Physical and Mental Health Aspects of Rehabilitating Children Freed from Slavery

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RESEARCH OBJECTIVES

What are the elements of effective medical and psychological support in programs that help children recover from the physical and emotional distress experienced in the worst forms of child labor? Free the Slaves surveyed such programs serving vulnerable children in Côte d'Ivoire, Haiti, India, and Togo, all intended to reintegrate the children into society prepared to exercise the same range of personal, social and economic choices as other citizens.

The study objectives were to:

1. identify the special physical and psychosocial needs of children who have been exploited, traumatized, abused or dislocated by the worst forms of child labor including slavery;

2. document and evaluate the approaches and means that organizations use to meet these needs and promote the children's reintegration.

It was hoped further that the study might identify how the rehabilitative needs of children vary according to such factors as the type, methods and length of their enslavement, their gender and age, and other cultural and family factors. Of particular interest was the rehabilitation of children working in cocoa production.

The worst forms of child labor

It is important to separate the child labor that is the norm in most societies, including the developed world, from that which fits under the rubric of the *worst forms of child labor* (WFCL), which includes child slavery. In all human societies work by children is seen as an important part of the socialization process. In societies with extensive access to schooling, this may be a very small part of the child's life – household chores, delivering newspapers, and the like. Where families rely more on the immediate production of the household for their income, as in subsistence agriculture, the work of children is both a critical component of family survival and an important process through which the child learns the skills needed for livelihood.

In and of itself child labor is not intrinsically bad; it is how children are used for their labor and how that work affects them that determines either a positive or negative impact. The damaging effects on children of the worst forms of child labor have been widely recognized, among them lost opportunity for education, loss of family and community, physical harm including stunted growth, permanent injuries, illness, traumatization, rape, and death.

Research literature indicates that very little is known about whether the needs of children in the worst forms of child labor differ markedly from those of children in other traumatic situations. What experts agree upon is that children in all cultures share the same basic needs for safety, food, sleep, hygiene, and medical care. They also need an environment that is gentle, predictable, accepting, and that allows them some control and the opportunity to form positive relationships. These factors are the beginning point for rehabilitation and are the program elements examined in this study.

Definition of slavery

Among the worst forms of child labor, slavery may be distinguished by the following:

- the use of violence or the threat of violence to control the person,
- a lack of payment beyond minimal subsistence,
- few or no opportunities to escape and
- the theft of labor or other qualities of the person for economic gain.

While life is hard for all children living in extreme poverty, especially in cultures where children are valued for their labor, there are extra difficulties for children who have been enslaved which need illumination, such as the traumatic bonding which may occur when someone is held captive and becomes attached to their tormentor.[i]

All children who no longer have parent(s) to care for and about them will suffer to a greater or lesser degree. Children who know or believe that their parents deliberately sent them away will have a different set of emotional problems than children who lose parents through death. Not only do they experience rejection, but they also fear they will not be welcome if they return, especially if they have nothing to show for their time away in enslavement.

SELECTION OF COUNTRIES

Clearly, it is not enough to simply address the damage done. To reduce the impact of the negative forms of child labor requires an understanding of the factors that drive it. All four of the countries selected are highly indebted poor countries with elevated levels of factors associated with risks of WFCL and slavery. Among these interlinked factors are poverty and rural residence, customs removing children from their birth homes, and human trafficking, briefly discussed below. Many additional factors, not expanded upon here, include corruption, cultural norms concerning the roles of women and girls, environmental destruction, conflict and social unrest, and the impact of HIV-AIDS upon families and societies.

Poverty and residence in a rural area

The idea that poverty makes families vulnerable to exploitative and damaging child labor, as well as child trafficking, is well understood[ii]. The extent of this poverty, however, is sometimes hard to grasp. For example, Indian rehabilitation workers describe the origins of trafficked children: rural Bihari families living in huts that cling to roadsides, washed away several months of each year, with no chance to build up assets and no resources to make a living except for their raw labor. When that labor power has no usefulness to landowners, whole families subsist on roots and snails. For such families, the possibility of money arriving from a child who was sent to work in another state can mean the difference between life and death.

While this is an extreme example, similar pressures can exist for families in Haiti, Togo, and Côte d'Ivoire. According to the director of UNICEF for West and Central Africa, poverty is a "major and ubiquitous" causal factor behind exploitative child labor and child trafficking. [iii]
It is important to distinguish between the economic compulsion to work that children suffer in destitute families, and the exploitative physical compulsion to work that occurs in situations of trafficking or enslavement.

Customs removing children from their birth homes

In all of the countries we studied, but especially in Togo, Côte d'Ivoire, and Haiti, there is a cultural norm of *placement* (sometimes translated as "fostering") that directly influences and drives the worst forms of child labor, including enslavement. The custom consists of "placing" children with relatives who might provide a better life for them, often in what might be thought of as an apprenticeship.[iv] Particularly in Togo and Haiti, many villages have little or no schooling available, and the alternative of sending a child to the city, or to another country to earn much-needed money and learn a skill can be appealing to parents and children alike. In Côte d'Ivoire, studies have found placed children include some from Mali and Burkina Faso. The outcome of *placement* for the child can be positive if they are treated well and given a chance to learn, or dire if they are exploited or if the process is simply a cover for trafficking and enslavement.

While it may be a well-intended social institution, *placement* can lead to exploitation of child labor. One common scenario is that poor rural children are sent to town to do the work no longer done by urban children who go to school. In Haiti, such placed *restavec* ("staying with")children, are fundamentally unpaid household servants under extensive if not complete control of the householders. It has been found that other children living in a household where an orphan has been placed will have higher than normal school participation rates.[v] The consequences and contrasts of this outcome are harsh: children from poor, often rural origins who work in drudgery all day living next to other children who play and go to school.

Human trafficking

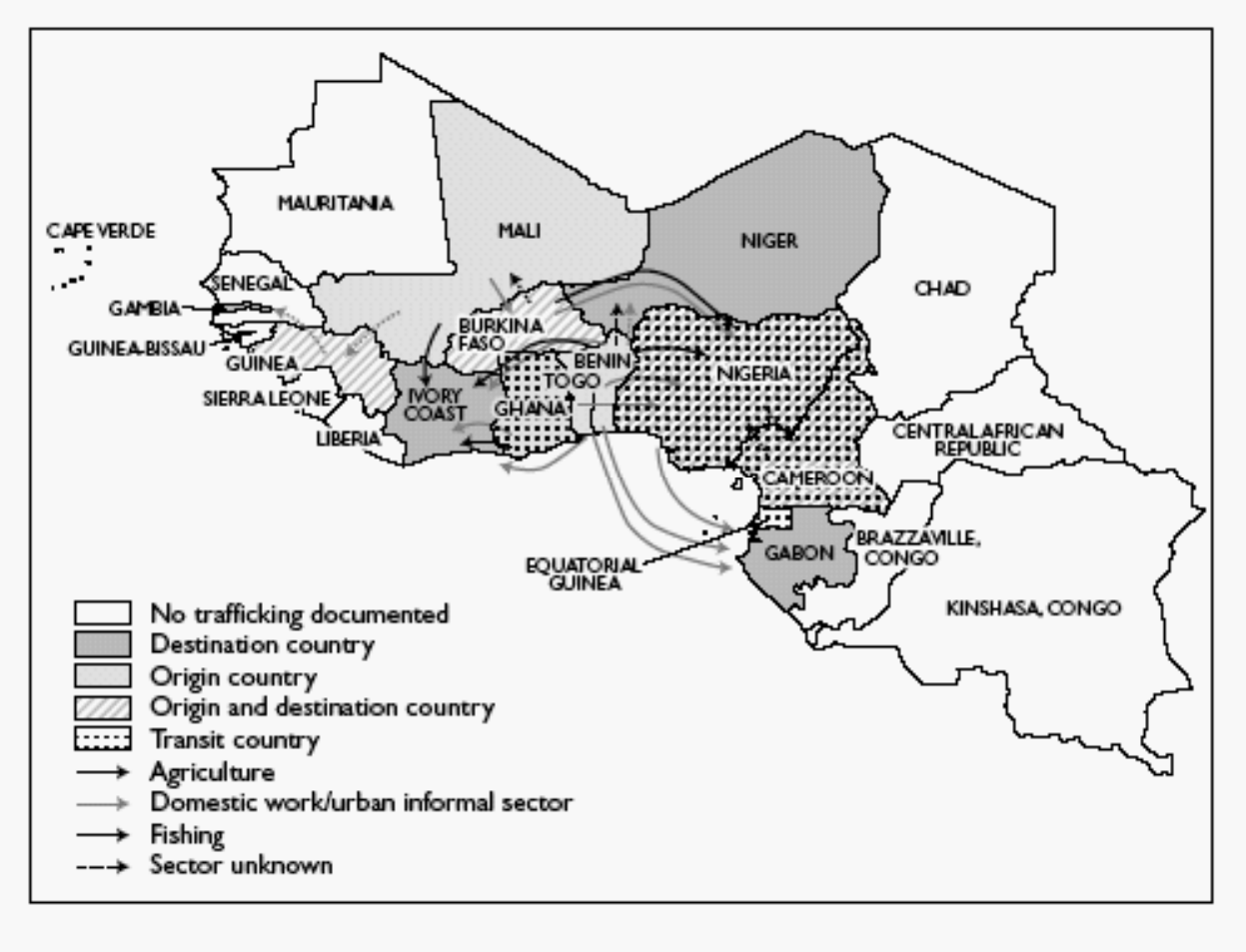
Placement or the offer of work to the child of a poor family can conceal human trafficking. At the same time, traditional labor practices or migration patterns, as well as benign systems of *placement* are so commonplace in the countries studied that it can be difficult to separate responses to poverty and deprivation that may be reasonable in their context from situations that support the worst forms of child labor. Castle and Diarra explore exactly this confusion in their examination of children and young men from Mali who migrate for, or are trafficked into, work in Côte d'Ivoire. They found:

> The types of hardship experienced by young migrants were similar both within and outside Mali and even sometimes between those who had apparently been trafficked and those who had not. A significant proportion of young people working in both domestic and foreign settings were often exploited, poorly paid or not paid at all, accused of lying or theft, and lived in poor conditions with insufficient food or medical care.[vi]

Those who migrate for work and do not fall into the hands of traffickers may possibly be exploited, cheated, and physically assaulted, but those who do fall prey to traffickers will certainly be. Trafficking is ultimately defined by the situation in which the person moving from one place to another finds himself or herself. The key is that if the final destination includes a work context where coercive control is exercised, and the person cannot walk away, then trafficking is assumed to have occurred. Clearly, trafficking of children brings them to some of the most dangerous and exploitative forms of labor. Traffickers supply criminals with labor that they would find hard to recruit or control if they were acting within legal boundaries.

The following map shows estimated flows of trafficked children in West and Central Africa, with an indication of the type of work in which they are exploited. Note that that two countries included in this study are clearly shown in these trafficking flows, Togo as primarily an "exporting" country of origin, and Côte d'Ivoire as a receiving or destination country.

All of the factors that are known to be drivers of the worst forms of child labor are present and strong in the four countries we studied. In each case of a child in need of rehabilitative care, these factors were present to a greater or lesser extent, often in combination with additional pressures such as abusive behavior of those who controlled them.



[MAP]Estimated flows of trafficked children in West and Central Africa including the type of work in which they are exploited. Source: "Etude sous-régionale sur le traffic des enfants en Afrique de l'Ouest et du Centre, 2000" (Bassi-Veil: UNICEF West and Central Africa Regional Office, 2000)

Côte d'Ivoire

Côte d'Ivoire has been set back by uprisings and military action since 2002. The deepening economic recession following civil strife has meant an increase in pressure on women to bring in revenue from the informal sector. This in turn has increased the demand for maids to do the work of the household.[vii] Kouakou notes that girls, often trafficked from Ghana, are employed as domestic workers and market vendors and in some cases are forced into prostitution.

According to the ILO, an estimated 19.7% of children between 10 and 14 are working in the informal sectors, particularly in agriculture -- cotton, cocoa, maize and rice growing -- and in the

mining industry. Boys who are trafficked into agricultural work in Côte d'Ivoire tend to be either Malian or Burkinabe. In 1998, Kouako[viii] reported that 750 children were identified as working in the gold mines based in Tortiya and Issia, most of them trafficked from Mali. Employers reportedly pay traffickers 37,500 CFA (US$5), 17,500 CFA for the boy's transportation and 20,000 CFA commission.

There are no statistics on the number of trafficked children intercepted by authorities in Côte d'Ivoire. However, surveys carried out before the current civil war in Côte d'Ivoire by NGOs in other parts of the region indicated that this was one of the major destination countries for children being trafficked for their labor. According to the Benin non-governmental organization SDDAC (Service Diocesan de Développement et d'Action Caritative), of 109 children intercepted at the Benin border, 75% were destined for Côte d'Ivoire.[ix] In another study, of 170 persons from trafficked children's biological families interviewed in Benin, 28% of parents confirmed sending their children to Côte d'Ivoire.[x]

A UNICEF investigation in 1998 uncovered the presence of forced child labor in agriculture in Côte d'Ivoire.[xi] In 2000, the U.S. State Department concluded approximately 15,000 children aged 9 to 12 were in forced labor on cotton, coffee, and cocoa plantations in the north of the country.[xii] A 2001 International Labor Organization (ILO) report also confirmed that trafficking in children is widespread in West Africa.[xiii] Some of these children become forced workers on farms growing cocoa as well as other crops. Many of these children come from countries such as Mali, Burkina Faso, Togo, Ghana and Benin. Trafficked children are abused and exposed to significant hazards in the workplace, such as the use of harmful herbicides and pesticides, and the use of sharp tools without protection. The children's vulnerability is increased by the remoteness of many of the Ivorian cocoa farms. In this isolation children can be forced to work in hazardous conditions and controlled by threats of violence.[xiv]

It is important to note that the reported patterns of both migration and trafficking are assumed to have been altered by the civil war that erupted in the Côte d'Ivoire in 2002. No formal research has been undertaken to determine the nature of changes to migration and trafficking patterns in the face of this conflict. However, informal reports suggest a slowing of the flow from Mali and Burkina Faso to Côte d'Ivoire, and a greater reliance on family labor on farms in the areas controlled by the rebel forces.

In Côte d'Ivoire there is now an ad hoc group of twenty experts from government, academia, civil society and trade unions which has conducted a first mini- evaluation and plans a more in-depth evaluation next year in order to enhance capacities and procedures.[xv] The actual number of children working on Côte d'Ivoire cocoa farms is not known. The British chocolate and confectioners' association commissioned a research report that stated, "There is evidence that slave labour is used in agriculture, and that child slave labour in particular can be found in other sectors, such as cotton, rice and maize farming, as well as in urban domestic tasks."[xvi] The report explained that the situation was complex, but that: "There is evidence that in certain circumstances the conditions exist in Côte d'Ivoire that would give rise to both the need and opportunity to use such [slave] labour."

