Mapping of Psychosocial Support for Girls and Boys

AFFECTED BY

Child Sexual Abuse

in Four Countries in South and Central Asia

AFGHANISTAN, BANGLADESH, NEPAL AND PAKISTAN

Save the Children

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Save the Children works for:

- a world which respects and values each child
- a world which listens to children and learns
- a world where all children have hope and opportunity

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by
Cath Slugget

Reviewed and edited by
John Frederick

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Preface

Child Sexual Abuse (CSA) is one of the most serious violations of children's rights in the South and Central Asian region. The extent of the problem is not known exactly as it is difficult to obtain data on it. However, there are clear indications that the problem is widespread and that it takes place in all spheres of life: families, schools, workplaces, communities etc. It is a well-known fact that sexual abuse has severe consequences for the concerned children and that the violation affects them for the rest of their lives.

Save the Children is committed to protecting children from child sexual abuse and exploitation through its commitment to the United Nations Convention on the Rights of the Child. Several articles in the CRC address the sexual abuse and exploitation of children. 'Child Rights Programming (CRP) means using the principles of child rights to plan, manage, implement and monitor programmes with the overall goal of strengthening the rights of the child as defined in international law.'[1] Positive beliefs and norms that recognise girls and boys as rights holders will lead to the development and evolution of child-friendly social institutions that are gender sensitive, inclusive and respectful of children's voices, and will encourage children's participation in decision-making processes. This in turn will result in a more democratic society that discourages all forms of oppression, exploitation and discrimination.

Working on CSA from a CRP perspective means; addressing the root causes of child sexual abuse, including patriarchal power structures and unequal power relations between children and adults, etc., and recognising children as rights holders and social actors. It means giving priority to children, creating child-friendly environments and providing child-friendly information on child sexual abuse and sexuality. Governments should be recognised as primary duty bearers, accountable for addressing and taking action against CSA. Parents and families are seen as the primary caregivers and protectors, and must be supported in this role. Using participatory and empowering approaches, partnerships and alliances must be created to promote the rights of the child for addressing CSA.

While working with the issues of CSA as one of the core programme areas, we realised that we need to increase

our knowledge of existing structures and mechanisms. It was decided to undertake a regional mapping of projects providing psychosocial support for boys and girls affected by child sexual abuse in four South and Central Asian countries: Afghanistan, Bangladesh, Nepal and Pakistan. The need to develop community-based approaches to combat CSA was highlighted. Working with men and boys to address the root causes of CSA was also recognised.

The mapping presented in this report clearly indicates that there is a huge gap in the provision of psychological support structures, in the establishment of minimum standards for care giving, and in the presence of community-based approaches for preventing and addressing CSA. There is also a gap in making these services child friendly and accessible to all children (including boys and girls from various ages, classes, castes, religions, regions, languages, disabilities, sexual preference, HIV/AIDS status, etc.). Children's active participation needs to be the foundation for assessing, designing, implementing and monitoring such services and programmes.

I am pleased to present this report to you. I hope it will go a long way in contributing to increasing our knowledge and understanding of how sexual abuse affects girls and boys and how we can provide best possible assistance. The report was written by Cath Slugget, and will provide a basis for further interventions in the region. The text was extensively reviewed and edited by John Frederick. Fasel Jaleel, Monowara Sultana, Obidur Rahman, Mehmood Asghar, Deeba Shabnam, Sita Ghimire, John Frederick and Gyani Thapa assisted in organising the field visits. Lena Karlsson and Ravi Karkara assisted in giving the final shape to the document.

Herluf G. Madsen
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Foreword

Child sexual abuse is defined as “the imposition of sexual acts, or acts with sexual overtones, by one or more persons on a child” – Save the Children, CSA Draft Policy. It can be fondling a child’s genitals, forcing a child to touch another person’s genitals, penetration of a child’s mouth with a penis, or penetration of a child’s vagina or anus by a penis (with or without ejaculation) or another object. It is abuse if such action is threatened. It is abuse whether attempts at such action are “successful” or not.

Many children in South and Central Asia grow up feeling unsafe and insecure. At the same time more and more cases of child sexual abuse are surfacing. Until recently it was assumed that only a small number of children were sexually abused. It was believed that most abusers were strangers or adults in positions of responsibility and only in exceptional circumstances were parents. "Abusers" come from all social classes and groups and can be either male or female, but statistically men comprise the vast majority of those who sexually abuse children. Abusers may be parents, teachers, employers or religious leaders, members of criminal gangs and networks or people from law enforcement agencies.

Abused girls and boys feel intense shame. They fear the consequences of reporting or feel that they have nowhere to turn or nobody to talk to. They might even blame themselves for what has happened. In some cases, survivors of sexual violence completely block out any memory of the violence, even as it is happening. In South Asian societies, girls and boys are socialised not to question adults or adult behaviour towards children, even if it is sexual abuse.

Bautista, Roldan and Garces-Bacsal (2001) emphasise that boys and girls have different ways of coping with distress. During early childhood, boys are found to be less resilient than girls. This is attributed to culturally defined sex-role expectations that inhibit boys from expressing their emotions, and is further compounded by the insufficient time spent with same sex role models or with their fathers. Boys are commonly raised in a feminine environment, mothers being the primary caretakers of children, and this puts boys at a psychological and social disadvantage (Turner et al. 1993).

The tides turn when children hit adolescence. By this time, girls are expected to adopt traditional feminine sex-role behaviour and to be more passive and dependent. Such conditioning leads them to believe that their fate depends more on the actions of others than on themselves. Thus, girls become less resilient than boys, rendering them more likely to experience a sense of hopelessness about the future. Interestingly, Turner et al. characterises children who

display signs of resilience as androgynous, saying that these children blend both masculine and feminine characteristics and act in a flexible, non sex-typed manner. These children are both "yielding and assertive, expressive and instrumental, able to care about themselves and about relationships with others." Thus, resilient girls are found to be more autonomous and independent, and resilient boys are more emotionally expressive, socially perceptive, and nurturing. They are not caught in the stereotypical role society assigns them.

It has been seen that patriarchal values and power structures (which result in different socialisation processes for boys and girls) lead to girls and boys adopting different coping mechanisms and manifesting the impact of abuse in different ways. Both are likely to experience low self-esteem, guilt and other psychological impact. Girls tend to internalise and develop more self-destructive behaviours, while boys may externalise behaviours and risk becoming violent. A family or social environment that encourages children to express themselves will lead to the development of more resilient behaviour and will enable them to emerge from the trauma as resilient individuals.

Sexual abuse of children and adolescents is committed primarily by males. Evidence suggests more girls are sexually abused than boys, although studies indicate many more boys than previously suspected are being sexually abused as well. Men take advantage of power, fear and availability to satisfy themselves at the expense of a young person. Sexual abuse of children and young people is a key issue of power disparity, and requires calling on and organising boys and men in the society to protest against violence and child sexual abuse and to take initiatives to create more equal gender roles and relationships.

Organisations working on provision of psychosocial support structures and mechanisms need to be trained on child centered and child friendly mechanisms and methodologies for providing psychosocial support for girls and boys who have been sexually abused. Interventions need to be sensitive to issues of gender and diversity (age, background, etc.). Conscious efforts should be made for establishing community based mechanisms and structures, here government and civil society can play a very crucial role by building around traditional psychosocial structure and marrying them with minimum standards, child friendly structures and mechanisms. Greater insight and capacity needs to be build for strengthening child resilience through their active participation throughout the psychosocial support system and processes.

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Note:
The views expressed in this report are those of the author, and do not necessarily reflect the views of Save the Children

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Cath Slugget
Consultant

1 Introduction

The mapping which follows was conducted over a period of six weeks during February and March 2003, including one week of preparation and one week of report writing. Regional working group members of Save the Children Sweden - Denmark (SCSD) in the respective countries took the responsibility for identifying and contacting organisations and individuals who are working to combat CSA, particularly those providing psychosocial support to children affected by abuse. A total of 34 organisations and individuals were met. Six days were spent in each country, except in Afghanistan, where only three days were spent. The six locations visited included Kabul, Dhaka, Kathmandu, Peshawar, Islamabad and Karachi.

Organisations met included those working on child sexual exploitation and sexual health, and those working with communities of street children, MSM (men who have sex with men), and trafficked women and girls. Many groups could not be visited due to time limitations. Non-governmental organisations (NGOs), university psychology departments, community-based organisations (CBOs), international non-governmental organisations (INGOs) and donor agencies, as well as independent research consultants and a theatre animator were amongst the contacts met. Interviews were held with those at management level, heads of organisations, coordinators of child protection units, trainers, programme officers, field workers, therapists and counsellors. Wherever possible, counsellors, therapists and caregivers working directly with children were interviewed.

Objectives

The objectives were to:

- collect and compile information on organisations working on community-based approaches to combat CSA and to assess their level of psychosocial support, including their structures and mechanisms; and
- map sexual health education projects which relate to children affected by CSA.

1.1 Methodology and Focus

The study was conducted primarily through meetings and semi-structured interviews with individuals and organisations. The discussions focussed on several key areas:

- Healing processes adopted for children affected by CSA
- Models and approaches to counselling
- Community-based interventions for preventing CSA or healing children affected by CSA
- Child participation and child-centred approaches
- Approaches for working on sexuality with girls and boys

Discussions lasted between one hour and three hours, depending on the availability of the staff member and the time constraints of the consultant. Information was recorded in note form. In Bangladesh and Pakistan, interviews were conducted with assistance from SC country office staff and volunteers. Discussions were informal and centred around questions to ascertain:

- how CSA is perceived in the country and the barriers and challenges encountered to providing psychosocial care for children affected by CSA;
- the type, quality and efficacy of psychosocial services being provided;
- the emerging models of healing environments; and
- good practices emerging from the region.

In the preparation week leading up to the mapping, secondary data from the internet on CSA issues in the region were collected, some of which have been included in the following country reports. Secondary data in the form of training manuals, reports, research documents, pamphlets and a film, all collected from the organisations met, have also informed the overall findings of this report.

Data were collected from a gender and non-discrimination perspective. The interviews were mostly conducted in English and the compiled findings, which were largely of a qualitative nature, were then analysed while writing the final report.

1.2 Challenges, Limitations and Achievements

Firstly, a major limitation while conducting the mapping was lack of time. This made it difficult to get a full understanding of each organisation and the quality of their work. A minimum of one day with each organisation would have perhaps have improved the data collected. Secondly, meetings with many organisations were limited to interviews with the heads of those organisations. Although this was valuable for getting insights into the visions and perspectives of each

organisation, without meeting persons involved with the delivery of psychosocial support, it was difficult to get an idea of quality of counselling and other mechanisms of support. When both the head and counsellor/caseworker were met, more in-depth data were obtained. Thirdly, it was not possible to meet either the clients or those involved in policy-making. This is a major gap in the study.

Some other challenges faced by the consultant included:

- The 20 years of conflict in Afghanistan has significantly affected the social milieu, and thus it was difficult to contextualise psychosocial support on CSA.
- At times, bias may have entered the reporting when the interviewee thought that the consultant was a donor.
- A few times, details of information were lost in the translation of the discussions.

Despite these limitations, a great deal of information came to light as information was given wholeheartedly and enthusiastically. Those interviewed were very accommodating with their time and resource materials, and above all were extremely warm and hospitable. Logistically, the study was managed excellently, with superb coordination at the regional level and between country offices. This helped the consultant enormously with meeting the needs of her assignment.

2 Summary

2.1 Child Sexual Abuse in the Home

The majority of organisations have encountered obstacles in working on child sexual abuse within the family. Most people said families were difficult to access, since the family is private terrain, which culturally cannot be questioned or looked into. Challenging these norms however were, organisation like Breaking the Silence (Bangladesh), Sahil (Pakistan) and Rozan (Pakistan). By working in schools and providing anonymous counselling through help-lines, email and postal mail, they seemed to be successful in reaching out to children within their homes.

In all countries visited, it was found that women were the primary target group in terms of psychosocial support and protection for children from abusers both within and outside the family. Talking to mothers on how to protect their children was considered to be a concrete step towards both prevention and reducing further abuse. Male members of families rarely came to centres for counselling, and no interventions were identified that focussed on working with fathers or other male family members. A study conducted by Sahil, called 'Conversations with Mothers about Child Sexual Abuse' investigated the family as a potential site of sexual violence.

Some interesting findings about family relationships and children's views of violence can also be found in 'The Children of Kabul: Discussions with Afghan Families', an as yet unpublished report by SC US, Afghanistan. It was seen that CSA was rarely addressed from a gender perspective. As well, few organisations made a concentrated effort to work with existing or prospective perpetrators.

2.2 The Impact of Cultural/Social Perceptions of CSA on Service Provision

Possibly one of the biggest barriers to providing psychosocial or protection services to children affected by CSA is the cultural silence that exists around sexuality. Child sexual abuse is viewed as something which should not be talked about, even if it is known and happening in close proximity.

Non-participation of children in the family is one of the reasons why sexual abuse often goes unnoticed. Children are rarely asked their opinions, even on non-contentious issues such as disliking school or on decisions that are being made within the family. If a child expresses discomfort with a particular person in the family, the discomfort will often be overlooked.

The taboos that surround CSA directly affect disclosure and consequently service use. Families and individuals are reluctant to seek services that openly work on CSA. Several organisations said that their local community views 'shelters' or projects for trafficked or sexually-abused girls as homes for 'bad' girls. Much of this stems from cultural notions of shame and family honour. While these notions are found throughout the region, they are particularly strong in Pakistan and Afghanistan, where maintenance of family honour can be literally a matter of life and death, especially for girls.

Across the region, little scientific work has been done on child sexual abuse, and research is limited. Areas that clearly need to be researched include culture-based definitions of 'child' and 'sexual abuse', and perceptions of sexual maturation. Clarity on these is fundamental for assessing service use and provision for several reasons: 1) children are often viewed as compliant to abuse; 2) sexual abuse is often viewed as only rape and sodomy; 3) man to boy sexuality is widespread and, in some areas, legitimated; and 4) though it is clear that sexual abuse socially impacts girls and boys differently, perceptions also prevail that boys are less psychologically impacted than girls. These assumptions are common and directly affect the way psychosocial services are accessed and provided.

2.3 Psychosocial Support in the Region

Most psychosocial support in the region for children affected by CSA is in the form of counselling services and rehabilitation and reintegration programmes. Rehabilitation and reintegration are both terms that need clarification. They are generally understood to include shelter, education, practical skills training, medical and legal aid, and social activities. Services are generally either centre-based or shelter-based, although very few children who are abused in the home are reached by such services. Some organisations interviewed, including Bandhu Social Welfare Society and INCIDIN in Bangladesh and Azad Foundation and AMAL in Pakistan, deliver counselling services at the community level for communities of MSM (men who have sex with men) and street children.

