Realistic Employment Options

For many participants, the meeting addressed a major concern: how to ensure the economic needs of the survivor upon reintegration. Recognizing the significant constraints in South Asia to the employment of survivors, particularly females who have been involved in prostitution, participants felt that guidelines had been provided to help determine viable employment options in a very difficult working environment. Participants recognized the value of conducting surveys to ascertain local job markets prior to determining skills to be taught. The ILO SIYB model provided an understanding that the facilities, as well as providing skills training, could be used as ‘incubators’ in which young people could ‘test’ their skills and start micro-enterprises in a setting that provided guidance, support and security from the risks of the outside business environment. The majority of participants working directly in rehabilitation and reintegration expressed a desire to learn more about applications of the SIYB model.

Next steps:

- Support organizations with skills and/or expertise to conduct surveys of localized markets in jobs, goods and services.

// We must not start on a skill training course before a considered market survey. //

// The training on any skill should be such that it fetches her/him an income commensurate with her living standards. //

// The most important thing which I can consider in my work is the SIYB-based model. I am looking forward to see how we would apply this model in our mission. //

- Conduct collaborative assessments of existing skills training activities and skills training capacities in organizations providing rehabilitation and reintegration services.
- Provide training in and/or trainers and ongoing support for developing the SIYB or similar models within organizations.

Other Recommendations

Additional recommendations from the participants included:

- Holding this meeting at the national level.
- Providing this form of meeting on specific topics in individual countries.
- Increased government support for rehabilitation and reintegration activities, particularly in community mobilization, assistance in developing care standards and monitoring caregiving practices, providing physical, human and financial resources for the expected increase of the number of survivors in rehabilitation, and providing trained human resources.
- Developing and providing care-for-caregivers training.
- Providing training on the use of peer groups, including peer education and counseling.
- For better orientation for those not directly involved in rehabilitation work, such meetings should include field visits to rehabilitation centers and screening of videos showing rehabilitation and reintegration activities.

Annex I. Seminar Programme

Tuesday, 11 June

Morning

- 8:30 – 8:40 Welcome by Leyla Tegmo-Reddy, Director, ILO Area Office, Nepal
- 8:40 – 8:55 **The ILO-IPEC Framework: Steps in the Process from Survivor of Trafficking to Adult Member of the Work Force**, by Tine Staermose, CTA, ILO-IPEC TICSА Programme
- 8:55 – 9:15 The Conceptual Framework for the Seminar, by John Frederick, ILO-IPEC Consultant
- 9:15 – 9:30 Self-introduction of Participants

SESSION ONE: INTAKE AND REHABILITATION

- 9:30 – 10:00 Paper Presentation: **Addressing Child Sexual Abuse: Dimensions, Directions and Good Practice Parameters for the Care Setting**, by Dr Shekhar Seshadri, National Institute of Mental Health and Neurosciences, Bangalore, India
- 10:00 – 10:15 Questions and Discussion
- 10:15 – 10:30 Tea Break
- 10:30 – 11:45 Paper Presentation: **Case Management Guidelines for Child Protection and Care Services**, by Atchara Chan-o-Kul, Center for the Protection of Children's Rights Foundation, Bangkok, Thailand
- 11:45 – 13:00 Panel Discussion and Plenum on Individual Case Management. Panelists: Atchara Chan-o-Kul (CPCR, Thailand), Dr Bogendra Sharma (CVICT, Nepal), Dr Shekhar Seshadri (NIMHANS, India), Zebunnesa Rahman (BNWLA, Bangladesh). Moderator: John Frederick
- 13:00 – 14:00 Lunch

Afternoon

- 14:00 – 15:00 Paper Presentation: **Integrating Indigenous Knowledge and Practices into Psychosocial Help and Support for Children Survivors of Commercial Sexual Exploitation**, by Dr Elizabeth Protacio-de Castro (University of the Philippines)
- 15:00 – 15:45 Questions and Discussion
- 15:45 – 17:00 Group Work on Integrating Indigenous Knowledge and Practices
- 17:00 Summary of the Day, by Bimal Rawal, NPC, ILO-IPEC TICSА Programme, Nepal