The Sustainable Tree Crops Program of the International Institute of Tropical Agriculture reported in mid-2002 that 284,000 children were working in hazardous conditions in West Africa, the majority -- some 200,000 -- in Côte d'Ivoire. They were found to be engaged in

dangerous, unprotected, or forced work, and possibly to have been trafficked. In Côte d'Ivoire, the 12,000 children found to have no relatives in the area of their work were thought likely to have been trafficked.

According to a 2005 research report by the International Cocoa Initiative, there has been a change in the past decade in the age and gender of child cocoa workers. Younger and younger children and more and more girls are pushed into migration for work in cocoa. Older males may go back to their home farms during the wet season, but younger children are at the mercy of whomever they are living with and what their parents have arranged with the traffickers.[xvii] ILO-IPEC believes that progress is being made in confronting the exploitation of children working on cocoa plantations. Among the gains since 2004 are the many awareness-raising and capacity-building activities, wide dissemination of tailor-made materials, and the withdrawal of more than 3000 children from the plantations who were counseled and placed in educational or vocational programs. Special efforts are being made to help children younger than 13 years old.[xviii] Côte d'Ivoire has ratified both the ILO Minimum Age Convention, 1973 (no. 138), and the ILO Worst Forms of Child Labour Convention, 1999 (no.182) and the government is working on a plan to address child labor.

Togo

Togo, a coastal country of six million people between Ghana and Benin, was selected for this study because of the amount of trafficking within and between its borders and its slow rate of compliance with minimum standards to combat trafficking. In 1997, one Togo organization asserted that 313,000 children between ages 5-15 were working in cities in conditions of actual or near slavery.[xix]

Togo is one of the poorest nations in the world, with little funding for basic services. Before the age of five, 22% of children will be stunted and 15% will die.[xx] It is estimated that over 70% of the population lives on less than $1 a day.[xxi] One World Bank official has likened Togo to "a patient on an intravenous drip."[xxii] Most support from the United States and the European Union has been withdrawn due to lack of free elections.

Togo has been identified in an ILO-IPEC report as a receiving and transit point for trafficking, as well as having significant internal trafficking.[xxiii] Government estimates of the number of Togolese children who have been trafficked are drawn from the number of children intercepted at Togo's borders and the number of children rescued and repatriated from abroad. At a regional meeting on child trafficking in January 2002, Togolese government representative Suzanne Aho reported that 297 children had been trafficked from Togo in 2001.[xxiv]

A Human Rights Watch report relates that, in a subsequent interview, Aho stated that the number of cases of child trafficking recorded in 2001 was 261, as compared to 337 in 1999.[xxv] Official estimates tend to be much lower than those put forth by non-governmental or inter-governmental organizations. For example, in 1999 the government recorded 337 cases of child trafficking and ILO-IPEC recorded over 800.[xxvi]

Certain regions in the country that have been identified as sources of trafficked children are characterized by an especially high birth rate and a relatively dense population. The regions most affected by trafficking seem to be the Maritime region, which covers the Departments of

Vogan, Yoto and Afangna, and the Central region, which includes the Departments of Tchaoudjom Gassarm Tchamba, Assoli and Sotouboua.[xxvii] Where children are displaced internally they are taken to Lomé, Atakpamé and Kara in the North of the country. Where the children are trafficked abroad, they are transported to Gabon, Nigeria, Equatorial Guinea and Côte d'Ivoire, with some transiting through Benin and Ghana. All in all, trafficking patterns tend to reflect the migratory movements of the population.

In the past there was not extensive documentation of forced child labor in Togo, but two recently published reports about child trafficking in Togo suggest that this is a major problem area. Serious problems were found in both the large numbers of children trafficked and also in the system for helping children when they emerge from trafficking and exploitation. The Human Rights Watch 2003 report *Borderline Slavery: Child Trafficking in Togo* makes these points:

- There are no precise statistics on the number of children trafficked annually in West Africa.
- Trafficking begins with a private deal based on deceitful promises between a family member and a trafficker. The child may then be moved around from one situation to another.
- Factors facilitating trafficking are poverty, corruption, family breakdown, HIV/AIDS, porous borders, lax regulatory environments, traditional migration patterns, ethnic affinities and inadequate information about trafficking and its risks.
- There are no rescue operations by Togolese or other authorities. Children come into the system when they find their own way to the police or the embassy.

A second report, *For the price of a bike: Child trafficking in Togo, (*March, 2005 presents a detailed study by PLAN-Togo of trafficking in all regions of the nation, based on interviews with 650 households. Among their findings:

- Almost two-thirds of the families studied had had at least one child victim of trafficking.
- Cultural issues play an important role in the maintenance of trafficking. Polygamy, early marriage of girls, changing roles of the African family, social pressure, violence and lack of communication at the family level are all implicated along with poverty.
- Of the trafficked children who came home, most were unhappy, traumatized, and exhibited anti-social behavior.
- Girls were trafficked at three times the rate for boys.

Both reports call for major policy changes and the creation of legal frameworks better able to protect children and prevent trafficking. Among its 31 recommendations, the Human Rights Watch report stresses the need to prioritize educational and vocational opportunities, especially for girls.[xxviii]

India

India has a population of over one billion people, with a per capita income equivalent to US$620. Seventy-seven percent of children attend primary school.[xxix] In 1996, Human Rights Watch published a report, *The Small Hands of Slavery*, documenting the use of bonded child labor in seven industries including children sweating in stone quarries, held captive at carpet looms, hidden away in domestic labor, working long hours in fields, or picking rags in city streets.[xxx] It

was HRW's assertion that of the estimated 60-115 million children working in India, "most or all of these children [were] working under some form of compulsion."[xxxi]

According to HRW's estimate, at least 15 million of these children are working in conditions of servitude in order to pay off a debt, that is, in *debt bondage*.[xxxii] The debt that binds them to their employer is incurred not by the children themselves, but by relatives or guardians -- usually by a parent. In India, these debts tend to be relatively modest, ranging on average from 500 rupees to 7,500 rupees, depending on the industry and the age and skill of the child. The creditors-cum-employers offer these "loans" to destitute parents in an effort to secure the labor of a child, which is always cheap, but even cheaper under a situation of bondage. The parents, for their part, accept the loans.

Bondage is a traditional worker-employer relationship in India, and the parents need the money-perhaps to pay for the costs of an illness, perhaps to provide a dowry to a marrying child, or perhaps -- as is often the case -- to help put food on the table. The children who are sold to bond masters work long hours over many years in an attempt to pay off the debts. Due to the astronomically high rates of interest charged and the abysmally low wages paid, efforts to repay through labor are usually unsuccessful.

As they reach maturity, some of the bonded children may be released by the employer in favor of a newly-indebted and younger child. Many others will pass on the debt, intact or even higher, to a younger sibling, back to a parent, or on to their own children.

The ILO gives this more conservative overview of the situation of child labor in India:

- The analysis of the 1991 census data reveals that the population of working children is composed of 6.189 million boys and 5.095 million girls. In addition, it is found that the majority of "main" workers are boys, whereas the majority of "marginal" workers are girls.
- According to the 1991 census, about 90 per cent of working children live in rural areas.
- Children are engaged in various types of work, including those that are classified as *hazardous*, i.e. harmful to the physical, emotional, or moral well-being of children. An estimated 2 million children work in hazardous industries.
- Although there are inter-state and inter-regional variations in India, the factors that generate child labor, and hazardous child labor in particular, include parental poverty and illiteracy; social and economic circumstances; lack of awareness; lack of access to basic and meaningful quality education and skills; high rates of adult unemployment and underemployment, and cultural values of the family and society.[xxxiii]

In their 2003 report on bonded child labor in the silk industry, HRW asserts that in spite of efforts by international bodies and intentions of the government, not much has changed. The U.S. State Department reported from a number of sources in 2001 the use of forced or bonded child labor in brassware, hand-knotted wool carpets, explosive fireworks, footwear, hand-blown glass bangles, hand-made locks, hand-dipped matches, hand-broken stones, hand-spun silk thread and hand-loomed silk cloth, hand-made bricks, and *bidi* cigarettes.[xxxiv]

Many of those studying the child forced labor problem feel that the government is doing very little to end it, while others see progress.[xxxv] Corruption, turning a blind eye, lack of training, lack of prosecutions, and bureaucratic processes all play a part in the absence of enforcement of the Bonded Labour System (Abolition) Act, 1976 or the Child Labour (Prohibition & Regulation) Act, 1986. India has not yet ratified ILO Convention No. 182.[xxxvi]

Haiti

Over 80% of Haiti's population of 8.4 million lives in poverty, and only 54% of children attend primary school. Total Haiti government revenue for 2005 was only $330 million; it is the poorest country in Caribbean, where 17% of children under five are underweight, 23% are stunted, and one in ten will die before the age of five.[xxxvii] Plagued by civil unrest and a total lack of security anywhere in the country, Haiti has found lasting social, economic, or political change elusive. In late 2005 and early 2006 the rule of law further eroded and kidnappings of adults for ransom had reached ten a day.[xxxviii]

Given the extremity of economic deprivation in Haiti, it is not surprising that desperate families will sometimes abandon or simply give their children away to better-off families or relatives to be fed, clothed and schooled. Haiti's system of domestic child slavery, a culturally accepted way of getting the most menial household tasks done, uses the French term *restavec,* which means "staying with." However, these are children who are abandoned, given away or snatched to serve better-off families. About 10% of Haitian children, that is around 300,000, are *restavecs*, about one quarter of them boys.[xxxix]

The government has done little to address the exploitation of *restavecs*, It has signed neither ILO Convention 182 nor Convention 138. The Limye Lavi Foundation, which works with *restavec* children in Haiti, describes their situation in this way:

> Poverty, lack of access to education, political unrest, and natural disaster are the main factors causing economically deprived families to send their children into slavery. Children in the *restavec* system endure emotional and psychological trauma. Many children are lured into slavery through the false promises of education, but rarely are they given the opportunity to attend school. Many men sexually abuse *restavec* girls, and the wives of these men often add psychological abuse.[xl]

According to the National Coalition for Haitian Rights, "Haiti's long history of repressive, autocratic governments has only been matched by its equally long history of embracing and signing off on international standards to which it afterwards has paid little attention."[xli]

THEORETICAL BASIS OF THE STUDY

Article 39 of the Convention on the Rights of the Child recognizes the victim's right to psychological recovery, and social reintegration. Psychological recovery implies healing from the distress in mind, body and spirit caused by external negative experiences, improved functioning, a greater sense of well-being and a more productive life.

In order to develop to full potential, all children need a sense of safety, nutritious food, sleep, medical care, secure attachment with caregivers, affection and validation, a sense of belonging, and opportunities for cognitive and spiritual development. What in addition does a child need in order to recover from trauma, exposure to violence, exploitation, instability, or other circumstances that go with enslavement, forced labor, and other worst forms of child labor?

This study was informed by three theoretical approaches to the question of what best helps children to recover from such damage. The first, parental acceptance and rejection theory, is from an academic, research-oriented perspective, and focuses on the child's parents and caregivers. The second, trauma theory, comes from a mental health clinical perspective and focuses on the child himself. The third, psycho-social approach to rehabilitation, is based on the experience of those who work in the field with children in difficult circumstances and focuses on the child's community.

Parental acceptance and rejection theory

According to the theory of Parental Acceptance and Rejection (PARTheory) developed by Ronald Rohner of the University of Connecticut, children's maladaptive behavior originates in parental rejection. It is important to note that the consistent caregiver seen as essential for the well-being of the child does not need to be, in fact, the biological parent of the child.

Children everywhere—regardless of cultural, racial, language, gender, or other such differences—respond in the same way when they experience themselves to be accepted or rejected, lacking a relationship with a consistent caregiver. Through more than forty years of cross-cultural research, Rohner has identified universal characteristics of rejected children: dependence, anxiety, hostility, aggression, passive aggression, problems with the management of hostility and aggression, emotional unresponsiveness, defensive independence, impaired self esteem, impaired self-adequacy, emotional instability, and negative worldview.[xlii]

According to Rohner, knowing the extent to which children perceive themselves to be rejected by parents or attachment figures predicts more of the variation in developmental outcomes, such as depression, conduct problems, psychological maladjustment or substance abuse, than any other known experience. [xliii] Not all children who end up in exploitative work situations have been unloved or uncared for, but no matter how much a parent or caregiver regrets having to send the child elsewhere, it is the child's perception that counts. There is at minimum a sense of abandonment and lack of protection; many children do not feel loved when they are sent to strangers or away from familiar ties.

Trauma theory

Complex post-traumatic stress disorder (PTSD) as described by Judith Herman arises from a history of subjection to totalitarian control over a prolonged period. For enslaved children who were in a state of captivity, under the control of the perpetrator, and unable to flee, a diagnosis of complex PTSD is usually appropriate.

Such conditions of enslavement can cause victims to lose their sense of personal efficacy and to become increasingly dependent on those who hold them captive, if merely to survive. Captivity brings the victim into prolonged contact with the perpetrator and creates a relationship of

coercive control and traumatic bonding. "In situations of captivity," writes Herman, "the perpetrator becomes the most powerful person in the life of the victim, and the psychology of the victim is shaped by the actions and beliefs of the perpetrator." The methods of establishing control, she adds, are based upon "the organized techniques of disempowerment and disconnection…[so as] to instill terror and helplessness and to destroy the victim's sense of self in relationship to others." As victims become more isolated, they grow "increasingly dependent on the perpetrator, not only for survival and basic bodily needs but also for information and even for emotional sustenance."[xliv]

The life-long symptoms of PTSD can include:

- persistent dysphoria ("a state of confusion, agitation, emptiness, and utter aloneness"[xlv])
- self-injury,
- explosive or extremely inhibited anger,
- compulsive or extremely inhibited sexuality,
- amnesia for traumatic events, dissociative episodes, depersonalization,
- reliving experiences, either in the form of intrusive memories, or ruminative preoccupation,
- a sense of helplessness,
- paralysis of initiative,
- shame, guilt, self-blame, sense of defilement or stigma,
- sense of complete difference from others, isolation, withdrawal,
- repeated search for rescuer,
- persistent distrust, and
- repeated failures of self-protection, sense of hopelessness and despair. [xlvi]

Child psychiatrist Lenore Terr shows persuasively that long-lasting negative effects are present in children who have been subjected to chronic abuse or who have experienced even one episode of terror. Some of these sequelae are fears connected to the event(s), phobias, fear of fear, feeling of being reduced to nothing,[xlvii] fear of the mundane, helplessness, rage which turns into aggression or passivity,[xlviii] denial, numbing, unresolved grief, freezing into permanently saddened states, or even deep depressions, shame, guilt, repeated dreams, and post-traumatic reenactments.[xlix]

That children in the developing world have been traumatized in the process of enslavement and the worst forms of child labor is not in question. What is not clear is the applicability of different approaches to the treatment of trauma in the context of the developing world. For example, Seedat has noted major gaps concerning children and youth in South Africa and Kenya exposed to sexual abuse, pointing out that very little work has been done on testing the usefulness of established treatments for youth diagnosed with PTSD.[l]

> The overall impression is that research concerning therapeutic techniques for traumatized children in developing countries remains at a very preliminary stage of development. It is not known to what extent western psychotherapeutic techniques, which were originally developed to treat Europeans and Americans, would be appropriate and effective for children in Africa. One concern is that the therapeutic techniques used are centered on the

> individual patient, rather than on the family or community, which might be more meaningful in many countries in Africa.[li]

Psychosocial approach to rehabilitation

Agencies with extensive field experience such as UNICEF, Save the Children, and PLAN International, are finding an emphasis on individuals too narrow. Focusing on individuals in isolation cannot express and assess the human suffering and gross human rights violations in complex emergencies and their effects on the child. These effects have much in common with those of enslavement and the worst forms of child labor.