Counselling is understood differently depending on the level of expertise and training undergone by staff. Some notable examples of training programmes on psychosocial support were found to exist in Nepal (CVICT) and Pakistan (Rozan). The CVICT course is a model that can be adopted in other countries as it takes in many cultural specificities in the way trauma is experienced, expressed and dealt with South Asia. A good example of capacity building for psychosocial care at the community level was observed in Pakistan (SACH), where young women from far-flung areas of the country are currently engaged in the first year of a

course on psychosocial counselling, in order to go back and create support services in their communities.

The word 'counselling' is applied to a wide range of activities, from information-giving and advice-giving to client-centred approaches. Most organisations professed to offer client-centred approaches. In some organizations, mechanisms of support were directed at providing reassurance and giving comfort, rather than working with deeper issues of trauma. Here, there was a tendency to view the child as a victim, rather than a person with resilience and capacity to heal. Approaches to counselling varied.

Individual and group counselling were common. Many organisations applied different approaches depending on the age group, but few varied their approaches according to gender. Very few said they adopted different approaches for boys. One or two organisations said that boys expressed themselves differently, and applied action-orientated approaches for boys such as physical games to release expression.

Some interesting peer group support models existed in Pakistan (Dost Foundation) and Nepal (CWIN), where it was found that children and adults initially expressed themselves about childhood violations easier with each other than on a one-to-one basis with a counsellor. Peer activities were found to build trust and help clients understand that they were not the 'only one' who had been sexually abused. One-to-one counselling was also seen as culturally inappropriate in Afghanistan, where sitting alone with a person while talking about 'confidential' matters was deemed suspicious.

Notable examples of psychosocial work with perpetrators of CSA were found in Pakistan (Dost Foundation and Hamdard University Department of Psychiatry). Rozan in Pakistan has initiated the White Ribbon Campaign, in which a group of young men talk to male lorry drivers in petrol stations about gender violence. It was found that the use of religious messages from the Quran to talk to men about CSA was a highly effective way to help men acknowledge responsibility for perpetrating sexual abuse on children and to prevent further abuse.

Some other points that emerged from the study and are expanded upon in this report include:

- Need for expanded rights-based perspectives in interventions, with emphasis on non-discrimination, gender and diversity.
- Limited understanding of and attention to root causes of sexual abuse.
- A lack of understanding of the impact of institutionalisation on social integration, especially for girls and young women.
- The 'rescue' approach predominating over a child-centred approach.
- Lack of child participation in psychosocial support, and lack of understanding by organisations on how to promote child participation.

- Inappropriate identification of orientation programmes as 'counsellor training', resulting in untrained persons engaging in 'counselling', with the danger of further traumatising the child.
- Only a few organisations having supervision structures to monitor the quality of counselling activities.
- Care-for-caregivers not being recognized as an area of need.
- Lack of clinical practice in counselling courses.
- Lack of minimum operational standards for caregiving facilities.
- Undeveloped mechanisms to enter and support families.
- Lack of accountability of the majority of duty bearers.
- Shortage of experts with capacity to work on CSA (many go abroad following training).
- Limited professionalism, procedures, protocols, extensive training inputs and infrastructure to provide comprehensive healing environments.
- Misuse of the term 'counselling'; lack of conceptual clarity about psychosocial support; lack of knowledge about caregiver roles, i.e., including counsellor, para-counsellor, guidance counsellor, social worker, etc.

2.4 Definitions

Counselling

Counselling is a two-way process for the benefit of child survivors, helping them to understand and work with feelings of depression, low self-esteem, sadness and hopelessness, for example. It is a process of listening and responding to a child in a non-judgmental way, assisting when they need to ventilate or express feelings, and providing support through non-verbal and verbal means. Complementing verbal counselling, experiential therapies use methods such as art, music and play to help children to project their feelings, and receive affirmative love or care.

The traumatic past of a child who has been sexually abused should not be delved into in this type of general counselling. The depth and manifestation of trauma can possibly be worsened by non-professional intervention. Discussion of traumatic events should only be conducted by a professionally trained person with sufficient clinical experience who can help the child re-look at things that have happened in her/his life, and assist in managing the trauma surrounding her/his experiences.

2.5 Roles in Caregiving Facilities

Professionals

Long-term training, including clinical experience, as specialists in a particular discipline. These include physicians, psychiatrists, psychologists, counsellors, lawyers, and social workers. Their tasks include medical assessment, psychosocial response to acute trauma, family assessment and legal intervention, for example.

Para-professionals

Persons with a comprehensive but medium-length training and clinical practice (four months to two years) in a specific discipline. These could include para-counsellors, para-medics and para-legal workers. They provide the majority of specialised tasks in a caregiving environment, such as general counselling for non-acute emotional problems, family assessment and problem-solving, first aid and emergency care, and routine legal preparatory activities. This cadre should, however, acknowledge their limitations and provide referral of acute problems to trained professionals.

Support Staff

These comprise the largest proportion of staff in caregiving facilities of organisations in the region. Support staff have the vital role of providing support, companionship and guidance to clients. As the persons most in contact with the abused child, they are essential for assisting in the development of self-esteem, providing stress management and conflict resolution, and helping clients clarify their needs and hopes for the future.

3 AFGHANISTAN Country Report

3.1 Background

Afghanistan has been torn by war for over two decades. This has had an adverse impact on the economy, on social and political institutions, and on the daily lives of the people, who have been displaced from their homes and families, physically injured, and have sometimes gone missing. Today, poverty, hunger and lack of resources are normal in Afghanistan. Girls and boys have been the worst affected: physically, emotionally, intellectually and spiritually.

The troubled situation in Afghanistan has heightened risks for the well-being of children. Half of the country's population is under 18, and have never known a situation of peace and stability. In addressing the needs of children, the greatest emphasis has been placed on strengthening the family, the source of stability and routine for the child. The ideal construction of the family reflects the family as it was 25 years ago, and is largely informed by religious tenets. In Afghanistan, there is a strong social division between the 'outside' (public) and the 'inside' (family), with the outside being perceived as hostile and the inside as protective. In Afghanistan, as in most of the region, the male is perceived as the provider and protector, and the female is sequestered in the home and primarily seen in the context of domestic activities.

CSA is known to occur in Afghanistan, but is very hidden. Sexuality is a highly taboo subject, and it is difficult to find information on child sexual abuse. No statistics on CSA are available and most information is from anecdotal accounts. It can be suggested that normalisation of cruel and violent behaviours in society due to the years of war may have resulted in increased tolerance levels towards domestic violence in the home. The frequency with which corporal punishment is used in schools and families, and the matter-of-fact way in which women speak about domestic violence, suggest the reality of widespread domestic abuse.

Affection between men and women in public is not tolerated. Gender restrictions for women and girls existed in Afghanistan before the war and continue today, with most women and girls staying indoors.

During the Taliban regime, providing girls with education would lead to severe punishment. Women also face discrimination in terms of accessing health care[2]. Mobility is restricted, impacting on girls' ability to learn about and access their rights. There are few positive female role models, and few who question oppressive norms. This scenario has implications in terms of vulnerability to sexual abuse within the home.

Men are seen as needing 'sexual release', the lack of which can even result in poor health. On the other hand, the ideal construction of the female is asexual before marriage, and sexually passive after. There are traditional precedents for 'accepted' child abuse. Reports of men using young boys for sexual gratification are well known and talked about[3]. Traditionally, 'keeping' good-looking boys adds status and prestige to the man, and adds to his image (self or imposed) of virility. Under the Taliban, a strict ban on homosexuality made more overt aspects of practise go underground. However, the practice of boys under 18 being brought to parties for entertainment is reported to still be taking place in some rural areas and in and around Kandahar[4].

Culturally, Afghanistan does not share the same ideas of youth as the universalised western concept reflected in the CRC. Young people from 14 to 18 are considered adult, and are often expected to fulfil the same roles as adults in protecting the home, community and family honour. This has been most apparent in the use of young boys to fight in the Mujaheddin struggle against the Soviet Union, and more recently, by the Taliban.

Estimates suggest that one in three girls and one in ten boys are married between the ages 15 and 19. In a recent study conducted by Save the Children Sweden - Denmark in Kabul, many young girls raised serious concerns about early marriage, saying that they were not prepared for getting pregnant. Their fears too, though not directly voiced, could have been about the sexual aspect of marriage. Socially and culturally, children are thus being constructed as sexualised beings at a young age. This is a consideration when attempting to uncover how sexual abuse is understood in the Afghan context.

3.2 How CSA is Viewed in Afghanistan

In keeping with the silence about sexuality, there is strong reluctance to acknowledge and raise the topic of CSA in Afghanistan. Teachers are afraid to bring up the subject with parents and parents are reluctant to solicit support from teachers. There is a felt need among organizations to create strong groups of parents and teachers to discuss, understand and address the issue. In training programmes conducted by SCSD where they have spoken about CSA, participants defined CSA as rape. This seems to be the dominant view and NGOs working in the area need to address changing the conception of CSA. Some people accept that CSA exists, but often deny that it happens in 'their' family or community. This came into sharp view when talking to the NGO Asianna, who believed there was not 'as much' sexual abuse happening in Afghanistan as in western societies.

A counsellor at the Social Volunteers Foundation recounted several cases of male family members threatening to kill their daughters who had been sexually abused. As well, there are reports of male family members threatening to kill the perpetrator of abuse against daughters. The response to the sexual abuse of girls differs radically from the response to the sexual abuse of boys. This would normally be some kind of monetary compensation. However, it is apparent that taking family action against abusers only happens if the issue becomes public. This is because high value is placed on the virginity of a girl, and reflects upon the honour of the family.

Tarbia (good manners and behaviour) is the framework in which all child behaviour is viewed, and regulates relationships inside and outside the family. It is of crucial importance that the child has good *tarbia*. On this rests the reputation of the child, the family and maybe the clan. Violation of this brings disgrace and perhaps ostracization upon the family. The notion of *tarbia* is different for boys than for girls. The standards for girls are higher, more restrictive and usually linked to women's sexuality and its control[5] .

People generally spoke more openly about male sexual abuse. There is an overall sense that boys are more vulnerable to sexual abuse than girls.[6] This belief is perhaps based on the fact that cases of male sexual abuse are more visible, often taking place in the public sphere, i.e., bus stops, hotels and parties. Many people believed that sexual abuse of girls was less frequent because they are in the 'safety' of the home.

There is strong evidence to suggest that CSA is not seen to be violence perpetrated against a child, but primarily as an offence against the honour of the family. One of the biggest dilemmas of NGOs is whether to challenge the idealised notion of 'family' – to present the family as a potential site of child abuse – in a situation where the family is often fragmented and the community is severely affected by displacement and death. There are hardly any sites for building social capital other than the family.

In Afghanistan, CSA is articulated to be a western phenomena and therefore distrusted. One organisation working with over 2500 children, held that there were no reports of CSA in the country. All five organisations visited in the study felt CSA to be an issue that has to be approached tentatively and strategically, due to various reasons discussed in this report. Since the concepts of child protection and psychosocial support are new in Afghanistan, most of the units are currently working on the survival needs of children.

3.3 Organisations Providing Psychosocial Support to Children Affected by CSA

Since organisations in Afghanistan are not working directly on the issue of CSA, the question of providing psychosocial support was a limited area of exploration. It was thought useful, however, to inquire what some of the existing support mechanisms have been in Afghanistan, as in the future these may inform the design of support mechanisms for children affected by CSA.

Asianna is an NGO that has several non-residential education centres for street and working children, and for children affected by disability and displacement. During the Taliban regime, Asianna developed home-based and centre-based education programmes for girls. They now provide formal education for more than 2500 children in Kabul, as well as conducting skills training, including tailoring and flower-making, for both boys and girls.

Mobile Mini Circus for Children uses theatre and circus activities to advocate for the concerns of children, while building their confidence and self-esteem. They train working and street children in the simple performance of plays, puppet shows and circus acts as a process of empowerment. While pleasurable, the training and performance activities require rigour and discipline. The training, the performance and the accolades from other children builds the self-confidence of the child. At the same time, ethics and positive values are communicated through the content of the performances.

Social Volunteers Foundation (**SVF**) has a centre in Kabul that provides a range of activities for street and working boys and girls. They conduct formal education programmes at the centre, home-based education for girls, vocational training and information programmes for teachers and children on landmine awareness, health, the CRC and gender.

SVF conducts psychosocial counselling using a trained psychologist, which includes sessions with the parents and children on various subjects, including the effects of smoking, tobacco chewing and drugs. SVF builds rapport with the community by making house visits, and has initiated a parents group for weekly discussion of parenting concerns, such as lack of income and the problems of schooling. In addition, SVF has started a teachers committee to discuss education from the teachers' point of view and to strategise how to enrol more girls in school.

In response to the effects of the long war in the country, SVF provides social activities in order to facilitate consultation with children. The psychologist, who took a short-term course by UNICEF on identifying CSA, has counselled children with certain behaviours indicating sexual abuse. In addition to standard counselling approaches, she suggested the use of religious mechanisms to help children cope with the guilt which often accompanies abuse.

SVF felt that the mechanisms they have already developed could provide an opportunity to talk about CSA with the parents of children who attend their centre. Currently, SVF mobilises 'family visitors' who go to the child's home and talk to parents on issues of children's rights. They report having seen a change in parent's attitudes. In their community groups, they initiate interactions between families to share ideas and models of child support. SVF felt that the trust they are building between their centre and the community could open a path to discuss issues such as CSA.

Save the Children Sweden is working with partners Asianna and SVF. They have a training team which

primarily works with training NGOs on the CRC, gender and corporal punishment in schools. They are currently focusing on using corporal punishment in schools as an entry point to raise issues of CSA.

Save the Children US is working on child protection issues, particularly regarding the immediate survival of the child. They recognise that the framework for child protection used in other countries, including responses to child soldiers and separated children, is not applicable in Afghanistan. Consequently, they have initiated consultation/dialogue activities with children on protection issues, and design programmes based on long-term relationships with communities. As well, they are developing packages for community workers to identify child protection issues, and are designing modules for teachers on psychosocial support for children.

The **UNICEF Child Protection Unit** is currently developing a psychosocial strategy addressing the effects of child labour, sexual abuse and exploitation as well as discriminatory practices against girls, women, minority groups and children with disabilities. One of their activities is developing training modules for response to psychosocial distress caused by abuse and violence against children. Another initiative underway is a national child protection network involving government ministries and non-government organisations.