Wednesday, 12 June**Morning**

- 8:30 – 8:45 Recap of Day One, by Bimal Rawal
- 8:45 – 9:15 Presentation of Group Work
- 8:45 – 9:00 Brief Overview, **Human Resources Development for the Care of the Sexually Abused and Sexually Exploited: A Resource Document on Training Programmes**, by John Frederick
- 9:00 – 9:30 Paper Presentation: **Training of Psychosocial Counselors in a Non-Western Context: The CVICT Approach**, by Mark Jordans, CVICT, Nepal
- 9:30 – 10:00 Questions and Discussion
- 10:00 – 10:15 Coffee and Tea
- 10:15 – 11:15 Paper Presentation: **Standards and Guidelines for the Care of the Sexually Abused and Sexually Exploited: Some Applications for South Asia**, by John Frederick
- 11:15 – 12:30 Group Work on Standards and Guidelines
- 12:30 – 13:00 Presentation of Group Work
- 13:00 – 13:15 Tea Break
- 13:15 – 13:20 Summary of the Day, by Shyama Salgado, NPC, ILO-IPEC TICSА Programme, Sri Lanka
- 13:20 – 14:15 Lunch

Afternoon

- 14:15 Departure from Godavari by bus for Kathmandu to participate in activities for International Child Labour Day, Royal Nepal Academy

SESSION TWO: COMMUNITY-BASED AND CENTER-BASED REINTEGRATION**Thursday, 13 June****Morning**

- 8:30 – 8:45 Recap of Day Two, by Shyama Salgado
- 8:45 – 9:00 Introduction and Conceptual Clarity
- 9:00 – 9:45 Paper Presentation: **A New Approach to Community-based Reintegration: The International Rescue Committee's Experience in Rwanda**, by Alexander Krueger, ILO-IPEC Consultant
- 9:45 – 10:30 Questions and Discussion
- 10:30 – 10:45 Coffee/Tea
- 10:45 – 12:30 Group Work on Community-based Reintegration
- 12:30 – 13:00 Presentation of Group Work
- 13:00 – 14:00 Lunch

Afternoon

- 14:00 – 14:15 Introduction, **Economic Empowerment: Occupational Reintegration and the Enabling Environment**, by Tine Staermose
- 14:15 – 14:45 Presentation: **The ILO SIYB-Based Model**, by Margot Lobbezoo, ILO-IPEC Consultant
- 14:45 – 15:45 Questions and Discussion
- 15:45 – 16:45 Group Work on Applications of the SYIB Model to Particularly Vulnerable Youth: Trafficked Youth and Youth Withdrawn from the Worst Forms of Child Labour
- 16:45 – 17:00 Summary of the Day, by Masud Siddiqui, NPA, ILO-IPEC TICSA Programme, Bangladesh
- 17:30 – 19:00 Reception

Friday, 14 June**Morning**

- 9:00 – 09:15 Recap of Day Three, by Masud Siddiqui
- 9:15 – 09:45 Presentation of Group Work
- 9:30 – 10:30 Questions and Discussion
- 10:30 – 10:45 Coffee/ Tea
- 10:45 – 12:00 Group Work: Actualizing Child Participation
- 12:00 – 12:15 Summary of Day Four, by Anil Raghuvanshi, NPC, ILO-IPEC TICSA Programme, Nepal
- 12:30 – 14:00 Lunch

Friday, 14 June**Afternoon**

- 14:00 – 14:15 Summary of the Workshop Topics by John Frederick
- 14:15 – 14:45 Participant Evaluations
- 14:45 – 15:00 Closing Session: Tine Staermose, Next Steps and Recommendations; Leyla Tegmo-Reddy, Director, ILO Area Office, Nepal
- 16:30 Press Conference, Kathmandu

Annex II. List of Papers and Presentations

(For papers presented in the Technical Meeting, refer to Volume II: Papers.)

Shekhar Seshadri

Addressing Child Sexual Abuse: Dimensions, Directions and Good Practice Parameters for the Care Setting

Sanphasit Koompraphant, Atchara Chan-o-kul et al.

Case Management Guidelines for Child Protection and Care Services

Elizabeth Protacio-De Castro

Integrating Indigenous Knowledge and Practices into Psychosocial Help and Support for Child Survivors of Commercial Sexual Exploitation

John Frederick

Human Resources Development for the Care of the Sexually Abused and Sexually Exploited: A Resource Document on Training Programmes

Mark Jordans, Bhogendra Sharma et al.

Training of Psychosocial Counselors in a Non-Western Context: The CVICT Approach

John Frederick

Standards and Guidelines for the Care of the Sexually Abused and Sexually Exploited: Some Applications for South Asia

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A New Approach for Community-Based Reintegration: The International Rescue Committee's Experience in Rwanda

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Occupational Training and Reintegration: The ILO SIYB-based Model (presentation)

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