Individualized approaches fail to take into account the powerful role of the social and cultural context of children's development.[lii] One theorist asserts:

> Aside from issues of culture bias and cultural sensitivity, the imposition of Western methods and modes of analysis is an act of psychological imperialism that marginalizes and undermines local ways of understanding and addressing psychosocial problems.[liii]

Psychosocial programming is based on the understanding that the most reliable prospect for children's recovery is based on consistent provision of a social context that is nurturing and meets their basic needs. It builds upon a child's natural resilience and family and community support mechanisms, and attempts to provide additional experiences that will promote coping and positive development, despite the adversities experienced.[liv] To qualify, a program must be rights-based, child-friendly, gender and age responsive, and culturally sensitive and sustainable. It must also take full account of the best interests of the child, and include them as partners in decision-making processes. In sum, "psychosocial programming is about emotional healing, social reconciliation and community building."[lv]

The psychosocial approach also encourages direct work with children, having many of the same elements as psycho-dynamically oriented therapy. A training manual on psychosocial counseling for trafficked youth developed by ILO-IPEC in 2002[lvi] stresses that the first imperative in working with a child is to establish a sense of safety, a goal shared in all forms of therapy with survivors of abuse and trauma.

Also recommended is an emphasis on solving problems of and in the present moment, rather than focusing on traumatic events in the past. The trauma may be responsible for a number of present-time problems, such as body pain, sleep disturbance, irritability, anxiety or inability to concentrate. The counselor should provide information about trauma and stress, reassuring the child that such problems are to be expected, thus normalizing what the child is going through. Such counseling may also offer relaxation techniques and stress reduction methods such as deep breathing, story reconstruction, thematic group sharing, guided imagery, and even meditation training.

STUDY DESIGN

There is much attention being paid and much work being done worldwide to bring about change in the worst forms of child labor through reports and collaborative efforts. Among these are UNICEF, PLAN International, CARE, Anti-Slavery International, the International Cocoa Initiative, the World Bank, Human Rights Watch, Free the Slaves, ILO/IPEC, the US Department of Labor, Save the Children, Hagar International and Ray of Hope. Locally, agencies may abound: in Abidjan alone, there are forty-seven children's agencies and organizations on a network roster, and there may be others besides.

A review of the existing literature was complemented by internet searches, as many works in this area originate with NGOs which publish on line. In addition, we participated in professional forums and meetings that brought together health practitioners, policymakers, NGO leaders, donor organizations and researchers. A week-long seminar organized by the World Bank examined the needs of the most vulnerable children in West Africa.[lvii]

It became clear that qualitative rather than quantitative methods would be appropriate in view of a dearth of numerical or even recorded data on children under care. The single-visit model of this study also did not permit the longitudinal studies that would allow conclusions regarding the whole psychological recovery process

Development of interview and observation guide

A questionnaire and observation guide were developed for interviews with those responsible for the care and protection of children, as well as with children who were the recipients of services (see box). Information to be collected included assessment, to the extent possible, of impediments to learning and social adjustment.

Enslaved children, given their dehumanizing experiences of coercive control, are at the highest risk for the most severe manifestations of problems. Through staff interviews and observations, suggestive evidence regarding the incidence of such problems was to be gathered.

Interview and observation guide for
Programs to help children freed from slavery or WFCL

1. Basic information about informant and program
Listen for number of others involved, what category of program (residential, emergency shelter, foster care informal network), ties with government or other NGOs, length of child's involvement, goals, theoretical assumptions about children's needs, degree of recognition and acceptance of the program by the community.

a. Do you help children who were once enslaved or working for no pay?
b. How long have you been doing this?
c. How many children have you assisted?
d. Tell me a little about how your program works.

2. The children
Listen for degree of awareness or sensitivity to the child's experience before coming here and in the program. Encourage specific illustrations of a generalization. If there is time, have the informant apply the questions to specific children, as a case study.

a. Demographics
1. age range
2. gender ratio
3. where they come from
4. range of lengths of stay
5. histories (type of work, how treated, circumstances of enslavement and rescue, family, special impediments to rehabilitation e.g. language differences)
6. knowledge of full name, parentage, their original place of residence, official documentation such as identity card, birth certificate

b. Describe what the children are like when they are first rescued, or you first encounter them.

c. Physical condition
growth, appetite, signs of malnutrition
illness, parasites, HIV status if known
signs of physical abuse (abrasions, burns, bruises, scars, missing hair)
sleep problems, nightmares
tremors, pronounced startle reflex
bladder, bowel function
teeth
stomach pain

d. Psychosocial status
affect(emotionally shut down, labile, giddy, fearful, anxious, detached)
aggression
withdrawal
cognitive delays
dissociation
obsessive repetition

e. Early adjustment
begins to communicate more freely
smiles
thinks of or tries to escape
approaches other children
plays by self
plays with other children
initiates conversation
expresses a preference, makes choices
enjoys being touched or hugged

3. Treatment: What are your goals for the child?

Listen for indications of the general climate of the program -- degree of warmth and acceptance of the children, laughter, ease, permissiveness, gentleness of expectations, ability to soothe or reassure.

a. What is the child's day like?
b. How do you help the child to feel safe?
c. How much freedom of choice or activity does the child have?(Is gender relevant?)
d. How do you help the child to develop a sense of identity as an autonomous self?
e. How do you assess each child's condition?
f. How do you help the child to play and talk with other children?
g. How do you help the child overcome stigma?
h. Which of the following forms of treatment are ever used and how well do they work? *[Judy, can we group these?]*
Individual counseling, group counseling
Trauma therapy

Active listening
Herbal remedies, psychotropic medications
Cleansing rituals
Healing massage
Behavior modification
Art, music, drama or play therapy

i. How do you prepare the child to go back to his family or manage in society?
Provide vocational training
Encourage family visits
Investigate viability of family for child's return
Teach literacy, teach numeracy
Educate about children's rights

j. Is the child consulted about involvement in the program or what happens to him after the program?

4. Information about staffing

a. How many paid staff? Role of volunteers?
b. What are the roles of staff?
c. Are credentials required?
d. Does a child center have to be licensed by the government?
e. Do externally set standards exist?
f. Does the staff get ongoing training?
g. What are the major challenges faced by the staff?

5. Follow-up

a. What, if anything, do you keep track of after a child has left your care?
b. Do you provide any services after the child leaves? (e.g. legal help, help with access to education or entitlements, referrals to other sources of help, connection with possible work sites)
c. If yes, how well do the previously enslaved children do when reintegrated into their villages or relocated elsewhere?

Selection of local consultants

The Free the Slaves senior researcher, who has extensive professional experience in children's advocacy, child mental health and development and systems for their care in the U.S., selected consultants for Togo, Côte d'Ivoire and Haiti based on their previous experience in appropriate child care agencies and their fluency in English and other relevant languages. It was possible in the three francophone countries for all work to be done by a male-female French-speaking team.

In Côte d'Ivoire, Kouassi Konan of MESAD and a partner of the International Cocoa Initiative helped to identify potential research sites and recommended our consultant Dominique Niava,. In Togo, with the aid of Cleophas Mally, Director of the NGO WAO-Afrique and a long-time partner of Anti-Slavery International, we located Komi Kpeglo an experienced consultant who contacted possible agencies. In Haiti, with the help of David Diggs of Beyond Borders, we were able to secure the services of JeanYves Plaisir, a faculty member at CCNY, New York.

The research in India was carried out by highly experienced staff of three NGOs that serve children emerging from slavery, domestic violence, and prostitution, as listed below.

IN-COUNTRY ACTIVITIES

Côte d'Ivoire and Togo

The local consultants made advance contacts with potential child-serving projects to inform them of the work to be done and to invite their participation. In Togo a "launch lunch" was organized to explain the project and to answer questions. Eighteen program representatives attended this event. Seventeen Lomé programs and NGO's were visited over a five-day period in October 2005. In Abidjan, Côte d'Ivoire, six site visits were made over four days. In Togo and Côte d'Ivoire, interviews were conducted with nine children, thirty adults involved in local child care agencies, three governmental officials, and four NGO representatives.

India

Researchers from Free the Slaves partner organizations visited organizations and rehabilitative centers in Northern India, primarily in the state of Uttar Pradesh and near the city of Delhi. Many of the children in these facilities came from the neighboring state of Bihar. As such, these agencies are indicative, but not necessarily representative of the wide range of possible forms of child labor and child bondage to be found in India.

In India, FTS contracted with Suman, the Director of the Mukti Ashram to oversee the research in that facility. Information on the Bal Vikas Ashram was gathered by staff member Rajneesh Kumar Radev, via discussions with all the staff who interact with children, including the gardener and the cook. He also interviewed approximately 25% of the resident boys. Programmatic information was also provided by Aparna, coordinator of the Social Action Research Centre (SARC), a program for women and children survivors of domestic violence, slavery in domestic work and forced prostitution.

Haiti

The mounting level of violence, kidnappings, killings, and government instability throughout the year threatened to eliminate Haiti from the study altogether. However, the postponement of elections and the confidence of the local consultant in the project's feasibility and value led to the decision to go ahead. Extra precautions were necessary: lodging was secured in an out-of-the-way, almost inaccessible, retreat center, run by an American diocese of the Catholic Church; the most dangerous areas were avoided; a transportation back-up plan was maintained; and all work took place behind the guarded gates which are omnipresent in Port au Prince.

A full day training session was developed for participants of the Restavek Network, which unites staff from a variety of programs working on the restavec problem, either through shelter and or educational programs, or advocacy. This allowed us to obtain a wider perspective on their level of awareness of concepts related to children's emotional well-being, such as parental acceptance, effects of trauma, and stages of psychosocial development. The training was attended by twenty-four representatives of thirteen programs. Research, consisting of interviews with staff and children, observations, and interactive play, was conducted at three centers for *restavec* children during the week of January 8-14, 2006.

Appendix B provides a table of the facilities visited in all four countries.

LIMITATIONS AND DIFFICULTIES

Exploratory research such as this expects to confront limits as well as unexpected challenges. Certain difficulties unanticipated during the phase of study design became evident during the site visits.

Identification of the target population

It was very difficult to distinguish between children that had been enslaved and other children receiving services. Often staff knew little of the conditions under which children had lived before they arrived at their facility for care. These caregivers usually did not and could not make any distinctions between youngsters who had been enslaved during the course of working in the worst forms of child labor and those who had not.

In India two of the three programs did serve only formerly enslaved children. In Haiti, all three programs selected for the study had been described as serving *restavec* children. However, upon arrival we learned that one of the programs, Timkatek, now served very few. In Togo and Côte d'Ivoire the shelters, drop-in centers, and neighborhood programs visited served many categories of children – street children, orphans, prostitutes and those affected by AIDS, as well as those rescued from enslavement on cocoa plantations. Some children fit several categories.

In Côte d'Ivoire, attempts were made to meet boys who had been working on the cocoa plantations. The director of MESAD, a shelter program in Abidjan, said that they did have two such boys there, but that they were away at present. The Ivorian consultant, who had worked as an *animateur*[lviii] with children at MESAD in the past, said that it was difficult to identify former plantation workers because they are ashamed of having been enslaved.

Incomplete case records

We noted wide variation in record keeping in the majority of agencies visited. Manual ledgers were the basis for most record keeping, even in the offices of the governments in Togo and Côte d'Ivoire. Computers were used in only two or three locations.

Aggregate or longitudinal data files were not kept, making it difficult for informants to give us answers requiring a generalization, such as our research question on factors affecting the rehabilitative needs of children.

In two of the agencies in Africa, no records whatsoever were kept about the children under care. In other agencies, we were told that dossiers were maintained on each child but the information forms shared with us suggested that basic information about the child's health or history was often missing.

Detailed information was not obtained about Indian record keeping, but the agencies do keep dossiers on their clients.

Interviews with individual children provided a general sense of the types of histories these children presented but not in sufficient number or accuracy to draw conclusions about the population as a whole.

In general, the available case histories tended to inaccuracy and incompleteness. According to some program staff, children were not reliable informants about their stories, due to shame, memory disturbances, or incomplete understanding of their circumstances. For example, children would not know whether any money changed hands for their labor. Several children, especially boys, had run away to the streets from abusive *placements*, which would perhaps qualify them as target subjects except for the intervening period of living on their own. Whether the majority of children at some time had been trafficking victims is open to question, since it was often difficult to pin down the exact circumstances that preceded their being brought to the shelter. However, it seems reasonable to assume that the great majority of children had experienced loss of parental ties and lacked current family support.

Interviewing and observing children

The nearly constant presence of authority figures is presumed to have skewed observations and interviews. Language also posed problems, and many adults did not pause when speaking to allow adequate note taking.

Talking directly with nine children in Haiti, Togo and Cote d'Ivoire provided insight into their cognitive processes and how they tell their own stories. The yield was necessarily limited by the lack of established relationship with the children, the softness of their voices, their being unaccustomed to talking about themselves to strangers, the frequent presence of authority figures, and the need for translation from vernaculars.

That children were not forthcoming in interviews might also arise from lack of experience in talking freely with adults, difficulty organizing their thoughts, or anxiety. Interviews were also limited by children's vague sense of time, uncertainty about where they had been, and unfamiliarity with relating experiences and feelings.

Children said only complimentary things about the programs they were in, such as 'I like it here', and were not able to articulate what was helpful to them and what was not.