Given the considerable support to children that has been demonstrated by extended families during years of conflict, UNICEF felt that the extended family system could have far-reaching benefits for the prevention of CSA, as well as the recovery and care of the children affected by CSA. It is considered that raising awareness amongst parents, relatives and elders of the need for children to be heard within the family, as well as bringing about an understanding of CSA as unethical, harmful and against any religious and moral value system, could mobilise extended families to confront perpetrators of CSA.

Regarding healing from the effects of CSA, UNICEF noted that no word for 'trauma' exists in local languages, and is not generally recognized as a concept. As well, UNICEF felt that counselling itself is a culturally unfamiliar mechanism. They felt that methodologies which are routine, and which encourage mobility, play, sharing experiences and making friends have been found to be more effective in creating spaces for children's expression than one-on-one methodologies of standard client-centred counselling.

3.4 Sex Education

The idea that sex education leads to the promiscuity of young people, especially girls, is strongly upheld. This prevents any kind of sex education from taking place in the schools or through agencies. UNICEF reported having been able to touch upon some sexuality-related issues through HIV/AIDS interventions. However, they have received total resistance from the government regarding the inclusion of sex education in school curricula. Education for girls in Afghanistan is still minimal, and the threat of closure of girls schools by fundamentalists is real and imminently executable. It is

generally felt that the introduction of sex education at this point would only further alienate girls from attending schools, as families would not allow them to go.

3.5 Good Practices

The UNICEF Child Protection Unit and Save the Children US are currently producing a training manual which focuses on responses to psychosocial distress and to abuse/violence against children. The manual is targeted at teachers, police, NGOs and health staff , and aims at increasing awareness of abuse and exploitation of children and of their psychosocial needs. The project also collaborates with various government ministries to incorporate psychosocial issues into curricula of government training courses. This provides an opportunity to raise the issue of CSA. Efforts to establish a national child protection network are also underway in Afghanistan. This will strengthen the potential to raise awareness of CSA at a national level.

Several organisations including SC Sweden and UNICEF spoke about the need to address CSA through discussion of other abuses of children. Integrating CSA into the discussion of issues surrounding corporal punishment may be a possibility. Through exploring issues of power and obedience, and the barriers to saying 'no', they believe that parallels with child sexual abuse will be able to be drawn, opening up the potential for discussion.

3.6 Barriers and Challenges

Talking to organisations about addressing CSA in Afghanistan largely brought out the many barriers that exist culturally and socially.

- Cases do not come out publicly. This is especially true of girl child sexual abuse, due to the high value placed on the girls' virginity and the practice of keeping them at home. Sexual abuse of boys is not recognised as well.
- Identifying the child as a survivor of CSA is problematic, due to strong social stigma of the abused and the shame factor for the family.
- Many children are afraid of others coming to know about their abuse, and do not disclose their experiences.

- There is resistance to the idea that CSA is a common-place happening in the society.
- The subject is seen as a western problem, and due to people's long history of fighting for Islam against western powers, there is a resistance to talking about this subject.
- Teachers and NGO workers don't have tools and techniques to identify children who have been sexually abused.
- Communities resist outside interference in sexual abuse cases.
- NGOs are hesitant to broach the topic, fearing resistance to their work.
- NGOs are reluctant to provide intervention in cases of domestic sexual abuse, because intervening in a 'family matter' is seen as too difficult.
- There is a strong priority on maintaining the family, even when it poses risk to the child. Even when a girl's family is threatening to kill her, the counsellor tries to counsel the parents to accept the girl back, attempting to convince the parents that it wasn't her fault.
- There is no cultural precedence of seeking assistance for mental health problems, due to beliefs that mental health problems are a penance to be suffered as a consequence of committing sins.
- Parents resist allowing girls to come to centres, due to their assumed sexual vulnerability.

4 BANGLADESH Country Report

4.1 Background

Child sexual abuse has been addressed in Bangladesh since the early 1990s. Theory and interventions have been split into two broad categories: commercial sexual abuse and non-commercial sexual abuse (here called CSA). Bangladesh is home to an estimated 6.3 million working children[7], 20,000-30,000 children living on the streets[8], and 10,000 boys and girls engaged in sex work within the capital city of Dhaka[9]. The visible location of commercial forms of child sexual abuse accounts for much of government and non-government response. A study carried out during the late 1990s in Dhaka brothel areas found that 405 of approximately 3,000 sampled commercial sex workers were less than 18 years of age. The same study reported that in a sample of 92 child prostitutes, the average age of entry was 13.5 years[10].

Trafficking is also a major problem in Bangladesh. Girls and women are sent to India and Pakistan to work as prostitutes, labourers and domestic servants. Boys, some as young as four or five, have been sold as camel jockeys to the middle east. Those particularly vulnerable to sexual exploitation and abuse[11] include the underprivileged and marginalised, religious and ethnic minorities or caste groups, those with disabilities, those in institutional care, working children, migrant children and bonded child labourers.

Regarding CSA, data are inadequate but available information suggests that the problem is widespread[12]. Denial of the problem is extensive. Victims frequently protect their family by refusing to acknowledge abuse occurring within the home. High tolerance of the abuser, in which he/she is forgiven and accepted by the society, is symptomatic of the great value placed on the family as a sacrosanct unit.

Aware of the need to address the enormity of the problem, Bangladesh was the first country in South Asia to sign the Optional Protocol to the CRC on the Sale of Children, Child Prostitution and Child Pornography. Bangladesh also hosted the South Asia Consultation for the Second World Congress Against the Commercial Sexual Exploitation of Children in November 2001. Here, a South Asia Strategy was developed, proposing

concrete measures for preventing commercial sexual exploitation and sexual abuse of children and for the rescue, recovery and reintegration of affected children.

The South Asia Strategy also translated into a National Plan of Action (NPA) [13], with the aim of eliminating child prostitution, trafficking of girls and boys for sexual purposes, sex tourism, and child pornography. Some of the salient points of the NPA, which emerged through intensive consultations with children, recognise the existence of child sexual abuse within the domain of the home, the necessity of psychosocial support structures, and the need to tackle entrenched cultural practices like child marriage.

4.2 How CSA is Viewed in Bangladesh

Despite vivid accounts of children testifying that they are being sexually abused by community and family members alike, the domestic sexual abuse of children is still denied, avoided and glossed over in Bangladeshi society. To bring public recognition of the magnitude of the problem would require challenging entrenched patriarchal social structures. As well, recognition of the widespread presence of sexual abuse within the family places enormous pressure on the institutional structure of the family.

Notions of privacy and loyalty operating within the family prevent children from protection by outside agency. As with the violations of women, children are blamed for the abuse happening. Especially in the case of girls, the notion of being 'spoiled' or *noshto meye* (bad/rotten) prevails across class and geographical location. Ways have been adopted to diminish the seriousness of sexual abuse, such as legitimating marriage between the abuser and the abused, despite two longstanding pieces of legislation in Bangladesh that criminalise the practice[14].

The stigma attached to CSA occurring particularly within the home accounts for a large part of the silence that encircles it. Families fear the stigma because it could result in problems when arranging marriages for other family members. Given this, intervention, whether retribution of the perpetrator or recovery of the abused, is seldom seen as an option. As well, counselling as a method of problem solving is also not understood as a 'helping' process, but is rather perceived as an invasion of privacy, owing to family insularity, unfamiliarity with the concept, and fears of breach of confidentiality.

A report by BNWLA on violence against women in the year 2000[15] revealed that the largest number of rape victims fell into the 13 to 18 age group – immediately after girls attain puberty. The so-called 'lesser' forms (as per international definitions) of CSA are not taken seriously by the court, law-enforcement agencies, parents or other caregivers. Boys and girls are often not believed when they report abuse, and can even face hostility when they express themselves to an elder. Moreover, children convey uncertainty over what they constitute to be sexual abuse, and are often confused over whether what happened was 'affectionate touch' or a violation of their body[16].

Gender discrimination informs the way child sexual abuse is perceived in Bangladesh. While a young girl is

expected to fulfil the role of an adult regarding household duties and responsibilities, she is not accorded the same 'adult' role regarding knowledge about her sexuality or her body. Instead, she is taught to believe that lack of knowledge, silence and ignorance about sexuality are virtues, adding value to herself as the commodity of 'wife'. This lack of affirmation directly contributes towards the confusion felt by children about sexual violation.

Though male children are as vulnerable as girls, the sexual abuse of young boys is perceived to be happening much less. Social constructs of masculine gender (i.e., boys should be able to protect themselves, the sexually penetrated is 'feminine', etc.) make it likely for disclosure to be disbelieved, and consequently make it difficult for boys to report abuse. This, and a sense of discomfort in talking about issues of homosexuality and about female perpetrators of sexual abuse, precludes male child sexual abuse from gaining importance as a serious problem.

There is a need to further understand the way in which urban or rural communities acknowledge, believe in and act upon children being sexually abused. Further, it is important to know how children define or perceive CSA themselves, in order to design culturally sensitive and appropriate interventions.

4.3 Organisations Providing Psychosocial Support to Children Affected by CSA

Over the span of six days, discussions were held with ten Dhaka-based organisations on mechanisms and structures of support for children affected by sexual abuse. Working within frameworks that range from rights to welfare, many of these organisations have focused their efforts on targeting 'vulnerable' or 'at risk' groups and providing institutionalised care settings such as shelters and transit homes.

Psychological approaches to helping children in Bangladesh recover from sexual abuse have emerged in the last few years, primarily from work with children involved in prostitution. However, organisations have set up in-house 'counselling' units, facilities and institutions, and started using terms like 'psychosocial support' without full recognition of the holistic approach required to address child sexual abuse, and consequently without adequate training, standards and protocols necessary to produce healing environments and effective interventions in support of the child[17].

Activities called 'counselling services', now commonplace in many NGOs, are said to have developed from family planning activities, in which 'counsellors' were advice-giving agents.[18] This advice-giving activity has been transferred from the familiar milieu of group and community to the individual child, and conducted on one-on-one terms in shelters and drop-in centres. The understanding of what constitutes 'psychosocial support' by the various organisations visited in the mapping was quite varied. Responses included 'providing mental support for the community', addressing 'social, mental and political issues', giving 'psychological help', and most often, limited to the idea of 'providing counselling'. Today, nearly all the organisations visited (with the exception of BTS, which runs school-based awareness-raising campaigns) are working within these fairly

narrow definitions, and largely focus on 'counselling' alone in addressing the issue of recovery.

Bandhu Social Welfare Society is a community-based organisation providing HIV services to men who have sex with men (MSM), but also reaching out to boys. Bandhu's programmes are peer-based, with MSM coordinating several drop-in centres in Dhaka and outreach programmes in five cities across the country. Their sexual health and HIV/AIDS interventions operate largely in public places where men go for sex with other men, such as parks and bus stands. Outreach workers distribute condoms and information about the legal, social and psychological support available at drop-in centres.

Bandhu's counselling and peer support groups give many MSM an opportunity to share incidents of early sexual abuse within the family. As well as activities to strengthen their self-esteem, men and boys are provided with strategies for safety, protection from assault and negotiating sexual activity. Staff members are primarily trained in HIV/AIDS counselling, but have attended short-term courses in counselling and communication. They acknowledge that they are not equipped to handle sexual abuse. A professional psychologist is referred to when needed.

Outreach workers reported frequent interactions with boys sometimes as young as nine who are sexually active or are working as sex workers on the cruising sites. While their main thrust is providing psychosocial support and a therapeutic environment to adults, boys also utilise the services at the centres. However, this is problematic in terms of legal issues for the organisation. They do not explicitly 'counsel' boys on CSA, but refer them to professionals and provide condoms, medical services and access to the drop-in facility. They also organise focus group discussions with boys on condom use and sexual negotiation skills.

Bangladesh National Women's Lawyers Association (BNWLA) has two shelters in Dhaka and provides rehabilitation activities and legal support for girls and boys. In recent years, a psychosocial counselling component has been added. A partner of Save the Children Sweden Denmark, BNWLA has a full range of shelter-based rehabilitation services for boys and girls which include survival support, legal aid, counselling (individual and group counselling) medical assistance, skills training and education. Currently, 140 girls and 40 boys have been 'rescued' from trafficking, sexual exploitation or abandonment and are living in their two shelter homes. BNWLA also coordinates activities in communities, raising awareness on violence against women and children, and mobilising community members to monitor and report sexual abuse and trafficking in their localities. Long-term aims are focused on effective reintegration of the child in the family and community, and a large part of BNWLA's work involves talking to families and other community players about acceptance of the child back into the community. Children who have the possibilities for being reintegrated together with their families in the local communities are prepared for reintegration through different ways and techniques. Community care

committees are formed in different areas for supporting children who have been abused. Other organization also refers children for psychosocial support to BNWLA.

BNWLA counselling services are located within the shelters and are delivered by a team of four counsellors, all females with background on psychosocial support. The counsellors reported that they did not find trauma related to sexual abuse to emerge as an issue for boys. Many boys in their care had been trafficked as camel jockeys to the Middle East at a young age, and likely suffered sexual abuse. However, the counsellors were not able to identify symptoms of abuse in these children. The counsellors have received orientations on counselling and child development from Sanlaap (Calcutta), INCIDIN and several independent professionals. The counsellors reported they had attended many short-term training programmes, but they felt the programmes provided insufficient skills. They expressed a need for further training in specific areas, especially

Breaking the Silence (BTS) was one of the first organisations in South Asia to address CSA. They began raising awareness on the issue in 1993, talking with women about CSA in a mother and child care centre in Dhaka. In 1997, they conducted a groundbreaking qualitative study[19] containing narratives of 50 children from rural and urban areas. The report, commissioned by Save the Children Sweden - Denmark, revealed sexual abuse to be an experience that cuts across class, geographical and gender boundaries in the country. It highlighted the great complexity of the issue in the Asian context, where perceptions of 'child' are constantly shifting, where violence is often normalised, and where constructs of sexuality are largely unmapped.

The Centre for Training and Rehabilitation of Destitute Women (CTRDW) provides shelter and day care for pregnant unmarried young girls and women, many of whom have been sexually abused and/or trafficked, and alienated from their families and communities. The Centre is institutional, targeting young women between the ages of 14 and 18. CTRDW provides residential shelter, food, clothing, rehabilitation activities such as 'functional education', and medical/ psychosocial care, as well as a day-care facility in the shelter for mothers and babies. Their reintegration approaches include 'reuniting' the women and girls with their communities and families.