Applicability of questionnaire

The questionnaire was sometimes used in full, and sometimes in part without going through the checklists. It guided the general questions to be covered in all four countries.

It was difficult to judge the appropriateness of local approaches to care and rehabilitation of children. A mental health orientation focusing on one's internal state was not readily adaptable to the cultures where the focus tends to be more on external manifestations of both the presenting or problematic behaviors and the external signs of participation, social integration and recovery.

Absence of comparative data

The fact that the centers in Togo and Côte d'Ivoire served a broad spectrum of vulnerable children while in Haiti and India formerly or currently enslaved children formed the bulk of the client population might have provided a basis of comparison for goals and methods.

But in fact, the differences in approach to psychosocial and physical care among programs were not a function of whether their clients had been enslaved. Programmatic differences were instead due to factors such as funding, numbers of children, years of experience, and the cultural and political matrix of which they were a part.

Lack of information on children in the Ivorian cocoa sector

The significant lack of information was due not to insufficient record keeping, but to a lack of children from the cocoa sector in the agencies visited.

There were three reasons for this. First and foremost was the context of current political conflict. The cocoa-growing region in the center and northeast of Côte d'Ivoire is under the control of rebel forces and not accessible. The government forbids travel by foreigners outside the immediate area around Abidjan, military checkpoints stopping all traffic trying to leave that city. Ivorian researchers avoid traveling into the rebel-controlled areas because of the danger of being robbed, kidnapped, or worse. The collapse of the rule of law in the "no man's land" existing between government and rebel-held areas means travel there is also hazardous. Our researchers were of necessity confined to Abidjan.

This smoldering civil war has had an impact on the second key factor concerning the rehabilitation of children from the cocoa sector. Following the exposure of slavery in cocoa production, a number of initiatives slowly came into being to address the needs of any children freed from this situation. The delays were caused primarily by the reluctance of the Ivorian government to recognize the extent of the problem. While one NGO was able to establish a transit center on Mali's border with the Côte d'Ivoire, and some other NGOs sent investigators into the cocoa growing region, none were able to establish an effective response mechanism.

In 2002 the newly formed International Cocoa Initiative began a program of working with cocoa-growing communities to sensitize them to the issue of child and slave labor in cocoa growing. This community-based approach was seen as crucial to successfully freeing any children since most rural communities considered such labor practices normal. While this preventative work was going on, preparations for a "safety-net" were carried out, so that any children found in the worst forms of child labor or enslavement could be removed to an appropriate service provider. No appropriate agency being found in the cocoa growing region, ultimately the Abidjan-based agency MESAD was contracted to receive such children. As this arrangement was completed the civil war erupted, closing off most access to the cocoa region. Communities that had been or were becoming sensitized to the issue through the work of local NGOs contracted and trained by the International Cocoa Initiative were beginning to identify children in need of liberation and rehabilitation.

Because of the political situation, the transfer of these children to MESAD was slow, and the first ten children freed in the cocoa-growing region arrived in Abidjan in August 2005. We were able to ask staff about these children, but as described above, found that little or no information had been collected about

their experiences. We subsequently contacted the Director at MESAD to ask specifically about these boys and he replied:

> Our program was launched in August. It's a little early to have a correct estimate of help for children from plantations. From that day we have about ten boys who say they worked on the plantations. The problem is that not having anything documented before that date, it would be pretentious to give an evaluation before completing a year of activity.[lix]

Finally, in conversations held with representatives of the Department of Labor as the project was being planned, there was the suggestion, based on an USAID-supported project, that children were being exploited not only on farms, but also in the transport and export areas such as ports. Local NGOs, as well as the investigators of the International Cocoa Initiative, were not aware of any such exploitative treatment in the port of Abidjan. While all concurred that children were working around the port, as tends to be observed in every part of the city, they agreed there was no indication that these children were enslaved or suffering the worst forms of child labor.

These three factors prevented our addressing the specific question of the rehabilitative needs of children freed from abusive work in the cocoa sector. This does not mean that the problem is eliminated. The ten boys brought to MESAD in August, despite difficulties, are an indication that this abuse is ongoing.

THE SITES AND THE CHILDREN THEY SERVE

Côte d'Ivoire and Togo

Selection: In Côte d'Ivoire it was difficult to identify agencies that were closely focused on the aims of the research since most served a broader category of clients such as disadvantaged, abused or street children. Some centers were projects of large international organizations with multifaceted programs, like Terre des Hommes, Soeurs Salesiennes de Don Bosco, and the Bureau Internationale Catholique de l'Enfance (BICE) which maintain shelters in diverse countries. Some were single-facility shelters like AD-Togo and AIDES. There were also three drop-in centers for neighborhood children that offered recreational programs, support groups, services for children in conflict with the law, AIDS prevention, food, recreational and creative activities.

In Togo, sites were selected providing a range of size and sophistication in first-hand work with children formerly involved in the worst forms of labor. In addition, we contacted major non-governmental organizations that influence policy, and governmental bodies concerned with trafficked children.

Facilities: What was striking, across all agencies in these two countries, was the ambitiousness of the programs given their lack of operating funds. Most relied heavily on volunteers, even for psychological and medical services. At one of the larger centers, the *educateurs*[lx] receive an annual salary on paper of $1960, but might actually only receive food and lodging. Some children were not able to receive the medical care they needed because of hospital costs. Many centers were trying to generate income by selling things made by their children, such as syrup or place mats. There was a dearth of materials that might be associated with educational, recreational or therapeutic programs, such as books, paper, toys, balls, games, dolls, and art

supplies. Three programs mentioned television viewing as a recreational option. Two had outdoor play equipment like a swing and slide. Most programs were located in enclosed spaces, or compounds, that did allow room in the open air for active movement and running. In most cases, kitchens were small dark rooms without running water, with a few cooking pots, limited food supplies, and a fireplace on the ground.

Goals: Program goals for children were primarily centered on education and reinsertion. Literacy and schooling for younger children, and vocational training for teenagers who did not want to go to primary school were universally recognized as essential for children to succeed. Because there were no long-term care alternatives and because the governments in both countries exert pressure for children to be returned to their communities and families, all shelter programs worked toward reinsertion (sending a child back to the family) and reintegration (having that child be accepted and helped to function in the community over time.)

Drawn from materials prepared by agencies in Togo and Côte d'Ivoire, the program objectives listed in various pamphlets give an indication of the range of goals articulated by their staff:

- To prevent all forms of marginalization and social deviancies which ruin childhood, especially adolescence; to be a crossroads for encounters and exchanges among young people, *educateurs* and parents; to be a reference point for youth; to become a leisure and recreation center; to be an incubator for projects initiated by youth; to help children lead an active life.
- To offer girls a welcoming home in a climate of family respect; to pursue training; to discover through group life a sense of the common good; to accompany the girl in her evolution after leaving the *foyer*; to establish a constructive relationship with her family to facilitate her reinsertion.
- To organize the youth of this quarter; to help neighborhood youth know the threats and the potentialities of the quarter; to be with youth in the identification of their own problems in order to help them find appropriate solutions.
- To help the child to flourish; to promote autonomy; to help acquire citizenship; to help parents and the community to assume their responsibility.
- To give psychoaffective support; to provide support for conceiving and realizing life projects; [to promote] socialization and education restructuring.
- To prevent prostitution; [to provide] care of the whole girl; to give literacy and professional training; to fight against the propagation of sexually transmitted diseases.

India

Selection: Three program sites in Uttar Pradesh and Bihar provided information for the study. The majority of children at Mukti Ashram had been engaged in, and were presumed to have been enslaved in, domestic servitude, the carpet industry, brick making, and agriculture. Many of these were bonded laborers from the "lower" ranges of Indian society: Scheduled Castes, Scheduled Tribes, and the most prevalent, *dalits* (formerly called "untouchables"). The Bal Vikas Ashram near Allahabad served boys released from the carpet industry and some other exploitative situations.

Parents of these children were by and large illiterate and unemployed or underemployed. They tended to have insufficient income to meet basic human needs. Laws against debt bondage and

other forms of coercive labor call for a rehabilitation package for such children including monetary compensation, placement in school, and depending on needs—housing, land or other assets that may help the parents overcome their situation of poverty.[lxi]

The Social Action Research Centre (SARC) worked with women and children, including domestic servants, affected by violence and sexual exploitation.

The Director of the Mukti Ashram has worked with more than 6,000 children since 1991. She pointed out key problems that she felt most of the children faced when they arrived at her agency[lxii]:

> All the emancipated bonded child laborers have one commonality among them: that is improper functioning of the thinking process. Before their incorporation in the Ashram, bonded child laborers had passed through such traumatic experiences that their brains stop thinking about anything except to follow the masters' orders, and fearing for the punishment for noncompliance with the instructions. This kind of unbearable work pressure and terror environ[ment] has developed a certain kind of fear psychosis in them, the basic impediment to rehabilitation.
>
> These bonded child laborers [were] clutched in bondage at such an early age that at the time of emancipation they scarcely remember their parent's name or in some cases their village name, or district etc., because a child from downtrodden family cannot be expected to know complete details about their native place due to lack of education and other means of imparting knowledge. Mukti Ashram finds it difficult to gather all such information [such as] their full name, parentage, original place of residence, and official documents such as identity card, birth certificates etc.

Facilities: The two residential centers had dormitories, classrooms, and full programs of teaching and other activities for their clients. SARC ran a smaller community-based program that emphasized basic literacy, street theater and other supportive activities on minimal funding.

Goals: Mukti Ashram operated on the assumption that all child laborers, whether bonded or otherwise, should be brought under same rehabilitation program, irrespective of the nature of their work. They felt that all these children fundamentally need the same sort of psychological rehabilitative support, though they may need different responses to the physical health problems that are the consequence of various forms of work.

The Indian agencies recognized the complex nature of rehabilitation, to which the key is held to be the eradication of the "mental slavery" that is seen to hold back progress. The philosophy of rehabilitation was based on both bringing the children into physical and mental health, and into a keen sense of their rights as individuals:

> Rehabilitation should be seen through a rights-based approach…. Normally the government officials, in charge of rehabilitation programs, have a charity attitude towards the beneficiaries, and recipients also possess the same attitude, out of ignorance. The rehabilitation program should be structured in such way that it not only falsifies this myth of charity, but also inculcates in the minds of all concerned that it is a matter of child rights….Material rehabilitation is not rehabilitation in deed, as understood generally. The

> financial aids, or other benefits, under the [governmental] rehabilitation program are not sufficient for children, because [they are] devoid of emotional aspect and no one can deny the emotional support necessary for the children emancipated from the traumatic and exploitative work conditions. They need regular counseling and assurance for their safety. [Suman. Fn needed]

Haiti

Selection: Of the three programs visited, Timkatek and the Foyer d'Accueil run by Fonds Communautaire de Credit Mutual (FCCM) were shelter programs, while Foyer Maurice Sixto (FMS) was an afternoon program for children still living with their *patrons* -- householders using *restavecs*. Spending more time in a single center was planned, to increase the possibility of observing staff and child interactions.

Facilities: The FMS center, open from 12-5 pm, offered uniforms, schooling, a meal, a summer recreational program, and *animations*, which are activities like drawing, themed discussions, or group singing and games. FMS was a very large program with 450 children enrolled and 350-400 coming each day, of whom 75% were girls. Ten classrooms for elementary level education and a dental and medical clinic occupied the compound of buildings in the Carrefour region of Port au Prince. The staff of sixteen full time and sixteen part-time employees included 10 teachers, vocational instructors, administrators, and other support people.

Goals: Although the Haitian centers did not provide explicit written goals, their common aim was to improve living and working conditions and so far as possible schooling for *restavecs* who continue in employment.

HOW DID PROGRAMS MEET CHILDREN'S BASIC PHYSICAL NEEDS?

Each of the service providers sought, within their own conception of care, to fulfill needs that can be categorized into physical or psychological and social aspects of a rehabilitation program.

Safety

Côte d'Ivoire and Togo: Physical safety was of paramount importance to the children. According to one informant, a survey conducted by PLAN-Togo asked children what they most wanted in their care center. The number one response was "a fence."[lxiii] Some children were afraid that those whom they had fled might come after them to seek retaliation or to reconscript them. Others did not want to see their parents or whoever had abused them.

Shelter programs visited in Togo and Côte d'Ivoire were behind walls, often with locked gates or guards. One program required visitors to be pre-approved and to show a badge to enter, and another would not allow in a person claiming to be a child's mother or other relative unless they produced a photo of the child. Some gave the child the right to refuse to see any visitor, including a parent. Most program personnel said that children knew they did not have to return home if they didn't want to.

Ivorian and Togolese programs serving street children, who are literally living on the street and getting by through selling or stealing, had a difficult time creating enough trust to persuade them to come to the shelter. A lengthy process of winning them over in a gentle, non-coercive fashion was the approach used to build trust and gain the children's involvement in the program.

Violence was not permitted in any program visited. All programs used nonviolent means of controlling behavior and disapproved of hitting children. Terre des Hommes in Togo had a three-page specific Code of Conduct on how children shall be treated by staff. Any form of physical punishment or sexual contact was strictly prohibited, as well as anything which might make the child feel ashamed, degraded, or bad. Since this program is a major player in the network of care centers, others look to Terre des Hommes practices for improving or developing their own policies.

Children may also fear being physically attacked by other children. No fighting was directly observed during the site visits, but children told researchers and staff that it did sometimes occur.

All shelter programs reported having at least one staff person present during the night when children were apt to feel more vulnerable and fearful.

India: A clear understanding of the need to provide actual protection and sense of safety was evident. In fact the word *Ashram* means a sanctuary, shelter, or place of religious hermitage. The Bal Vikas Ashram (BVA) served children rescued from bondage through raids by police and labor department officials. These officials thereby became familiar with the rescued children and provided support to BVA's security measures. The local police were asked early on to speak to a new child and to reassure him that the police won't let the owners or traffickers near him

Nevertheless, slaveholders and brokers sometimes tried to find rescued children to reclaim them or harm them. To ensure the children's safety, BVA barred entry to anyone without proper identification. A guard offered further protection.

At SARC, children were not allowed to leave the premises without a responsible person known to or vetted by the center staff. Girls knew that no one is allowed to enter their rooms without permission.

Rescued children at both BVA and the SARC center were often terrified. According to one informant,

> they are very much afraid of the rescue team. They are not able to speak, they cry, sometimes they start shouting because they feel that again they will be taken to another owner who may treat them more badly than the previous owner. They feel themselves lonely in this world. They do not believe any one since everyone has cheated them.[lxiv]

A respectful intake process and the constant presence of caregivers helped to create a climate of security. Children were brought into the Ashram and shown around, especially where they would sleep, and then were allowed to take things at their own pace without pressure to engage in activities. When they observed other children playing happily and saying that they didn't want to leave, the fearfulness and distrust of the newcomers began to diminish.

Haiti: Safety was of necessity the number one concern in all of Port au Prince. Haitian programs maintained strict security against the threats of the world beyond their solid steel gates. The two shelter programs kept their gates locked and children were permitted outside only to go to school. In times of heightened stress, schools did not open at all. Because of the general strike called for the first day of the research visit to Haiti, schools were shut down as a protective measure and operated in a reduced way the rest of the week.

According to the Fonds Communautaire de Credit Mutual (FCCM) director, funds would have to be spent on additional safety measures that would allow them to complete construction work on an addition. Children there in two interviews reported feeling safe, though cut off from former relationships.

Health

Côte d'Ivoire and Togo: It is important to note that little information about children's health was collected by programs. Health was not listed as an objective by any program that provided written information, except for preventing AIDS. Children's health status did not seem to be evaluated in a systematic or formal way upon entry into the program. The most comprehensive documentation in any program was a fourteen-page form that asked about everything *but* physical status. Another intake form gave only one line for "physical development," by which was meant sickness or handicaps. Other forms asked about the child's general state (good, good enough or bad) and hygiene (clean, acceptable or dirty).

Typically an outside doctor or hospital, or the program nurse, treated any blatant problems such as wounds. Programs serving prostitutes had on-site voluntary testing for AIDS and STD's. There was one on-site fully staffed clinic with a pharmacy that could also provide STD though not HIV testing. Across all programs, and indeed society at large, the high cost of treatment for AIDS victims, who were often sick, was a barrier to their getting proper health care.

Upon inquiry, it was clear that children did have a number of health problems, including parasites (frequent), earaches, oral fungus, typhoid fever, constipation, and stomach pains. African child labor experts note the frequency of permanent injuries to hands and wrists, from being hit, crushed and burned.[lxv] Malaria, a major threat in western Africa, was not mentioned, nor were many mosquito nets in evidence.

Health education objectives were mentioned by programs serving adolescents.

India: The poor physical condition and compromised health of children upon intake made medical care an early priority. Children suffered from a host of physical problems, including old and new injuries, tuberculosis, malnutrition, stunted growth, worms, gastroenteritis, night blindness, black skin patches, and jaundice. A boy rescued from a carpet loom in India, and treated in one of the centers visited for this report, recounted the treatment he received from the loom owner's wife for his infected fingers. She had poured kerosene over them and burned them.[lxvi]

The staff treated most of the problems, and if more care was needed, a doctor at a government hospital was consulted. At Mukti Ashram there was an infirmary for contagious illnesses and more serious cases go to the hospital.

Believing that allopathic treatment was often not well suited to children, at both Ashrams the staff were well versed in the use of natural remedies, including nutritional supplements, and the children were also trained in their use. They relied on *neem, tulsi*, camphor, coconut oil, grass, black pepper, lemon water, and local herbs to cure conditions such as colds, coughs, jaundice, swelling, itches, severe pains, weak hearing and weak concentration.

Haiti: Health problems were frequent among *restavec* children. Poor diets, long hours, heavy loads, physical abuse and dirty working conditions resulted in compromised health. As reported by staff, they suffered from wounds, skin diseases, blisters, hernias, malnutrition, yellow hair (indicating nutritional deficiencies) diarrhea, malaria, vaginal infections, and sexually transmitted diseases.

Upon arrival, children were given a medical examination and treated. FMS had a facility of its own where medical and dental services were provided both to their children and to the neighborhood.

Nutrition

Côte d'Ivoire and Togo: All programs provided three meals a day, including occasional snacks. Food was normally purchased daily and prepared on site, sometimes with children assisting, in small kitchens with limited equipment.

No obvious signs of malnutrition were seen. However at one center a life-skills educational session with teens featured a presentation recommending a nutritional supplement displayed by the presenter's assistant.

India: The Ashrams recognized that for the first month in the child's stay, he or she needed more food than in the normal diet, which was a well-balanced vegetarian cuisine. Children were allowed as much food as they want. A doctor was consulted for special dietary needs, and vitamin therapy was also administered. Sitting in sunlight as a source of vitamin D was encouraged for the pain associated with bone deformities.

Boys as well as girls were involved in choosing the menus, working in the kitchen and washing their own dishes.

Haiti: Mealtimes were observed in all four centers. Typically, children were served a large helping of some kind of grain or bean dish at long tables. Other menu items included rice, sardines, meatballs, chicken, cornmeal and cabbage.

Domestic workers in Haiti are much shorter and 40 pounds lighter than children of the same age who are not in domestic work.[lxvii] It was therefore valuable that the children could have as much of the main dish as they wanted to eat, and drinking water was accessible. At Timkatek, children are given multivitamins daily.

Sleep

During sleep the executive function of the conscious mind goes off duty and terrors and conflicts rise up to be worked on and mastered. Frequent nightmares, of course, detract from the quality of sleep. Psychological aspects of recovery may interfere with primary needs, including sleep. Traumatized children can suffer from intense and persistent nightmares.

Côte d'Ivoire and Togo: Children living in difficult circumstances had become accustomed to sleeping in noise, heat, light, and without conventional bedding. One child recounted that when she was forced to work in a restaurant with almost no time for sleep, she would doze off leaning against the wall.

It was hard to determine whether the children in the west African shelters were getting sufficient sleep, but this was certainly aided by regular bedtimes which varied from 8 to 9:30 pm. Some daily schedules also included a "siesta". Sleeping accommodations varied from four-person rooms with beds for teens, to bunk beds in dormitories, to barren rooms with no beds but only thin sleeping mats on the floor.

Program staff interviewed did not report nightmares. However, nightmares may be more common than staff realize, since children are not used to sharing their inner life with adults.

A girl's dream (Côte d'Ivoire)

Although she had not been enslaved, eight-year-old Marie exemplifies one psychological reaction to traumatic experiences. She had been brought to the shelter five days before because of severe beatings by her alcoholic father.

In our research interview, Marie was given drawing materials to reduce tension and anxiety, but still she became progressively non-responsive, incoherent and disassociated.

A final question, "What do you dream of?" brought forth an elaborate description of a nightmare in which many people with blood on their faces came to take her back. She reported that in the dream, witches including her father who was angry, were chasing her. She woke up when they began to force her to go back.

India: Mukti Ashram children slept from 10:00 pm till 6:30 am in bunk beds, 16 to a room. There was electricity, backed up with a power generator, for nighttime reading. Newer children were reported to have trouble getting up in the morning.

Haiti: The children in shelters slept dormitory style in bunk beds. The program for girls allowed free access to beds, and at least one girl was observed sleeping during the day. At the boys' shelter, however, where 40 boys are lodged, the dorm room was kept locked during the day and the beds were so close together that the far side beds were reached by crawling across other beds. There were also small cupboards just under the ceiling, making the beds difficult to access.

Hygiene

Côte d'Ivoire and Togo: All programs considered this an important area of concern and learning. One Togo center even scheduled two showers a day. Hygiene came up frequently on intake forms and written behavior guidelines. One such set of instructions from Côte d'Ivoire read:

(1) wash hands before eating
(2) to avoid insects change dirty clothes
(3) comb hair well
(4) wash with a sponge
(5) brush teeth right away upon arising.

Staying clean was a challenge where children live in quarters with dirt courtyards, but children all appeared clean enough. Some centers expected children to launder and hang their clothes to dry.

India: Enslaved Indian children being unaccustomed to bathing, this new expectation was sometimes met with resistance.

Exercise

Cote d'Ivoire and Togo: The value of gross motor activity for physical development and health was not a concern to most Togolese and Ivorian programs. No one talked about the value of exercise, possibly because daily life required so much physical activity already, walking to school or to an apprenticeship, carrying water, or other forms of manual labor.

The importance of motor activity as a way of discharging energy and getting out frustration was recognized but not its role in overall development. Some programs had play areas for kicking a ball, basketball hoops, or a small jungle gym. One had put up a tire swing. Girls might be offered dance as a recreational activity.

India: Prior to arriving at any rehabilitation program, many children had been forced to perform repetitive labor that restricted movement or overtaxed a part of the body, which may well cause harm. For example, many children had been rescued from carpet weaving, a task that required a hunched sitting posture for up to sixteen hours per day and repetitive movements of the hands and arms.

The Ashrams included daily yoga and physical therapy to "make them fit." To counteract the physical damage of repetitive work, specific exercise regimes were prescribed, such as rotating body parts one by one to improve circulation. Boys participated in active sports like cricket, football, volleyball and Frisbee.

Haiti: The only open spaces available for active play were the roof top of the building at FCCM and a small court yard at FMS. Only at this latter program were group activities involving vigorous movement observed.

HOW DID PROGRAMS ADDRESS CHILDREN'S PSYCHOLOGICAL NEEDS?

In order to thrive, all children need to feel cared about, cared for, secure, useful, and accepted by the group. They need a sense of self as separate from others (identity) and a sense of being able to affect their environment (self-efficacy). The PLAN-Togo survey revealed that the second item on the children's wish list was to be "treated like one of your own children."[lxviii]

Children who have been exploited and traumatized have a special need for an environment that is predictable and over which they have some control.

Predictability and control

In all countries, it was the norm for programs to have a daily schedule of meal times, sleeping and waking, school and recreation. A daily schedule was part of teaching children punctuality, which some programs believed helps them recover faster. At Mukti Ashram, for example, children arose at 6:30 for exercise and meditation, chores, and breakfast. From 9:00 am to1:00 pm they attended classes in literacy and vocational training. After a two-hour lunch period there was a two-hour social education class that often focused on the human rights of the child within the larger community. Between 5 and 8 pm was free time, followed by dinner.

Cote d'Ivoire and Togo: In the Foyer Marie Dominique, in Abidjan, children were free to choose non-school activities as a group within the broad outlines of the daily schedule. Programs were not set up for individual children to do something on their own. Some programs allowed children to come and go freely beyond the walls, although the programs in Haiti and India of necessity had higher security restrictions.

When it came to making major decisions about the child's plan or schedule, whether to go to school or begin an apprenticeship, the adults had the deciding voice. One boy at a center was disgruntled because he had to continue washing windows of cars stuck in traffic when he thought he was ready to move on to an apprenticeship. The area the child seemed to have the most say in was whether he or she would go back to his or her family. Most programs in Togo and Côte d'Ivoire indicated that the child had veto power over contact with the family, although the agencies may strongly encourage exploratory visits.

PLAN-Togo's youth empowerment approach took the principle of control a step further. A key to preventing trafficking and bringing about true psychosocial change is helping children to have a real voice in the community. PLAN-Togo was therefore implementing a successful program empowering young people to run their own radio stations. Such radio stations disseminated information warning and informing young people about how to recognize the dangers of trafficking.

India: For Indian children rescued in a traumatic raid in which they felt suddenly overpowered and terrified, it was crucial that their experience in the Ashram bear no further resemblance to the domination which had reduced them to feeling less than human. Having a sense of control and being fully informed about what to expect in this new setting was very important for all children sheltered there. To that end, all Ashrams began very gently with a new child, showing him or her around, telling her or him how the place functions, and inviting him or her to rest and watch.

In India, the assumption was that a child will go back home, although exceptions are made in high-risk cases, or in the case of orphans or children who were enslaved at a very young age and were unable to remember who or where their parents might be.

In the Indian programs, children were encouraged to express their demands or wishes. There appeared to be a balance between giving children free choice around their level of involvement in activities, and requirements for specific programs and activities. At times informants on staff spoke of *making* a child do something, but this may reflect a language gap rather than meaning strong coercion is used. No evidence of such coercion was observed.

A child's expression of preferences (for food, games, books, etc.) was taken as a sign that he was on his way to recovery. Programs placed strong emphasis on children being able to speak up on their own behalf and eventually to advocate for the rights of all children. To that end, they worked to develop "the personality" of the child, by which they mean personal magnetism and the ability to influence others.

The freedom offered to children in Ashrams stood in sharp contrast to the totalitarian lives they had come from. Here, in the first two weeks and later, in the leisure period in the afternoon, they were free to do whatever they pleased — sleep, relax, play, sing folk songs, dance, or even go outside the gates after the adjustment period when escape was more likely to happen. The child, perhaps for the first time, was suddenly able to be self-directing. Such decision-making is empowering.

Haiti: Another kind of freedom common to all children who had been removed from abusive work situations was freedom from the constant worry over whether they would get beaten or yelled at for making a mistake. When such real threats diminish or disappear, the child can begin to relax and cease to be anxious, nervous, watchful and hyper-vigilant.

The children attending the afternoon program at FMS in Haiti were still subject to harsh treatment by their *patrons*, but they had recourse: if the staff learned of serious mistreatment, a committee of three or four would visit the *patron* and exert pressure to treat the *restavec* more humanely. A staff person at FMS explained that this policy has led to a radical change; children were more apt to run away from their *patrons* now than to put up with harsh punishment.

Consistency and quality of care-giving; positive attention

Cote d'Ivoire and Togo: In these programs, there was some recognition that each child needed to have one person to be a point of primary care and reference for him or her. The *educateur* or *tantine* roles carried responsibility for listening to a particular child and helping to solve problems.

Many programs had posters affirming their commitment to listening to children. This practice reflected a relatively new awareness and cultural shift that children have the right to speak and that adults should be receptive and respectful of the child by allowing him or her to speak freely. It did not necessarily mean, however, that adults had skill at drawing a child out, or that an adult was encouraged to try to find out what a child was thinking or feeling. The old pattern of adults giving orders and directions and children obeying was still very much in evidence.

One exception was noted in a drop-in center in Togo where the *educateur* had received special training in active listening, demonstrated in a photo of an active listening session which showed him sitting on the ground with a boy, mirroring the boy's relaxed posture. Another similar program in Côte d'Ivoire had developed excellent ways of getting children to be less self-conscious and talk more freely in a group. These leaders had special skills that successfully conveyed to children that they were liked and important. The skill level of other group work leaders was not known, but given the physical and economic constraints faced in most agencies, a truly therapeutic experience for a child participant was likely to be more the exception than the rule.

The extent to which children in shelters had the luxury of a single primary caregiver readily available to them was difficult to determine. But it was doubtful that even the most resource-rich program could meet this need to the degree that such deprived children need. Given the number of volunteers who supplemented the paid staff, we assume that children in shelters are exposed to a changing stream of helpers and caregivers.

In both Togo and Côte d'Ivoire children appeared to be on a thin diet when it came to emotional sustenance. No signs of the affection or physical warmth that might be expected in some other culteres were observed. Very young children did not even go to their caregivers when strangers entered their space. They appeared not to have had much experience with being physically comforted or held. There were no comments by any staff about particular children's strengths, abilities or skills, suggesting that staff were not used to thinking in those terms.