CTRDW places major importance on teaching girls 'survival skills', and 'counselling' them towards the idea of giving up their babies for adoption. Two 'counsellors' have gone on several basic counselling courses. Counselling is mostly individual and can be for the duration of the time the person is in the shelter. CTRDW is exploring ways to start group therapy, which, they feel, would be more effective. CTRDW also believes in the long-term endeavour of reuniting the girls with their families. Towards this end, they are working with family members, encouraging them to support the girls emotionally and financially after they leave the shelter.

Dhaka Shishu (Children's) Hospital has a child

development centre and a psychosocial team which deals with a substantial number of cases where children have been sexually abused. They provide drop-in therapy spaces for young adolescents and children with development and behavioural problems. They have instituted 12 other units in hospitals around the country. Three focal staff members (social workers who have undergone short training courses in counselling skills and one professional psychologist) form the team.

Dhaka Shishu Hospital holds a strong belief that by identifying itself as a 'child protection' or 'CSA' unit, clients would be deterred from accessing the services. Therefore, they have adopted a 'holistic' approach to child development. The need for psychosocial interventions on sexual abuse emerges when parents bring in their children with problems such as bedwetting and sexualised behaviours. They place importance on working with families, encouraging parents in the process of counselling to adopt techniques to 'protect' the child from further abuse. This is based on the assumption that the family can ultimately resolve the problem of sexual abuse from within. The lack of intensive training for their staff in psychotherapy was articulated as a limitation that prevents them from working on 'deeper' levels with children who have been abused. The team also conducts awareness programmes on sexuality using an educational film they have produced, called 'Adolescents Voices'.

INCIDIN focuses primarily on research, but also conducts some projects, including a street children's project. Finding a high prevalence of sexual abuse of street children led the organisation to develop counselling as part of their drop-in and outreach programmes for girls and boys. Recognising that their staff needed specialised skills to work with sexually exploited children, training has been provided, including three-month to six-month courses on the medical and psychosocial aspects of sexual abuse. One such course has been designed by the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP). Field-level workers have also attended a series of 12 micro-counselling training modules, designed to give a theoretical understanding of trauma and stress, which they report gives a 'basic level of understanding of the mind of the abused child'.

Caregiving facilities at INCIDIN include a drop-in centre where a team of professional psychologists and para-counsellors organise group and individual activities for children. Facilities also include outreach services, where psychological support and counselling are made available at street level through outreach workers. Referrals are made to experts in cases that are beyond their capacity. Approximately 100 girls and 30 boys currently access the centre and many more are contacted during outreach activities.

Describing much of their work as 'street based', counsellors found that group counselling techniques work well with boys and girls who have been sexually exploited on the streets. INCIDIN staff members raised the important question of needing minimum standards of care in Bangladesh. This they felt crucial to provide psychosocial services which aid and support children in

a professional manner. They noted the risk of creating further psychological damage to children through organisations and individual staff members failing to recognise the limitations of their training.

Naripokkho, traditionally an activist organisation, has a strong focus on legal recourse for violence perpetrated against women and children. In 2001, they established a help line aimed at women in violent situations. At the same time, they developed a centre-based psychosocial team to assist in the recovery of women and children affected by sexual abuse. The team works in conjunction with the legal arm of the organisation. It is comprised of trainee psychologists from the Clinical Psychology Department, University of Dhaka, and several para-counsellors who have undergone short-term training courses on 'person-centred' counselling by Parivartan, OXFAM, and by an independent psychiatrist based in Dhaka. They reported that 70% of their clients are adult survivors of sexual abuse. Naripokkho also provides training on communication skills to other NGOs who work with children.

Save the Children in Bangladesh (SCSD as the lead agency) has undertaken a study of children's perception of abuse together with the Government of Bangladesh and UNICEF. The study is intended to lead to joint intervention and advocacy initiatives between the three actors. The Alliance members in Bangladesh have formed a working group on child protection issues. Child sexual abuse is one of the areas that will be addressed by the working group. Save the Children members are active in the subgroups of the NPA on child abuse and exploitation, including trafficking. SCSD is the co-chair of the NPA subgroup on children's participation. The study on children's perception of abuse falls under both the subgroup of participation and the subgroup of protection. SCSD is planning to undertake a media campaign on child sexual abuse as soon as appropriate psychosocial structures are in place. Part of SCSD's workplan for 2002-2005 is to support community-based psychosocial structures for children who have been sexually abused, with a clear focus on children's active participation in the process.

The consultant was not able to meet with ASK, one of the key organisations in Bangladesh providing psychosocial support.

At the **Clinical Psychology Department of the University of Dhaka**, graduate students, under supervision of professional psychologists, provide NGOs with professional assistance in trauma counselling. Second and third year students are placed with NGOs such as Naripokkho and BTS, and provide therapy for cases that are beyond the ability of resident para-counsellors.

Bangladesh has lack of expertise on child sexual abuse due to a longstanding lack of applied psychology courses and a dearth of professionals working in child psychology. This problem is now being addressed by the University of Dhaka. In 1997, a Clinical Psychology Department was created to provide a three-year postgraduate course in clinical psychology. To date, seven psychologists have graduated, some of whom have

specialised in the area of children. The problem of developing national expertise continues, however, as many graduates have gone abroad to practice. However, committed efforts are being made by the department to bridge the gap between the NGO and the professional sector.

4.4 Qualitative Analysis of the Support

Interventions on child sexual abuse revolved around three key areas: prevention, survivor recovery and justice for the abused. To date, most of the organisations visited had targeted 'children in difficult circumstances', and these children's experiences of sexual abuse have been posited as taking place primarily in the 'commercial' sector (i.e., by pimps, traffickers or strangers) rather than in the home. Most organisations found the home to be problematic to access. Only one organisation (BTS) solely focused on 'non-commercial' child sexual abuse, though this organisation did not work on recovery aspects.

The activities of organisations fell into several major categories as follows:

- Telephone counselling
- Individual counselling
- Group therapy
- Legal aid
- Community / social reintegration and family counselling
- Community awareness raising
- Sexuality or life skills workshops
- Outreach

Most organisations had institutional caregiving facilities such as long-term residential facilities, drop-in centres, short-stay ('transit') homes and day care clinics. Most children enter NGO support systems through interaction with outreach workers in public places such as the street, parks and bus stations, or through referrals from other NGOs, police, private clinics or hospitals. Depending on the type of facility, whether residential or day care, providing access to medical care was commonly part of the intake procedures. This was either provided onsite or through referrals to hospitals or private doctors. A standard medical examination and counselling session for immediate case assessment seemed to be common practice for all children who enter establishments.

The roles of caregivers in facilities were often poorly defined, and psychosocial teams were often found to have inadequate skills and experience to deal with the kind of care and support required by sexually abused children. For example, the role of social workers, necessary to form links between the child and her/his social networks, was largely absent. One respondent at Dhaka Shishu Hospital said that frequently social

workers in hospitals are limited to managing bed availability, rather than working on children's social issues. At BNWLA and Dhaka Shishu Hospital, counsellors were involved in visiting communities and homes, indicating a merging of the roles of counsellor and social worker.

The ability of outside agencies to make effective interventions in home situations was questionable, given dominant notions of privacy. Counsellors said that enquiring about the safety of the child within the family was 'difficult'. On the other hand, intervening in sexual abuse cases of young female domestic workers was possible, to the extent of being able to remove the girls from the environment and place them in a shelter[20].

The term 'counsellor' was generally used to describe what are technically para-counsellors or peer counsellors. These persons varied from being laypersons having undergone varying INGO/NGO training activities on basic counselling and communication skills to persons with backgrounds in psychology but lacking clinical training. Training courses which were spoken about included those by the UNDP/ARISE Project, UNICEF, INCIDIN, UNESCAP and Parivartan (India). Course content included counselling skills, child development, trauma treatment, rehabilitation of sexually abused children, and sexuality issues. Most people felt these courses to be inadequate in content, too short in length, and lacking follow-ups. Dhaka Shishu Hospital identified lack of adequate training as a barrier to being able to work on 'deeper' issues with children.

Many of the organisations lacked professional expertise on their teams, such as psychologists, psychiatrists or physicians. (However, Dhaka University is beginning to provide a foundation of professional human resources to support NGOs.) As acknowledged by many interviewed in the study, the underdeveloped skills of 'counsellors' raises questions as to whether NGOs, though well meaning and highly committed, have the expertise to work with the complex personal issues which emerge from child sexual abuse. Since courses in Applied Clinical Psychology have only been available in Bangladesh in the last two years, persons with therapeutic skills are few.

Apart from training, another lacuna found was practices of care for caregivers. This has resulted in high burnout of counsellors, risk-taking in the counselling process, and lack of mechanisms to evaluate the efficacy and quality of the care provided to children. Other caregivers who were identified (though not interviewed) in facilitating recovery and dealing with everyday activities of children included housemothers, care assistants and peer educators. Again, the level of training inputs was low for these staff, given the major amount of time which these 'lower level' staff members spend with the children.

Definitions of counselling constituted 'talking to the child', 'listening', 'allowing the child to express', 'talking about how she can protect herself', and mainly 'supporting' the child. These were spoken of in terms of instilling trust in the child and opening up channels of communication. Common themes which were

addressed through counselling, included self-blame, guilt and low self-esteem.

Where professionals were part of the team, Cognitive Behavioural Therapy (CBT) was commonly practiced. Where professionals were not part of the psychosocial support structures, 'person-centred counselling' was apparently the model used. The only reasons given for using 'person-centred counselling' were 'confidentiality', 'being non-judgmental', 'rapport building' and creating a 'non-threatening environment' for the child. Some organisations reported having tried out counselling approaches such as the 'Rogerian' method and found these difficult to apply in the local context[21].

Depending on the age and sometimes gender of the child, different experiential techniques were applied. Play, art and drama were used to elicit emotions and expression. As for adapting methods appropriate to age or gender, several groups reported using play therapy with very young children, and art and drama with older children. Altering approaches depending on the individual was endorsed as a better practice than altering approaches according to gender.

All of the organisations visited, with the exception of two, work with both girls and boys. Most organisations did not recognise the different impact CSA has on boys and girls. Two organisations said that counselling approaches should be different for boys than for girls, because boys felt more shame around the abuse, and expressed themselves differently. Approaches for boys included methods such as physical activities to get them to express themselves. However, BNLWA reported the reverse, saying that girls have to deal with more anxiety and find it difficult to express themselves because of shame and social stigma.

Case management was not fully conceptualised by most organisations, though maintenance of confidential case files to monitor progress and team sharing in planning activities for each child were practiced. Monitoring of counsellors was not common since most organisations didn't have qualified professionals on their staff.

Perspectives on the use of 'western' models of psychology were largely uncritical. Most organisations seemed to adopt western methodologies in their counselling practices with few modifications, though with some recognition of the need to indigenise these models. For example, some adaptations had been made to adjust the language when it was found that children could not relate to some of the vocabulary for feelings and emotions used in client-based therapy[22]. Overall, culturally-appropriate theoretical frameworks were lacking. Psychosocial support was seemingly neither grounded in (albeit western) theories of enabling well-being, or in indigenous methods of healing.

INCIDIN and Bandhu reported that a one-to-one approach in outreach settings was detrimental to trust building. A group approach was a far more functional model, helping children to support each other, while feeling free to come and go. Group counselling for street boys revolved around themes like HIV/AIDS, power relations, sexual abuse and feelings of guilt, future plans

and dreams. BNWLA and CTRDW also stated that group counselling was helpful because it helped the child feel less alienated with the experience of abuse. Group counselling is usually organised age-wise. At BNWLA, groups may be formed around thematic issues of importance to the children.

A number of organisations including Dhaka Shishu Hospital, BTS and Naripokkho interact with family members, particularly mothers, offering counselling and advice about protection. This is aimed at helping the parents implement direct protection and equipping them to talk to the child about protecting himself or herself.

It was considered very helpful to encourage parents (particularly mothers) to identify child behaviours indicative of sexual abuse and to encourage them to 'protect' the child by creating protective spaces for the child (i.e., not having the child sleep in the same room with the suspected perpetrator or keeping the child away from him or her). However, simply creating such awareness has limited impact, as it places much of the responsibility on the child to protect himself or herself from an adult perpetrator. As well, without engaging other (particularly male) family members in dealing with the perpetrator, it is unrealistic to expect mothers to be vigilant about their children's safety 24 hours a day.

An awareness of the child's resiliency and capacity to survive child sexual abuse was recognised by some of the counsellors interviewed. Counselors provided examples of how resilience could be fostered by focusing on the child's positive qualities and strengths, and engaging them in dance, singing, play and task-orientated activities[23]. Resiliency was recognised as being dependant upon personality, support, coping powers and intensity of the abuse.

Shelter-based activities quite often revolved around learning practical skills. Rather than utilising learning spaces to teach living issues and life skills, such as gender violence, discrimination, or learning how to protect oneself, learning was limited to functional education, such as dressmaking. These functional skills were gender stereotypical, educating girls to occupy feminine domestic roles. In summary, while immediate relief from difficult circumstances was provided by shelter-based support, skills education reinforced ideas of gender dependency and did not equip girls and women to deal with the stigma, segregation and other gender-related problems they would face upon returning to society.

4.5 Sex Education

Making information available about sex to young people is a challenging area which is rarely acted upon by the adult world in South Asia, though it is an expressed need of young people. Child sexual abuse presents issues that are exceedingly complex due to cultural contexts of sexuality. An example is the issue of agency of the child to consent to sexual activity. This is a central issue, given the prevalence of child marriage and the adult responsibilities which South Asian children undertake. Adults who are in a position to provide information on sexuality, i.e., parent or teachers, often lack the confidence

or hold beliefs that such information will lead children into sexual experimentation or promiscuity.

The study found that though working on child sexual abuse, few organisations tackled the issue of sexuality in their work. For example, team members at BNWLA, though able to give information sessions on HIV/AIDS, uniformly spoke about the difficulty they face in talking about sexuality with girls in the shelter, and expressed confusion on how to deal with sexualised behaviours exhibited between the girls. Naripokkho, which conducts workshops in schools, reported that sex education was not included due to fear of how school authorities would react.

Dhaka Shishu Hospital's film 'Adolescents Voices' is candid in the way it talks about sexuality, although it has a clear gender bias. It highlights sexual behavioural changes in boys, but only focuses on reproductive changes in girls, perpetuating the myth that girls do not experience sexual desire. Bandhu Society found that organising focus groups on sexuality with young boys who are sex workers was a good way to talk about sexual empowerment and sexual negotiation in potentially abusive situations. Their experience in working on sexuality and gender issues with men and boys is significant, and they have undertaken a survey on levels of understanding about sex education amongst adolescents in two areas of Bangladesh.