Signs of emotional hunger surfaced when we entered the children's realm. One little girl wrapped herself around the legs of the visiting Director. She failed to get much response, so she tried again later, to the same effect. Many children appeared to struggle with the conflict between their inhibitions with adults and their longing for attention.

India: There was a warmer climate in the Indian programs. Teachers, caregivers and other staff displayed caring, support, and acceptance in a number of non-contact ways: friendliness, praise, shared laughter, special names, and attentive listening. The boys tend to be *dalits*, "who have been discriminated and deprived of their rights in the society and they have never been exposed to [touching and hugging] gestures as a sign of love and belongingness."[lxix] For these boys, affection was expressed through playing, reading with them, and most importantly, listening to them. Being in an atmosphere where all were treated equally and respectfully was an extraordinary experience for these formerly invisible children.

Ashram children did not have a specific adult assigned as primary caregiver, but they had ready access to the full staff, including the cook and the gatekeeper, as well as teachers, coordinators, counselors, volunteers, training instructors and community organizers who do follow-up in the source villages.

Haiti: The best example of meeting children's psychological needs by a compensatory relationship with a surrogate parent was observed at FMS in Haiti. The project was begun in 1990 by a Haitian priest, Father Miguel, who recognized that children in domesticity (i.e. *restavecs*) had five basic needs that were not being met: survival needs such as sufficient sleep and food; protection and security; the need to belong and be accepted; the need for validation;

and the need to reach full potential. Father Miguel, supported by Terre des Hommes Switzerland, launched a program in Port au Prince to sensitize the *patron* families in order to improve the working conditions of *restavecs*, and also to provide *restavecs* with educational and psychological support in an afternoon program they could attend when they had finished their chores.

The project caught hold and more and more children were allowed to attend. Father Miguel, however, had realized that something was missing from the program: the all-male staff lacked a mother figure. Ten years earlier, he had hired Mami Georges, a trained elementary teacher, to take on that role. Since that time, she has nurtured thousands of children, listening to them, comforting them, playing with them, and even shopping for them. In an interview with this warm, radiant, older woman, it was easy to believe that she was very good at gaining trust, activating withdrawn children, tending to the sick, and giving affection. It was common for graduates from FMS to continue a relationship with her long after they have left. She also had been chosen as godmother to many children and had taken at least one child fleeing an abusive guardian into her home.

Social needs and relationships

Children need relationships with others that recognize their individuality, affirm their acceptability, provide them with a sense of belonging, and teach them what they need to know in order to manage in society. The relational context begins at birth and is the matrix in which the child develops and which determines the lessons learned from birth to the late teens: trust vs. mistrust, autonomy vs. doubt, initiative vs. guilt, industry vs. inferiority and identity vs. role confusion.[lxx]

When children are treated harshly, without nurturance and attention to their needs, they are unable to master the early developmental tasks that prepare them for the next stage. We would assert that when children are treated like objects or servants without intrinsic value they learn mistrust, doubt, guilt, inferiority and role confusion. Relationships with peers are very much affected by adult-child relationships.

Ideally programs in each country would help children to overcome these early dehumanizing experiences by providing compensatory or corrective relationships. It takes effort to establish trust, engage children in animated conversation, teach them what to expect from others, find specific achievements to praise, give them choices, show them how to work out conflicts without violence, let them experiment, play with them, laugh together, and give them the tools for living in community and making friends.

Cote d'Ivoire and Togo: The programs naturally reflected west African cultural norms for adult-child relationships. Adults speak to children to give orders; children obey. This was written on a chalkboard in a classroom for adolescents: "The duties of the child: the child should help the parents in domestic work; the child should obey his parents."

Children may not have been encouraged to talk freely with adults, which has implications for language development and problem solving. Children have to be trained to converse, which happened in discussion groups run by some programs, and to speak loud enough to be heard. At

the lunch table of one shelter, the older girls dominated and several younger silent girls seemed very uncomfortable at being encouraged to make a contribution to the discussion.

It would be hard to say whether African children interviewed for this study were struggling more with inhibition, natural immaturity, or cognitive impoverishment. Most had difficulty answering questions calling for a feeling or a preference, though this may have been caused by inhibition caused by confronting a strange and foreign interviewer. Many did not know their age (also true in India) nor how long they had been in the shelter.

African programs were all strong on setting limits and expectations for *comportement*, in areas such as hygiene, dress, respecting rights, cooperation, drugs, alcohol use, and sexual behavior. Two that worked primarily with teens required a signed contract listing the terms that had to be met for participation in the program. There did not appear to be much problem with unruly or defiant behavior.

All programs recognized the importance of establishing trust and understood that persuasion rather than coercion was the better way. Those who had the biggest challenge in gaining the children's trust were African staff members trying to help street children or prostitutes. They gained trust, they said, by showing up over and over, explaining the advantages of the center, but not applying pressure or coercion, and by engaging the child gradually in conversation.

In two centers, non-client children were permitted to drop in for food or company, although they weren't formally enrolled. This porous boundary allowed children to feel not entirely cut off from the world beyond the wall, and to interact with children who were not as disadvantaged.

The atmosphere in African centers was often relaxed, tolerant, even permissive. There did not appear to be rigid generational barriers limiting interaction between adults and children. Many staff spoke of aiming to create a feeling of family. In one of the programs in Togo, the boys had been rescued from their life as homeless porters at the Benin border where they were regularly robbed and molested at night. They called the director "grandfather" instead of "sir." This director expressed the wish that he had the funds to hire a woman to be a mother figure for the boys.

African children seemed to be more given to compliance than complaint. Although they didn't necessarily like being in a shelter, with the stigma associated with the reasons they were there, they recognized that they were better off than before. In the shelter they were fed and were not beaten. They also had a chance to learn to live in community—to share responsibilities, to take turns, to help one another, to form alliances, and perhaps even to make a friend.

India: Indian programs were more likely to value a child speaking up, expressing a preference, asking questions, or even showing anger. Signs of growing assertiveness were welcomed as "personality development." One program listed as psychological objectives for children "the feeling of cohesiveness, self-confidence, interpersonal communication skill and the ability, concern and courage to express their views."[lxxi]

Follow-up work with children suggested that the Ashrams do a good job of preparing their children for life in society. There were many opportunities on a daily basis for being part of the group. Children recited prayers in unison and sing chant-like songs together; they intoned a

group welcome for visitors; they chopped vegetables together, ate together, slept in a dormitory, studied together, attended discussion groups and classes in social education, and were even taught to conduct business meetings. They learned something about laws and rights, and were encouraged to think about how they might one day be able to make a positive contribution in their home communities.

In the Ashrams, the boys all said that they liked it there and didn't want to leave.

Haiti: Some elements of traditional Haitian culture tend to devalue children. The observation made by one program director, that the boys in his program were "like animals," is echoed in a treatise on the Haitian family, written by Haitian psychiatrist Legrand Bijoux. In his view, generally in Haiti children are regarded as little animals who understand nothing, have no desires of their own, and are brought into the world so that the mother can rest.[lxxii]

Bijoux notes that nothing is done to build up the child's confidence in what adults say or do, and that adults deliberately tell all sorts of lies for no apparent reason other than to amuse themselves. Worse, he adds, is parents' enjoyment of frightening children with stories of the devil and werewolves. The child has no right to challenge the word of an adult, or to express feelings or opinions. Finally, he observes that parents, without much thought or consideration may move the child around from one social milieu to another, separating him or her from brothers and sisters. "*Ils sont prets à donner leurs enfants en adoption ou en service à n'importe qui*."[lxxiii]

With early socialization that may range from indifference to sadism, it is not surprising that Haitian programs focused a great deal on positive socialization. Timkatek aims to change the boy's mentality, "to humanize" him. Up to the time of entrance, the child was seen as to have been struggling for survival and not to have mastered basic civil behavior. The staff recognized that "civilizing" was a slow process that takes place through the little details of life. The Director asserted that one way of doing this is by having a little prayer before meals, which helped boys to eat calmly. "*Ils doivent avoir une certaine noblesse devant la nourriture*" said the director. [lxxiv]

Boys were further helped to function in society by being assigned to work teams to learn housekeeping skills. They were educated about sex to help them learn to "dominate" their sexual instincts, lest they prey on victims once on their own. Older boys did not have an opportunity to interact with girls as part of their maturation process in this program. They were exposed to girls and young women only as portrayed on television.

At FCCM girls just entering were seen as very aggressive, badly behaved, cursing, and frustrated. FCCM offered a code of conduct to make the rules clear and to help the children adjust. With three or four exceptions, most girls appeared to be integrated into the group, and to have positive relationships, taking turns, actively responding to one another and contributing to an atmosphere of laughter and gaiety. Most of these girls readily interacted with the researchers without hesitation and with interest and enthusiasm.

No child expressed any complaints to the interviewers, although one girl wrote her complaints out in Creole, to keep it secret from staff. She wrote that she didn't like being isolated from her previous life and cut off from friends.

PSYCHOLOGI CAL ASSESSMENT AND TREATMENT

The current functioning of a child is the product not only of whatever trauma and mistreatment she or he may have suffered in a work situation but also of all of her or his experiences in family and community that came before. The exploited child often comes from a family with a very limited set of choices, where the situation in which their children end up may have seemed to be the best available option. The harsh treatment a child then experiences in a rug loom, cocoa plantation, or kitchen may seem to be a continuation of the hardships he or she has already known.

It is a challenging task to assess and treat a program full of children suffering the effects of a lifetime of poverty exacerbated by neglect, abuse, terrifying experiences, physical and psychological trauma.

Behavioral and emotional observations provided by program staff		
Côte d'Ivoire and Togo	**India**	**Haiti**
Fabrication, lying, hypocrisy, saying what you want to hear		Lying
Shut down, passive, non-reactive, mute	No facial expression, almost silent, disengaged, withdrawn, does not initiate conversation, halting speech	Closed Keep a distance
Trembling, palpitations, perturbation	Tremors	Restless, Turbulent
Unstable		Suicidal
Aggressive	Aggression, instant anger, frustration, irritability	Aggressive
Crying all the time	Crying	Crying
Dreamy, unable to focus	Difficulty understanding	Somnolent, daydreaming
Hallucinating (*delire*)		
Wild, out of control	Obsessive demands	Uncivilized, wild
Can't forget	Intrusive thoughts about trauma	
Lost her memories	Poor memory	
Doesn't know what she was saying	Confusion	
Nightmares, trouble sleeping	Sleep problems, nightmares	Bedwetting
Defiant, angry at being here	Escape attempts	Anger
Totally unsocialized, doesn't know how to conform, not behaving well		"Like animals"
Superiority complex, alienates peers	Sense of inferiority	Egotism
Fear	Fear psychosis fear of dark places, starving, being beaten up, not following orders, death	Fear, timidity, anxiety
No confidence	Helplessness, shattered confidence	
Nervous	Pronounced startle reflexes	React briskly
Stigmatized	Stigma of caste, enslavement, inferiority, illiteracy	Stigma
Identity issues -- may not know age	May not know age, names of parents, or village	
Won't go to school		
Can't stand the presence of adults	Aloneness, alienation	
Years of accumulated sadness	Sadness	Sadness

All programs would probably agree that they were providing a safe, secure, accepting environment in which children can learn, make friends, and begin to visualize a different future. They also provided what they could to make it possible for a child to survive on his own and avoid re-victimization. Within that framework, there were a variety of specific methods that facilities and their staff employed in response to the perceived needs of their clients.

The following table provides a basis of comparison across cultures of the perceived problems as well as an insight into the differing mindsets of the service providers. The observations of problems are translated from the words of, and as described by, program staff in the four

countries studied. An effort has been made to collocate equivalent symptoms despite variations in the language used. The language of service providers in Togo and Côte d'Ivoire seemed to be more judgmental, and in fact, the children in the centers there were more apt to see themselves as blameworthy.

Many of these problems are directly understood or translatable into western mental health concepts. The trauma theory list of indicators (page 12) yields these equivalents: intrusive memories, ruminative preoccupation, paralysis of initiative, sense of defilement or stigma, explosive or inhibited anger, and dissociative episodes. Several items belong in the collective category of *persistent dysphoria*, "a state of confusion, agitation, emptiness, and utter aloneness" coming from the coalescence of repeated experiences of terror, rage and grief.[lxxv]

According to Terr, two kinds of fears continue to plague the trauma victim: literal fear directly connected to traumatic experiences, and a more subtle kind, such as fear of looming objects, of being alone, of strangers, of the dark, or of being outside.[lxxvi] Rohner's cross-cultural studies point to anxiety as a universal sequel to rejection.

The children in this study had little experience in talking about their feelings. The caregivers also often lacked experience or training in the language of feelings, and so did not know how to go beyond symptoms like trembling or crying to the underlying cause. They might also misread the outward manifestation of inward distress. In one program, a recently arrived girl who had been beaten and scarred with an electric cord had been judged to be trying to get attention when she complained about her stomach hurting.

Children who have been made to feel helpless again and again in situations of overwhelming physical pain or fear, may become immobilized and unable to help themselves. Once out of the situation, they may be filled with rage that lasts a lifetime and is directed indiscriminately at any source of frustration. In cultures that rely on corporal punishment it is not surprising that children learn ways to keep rage hidden. It may be that such a presenting behavior is defined or described differently, as in displaying "instant anger" or being "aggressive; wild, out of control".

Evaluation and assessment

On entry to the Indian centers, the poor condition of children was self-evident: skeleton-like appearance, wounds, hyper-vigilance, sunken eyes, stunted growth and jaundiced skin, which were diagnostic indicators of the unspeakably poor treatment they had been subjected to. While many children in an area might be suffering from the malnutrition that comes with poverty, the condition of the rescued children was worse. Sometimes children were so weak that they couldn't stand for five minutes and fell down during the evening prayer. Some children in the African programs also arrived in a life-threatening condition that took months or years to repair.

No formal psychological or developmental assessments were routinely performed in any of child-care centers visited. Intake forms might include space for impressions of the child, but these were by no means systematic. Observation, chatting, and staff discussion were the principal means of gaining information about the mental status of the children.

> Staff members sit with the children to talk with them, counsel them to know what goes inside. Assessment of each child's condition is done by observing its physical growth, ability to communicate with the other children, and staff members, and ability to understand the message conveyed to them. All this is done through close interaction with them.[lxxvii]

A Togo program director trained in Europe gave his opinion that staff people had good instincts but were guided only by what occurs in the moment and didn't have any theoretical base or system in common. "They have no organized way to address trauma. For children, it's therapeutic just being here. It's very different from everything they know." This program director was trying to raise standards of care by developing training for social workers and *educateurs*, who had the most direct responsibility for sheltered children.

Counseling

All programs reported that they provided some form of counseling. In Côte d'Ivoire, Togo, India and Haiti, it was often difficult to pin down a precise definition or purpose, beyond being a process which went on between a child and adult by prearrangement or spontaneously. Counseling might focus on a problem or concern of the child or it might spring from an adult's assessment that action must be taken to help change something about the child's behavior or emotional state

Counseling might or might not take place in privacy. One Togolese center hung straw circular panels from the roof of the gazebo to create an illusion of privacy since they had no spare rooms for sessions. The brochure of an Ivoirian drop-in center listed a service of "supportive listening." However they had no private space where this could take place. The freestanding metal booth labeled "listening room" in the courtyard had been closed down by the parent organization due to lack of funds. In part this was due to the lingering effects of the civil uprising of 2002, which led donor nations and international NGOs to withdraw their support suddenly. It was noticed, however, that this center did have a large performance room with a stage that was unused by anyone at the time of the visit, except for two adults playing checkers in the corner.

Counseling at one Ashram we visited was provided by caregivers who had no special training in psychology, mental health, child development, or child trauma -- although there was a staff member with the job title "counselor." Staff training did stress children's need for love and affection, care and support, guidance and security. In this Ashram, individual or group counseling was conducted once the child had settled in, and if a child felt he or she had a problem, he or she could approach anyone, including the Director.

Individual counseling appeared to be a semi-structured and scheduled process in the Indian programs visited. It involved first understanding as much as possible about the child's family, cultural, economic and social background. The most important aspect was to have the child talk about personal problems that couldn't be talked about with anyone else.

> Staff involved in it focus on the feeling of the child before and after rescue operation and try to help them in recovering from bad experiences. Love and affection shown by the counselor plays a crucial role in recovery of the child.[lxxviii]

In Haiti, ongoing, scheduled sessions with individual children were uncommon. One program director reported that each child had one private session per month. He listed prayers, affective training, discipline rules, and monthly group meetings with different themes as the primary ways

children were helped to develop and deal with their mental health. The children had to ask themselves why they did what they did. He added, "We give every child a leaflet or brochure to help them to reconstitute themselves."

Group sessions, reported by nearly all programs, may be a more powerful form of therapy than individual counseling because the stories of others' experiences serve to diminish the sense of isolation, reduce the stigma attached to low status and enslavement, and provide perspective. In the group, children are also encouraged to think of ways to prevent child abuse and enslavement, such as reporting suspected traffickers to the police. Children develop ties to one another through the group process, which adds to their feeling of belonging, security and support.

Use of mental health specialists

With almost no psychiatrists, and few psychologists, available, social workers with various levels of training in child development or children's mental health were more common in the programs studied. Most of the programs in Togo and Côte d'Ivoire recognized the occasional need for specialized help and had some reliance on psychologists. Psychiatric help was not available, although by western standards, it would certainly be indicated for children described as "delirious" (hallucinating) or "carrying years of accumulated sadness." Psychotropic medication was almost unheard of.

There was no mention of psychiatry or psychotropic medications in any Indian program. One Ashram indicated that they do occasionally call upon psychologists to provide trauma therapy, as well as providing individual and group sessions themselves. Only one of the three Haitian programs reported using psychological consultation, and then it was reported to occur only once every two months. All Haitian programs recognized that they had children who were not adjusting well and needed more help than they were getting.

The amount of psychologist time available to the programs varied from daily to once every two weeks, to an on-call basis. "Most kids are not pathologic," said one psychologist serving a program in Togo. "They go wild at first. At nights sometimes they go overboard." Some program directors expressed a need for more psychological assistance, but recognized that there were few psychologists in their geographical area, and little money to pay them. The director of one program serving prostitutes said that they had access to a psychologist, but the girls refused such help as they believed it to be completely irrelevant to their lives.

Three psychologists in Togo and one in Côte d'Ivoire were interviewed to learn how they go about understanding and helping children. They all remarked that shared cultural patterns that inhibit children from talking to adults, and the extra layer of maltreatment at the hands of adults, made the psychologist's traditional role of getting children to open up particularly challenging. "An exploited child won't talk about what has happened. I'm not sure why not," said one psychologist.

Instead of exploring the interior life of a troubled child, the psychologists were more apt to focus on the child's behavior and external problems, and to make suggestions to the child or the staff for solving them. One goal of therapeutic help, according to one psychologist, was to get the

child to break ties with the tragic past. That was accomplished through theme drawings, making and using puppets, putting on a circus, and gymnastics and running around (referred to as *ergotherapie*). There was no mention of exploring with the child what it means to be without mother or father.

The pain of separation

Because her mother could not provide for her, Deezou, who is now 11, was sent to work in someone else's house in exchange for food. There she had to wash the clothes, sweep the floor, wash the dishes, clean the shower, and watch the baby. Once her mistress threw scissors at her, causing a wound to her back.

One day when she was given nothing to eat, she went to neighbors for food. That angered the mistress, who beat her. Deezou ran away to the police, who brought her to the shelter where she had been for several months. "They do help me here," she said.

Her mother lives in a distant village and Deezou has not seen her. When the interviewer said "It must be very hard not see your mother," she nodded and tears began to run down her cheeks.

Soothing, smoothing things out and solving practical problems of daily living, rather than exploring and treating, seemed to be the province of mental health specialists. One Ivorian psychologist had invented his own tools of the trade. Wooden boxes, open on one side, with a mirror attached to the opposite side, were used to calm down agitated children by asking them to trace a dotted design while looking in the mirror, a frustratingly difficult operation. For children who had trouble sleeping, he had made CD's of five kinds of music, each geared to a different need, which he played on his computer for the would-be sleeper on a cot in his crowded office. For diagnostic purposes, he sometimes relied on the child's handwriting, magnified for clues to the child's make-up and problems, a skill that is normally thought to require special orthographic training.

When asked about outcomes for children this psychologist has treated, he reported positive results. The raped girl, who didn't talk when sessions with her began, now was smiling, spoke, and went to her training course. The boy traumatized by war could now sit still and understand. His nightmares were quiet. Another boy was now a good worker at his apprenticeship. The psychologist felt that defiant children take a longer time to help, and complained that often it was hard to find the parents of children in the shelter. He ended by saying, "And there are so many children."

A Togolese female psychologist worked with teen girls who were formerly exploited as street porters, and may also have been involved in prostitution. To get the girls to go into a twelve-bed rehabilitation center, the staff social worker slowly gained their trust in the marketplace and finally convinced them to go into the center. The psychologist, who kept a confidential record, required a girl to sign a contract for behavioral change, first exploring what she saw as her bad behaviors, such as lying, stealing, or "not being able to communicate." The social worker also helped her to see whether she was motivated to change.

The main ways of promoting positive change, in addition to providing a safe shelter, were by getting the girls to take responsibility for the cooking and other household tasks, by group discussion, and by loving them as human beings. To manage anger, they were taught to relax by deep breathing and to discharge aggression through exercise. Faith and a spiritual life were encouraged. The staff also worked with the girl's family. They assessed progress by the girl's improved behavior. When asked how they knew whether a girl actually felt better about herself, the response was "by looking at her life now. She no longer sleeps outside."

Religious teaching

In all settings, developing spiritual awareness was thought to make children feel good. Incorporated into the daily schedule in the Ashrams were group prayers for one another and the Ashram. God was referred to in regular discourse in programs run by Christian organizations and orders. The degree to which this helps the child or fosters a strong faith is unclear.

APPLICATION OF THEORY TO ASSESSMENT AND TREATMENT

The story of one exploited child is examined from each of the three theoretical perspectives on which this study was based. Each of these three theories could inform a clinical assessment and treatment plan for Therese.

Therese's story (Togo)

As she tells it, Therese doesn't have any place she comes from. Nor does she know how old she was when her father placed her with a stranger. Working in the restaurant was really hard. For about two years she lived this schedule:

Get up at 2 am to cook food to be sold between 7 am and 11 am.
After a short rest, cook all afternoon for the evening meal.
Serve food from 6pm to 11 pm. Wash dishes.
Sleep on a thin mat on the floor from midnight till 2 am.

She was so tired she sometimes slept leaning against the wall. Then she would be beaten or have her ear pulled. Crying would increase the beating, but she would cry anyway.

One day she ran away and rested. A lady took her to the radio station where lost children were announced. She was reclaimed by the restaurant lady who took her back to her father.

Her father understood that the restaurant was not a good placement for her, so he gave her to a woman who sold material in the market. Her domestic service consisted of taking care of her baby at a relative's house, then returning home at the end of the day to begin her housework. She could go to bed only when it was all finished, around midnight. At this house she was beaten more than before. One day after she finished all her work, she left the door open by mistake. For that she was beaten with ropes and a pestle.

She ran away and eventually found her father. After hearing her account, he kept her with him for a couple of months. Another woman needed help selling water and agreed to pay her $2-$4 a month. She did as instructed, but never received any money. She would be beaten and shouted at if she didn't sell

enough water. One day, water customers told her to come back to their stall at the end of the day when they would have money to pay her, but when she went back, they were gone. She was beaten again.

She ran away again, ending up in the market where she joined with other child porters, and prostitutes. She asked everyone in vain where to find the road to her father's village.

Four years ago, a woman found her in a market stall and took her to a rescue center in Lomé. From there she went to a long-term program for young prostitutes. That program's tireless search for her father was finally successful, and Therese got to see him once more before he died.

Now 17, she has finished her training as a seamstress and is waiting for her diploma. Her hope is that the center will help her set up a shop, but she doesn't know if that is possible, because they haven't discussed it.

Parental acceptance and rejection theory

Clinical assessment. We would be alert to characteristics consistent with a history of parental abandonment and rejection. We know nothing about the quality of Therese's early nurturing or what became of her mother, but we do know that her father sent her away again and again into abusive situations.

If the initial episode of sending her to live and work for others occurred before Therese had the cognitive faculties to understand anything about why her father acted as he did, she would have felt profoundly rejected and abandoned. This is true *regardless* of his motives, or any personal or environmental conditions beyond his control that may have informed his actions and curtailed his options. Young children feel a strong sense of loss when separated from their parents, even when a parent has been abusive.

In addition, if we scratch the surface, we would expect Therese to have a negative worldview, feelings of inferiority, depression, or anger, a lack of confidence, and anxiety.

Clinical intervention. It is probably too late to make up for the absence of a nurturing, protective, loving caregiver. The best one could do at this point would be to provide her with a surrogate parent, someone who would take a genuine and affectionate interest in her over many years.

Often this is impossible to achieve. The level of damage to the child's ability to trust, to experience affection without fear or to manage deep ambivalence toward caregivers may be very high. In that case, a setting of greater emotional neutrality, like a group residence with paid caregivers, might be more helpful

Trauma theory

Clinical assessment. We would direct our focus to the effect of innumerable beatings following mistakes that would enrage those who had authority over her and possessed unlimited power

over her life (or death). The consequences of these deeply damaging events were exacerbated by Therese's subsequent experiences in the market as porter or prostitute.

Taken as a whole, the cumulative weight of these experiences might qualify Therese for a diagnosis of complex PTSD using Herman's taxonomy. Whatever her innate personality, it would have undergone profound alterations as she coped with the disregard for her personhood and the chronic abuse meted out by powerful adults.

Therese would likely have in store for her a lifetime of turmoil and instability in psychologically important relationships, periods of acute fear, and somatic manifestations of her chronic anxiety and depression like constant fatigue, insomnia, stomach gastrointestinal problems and migraine headaches. Tragically, Therese would also be highly vulnerable to re-victimization.

Clinical intervention. Trauma theorists, including Herman, maintain:

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation.[lxxix]

Recovery from trauma is best accomplished within the context of a relationship with a therapist, who knows how to establish safety, diminish helplessness, restore autonomy, foster insight, develop empathic connection, restore an ability to trust, work with rage, negotiate boundaries, set limits and develop a positive self view.

Yet such therapists do not exist in the world where Therese lives, and may not be available in her country at all. John Frederick describes such a situation, for girls returning to Nepal from India.[lxxx]

Psychosocial approach

Clinical assessment. This theory claims that the presence of severe and prolonged developmental disruption, arrest or regression is the basis for the problems with which Therese presents. It is based on the notion that a child's natural resilience will lead to recovery from harsh circumstances if they can live within a benevolent social context.

Therese's psychosocial development has been severely inhibited and damaged, probably along several critical dimensions, by the acute and chronic horrors she has experienced for perhaps her entire life. She has been robbed of the chance to achieve critical milestones of cognitive and emotional development -- milestones that create young people who view the future with confidence, mastery and creativity; relish opportunities to act autonomously; work productively; self-regulate unpleasant feelings and impulses; know how to comfort and reassure themselves under duress; forge mutual relationships that foster committed friendships, long term intimacy and unconditional support; and have a solid enduring sense of self-worth.

Clinical intervention. Therese will recover a degree of normal functioning once she feels secure in a structured and predictable environment and have developmental opportunities restored. Though ideally that environment is the child's family of origin, surrogate families and residential treatment facilities may also be capable of fulfilling these requirements.

Some of Therese's experiences in the two centers that have cared for her seem to have been restorative. For over three years she has been reaping the benefits that come with living in a safe and stable environment and being treated in ways that reflect the programs' strong ethic of protection, child rights, and empowerment through education and professional training.

The center where Therese now lives itself has to serve as the psychosocial locus and do whatever recuperative work it can during the child's stay. It strives to provide a number of the elements that repair and enhance developmental growth: mutual respect, shared responsibilities, support to achieve goals, regular daily routine, boundaries (girls are only allowed off site on Sunday afternoons), group process for decision making, working together to earn money for their support, attention to medical, educational, vocational and recreational needs, consistency in caregivers, and validation rather than judgment. When asked what happens to the girls when they leave, the center Director answered that they marry or they go back to their families, or they die of AIDS.

Whatever theoretical perspective might be used to consider an appropriate response to her exploitation, Therese is facing a grim future. She apparently has not yet developed enough assertiveness to discuss her most pressing question -- whether the center will help her set up a shop -- with the adults she has lived with for three years. This may reflect a problem in relatedness that has not yet been worked through

HOW PROGRAMS GAUGE SUCCESS AND FAILURE

Each program in every country reported a high level of treatment success. However, concepts of success or failure in different cultural contexts may differ. A program with the goal of "stabilizing" children claims a high rate of success, defined as achieving the minimum goal of obedient participation in program activities. Varying additional measures of success are used informally by program staff.