4.6 Good Practices

While the area of clinical management of CSA clearly needs strengthening in all organisations visited, all showed a clear commitment and dedication to assisting children. Some good practices observed in one or more organizations in Bangladesh include advocating the use of legal action, systematic team feedback, drama therapy with the children as a method to reverse roles and explore abuse as an issue of power, relaxation and meditation as part of the healing process, direct and immediate crisis intervention. Also noted were community-level approaches, particularly with influential community members, involving stakeholders in decision-making, advocacy with teachers on understanding child development, organising schools workshops with girls and boys on CSA and on understanding rights and violations of the body, and working with caregivers and teachers to change methods of discipline from corporal punishment and a correctional approach to identifying problems and promoting positive behaviours.

4.7 Barriers and Challenges

- The construct of the family as closed, private and sacrosanct;
- Stigma surrounding child sexual abuse;
- Blaming the child rather the perpetrator for the abuse;
- Reluctance of women to report CSA;
- The practice of getting the abused child and the perpetrator married to avoid social censure;
- Resistance from male members of families to engage in dialogue about CSA;
- *Salish* (endemic community mediation mechanism) not being accessible to children (in the past, though sexual abuse has been brought to the *salish*, community influence has allowed the perpetrator to go free);
- Shelter homes face social stigma of housing 'bad' girls, which impacts on child and family access to services;
- Absence of CSA in the school curriculum;
- Resistance from teachers and principals to deal with CSA;
- Stigma of therapy as being an activity to address 'mental illness';
- Difficulty of working with boys due to validation of sexual activities by masculine gender roles;
- Lack of experience and skills in dealing with sexuality issues, in particular the presence of barriers around the issues of female sexual desire, homosexuality and lesbianism;

- Lack of knowledge on child sexuality and trauma management, including children's perceptions of trauma and CSA;
- Lack of professional, clinically-trained expertise in counselling;
- Short and inadequate training inputs which promote false notions among trainees of being able to counsel children's trauma;
- Serious problem of counsellors attempting to work with situations they are not trained for, and not referring complicated cases;
- Psychosocial counselling often not being merged with other recovery and reintegration activities, and being centre-based rather than community-based;
- Models of counselling following western norms that are difficult to apply to the local context;
- No evaluation of interventions;
- Lack of networking and mutual support among organisations; and
- Lack of communication between INGOs, resulting in replication of support and interventions.

5 NEPAL Country Report

5.1 Background

Over the last 10 years, international, government and non-government agencies in Nepal have been responding to a significant increase of reported incidents of sexual exploitation of women and children. Working children and those living on the streets are known to be significantly affected by sexual abuse. However, little information is available about the magnitude of sexual abuse taking place within the family.

Data on CSA in the domestic sphere are scarce. One study by two Nepalese psychiatrists points to sexual abuse as prevalent amongst all ethnic groups, for the most part affecting boys and girls between the ages of 11 and 15 years. It also states that perpetrators are frequently family members, relatives, neighbours and teachers[24]. The media monitoring task force of Save the Children Norway revealed 147 news items in 1999 alone regarding the sexual abuse of children: 73 cases were the rape of girl children, of which 20 were perpetrated by family members.

The formal mental health system in Nepal is centralised in the capital of the country and is understaffed. Following current estimates, there are 25 psychiatrists for a population of 24 million, with an average of three psychiatrists being trained every year. However, indigenous healers are widespread, and are most utilised by the Nepalese for both mental and physical health problems. Mental health problems in particular are usually presented to the indigenous healer before consultation with the formal health system because, among many other reasons, of the costs involved in reaching the urban centres where this system is concentrated[25].

A National Plan of Action (NPA) on Trafficking of Women and Children for Commercial Sexual Exploitation was developed in April 1998 and adopted in January 1999. The Ministry of Women, Children and Social Welfare is responsible for the Plan's implementation and coordinates the activities of other government departments, NGOs and INGOs. It is still in the process of being implemented. Priority areas include: policy research and institutional development;

enforcement of legislation; awareness creation, advocacy and networking; health and education; income and employment generation; and rescue and reintegration[26]. Major obstacles in the implementation of the Plan include: lack of law enforcement, particularly in relation to prosecuting traffickers; lack of awareness of the new laws, especially among the police; lack of awareness, even among government and NGO officials, of the NPA; lack of coordination; and gender discrimination.

Nepal has ratified all major international human rights instruments which ensure the fundamental rights of children, e.g. CRC (including Optional Protocols), CEDAW and ILO Convention 182. Processes have been started to improve and reform the existing laws against trafficking in children and child sexual abuse.

5.2 How CSA is Viewed in Nepal

Though clinical experience indicates that physical and sexual abuse is common in Nepal, sexual abuse is not considered a topic for public discussion. Commonly, the media tend only to report cases of rape and sexual abuse of children by foreigners. The predominant attitude, as reported by Save the Children Norway, is that there is resignation: 'it happens'. This is especially so when it comes to hearing about or acknowledging other forms of child sexual abuse. Legislation in Nepal pertaining to sexual violence reiterates the same assumptions, legitimating the view that only penetrative sex allows a claim of sexual abuse[27]. NGOs such as Saathi, a women's rights group, have been trying to change this by drafting and proposing bills on domestic violence and child sexual abuse[28].

Social attitudes towards gender also inform the way that CSA is perceived and discrimination is practised in Nepal. Viewing female children as commodities, either to be bartered off in marriage or as a burden if unmarriageable, many families commonly marry off their daughters before menarche. According to UNICEF's Regional Office for South Asia, 40% of all marriages involve a girl less than 14 years of age. Child marriage seems to fall outside of the ambit of what is perceived as child sexual abuse simply because the 14-year-old is not seen as being a child. Though there is a growing incidence of HIV/AIDS, there is hardly any discourse on or interventions with men who have sex with men. Anecdotal evidence suggests that there is a high incidence of man-boy sexual interaction in Kathmandu.

According to CWIN, most cases of CSA go unreported due to social stigmatisation and inaction of law enforcement agencies. Perhaps the greatest silence surrounds around the issue of male sexual abuse, regarding which there appears to be little specific research and as yet no interventions.

Save the Children Norway, along with the NGO Child Workers in Nepal (CWIN), recently conducted a survey to assess the level of understanding and the prevalence of sexual abuse amongst children. Interviewing 6000 school and out-of-school children across the country, they found that 13% of the boys and 15% of the girls reported experiencing some kind of sexual abuse. Abuse ranging from rape to sexually-related verbal abuse. A number of children reported abuse by teachers in school[29]. CWIN has also reported that almost all street

children they interact with have experienced sexual abuse, and that 5% of migrant children have experienced sexual harassment. The Save the Children Norway study revealed that children were not clear what sexual abuse was, particularly non-penetrative forms such as touching or fondling. Further, they were confused as to whether this was affectionate display of love or abuse.

From the organisations met, it is clear that child sexual abuse is seen in isolation, and is not embedded in larger social processes. As trafficking is a major problem in Nepal, the issue of CSA is conflated with trafficking. Therefore, interventions regarding CSA are restricted almost exclusively to counselling and shelter. Although these may address the immediate needs of abused children, they do not challenge the institutions, including the family, and the institutional values that produce and legitimate CSA.

5.3 Organisations Providing Psychosocial Support to Children Affected by CSA

The four organisations met as part of the Nepal study focus primarily on the issues of child sexual exploitation and trafficking. All were met in Kathmandu, though many have programme activities running in different parts of the country. Several people interviewed in the study acknowledged that there was a lack of psychosocial support in Nepal for children affected by CSA. All of the organisations met have integrated some psychosocial support mechanisms into their existing services. Psychosocial support found in one or more organisations included shelter, rehabilitation activities such as skills building and education, medical support, psychotherapy, crisis and ongoing counselling, counselling with family members and stress reduction activities, among others.

ABC Nepal is a social organisation working for the rights of women and children with a special focus on the prevention of trafficking of girls into prostitution. They have an integrated community development approach to empower women and girls, and raise awareness on the issue of trafficking and HIV/AIDS. ABC Nepal has a shelter in Kathmandu and 'transit' shelters in four locations along the Nepal-India border which offer basic shelter and food. Shelter is offered for three to six months, though some girls have stayed up to one year. ABC Nepal makes contact with parents and encourages the return of clients to their families, offering seed money to help them towards social reintegration.

The ABC Nepal shelter visited in Kathmandu has capacity for 25 girls. Rehabilitation includes non-formal and formal education, skills building, social activities, medical care and counselling. Most of the residents have been rescued from Indian brothels, are survivors of rape or domestic violence, or have been apprehended and referred by the police because of sex work.

The Centre for Victims of Torture (CVICT) Nepal was established in 1990 to rehabilitate victims of torture and trauma, and advocate for the prevention of human rights violations and abuses. CVICT provides professional medical, psychosocial and legal services to those in need, including children affected by sexual exploitation and sexual abuse. They have produced several training manuals on psychosocial counselling for youth. They have drop-in centres scattered across the country for

people in need of help. Shelter-based rehabilitation includes counselling sessions, physiotherapy, yoga, meditation, relaxation and other therapies such as EMDR. Since they rarely come across boys who are sexually abused, their shelters are for females only.

CVICT currently provides shelter facilities to 20 women and girls who have faced different kinds of sexual abuse and exploitation. Most are referred by other NGOs and CBOs from different areas of Nepal. Clients can stay up to three months in the shelter. Follow-up is conducted through community-based counselling facilities which are linked with local NGOs and monitor and respond to CSA in the community. At the time of meeting, there were three such community-based centres. Eight more are being developed. CVICT encourages clients to come back for follow-up counselling up to three months after their shelter stay. They offer counselling to family members if the clients are agreeable, largely to help them overcome issues of blame and social stigma. Community-based counsellors also create awareness on the benefits of counselling, an unfamiliar notion within the community. Rather than group therapy, CVICT adopts a 'one-on-one' counselling approach, which they feel at this point is easier to apply.

Maiti Nepal focuses on the prevention of girl trafficking and rescuing girls who have been forced into prostitution and helping them to reintegrate into society. They have ten transit homes on the India-Nepal border, two shelters in Kathmandu, several 'prevention homes', and a hospice in eastern Nepal for HIV positive girls and women. In Kathmandu, Maiti Nepal's two shelters currently house over 200 boys, girls and young women. One shelter is for orphaned, abandoned and sexually abused children, and currently houses 145 children. The other is for trafficked women and girls, and currently houses 60. 15% of the children are boys and they have recently opened a separate living facility for older boys. However, they report that they rarely get cases where boys reveal they have been sexually abused. Children are given shelter up to Class 10. Activities of the centres include providing shelter, medical aid, income-generation skills and non-formal education. Maiti Nepal started providing psychosocial support last year, although prior to this an intervention to introduce counselling had failed. The reasons for this are not clear. They also have legal consultants, and have dealt with up to 300 cases where litigation has been required.

Child Workers in Nepal (CWIN), established in 1987, is an advocacy organisation for child's rights with a focus on children living in and working under difficult circumstances. CWIN's main areas of concern are child labour, street children, child marriage, bonded labour, trafficking of children, children in conflict with the law, and commercial sexual exploitation of children. CWIN works extensively with para-legal and legal women's organisations, and often act as representatives for children in cases where the abuser or trafficker is prosecuted. They have developed girls' forums to solicit ideas through the participation of young people. The data from these forums provide the basis for designing a number of interventions.

CWIN offers a full range of protection services for children in different parts of Nepal. This includes emergency services, medical care, a hotline, a socialisation centre, psychosocial counselling, a health clinic, night shelters for street children, transit homes for children at risk, a contact centre at the bus park for migrant children at risk, educational support programmes and student hostels. CWIN has hostels which provide residential care for highly traumatised children over a long-term period. One currently houses 40 boys, the other 30 girls. Though the stay is permitted for up to three years, many street children stay for only one week and many others less than six months.

Ray of Hope is a consultancy organisation dedicated to strengthening the activities of children's, youth and women's organisations that provide protection and care for those who are at risk of, or are survivors of, trafficking, child prostitution, sexual abuse, domestic violence, child labour and HIV/AIDS. Ray of Hope is an intermediary organisation which works at the request of funding agencies to provide technical and organisational support to governmental bodies and community-based NGOs.

Save the Children Norway, Nepal Office, works with partner organisations such as Maiti Nepal and CWIN to fulfil their mandate of working in the areas of children in armed conflict, children and poverty, children and education, sexually abused children, and the structural causes of violation of children's rights. Save the Children Norway is working to create a database of abuse and rights violations through surveys of school children and media monitoring. In addition they have been providing orientation on CSA to facilitators of children's clubs throughout the country.

5.4 Qualitative Analysis of the Support

Several concerns were repeatedly raised during meetings with organisations and experts on the psychosocial support being provided for children affected by sexual abuse and exploitation. These included: the quality of counselling; lack of clarity of terms such as 'reintegration' and 'rehabilitation'; addressing training needs, particularly of non-counselling staff; and the oversimplified approach taken by donors and delivery agencies towards psychosocial support. As noted by Save the Children Norway, the word 'counselling' is frequently used without full understanding of its implications as a discreet type of caregiving practice. Ray of Hope also spoke of the high prevalence of short-term counselling courses that have mushroomed across the region in recent years, which provide only basic orientation to psychosocial issues but give trainees the impression that they are sufficiently trained to conduct psychosocial interventions.

Dr. Elisabeth Protacio-Marcelino has shared similar sentiments in her analysis of training needs of caregivers in Nepal[30]. She points out the problem of organisations promoting the psychosocial recovery of 'rescued' girls, but lacking the capacity to undertake genuine psychosocial rehabilitation work. She states that 'a conceptual and methodological confusion' exists 'due to the tendency to equate the provision of counselling,

support and care with psychosocial rehabilitation'. Instances have occurred where untrained persons have attempted to counsel trafficking survivors with the result of aggravating their trauma.

In Nepal, the concern seems to be lack of expertise, as is evident in the other countries covered by this study. Graduate courses in psychology focus entirely on theory, and lack clinical training, with the resulting professional psychologists being inadequately prepared for clinical application. As well, graduate training is too expensive for many to access.

Because psychosocial concerns are new in the development arena, donor agencies, government agencies and NGOs have limited knowledge of how to operate comprehensive psychosocial support systems. This, however, is becoming recognised. There is a growing sense amongst all that uniform minimum standards and guidelines for psychosocial care have to be instituted, in the same way that standards and guidelines were instituted years ago in the medical profession.

CWIN has a large staff, including professional psychologists. Difficult cases are referred to the Mental Health Project at the University Teaching College, Kathmandu. Other staff at CWIN include *residential staff* who oversee day-to-day activities; *house (para) counsellors* who spend maximum time with children throughout the day and evenings; *field workers* who make contact and interact with family and community members; and *medical staff* who work in the health clinic. All staff undergo training in basic psychosocial counselling, CSA, sexual exploitation issues and gender issues. The psychologists have undergone specialised training from CVICT on psychosocial issues affecting sexually abused children.

CVICT has a team of counsellors who specialise in sexual abuse trauma counselling. They have developed a counselling training course in conjunction with ILO, UNICEF and specialists. This is the only counselling training course presently available in South Asia which provides extensive clinical training. CVICT has also instituted a high level of supervision for its newly-trained counsellors.

Maiti Nepal has no professional counsellors, but a team of 'para-counsellors' who visit their shelters on a rotational basis. Training for some of these persons has included the four-month course on counselling for trafficked youth delivered by CVICT. Other staff interacting with children regularly include teachers, nurses, centres-in-charge and child caregivers. These persons have not undergone any special training in counselling skills.

ABC Nepal has two trained counsellors, one of whom has been trained by CVICT. Other staff dealing with women and girls includes a staff nurse and a night warden, the latter having undergone some basic training in counselling.

'Interviewing' and documenting information about the child's situation, family background and current state is

the first step of intake made by all the organisations. Generally, the documentation is primarily demographic data about the 'victim'. When a child is referred to CWIN, the process begins with immediate or emergency medical assistance, if required. ABC Nepal has a doctor on call and refers serious injuries to local hospitals. CVICT and Maiti Nepal have onsite health staff, but also refer in emergency cases. In most NGOs, children are automatically taken to see the counsellor, if there is one, soon after entry. Developing a care plan for the individual was also mentioned as an early procedure by several organisations, although it is unclear whether this activity actually exists in substantial form. At CWIN, two staff members are appointed as caretakers for each child, which they felt gave the child a sense of stability.

At ABC Nepal, it was not clear however what counselling techniques or strategies were followed. Counselling was reported to be 'based on what the client needs'. The counsellor reported that 'time is given for the girl to rest, access any medial treatment and express emotions, like crying'. Many women break down within the first few days, and when this 'gets normal' (usually after two weeks) the counsellor tries to get the client to 'talk about the incident', 'giving assurance' that there is support for them now that they are 'sheltered'. It is likely that this assurance leads to dependency, as later the counsellor spoke of how sometimes the girls are 'too needy' and feel 'neglected' when the counsellor doesn't spend time with them. Frequently counselling seems to revolve around guilt and blame, and relates to recounting past experiences and thoughts about returning home. After a month or so, the counsellor finds the client needs more 'attention' due to recall of trauma. Here, much of what was constructed as 'counselling' seemed to be based around ventilation of experience, which was believed to have the desired effect of the girl recovering. Whether this indeed leads to recovery is a moot point. There was no indication of attempt to address and solve problems. There was no clarity on how the process evolved, or indeed terminated.

In the event of a client 'misbehaving' or rather, demonstrating difficult behaviours, the counsellor would 'counsel them' on the difference between 'normal' activities (i.e., 'good' activities) and activities which were akin to prostitution (i.e. 'bad' activities). This discussion, claimed the counsellor, helps in 'choosing' how to lead a 'normal' life. Notions of sexual morality appear to be operating here, which can work to the detriment of the well-being of clients. Some indication that girls sometimes 'run away' (the reason given that they want to earn money) was mentioned, which brought into doubt the level of free choice with which the residents are staying at the shelter. ABC Nepal does 'peer counselling' as well. This involves getting two or three women with similar problems to discuss a problem.

Processes of counselling at CWIN involve daily individual sessions, which are informal and help put the child at ease. The children also meet with each other everyday for sharing time, which involves storytelling sessions. Here they are encouraged to tell stories about the 'experiences of their friends' – that is, when children

talk about sexual abuse, the story is narrated as though it happened to a friend. These stories may present, or lead to, the child's own stories. These peer support activities complement individual counselling. Sometimes counsellors also use child rights to bring out stories that explore a child's experiences of sexual abuse.

Maiti Nepal bases its counselling on selecting children who seem to be traumatised or who demonstrate 'difficult' behaviours. Much of what was deemed 'counselling' by those interviewed seemed to involve trying to change thinking regarding blaming oneself for the abuse.

CVICT adopted a different approach towards trauma healing, beginning with not assuming that the person needs or wants counselling. Rather their approach, which was perhaps the most comprehensive and professional seen in Nepal, is based on the idea of providing emotional support and assisting with problem management. Problem management included problem identification, goal setting and problem solving techniques, and support. This is provided as part of a multi-disciplinary approach to rehabilitation, including medical care, legal assistance, vocational training and mental health care. They work on an individual basis with the child and have not yet worked with group therapy as a process.

Experiential approaches were also mentioned by CVICT and CWIN when working with children under 10. These included creative therapy, play therapy, and for non-school going children of all ages, using pictorial methods. CWIN had adapted toys, such as dolls, to fit the Nepali context.

Most of the NGOs also conducted discussions with family members in community-based outreach interventions, with the hope of reintegrating children with their parents. This activity is primarily motivated by lack of resources to keep children for extensive periods of time and a fundamental belief that the child should be reunited with his or her parents as soon as possible. As well, some NGOs are realizing the psychological and social constraints of long-term 'institutionalisation' of the child.

At CWIN, most of the children stay at the shelter for a week before being returned. Others stay up to six months. To effectively reintegrate the child back into the community, CWIN's community involvement includes enrolling the child into a local school and providing a minimum six-month follow-up for the child through community-based workers. Emphasis is placed on developing contact with other community players such as police and teachers who are able to keep in touch with CWIN and report on the progress of child's reintegration. Their community work also involves promoting counselling as a helpful resource. Counselling, they report, is an unfamiliar concept in the rural areas.

ABC Nepal reported that they make contact with family members, visiting them two or three times as part of their reintegration work. Most of the families, they report, fear that the girl is infected with HIV or has

AIDS, and counselling involves 'convincing' them to accept the girl back. Again, here the term 'counselling' is loosely applied to what seems to be advice-giving.

Several questions arise in relation to rehabilitation and reintegration interventions that were unable to be addressed during the study due to time constraints. Firstly, it appeared that insufficient consideration was given to the impact of family reunification on the child, if the site for CSA and violence is the family. CWIN stated that many of the children report domestic violence at home as the main reason for leaving their homes.

Secondly, it is thought necessary to address the stigma attached to being in a 'shelter' or 'home'. Maiti Nepal, for example, has reported community members linking 'being from Maiti Nepal' with 'being a prostitute'. In a society that places high value on marriage, the impact of institutionalisation and its stigma on future marital opportunities need to be considered. It should be questioned whether rehabilitation activities adequately prepare the girls to address this.

Thirdly, most organisations do not seem to recognise that caregiving is very stressful work. World over, it has been recognised that caregivers need sustained care themselves. Care for caregivers is necessary to prevent burnout, to maintain the quality of caregiving and to respect the rights of the caregivers themselves. Save the Children Norway, recognising this, has conducted a training programme on care for caregivers. However, this activity was not reflected in the meetings with any of the organisations. CWIN is the only organisation that has tried to implement a support system for their caregivers.

5.5 Sex Education

In a CSA survey conducted in 2002 by Save the Children Norway, most of the children surveyed said that sex education would be useful in preventing CSA. Regardless of this, sex education is not part of the education curriculum in Nepal. Sexuality was generally found by the organisations as being too complicated to tackle, due to its being perceived as a 'sensitive subject' and one which is normally not talked about in Nepal.

CWIN, however, gives orientation on sexuality issues to its staff members, and also delivers 'adolescent' education to all children who stay in the shelters. In collaboration with Save the Children Norway they have developed an orientation manual on sexuality.

Ray of Hope pointed out the need to understand more about the way that boys in particular experience their sexuality in South Asia. Adolescent sexuality must be addressed considering the prevalence of gender segregation, the social acceptability of homoaffection, and same-sex social spaces which can easily provide opportunity for homosexual contact between both males and females. Questions to explore would be how and if this is perceived as abuse by adolescents, and whether homosexual (as opposed to heterosexual) behaviour among children is perceived by adults to be 'abuse' because they perceive homosexuality to be 'abnormal'?

Another question to explore would be how to create spaces to talk about affirmative sexuality with young people. Lack of dialogue on these and similar issues provides more opportunities for further violations to occur.

5.6 Good Practices

Good practices observed in one or more of the Nepal organisations included using CSA research findings as an advocacy tool to work towards getting sexuality on the school curriculum, approaching the needs of the child in terms of child development, rather than in terms of counselling, having counselling spaces bright and colourful, and indigenising western models of counselling. Some centres illustrated practices of developing girls' forums to share complaints within the shelter, developing girls advocacy tools to talk about trafficking and sexual exploitation with other 'at risk' children, having a peer support system for children in the shelter, and building community rapport with police, NGOs and teachers in rescued children's localities. Among ways of approaching abuse were exploring sexual abuse through story-telling, taking consent of the child before initiating legal action against perpetrators, involving returnee girls in community work to advocate against trafficking and sexual exploitation, designing and implementing counselling courses with extensive clinical training, creating culturally relevant training materials on psychosocial counselling, and instituting long-term supervision of newly-trained counsellors working in the field.

5.7 Barriers and Challenges

Some of the barriers and challenges for developing effective psychosocial support structures included:

- Lack of awareness among NGOs about the role of counselling within the broader healing process of the child;
- Role and value of the routine, lower-level caregivers not being recognised, and excessive emphasis put on counsellors, who spends much less time with the clients;
- Ignorance of the concept of 'social work' and lack of social workers, necessary to link the child with the family and community;
- Lack awareness among caregivers and teachers on sexuality;

- Among many donors and NGOs, preference for short-term orientation programmes as a substitute for quality training with clinical practice, resulting in poor service delivery, including potential malpractice/ injury to clients;
- Lack of knowledge about how to integrate a child-centred approach in psychosocial support services;
- Lack of clarity among many donors over the components of professional caregiving, resulting in inadequate training and poor service delivery;
- Lack of understanding within NGOs of the importance of ongoing psychosocial support, with a tendency to end healing interventions when they think that abuse is contained;
- Low levels of awareness on the concept of child resiliency;
- Difficulty in finding adequate support within the community and family to care for children in need, coupled with lack of resources to keep children in institutional care for lengthy periods of time;
- School environments are not child friendly;
- Large output of NGO resources for conducting legal procedures around CSA;
- Contact workers sometimes suffering from secondary trauma from working intensely with abused children, and lacking support mechanisms;
- Teachers unwilling to accept child protection and guidance roles;
- Difficulty in providing quality psychological interventions, due to lack of therapists and high cost of therapy;
- Lack of public awareness about existing psychosocial support services for children; and
- Inadequate dialogue between groups working on trafficking and sexual exploitation and groups working on other sexuality-related areas such as HIV/AIDS and sexual minority issues.

6 PAKISTAN Country Report

6.1 Background

Despite media reports of 4078 cases of sexual assault by men on 2309 children between 1997 and 1999[31], child sexual abuse continues to be a largely unacknowledged phenomenon in Pakistan. Prevalence appears to be high. In a study conducted in 2002 with 100 adults from three psychiatric units in Karachi, 33 persons had experienced CSA[32]. In another report carried out in the North-western Frontier Provinces (NWFP), 47% of male respondents believed that the practice of men keeping boys for sexual services was a common practice. During the current study trip, one organisation reported that 16 out of 20 children in their care had been sexually abused[33], while in a school-based study 20% of the children interviewed had reported facing one or more forms of sexual abuse[34].

Though there has been scant scientific work on child sexual abuse in Pakistan, there has recently been considerable response from the government, NGOs and some dedicated legal and medical professionals to put child sexual abuse on the map. Pakistan has ratified the Convention on the Rights of the Child and is a signatory to the Stockholm Agenda and Plan of Action against Sexual Exploitation of Children. The Stockholm Agenda demands that signatories strengthen strategies, promote attitudes and facilitate practices to ensure child rights.

A national consultation was held in 2001 for developing a Policy and Plan of Action against Child Sexual Abuse in Pakistan. The National Commission on Child Welfare and Development, the Pakistan Paediatric Association and Save the Children Sweden - Denmark sponsored the consultation, inviting experts from non-government organisations, health practitioners, lawyers, psychologists and government functionaries. It was the first time that such a consultation has been organised by the government.

Social understanding of what comprises child sexual abuse is often limited to rape and sodomy. There is no legislation specifically dealing with CSA[35]. Lack of information and procedures regarding lodging police complaints for cases of CSA exacerbates the problem.

The provisions of juvenile legislation are frequently unknown to the police and lawyers. The impact of this is the further traumatisation of the child.

The educational system does not permit any discussion of the issue, for many reasons. In addition, there is no safe space for disclosure. Police are largely insensitive to the impact of CSA, and many medical professionals do not comprehend the gravity of the offence and often uphold the dominant ideology of family stability and privacy. There are few counsellors available for survivors. The state legal system is unaware and often unwilling to be proactive to the issue.

Direct action against domestic and commercial sexual abuse of children in Pakistan is minimal. Children remain at high risk in their own homes and in public places like video centres, video game shops, snooker clubs, cinema halls, bus terminals and roadside hotels[36]. The transport industry is an institution where child sexual abuse thrives and roadside hotels are places where children in difficult circumstances can be easily trapped into sexual service and abuse. In some areas, religious shrines have been identified as high-risk places[37].

There has been no research in Pakistan to ascertain the impact, responses to and reasons for CSA in terms of gender. Research by Sahil found that though male children are regularly subjected to sexual assault (in 1999, 44% of the total known victims were male children),[38] the print media generally reports incidents of sexual abuse of girls due to the fact that the female body is seen as a sex object, as more vulnerable. Girls are 'dishonoured' by men as a public act of revenge to settle outstanding scores with rivals.

However, hundreds of young boys work in workshops and sordid hotels near bus stations, such as the Pirwadhai bus station in Rawalpindi[39]. Here, local hotel owners promote the trade by employing children who are used to attract customers. According to several organisations, the North-western Frontier Provinces and other tribal regions of the country are well known for men keeping boys specifically for sex. This strictly male-to-male practice increases the status and prestige of the man, depending on the number of 'good-looking' boys he has with him. There are no cultural or social mechanisms to check this practice. On the contrary, it is publicly visible, unlike sexual abuse of girls, which is hidden and outwardly condemned.

All this seems to be a result of the rigid segregation of men and women in Pakistan, which is most seriously enforced in the Pashtun areas of the North. Under Pashtun culture it is very difficult for a young man to interact with the opposite sex, particularly in the rural areas. Thus, young boys become the targets of abuse.

Another important aspect of child sexual abuse is incest. Generally, it is perceived that this phenomenon is non-existent or negligible in Pakistan society. Sahil data show 70 cases of incest during 1997 to 1999. In these cases, the predominant abusers were fathers. For the most part, the mother was the one who took action and approached the police. In all the reported cases the crime was rape. Interestingly, all the victims were female

children and there was not a single reported case where a father or brother had sexually assaulted a male child. Father-to-son abuse was however reported by relief workers in refugee camps in Peshawar[40]. The indisputable status that a husband enjoys and the fact that families are dependent economically and socially on the male head of the family make it exceedingly unlikely that cases of incest will get reported to the authorities.

6.2 How CSA is Viewed in Pakistan

Child sexual abuse is a complex issue in Pakistan, for a number of reasons. The language of sexuality is restricted, especially for girls and women, definitions of the child are unclear, and children are all too often not given space to express their concerns. Demonstrative homo-affectionate behaviours can easily become blurred with sexually abusive ones, and male power and space tend to violate the personhood of the less powerful. These are constantly legitimated and reiterated at all levels of society.

Most people are aware that child sexual abuse exists, although they are not vocal about it, may deny it exists in Pakistan, may dispute that it happens in families, or may even condone it. In one study in the NWFP, 1800 men were interviewed about their feelings about child sexual abuse. One third of the respondents said they did not consider it to be bad, let alone a 'crime' or a 'sin'. At one organisation met during this study, counsellors reported that many men they come in contact with are not aware that the sexual abuse they had committed was wrong[41]. According to the men, it was a part of life. Said another person interviewed, 'abuse is not seen by most men as wrong. It is normalised and they express neither pleasure nor guilt. They express it as 'killing time'.[42]

Regarding women's views, in a survey conducted by the NGO Sahil[43], 99% of mothers were aware of child sexual abuse, though most women believed that it happened more outside of the family, and that *Maulvis* (religious leaders) were to blame for sexual abuse rather than male relatives. Children are time and again viewed as compliant, or worse, are to be blamed for the abuse. In the same study, 19% of the women reported to have a negative attitude toward abused girls, and 17% towards abused boys, confirming that many children are held responsible and further victimised by their own families.

Social norms, particularly those surrounding virginity and family honour, tend to normalise rather than denounce child sexual abuse. The notion of honour (and its contrary, shame) deeply informs most social practices and norms in Pakistan. Transgression of these norms, whether it be in the form of violence, child sexual abuse or consensual arrangements (i.e., sex outside of marriage, multiple partners or same-sex relationships) are all ruthlessly stigmatised if publicly displayed. If disclosed, such behaviours bring immeasurable shame upon the child and more importantly upon her or his family.

Thus, it becomes imperative that all sexual behaviours which defy norms or question the foundations of what

constitutes 'family' remain firmly hidden from public inquiry and therefore unchallenged. Embedded in the protection of the family is male superordination and the institutionalised silencing of women and children. Within this climate, child sexual abuse goes unchecked.

Due to widespread child marriage and the placing of adult responsibilities on children at an early age, the child is held sexually accountable when the police, court or society confronts a child sexual abuser. Abused girls are deemed to be 'damaged goods', losing their opportunity for marriage, whereas boys can still get married, and their individual and familial honour can remain intact. Honour killings are evidence of this. A few points have emerged from organisations that have interacted with both boys and girls on the issue of sexual abuse. For example, boys were found to be dealing with fear of marriage, sexual performance, homosexuality, anger, guilt and confusion about whether excessive masturbation was linked to abuse. On the other hand, girls were grappling with virginity issues, confusion over whether abuse may have made them pregnant, and concerns over eligibility for marriage.

Some counsellors found that boys could channelise their experience much better through physical activities and that they were more conducive to rehabilitation than girls[44]. This was ascribed to boys getting more support from the family and to the supposition that girls were more likely than boys to feel that abuse was their fault. Girls were more often found to be subdued and were harder to access, being hidden by the family. Boys generally had more access to resources of recovery than girls, and were less constrained by issues relating to family honour. Some organisations tried to promote mixed gatherings to discuss the issue of CSA, and one organisation found that different verses of the Quran could be used to help girls overcome shameful feelings[45].

6.3 Organisations Providing Psychosocial Support to Children Affected by CSA

The situation of psychiatric and psychological education in Pakistan is severely hampered by a lack of courses in behavioural sciences, lack of opportunities for clinical training, and lack of recognised institutions with postgraduate training. This has resulted in a shortage of trained professionals in mental health across the nation. For instance, Karachi, with a population of 9.33 million only has a total number of 72 practicing psychiatrists.[46] This has particular significance when it comes to psychosocial support for child sexual abuse, a gap recognised in the National Plan of Action and many of the organisations visited.

Engaged in diverse psychosocial support and reintegration programmes, the organisations visited work with varied populations including juvenile offenders, refugee children, out-of-school children, street children, employed children, school-going youth, and trafficked and sexually exploited children. Levels and structures of support differed greatly, and all organisations have a multi-disciplinary approach to working in the area of child sexual abuse.

Aahung, Karachi, conducts programmes to train

teachers and health service providers on sexual health issues and CSA. They are actively pursuing the inclusion of sex education in the curriculum of schools. Working with Save the Children UK, the organisation has developed a life skills curriculum that seeks to raise Pakistani adolescents' awareness of sexuality and reproduction, build their self-esteem, and increase their access to quality sexual health services. The curriculum makes a special effort to ensure sensitivity to issues of gender.

AMAL, Islamabad, works primarily in awareness raising about HIV/AIDS. AMAL has worked mainly in outreach to young people in Gawal Mandi, a district of Rawalpindi where child labour and child sexual abuse is highly prevalent. They have initiated peer education projects in areas that have a concentration of truck repair workshops where there is a significant population of young boys. In the process of awareness raising, the high prevalence of CSA emerged as a crucial issue. In collaboration with UNICEF they are producing a life skills training manual aimed at linking and integrating CSA into life skills for children. Though they don't have institutionalised psychosocial support structures, they have included psychosocial intervention in their work on the street.

Azad Foundation conducts direct interventions with street children and youth. Through long-term relationships with the children they raise awareness on street children's rights, as well as arranging activities affirming childhood, such as picnics. In their experience, 90% of the boy street children report sexual abuse. Sexual abuse cases are referred to the Foundation's resident psychologist. The Azad Foundation works with families with the aim of providing traditional support for street children, and has started a project to record data on street children, in order to assist families in locating their missing children.

Dost Foundation in Peshawar is a drug rehabilitation centre. The target constituency is adult and juvenile offenders within the prison system. This has inevitably led to address issues of CSA because 90% of child substance abusers report histories of child sexual abuse. They have found that substance abuse and crime are inextricably linked to CSA. They have a wide range of interventions which include skills training, counselling, therapy and de-addiction. Interventions are conducted both from the centre and in the prisons. Dost Foundation also works with abuse perpetrators, and conducts sensitisation programmes for the police on CRC and CEDAW.

Dost Foundation's Therapeutic Community Model for juvenile offenders is located in the juvenile barracks of Peshawar Central Jail and caters to the rehabilitation and reintegration needs of young offenders. Though there is no specific programme on CSA, they recognise the linkages between sexual abuse, drug abuse and crime, and adopt a holistic approach with the young people. Interventions are conducted by a team which includes psychologists, caseworkers, vocational trainers and teachers. They also offer a similar therapeutic community for women and children in Peshawar Central Jail.

Hamdard University Hospital Day Care Centre, Karachi, was established by the Psychiatric Department of the University. They have a day care centre designed for psychosocial support for child and adult survivors of sexual abuse. The primary focus of intervention is the family, and they work with perpetrators as well. They are aiming to do work on CSA with the *mullahs* (religious leaders).

Lawyers for Human Rights and Legal Aid (LHRLA), Karachi, is a legal intervention NGO working to secure justice and support for survivors of violence and sexual abuse. They litigate and use training as a tool of advocacy with the community and the *Nasims* (the local mediators). The organisation is working towards elimination of discriminatory practices, such as the repeal of the Hudood Ordinance, a law that victimises female rape victims. LHRLA has succeeded in getting acquittal for many women unjustly indicted in *Hudood* cases.

The majority of the people who approach LHRLA to seek help or initiate proceedings also need counselling or/and crisis intervention. LHRLA provides the service of trained clinical psychologists for the benefit of legal clients. LHRLA has also initiated a help line, and refer psychosocial cases to professionals. In addition, they have an outreach programme in Korangi, which has a high population of migrants.

The organisation **Rozan's Aangan Project** in Islamabad works on issues of CSA and the emotional well-being of children and women. The Aangan Project has five programmes: children and violence; women and mental health; gender sensitisation for communities and institutions like the police; a youth help line; and school packages designed to sensitise teachers on CSA and other child development issues. Aangan focuses on domestic CSA rather than commercial sexual abuse of children.

The Aangan Project provides psychosocial support also in the form of counselling and therapy, although given the social seclusion of Pakistan children do not have the freedom or opportunity to physically meet counsellors to discuss their CSA experiences. Children who attend school workshops or counselling camps are given the Aangan Project address, email address and help line numbers so that they can contact counsellors to discuss CSA incidents. Many correspond with the project by letter, developing rapport with counsellors in writing. According to a project coordinator, both girls (55%) and boys (44%) access the services.

Struggle for Change (SACH), Islamabad, conducts community-based programmes with refugees and internally displaced children, and provides shelter to women and children who have endured domestic physical or sexual violence. This affords an entry point for providing support and raising awareness about CSA through education programmes. SACH has been working with torture victims since 1994, and has shelter homes for victims of torture and abuse. They conduct programmes for sensitising the police, and actively engage with the Law Ministry and the Women's Ministry. They have a psychosocial rehabilitation team consisting of a doctor, psychologist, physiotherapist and

several counsellors. They have long-term training programmes in counselling skills for women in distant districts to enable them to work in their areas.

Sahil was the first organisations in Pakistan to work solely on the prevention and treatment of CSA in the family. They conduct identification of CSA, counselling interventions and prevention through awareness. Though based in Islamabad, they have programmes in the conservative areas of Baluchistan, Chilas and the NWFP. Awareness and advocacy activities are conducted through the media, communities and schools. Activities are also directed at the government, including the sensitisation of the police.

Sahil has recently set up a counselling centre, called the Jeet Healing Centre, in response to the need recognised during their awareness-raising work in the schools. The centre is based in a shopping centre and a board outside openly publicises the organisation as working against child sexual abuse. Sahil's focus is on reaching children who face sexual abuse at home, and reach out to children through a help line which is advertised widely in the print media and on the radio around Islamabad. Professional clinical psychologists offer free therapy and providing email counselling for both children and adult survivors.

Save the Children UK, Peshawar, is an organisation working on child protection in the North-western Frontier Provinces (NWFP) of Pakistan. Their present work on CSA has evolved largely from their experiences with children in Afghan/Pashtun refugees camps within Pakistan. The organisation does training in child development, including stages of sexual development and the indicators and consequences of CSA. They have initiated and are the hub of a referral network of individuals and organisations for the protection of children in the NWFP. In the Kotkey Afghan refugee camp, SC UK has conducted a programme to sensitise doctors about the special requirements of CSA cases. Feedback from the programme indicates that the mothers of CSA victims are actively involved in supporting their children. Save the Children UK is also working in Torkham, a tribal community with a high prevalence of child labour. Here, an all-male team is working to raise awareness of CSA of young boys. Activities include forming peer groups of children, and sensitising children and mothers regarding CSA.

6.4 Qualitative Analysis of the Support

All organisations visited, with the exception of the Azad Foundation, had 'teams' of psychologists working with children. They also had staff ('counsellors') who had undergone some form of training or orientation on psychosocial counselling, usually short-term courses and sometimes delivered by experts from abroad.

The 15-member team at Hamdard University Hospital Day Care Centre has received specialised training on trauma management from Karachi University. The Dost Foundation, Rozan, Sahil and SACH all have in-house specialised training on CSA and supervision structures for all newly-appointed psychosocial staff. As well, they all had a policy of appointing only professional

psychologists to work with abused children. As in other countries, reports revealed that the term 'counselling' was a misused term in Pakistan, predominantly coming from the model of family planning motivational counselling.

Counselling sexually abused children, as reported by the organisations, included placing emphasis on the child's ability to heal; helping the child understand that abuse was not her/his fault and should not have happened; ensuring confidentiality; and explaining to the child that sexual abuse happens to others. That values and attitudes should be kept out of counselling processes is endorsed as a priority condition for effective counselling.

Using various tools and techniques depending on the clients' age, class, personality and behaviours was considered vital by the organisations. Many groups adopted methods of puppetry, story-telling and games when working with young clients. One method found useful in working with older clients was telling them about famous people who are also sexual abuse survivors. Many organisations said children require varying degrees of help in recovery from sexual abuse. Some counsellors reported children only needing 'support', and counselling techniques were used primarily to provide relief and space for ventilation. Several organisations in Pakistan use support group techniques with boys, girls, mothers, teachers and perpetrators. These activities explore issues like blocking feelings and grieving, as well as using cathartic approaches like letter writing to the abuser.

Hamdard Centre organises therapeutic groups based on supportive psychotherapy models for parents and children together, as well as a therapeutic group for perpetrators. They work mostly with sexually abused girls. Activities include imparting skills in self-protection, including karate training, and showing films on CSA. With younger children, they provide the mother with knowledge of how to empower the child. Removal of the child from the family for protection reasons by social workers and lawyers is adopted as a strategy, but has been very difficult to put into practice.

When Rozan works with children accompanied by their parents, they begin with taking a history of the abuse from the parents and noting how they are coping with the situation. Sessions with children at Rozan cover rapport building and affirming confidentiality both to the child and the parents. Ongoing counselling processes involve dealing with feelings of guilt, anger, helplessness and mistrust, working on self-esteem, developing a positive body image, and providing information on protection. Individual meetings with parents are conducted regularly to help them deal with their own feelings about the traumatised child.

Sahil's approach is to offer six sessions without disclosure of sexual abuse, after which clients are referred to other services if their issues are not related to sexual abuse. Their counselling facility is also open to adults, though they prefer to refer perpetrators and clients with severe problems to outside professionals. At Sahil, art therapy, play therapy, story telling, colour therapy, Reiki healing, yoga and meditation are offered

in conjunction with counselling. They have adapted techniques of TAT (pyshological-test) using animals instead of humans in pictures if there is a low level of literacy or if the child is very young.

The Dost Foundation uses an entirely different approach to counselling: a 'therapeutic community', which means creating a supportive environment through peer group support. The 'healing family' allows young people to talk and support each other in their problems. They find that peer counselling initially works more effectively as the child doesn't readily open up with the counsellor about sexual abuse. After the child feels more comfortable through recounting her/his experiences to another child, it is easier to develop a relationship with a counsellor. Stress management techniques are also imparted. Dost counsellors work extensively with children on feelings of guilt. Dost sees a clear link between guilt, continuation of drug abuse, and psychological problems such as depression and behavioural disorders.

AMAL mixes behavioural therapy with local adaptations of experiential therapies. One example is 'reading therapy', which begins with a small lecture on sexual abuse, after which the child is invited to read in more detail about the subject. After a day or two she/he is invited for a session to talk about the topic. If the child identifies with the issue she/he can enter into a counselling process. In AMAL's street interventions, psychosocial processes were incorporated with protection and negotiation skills. Most important, the child is given the necessary skills to report the abuse to someone older.

Many organisations used HIV/AIDS and CRC Article 34 (sexual exploitation) as entry points to discuss sexual abuse. Several organisations used verses from the Quran, prayer, relaxation and *Wooso* (a ritual cleansing process), finding them helpful in overcoming guilt and feelings of pollution from the abuse, as well as preventing further abuse by perpetrators.

6.5 Sex Education

Pakistan is a society with tremendous reserve about discussing sexuality, and little research is available. The education system and media are both excellent avenues to impart information on sexuality issues to young people, but the common belief is that such information would lead young people into promiscuity. As children grow up, the craving for information results in children being misinformed about sexuality by visiting *hakims*, reading pornographic stories, and seeing pornography in videos and on the internet. In Pakistan today there is a growing movement among organisations to bring sexuality issues to the forefront. Much of the urgency to talk about sexual issues comes with increasing concerns about HIV/AIDS and sexual violence.

Most of the organisations are convinced about the importance of equipping the child with skills of body protection, disclosure to an adult, and negotiating sexual advances from the adult world. The organisations do this through body mapping techniques, theatre and story-telling, among other tools.

One of the challenges faced by many of the organisations interviewed is getting sex education into the school curriculum. AMAL has worked with this in conjunction with UNESCO, and has produced a life skills manual. However, they have come across significant resistance from the government. The government decided that certain pictorial information pertaining to sexual / reproductive organs had to be removed as it did not fit the 'cultural context'. AMAL say this has been quite detrimental to teaching children about their bodies and sexual functions.

Aahung has also found resistance in their work to get schools to integrate sex education into their curriculum. Aahung is currently affiliated with a teacher training institute which works with seven schools. They report that teachers agree that adolescents need sex education but are unwilling to take a stand on it. Teachers' fear what parents will say, and fear being blamed for promoting irresponsible sexual behaviours.

Rozan imparts information on sex education through their help line and by correspondence with children. Their communications cover sex education, and normalising sexual feelings, experiences and behaviours. SACH also said they have imparted teacher training in sex education that included 'health and hygiene', HIV/AIDS and reproductive health. Azad Foundation said that through rapport building with street children over the last three years, talking with them about sexuality and child sexual abuse issues is now easy. Other organisations visited in the study expressed great reluctance to talk about sexuality in their work on CSA. SC UK said they adopted methods such as story-telling as a way to open up, for example, the topic of puberty.

6.6 Good Practises

Good practices observed in one or more of the Pakistan organizations include providing support group activities as a follow-up to CSA workshops for teachers, mothers and children, use of Theatre for Development as an awareness-raising tool with adolescent sexual abuse survivors, promoting mixed gender gatherings to discuss the issue of CSA;
initiating the 'White Ribbon Campaign'[47] with young men in Islamabad to address issues of gender violence, and organizing a boys' peer group, the 'mechanics group', which developed a tool kit on rights and CSA. Other notable practices include working with *Mullahs*, raising awareness about CSA by quoting from the Holy Quran, and connecting the process of counselling to religious rituals, conducting legal awareness on CSA with *Nasims*, providing awareness training on CSA to teachers, social welfare officers and doctors, training teachers and parents in how to identify CSA, and forming committees in the community to advocate for the prevention of CSA.

6.7 Barriers and Challenges

Following are a few identified by the organisations:

- Lack of reporting of child sexual abuse;
- Parents further victimising the child after disclosure;
- Parental attempts to get children to change their statement after reporting CSA;
- Women's dependence on men's preventive activities to stop abuse;
- No definition of sexual abuse in Pakistani context;
- Parental discomfort with sexualised behaviours of the child;
- General discomfort with the issues, resulting in trivialising or denial of CSA;
- Lack of trained expertise on CSA;
- Lack of proper case management;
- Poor medical and legal procedures which may further violate the child;
- Lack of awareness amongst lawyers about CSA;
- Lack of legal remedies or specific legislation for different forms of CSA;
- Inability of children to access protective and healing services without their parents;
- Key persons in contact with children (teachers, parents, etc.) lack knowledge on how to identify child sexual abuse;
- Difficulty in talking about CSA in awareness-raising programmes;
- Limited public knowledge on lodging of police reports on CSA;
- Lack of CSA networks in Pakistan;
- Insufficient time and resources spent on capacity building; and
- Inadequate support for caregivers working with abused children.

7 Recommendations

Recommendations

Save the Children is committed to protecting children from child sexual abuse by addressing the issue from a child rights-based approach. 'Child Rights Programming (CRP) means using the principles of child rights to plan, manage, implement and monitor programmes with the overall goal of strengthening the rights of the child as defined in international law.'[48]

Working on CSA from a CRP perspective means **addressing the root causes** of child sexual abuse, including patriarchal power structures and unequal power relations between children and adults, and recognising children as rights holders and social actors. It means giving priority to children, **creating child-friendly environments** and **providing child-friendly information on child sexual abuse and sexuality**. **Governments should be recognised as primary duty bearers**, accountable for addressing and taking action against CSA. **Parents and families** are seen as the primary caregivers and protectors, and must be supported in this role. Using **participatory and empowering approaches, partnerships and alliances** must be created to promote the rights of the child for addressing CSA.

Research

- **Areas that need to be researched include** culture-based definitions of the child and sexual abuse **and** perceptions of the sexual maturation of girls and boys**. This will help to clarify misconceptions which are constraints to addressing the issue, such as 'only girls can be sexually abused', 'children are compliant with abuse', and 'the only kind of sexual abuse is rape'.**

- In order to develop appropriate psychosocial interventions, research is needed to better understand the **social and cultural context** (family and community structures, norms and values, such as the notions of shame and honour). This will allow interventions to be built on positive, supportive and child-friendly values, structures and mechanisms. It is important to

learn more about the family systems, as well as about families' and **children's own coping mechanisms**.

- In countries where child sexual abuse is not 'accepted' as an issue or concern, quantitative research is necessary to determine the **magnitude of the problem**, in order to raise public awareness and to lobby governments to address the problem, including promoting the development of psychosocial support mechanisms.

- It would be helpful to conduct research on **children's own perception of child sexual abuse** (who abuses them, why they think adults abuse children, what can be done to prevent and address child sexual abuse, etc.). This understanding will assist in developing appropriate psychosocial interventions.

- Research on **gender relations, masculinities and sexuality** will increase understanding of the taboos and barriers that need to be addressed. It will help in the development of psychosocial support mechanisms that are gender sensitive and help children develop their personal sexual identity.

- More research needs to be done on **how CSA affects children of various backgrounds**, especially children with **various forms of disabilities**. This research needs to be conducted from a gender perspective to clarify how interventions to address CSA affect boys and girl from various backgrounds.

- Lack of children's participation is one of the root causes of child sexual abuse. Sexually abused children are typically reluctant to disclose their experiences due to feelings of guilt and shame, dependency upon the perpetrator, inability to understand the sexual meaning of the abuse, and other reasons. Research on **children's participation in the family and other social institutions** (educational, religious, etc.) can identify situations in which girls and boys are able to express themselves and circumstances in which their views are taken into consideration. This will help in developing appropriate psychosocial support mechanisms with the involvement of children, and in promoting a society that respects children's views and acts according to children's agendas.

- Research on girls' and boys' **resilience**, including case studies of boys and girls who have been able to overcome the negative experience/trauma of sexual abuse, will help in designing interventions that **build on and develop children's resilience and coping mechanisms**.

- Research and study of best practices on **community-based approaches** for addressing various forms of trauma (for example, the trauma of children affected by armed conflict) can provide important information for developing community-based psychosocial interventions for addressing CSA.

- More study and information is needed on 'young perpetrators' and their psychosocial needs.

Prevention

- It is important to strengthen and **develop professionals** through schools of social work, departments of psychology, etc. and to ensure that CSA issues become part of university curricula and clinical training. University training should provide a clear **child focus**, and **clinical practice** should be part of the curriculum for all persons who will work with CSA.

- **Awareness of the extent and the impact of the problem** is an important component of any strategy to address child sexual abuse. Various stakeholders need to be aware and to accept that child sexual abuse does exist and that it can happen to any girl or boy. On the other hand, to initiate awareness campaigns on child sexual abuse without having appropriate psychosocial support and interventions in place to address the problem will create unfulfilled expectations and might create further distress for children who have been sexually abused.

- **Awareness campaigns** on child sexual abuse needs to be specifically **targeted at fathers**, **teachers**, mothers, decision-makers, etc. The information needs to be **age, gender and diversity sensitive**, relating to girls and boys of various backgrounds and ages. **Children should be involved in designing and field-testing information materials, including child-friendly information materials for girls and boys.** Many information materials are available (globally as well as in South and Central Asia) that can be adapted and translated into local languages. **Positive religious values that condemn child sexual abuse can be incorporated into the messages of the awareness campaigns**.

- Awareness and education on **life skills** (negotiation skills, assertion skills, etc.), **sexuality, sex education, gender roles and relations, power relations responsible sexual behaviour**, etc. will not only help to prevent abuse, but will also help children recognize that they have been abused. Appropriate and age-specific information will also help the child to develop a strong sexual identity as part of the healing process. It is also important to make the public aware that **both girls and boys can be sexually abused**.

- Promote **programmes for young men on parenting** and stress the benefits of all male members of society playing a more active role in nurturing their children and abandoning the culture of violence and abuse as a proof of masculinity.

- It is important to **increase knowledge of gender issues and child sexual abuse among professionals,** such as teachers, medical doctors, lawyers, police and law enforcement institutes, and to include working against CSA in school and teacher-training curricula.

- The majority of the perpetrators are men, it is therefore important to **work with boys and men in order to challenge gender discrimination and to address child sexual abuse**. Working with boys and men to promote gender equality and child participation is essential for bringing about a paradigm shift in socialization processes and institutions. This will lead to a more inclusive and participatory culture that respects the rights of all human beings and denounces all forms of violence against children and women. Boys and men can learn from initiatives where they are mobilized to challenge violence against girls and women, such as the White Ribbon Campaign.

- It is important to share and analyze **good practices of working with boys and men to promote gender equality and to prevent child sexual abuse**. It is also important to identify boys and men who break traditional stereotypical behaviours and internalize gender equality, and to engage them in programmes addressing violence and child abuse.

Interventions

- It is recommended to develop **family-centred, community-based psychosocial approaches**. Many organizations tend to withdraw the child from the family rather than trying to address abuse in the family setting. Both male and female family members should be involved through family counselling, and by developing family-based and community-based supportive structures and mechanisms.

- The word **counselling** is understood and applied in various ways. Conceptual clarity needs to be created in relation to the role of various caregivers, including counsellors, para-counsellors, guidance counsellors, social workers, etc. It is important to develop **minimum standards** for the levels of psychosocial support, including counselling, provided by various professionals. It is also recommended to establish supervisory structures to **monitor the quality of counselling activities**.

- It is important to develop various stakeholders' capacity to address child sexual abuse. **Caregivers need to have appropriate knowledge on what support they can and cannot provide**, as well as access to professionals to whom they can refer children with acute psychological concerns.

- In many countries, families and individuals are reluctant to seek services that openly address CSA. It is important to break cultural barriers that restrict access to services and to seek alternatives where services, such as individual counselling and shelter homes, are considered culturally inappropriate. Concepts such as **rehabilitation** and **reintegration** also need to be clarified.

- **Organisations** providing psychosocial support **need to be trained on child-centred and child-friendly mechanisms and methodologies**.

- Very few organisations target the **perpetrators**, since child sexual abuse is a very sensitive issue and

family members tend to protect the abuser. There is a strong need to find mechanisms to approach the abuser in order to stop the abuse. It is also important to work with men and boys on sexuality and dominant forms of masculinities as well as with girls and boys on gender roles and relations in order to **prevent the recurrence of child sexual abuse**.

- It is important to encourage the development and application of **child protection policies as well as gender and diversity policies** within organisations in order to prevent child sexual abuse.

Policy And Law Enforcement

- **Few laws against child sexual abuse exist**, and if they do exist the **laws are seldom implemented**. In some countries, legislation only applies to the sexual abuse of girls, since it is perceived that boys are able to protect themselves. It is important to lobby for the implementation of laws against CSA, in order to demonstrate to society that CSA is unacceptable. There is a need to be sensitive to the ways in which laws are implemented, since a child may be reluctant to report CSA if she/he is afraid that her/his close relative might go to jail.

Addressing CSA from a rights-based approach means:

- Addressing the root causes of child sexual abuse, including patriarchal power structures and unequal power relations between children and adults;
- Putting children at the centre, and recognising them as rights holders and social actors;
- Giving priority to children, creating child-friendly environments and providing child-friendly information on child sexual abuse and sexuality;
- Recognising governments as primary duty bearers, accountable for addressing and taking action against CSA;
- Seeing parents and families as the primary caregiver and protectors, and supporting them in this role;
- Using participatory, empowering approaches and creating partnerships and alliances to promote the rights of the child for addressing CSA; and
- Providing long-term goals that are clearly set out in international legal frameworks, and encouraging legal and other reforms, such as the establishment of regular monitoring mechanisms, that bring about sustainable change.

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