Completion of training

In the African context, one measure of success outweighed all others: becoming economically productive and self-sustaining. Particularly gratifying were those "graduates" who operated their own shops and took in younger apprentices from the program. Such a man was Mitterand, a former street child. Now 25, he painted signs in a tiny atelier, assisted by two apprentices. Helping another youngster learn the trade was the way he repaid the center for all they did for him.

The African programs count as failures children who do not follow and complete the prescribed plan of school or vocational training. Amina was presented as a failure story. (see box)

A "failure" story (Togo)

When both her parents died, Amina went to live first with her grandfather, then her aunt. To correct Amina's "behavior", her aunt carried out a *sara* ritual, involving seclusion, then putting food three times down a toilet hole, and finally having Amina serve food to everyone, and join in.

Amina was thirteen when her aunt decided to take her to work in Gabon, along with three other children. At first Amina was happy at the prospect of a boat ride but when she saw how small it was, she became frightened. Twice she was moved from boat to boat. Finally, they reached a port, and the children were exhibited on the dock to several people who came to buy them. She was considered too young to be a good worker, but a woman took her anyway. The woman threatened her with police action if she didn't work harder. Soon she was selling oranges in the market.

After a while, her aunt reclaimed her and gave her to a Malian family to be a domestic servant. That place was better and they were good to her, but her aunt moved her to another Malian family where she had to work selling couscous till 1:00 am, and then start again with only four hours of sleep. Her aunt got the money from the sales; Amina was never paid. She fled back to her aunt who simply returned her the next day.

More placements followed until one day when she was selling milk she was knocked down by a "moto" and her milk container was destroyed. For this she was beaten. As the owner of the house set about putting pepper in her genitals as further punishment, she fought back and escaped.

With the help of another woman, she found her way to the Togolese embassy, which facilitated her return by plane to the care of the Directorate for Child Protection, the governmental agency charged with assisting trafficked children. After a day in prison, the aunt paid restitution to fund a small account of about $270 to aid Amina's future. Amina also received $50 to spend as she wished.

Now fifteen, and out of the rehabilitation center, she is living with relatives, including an older sister. She did not want to go to school any longer because she felt she was too big for the class she was put in and did not do well. Although she wants to learn hairdressing, she has been told she can't do that and must learn to be a seamstress. It is not clear whether she will go on with any sort of training.

Personality development

The Indian programs focused on symptom amelioration. The table of behavioral and emotional observations (page 36) shows that they identified many signs of distress in clients. One ashram reported that almost all boys (98%) are asymptomatic when they leave.

Indicators of personal adjustment and well-being were also looked for. Ashram informants were eloquent, almost poetic, in their descriptions of how well children under their care were doing. They saw them as surprisingly quickly becoming healthy, happy, smiling, self-confident,

responsible, assertive, "cohesive," able to get close to others, literate, and empowered to take protective action.

The ashrams also aimed to provide education in life skills, business management, bookkeeping, agriculture, or other vocational areas. Their goal was to rehabilitate children to the point where they could not only go back to their families, but also become economically self-sufficient and be positive change agents in their communities. Sanjay was presented as a success story.

A success story (India)

When Sanjay's father died, his mother was unable to provide for him and his six brothers and sisters, so at age six, he was sent into bonded labor, to work in the carpet looms. He was sold several times until he was found by an activist who contacted CHILDLINE in Allahabad.

After rescue he was placed at the Bal Vikas Ashram. Since he could not remember the name of his village, he ended up staying there a year. With a great deal of effort, his mother was finally located and he went to live with her.

Sanjay is currently in primary school there. Through Bal Vikas Ashram's income generation project, his family got enough money to buy a cow, which provides income to the family from its milk and offspring. The family is looking forward to going further into animal husbandry and Sanjay is ready to apply the skills for daily living that he learned at BVA to earn a living and participate fully in the life of the community.

Improved conditions for employed children

Foyer Maurice Sixto described good success over the past ten years with its different approach to helping Haitian children in domestic servitude. Their work did not usually culminate in reinsertion but in improved conditions for *restavecs* wherever they were. If a child revealed that he or she was being treated cruelly, the host family received a visit from the FMS committee, inquiring how things were going and suggesting other ways of discipline.

Patrons were persuaded to allow the children to attend school or vocational training programs in the afternoon, once their work was completed. FMS provided free uniforms, a meal, and an education (which the *patrons* were supposed to do according to their agreement with the family of origin). FMS argued that it was in the employer's interest to let a *restavec* attend because the day's work would be finished more quickly by a child who had something to look forward to.

A Dutch missionary, Sister Marte Vonrompay, was working with 48 *restavecs* using the same strategy as FMS. She did not think the *restavec* system should be abolished entirely because their biological families lacked the ability to provide for the children. She worked to educate *patrons* about children's rights and encouraged the children to learn their duties and carry them out well. She informed us that the *restavecs* she had been working with were given better food, some free time, and better sleeping accommodations.[lxxxi]

Reinsertion and reintegration in the home community

The usual expectation in all countries and shelter programs was that children will go home, to parents or to the extended family. Yet this is difficult, expensive, and often may not prevent re-trafficking of children. Reinsertion as it is now practiced is considered problematic by many caregivers. One African director said that in her opinion, reinsertion was not the best outcome for the child and that she was hopeful that this study will show a better way.

Re-integration of children is profoundly difficult due to extensive gender discrimination, possible dysfunction of the original family, extreme poverty of families, the absence of women in the workplace or living independently, the reluctance of families and communities to accept children whom they do not feel that they can adequately care for, or who are stigmatized by their abusive experiences, the absence of employment opportunities, and the lack of educational provision in their home areas. Added to the difficulties of locating the family, and when found, their reluctance to receive the child back, their possible unsuitability as caregivers, and the likelihood of re-exploitation or mistreatment, reinsertion is a dubious approach to providing for children in the long term.

Ideally there would be frequent visits for a year or more to provide guidance to the receiving caregivers, to assure that the child is not being exploited again, and to activate the community to provide for and protect children. Few programs can afford this level of monitoring and intervention, especially if the child is at some distance.

Kielland and Tovo point out the difficulties of the overall process of rescuing, restoring and then reinserting the child:

> Rescue operations can be very complex in at least two ways. First, the rescuer must be prepared to take the responsibility for the children rescued, with all that is involved. Sometimes this turns out to be both more costly and more difficult than anticipated. For instance, the child's parents may turn out to be unsuitable for reunification efforts, or the child turns out to have developed conditions, such as HIV or severe psychiatric disorders, that demand great resources to be dealt with.
>
> Second, rehabilitation and reinsertion require long-term follow-up, which is both costly and difficult. Not coincidentally this is one of the most common weaknesses of many current projects. For example, evaluating a reinsertion project for children who had been intercepted during trafficking, the project team found that 80 percent of the children had been re-trafficked. Enormous amounts of money tend to be wasted because not enough attention is paid to follow-up, thus jeopardizing sustainability and wasting resources.[lxxxii]

Terre des Hommes has had twenty years of experience in *insertion*, a term they prefer to reinsertion because they do not want to put the child back into exactly the same situation. They attempt to do three follow-up visits with some 300 children a year that they return, but this

strains the capacity of the staff. For this reason, they are developing partnerships with local organizations to monitor placements. They have found that bringing a child back home is not always a happy moment, for it means that the family's decision to send the child away has been a failure: the child has been abused and exploited and they are no better off. The child may now question the decision of the parents and other adults, which is not seen as an acceptable behavior.

Terre des Hommes is now questioning whether reinsertion is a desirable goal at all. For example, in Togo, three-quarters of the trafficked children are used as domestic servants and if a child is taken away, the family or place that had the child will very likely just replace her within weeks.[lxxxiii] Instead of rescuing, they are considering the option of maintaining and improving the situation of the child in her "host family", a gentle term for the *patron*. They would try to persuade them to send the child to school, provide access to medical care, and allow communication with parents. The experience of the Haitian programs suggests that this is a viable option.

The child's role in the decision

Often the village has nothing to offer the child that makes it attractive for the child to return – no school, no electricity, no water, no employment possibilities, no strong relationships, a dead end.[lxxxiv] There are many dimensions to take into consideration and there is considerable variation from village to village and country to country.

Many children are returned against their will. John Frederick, Director of Ray of Hope in Nepal, indicates that in Asian countries the family circumstances that led to trafficking are given zero weight in the decision to return a child. In practice, children are routinely returned to abusive and trafficking families. He feels that active effort is needed, and is going on, to improve the situation.

A child expressing reluctance to return should be taken very seriously. The director of one Ashram did so on hearing the boy who cried and begged not to be sent home because "my father is a drunkard and he will send me back to the looms."[lxxxv] The plan is for him to go to a boarding school instead, depending on donations. Most projects, though, do not have the option of alternative long-term care.

As Kielland points out:

> exactly how to respect children's will is a real challenge since sometimes they have a limited understanding of their alternatives, and may therefore defend their right to stay in an unnecessarily tough situation. In addition, children are often loyal, even to abusive parents and exploitative employers. In particular, those who are used to exploitation and abuse from early on can easily be manipulated into loyalty with the wrong people. Besides, acceptance and submission is a survival mechanism. It is therefore important to stress that listening to a child should not mean to give that child sole responsibility for decisions that can be critical for his/her future.[lxxxvi]

Return of the Haitian *restavecs* to their biological families was sought by FMS for only the most seriously abused and the youngest children. Decisions to seek reinsertion were made by a

special committee consisting of the founding director, Père Miguel, the social worker and two others.

The committee went in search of the family, even if far away. They explored with the family their attitude toward the child, their ability to have the child back and what kind of help they might need to ease their situation. Just as the committee approach brought the force of the community to bear on host families, it also worked well in getting families to understand why the child should not remain a *restavec*. FMS provided the resources necessary to make sure the child would continue in school.

A successful reinsertion story (Haiti)
told by Mami Georges of Foyer Maurice Sixto

Robert, age eleven, was sent to work in a beautiful house. He was expected to sell water in the market. Once he used a few coins from the proceeds to buy something to eat. His employer beat him with a cowhide strap, which was observed and reported by children enrolled at FMS. The center staff allowed Robert to come for the afternoon meal, which assuaged his hunger.

One Saturday, when FMS was closed, he was so hungry he used all the water proceeds for food. That time he was so badly beaten that he came knocking on my door. My heart was broken. I called Père Miguel who came the next day.

We contacted the police who authorized the FMS committee to take custody. When he had recovered, we went looking for his family in Gonaïves. We discovered that the family's house was even more beautiful than the employer's house in Port au Prince. The parents said that they had thought he would have a better life in the city than they could give him. They had not understood at all what his life would be like.

We made sure they would send him to school. They were so happy to have Robert back. In gratitude, they sent turkeys and eggs to FMS.

DISCUSSION

Kielland and Tovo tackle the thorny question of whether placing limits on child employment in Africa represents a form of cultural imperialism. They conclude

> Child labor should be reduced in Africa today because it interferes with good child development and it jeopardizes economic growth. Regardless of culture, most people share the desire to raise smart and strong children that will turn into successful and responsible adults, and that is what this debate should be about. Integration of knowledge does not necessarily require dramatic cultural change.[lxxxvii]

Heavy and prolonged laboring quickly wears children out. According to Meillassoux:

> they cease to represent the seeds of the future either for their families or for themselves. ...They need to be put to work at an ever younger age. And the children themselves rarely have enough time or energy left to devote to their studies and prepare for the future.[lxxxviii]

We did not aim in this research to address the contention of some in the field of child labor that attempts to remove children from the labor force, including the worst forms of child labor, should be undertaken only if better economic alternatives exist for the children and their families. Certainly that question has been a source of debate among reformers and policymakers in modern times, even in the United States. As late as 1922 a broad coalition of child advocates in this country held that social and economic safety nets should precede legislation that set a minimum age for employment, lest child safety were to come at the expense of family starvation. Fortunately, this argument became a catalyst for relatively swift and dramatic changes in family and income maintenance policy at the state and federal level. We hope those that hold similar concerns today will make them a springboard for change internationally.

We set out to identify the needs that should be addressed in order to successfully reintegrate children who have been enslaved in Côte d'Ivoire, Togo, India and Haiti. We discovered that it was possible to identify the impact of enslavement and the worst forms of child labor for many children, but impossible to explain how these needs vary according to differences in gender, age, type and length of enslavement, or cultural factors. We had assumed a level of record keeping that was not present. In addition to complete case records, longitudinal and aggregate data would have been required to answer those questions.

Case management

We discovered that in nearly all the agencies surveyed, case management was, at best, rudimentary. The lack of intake information, the uncertainty of the role of some caregivers, and the absence of a coherent plan for each individual meant that while children were safe, they may not have been progressing as well as they might have been.

The key stages of management from intake through treatment and rehabilitation, and onward to reintegration and autonomy, can be both charted and facilitated through reasonably simple management tools. Record-keeping as a treatment and planning tool and a suggested interview protocol are provided in Appendix A. Clearly, there must be sensitivity to the emotional fragility of an abused child in the collection of their information and experiences after they have reached a shelter. However, given that proviso, from an initial assessment an appropriate plan can be constructed.

We observed a number of appropriate rehabilitative activities that might be part of an initial and ongoing plan taking place in the agencies surveyed. These included:

- child participatory activities, giving children a sense that they have some control over their own environment and activities,
- sharing time, when children talk together about themselves, sharing feelings and concerns,
- cooking and other joint maintenance work, giving children a feeling of accomplishment and caring for others,

- art, music, dance and other creative therapies,[lxxxix]
- the chance at the experience of education (in addition to the information and skills learned, education gives the child a sense of accomplishment and a knowledge of working in a group toward a planned future), and
- the chance to establish a compensatory relationship with a trusted caregiver or volunteer, helping the child to build up a healthy relationship, trust and attachment.

The need for psychological recuperation

While these activities set the stage for growth and healing, they may not be sufficient to address the emotional trauma of the child's experience of enslavement or the worst forms of child labor. Some children will require much more support to address their feelings of despair, hopelessness, fear or anxiety, post-traumatic stress disorder, stigmatization, disrupted sense of sexuality, or their anti-social behaviors. The site visits left no doubt as to the significant and complex needs of traumatized children. The table (page 36) giving the presenting or "problem" behaviors as described by program staff in shelters and rehabilitative centers, clearly shows extreme psychological and physical symptoms and needs.

Whatever the theoretical or practical orientation one might take, a child who is hallucinating or given to instant rage or expressing physical manifestations such as bedwetting or the inability to sleep without nightmares is clearly in need of intervention and support. There is, however, little consensus on what comprises effective rehabilitative counseling.

The children who were subjects of this study run the risk of invisibility or annihilation of their selfhood. Children need to be prized by someone, even if it is not their birth parent. Any kind of resilience demands that each child feels special. At the same time, it can be difficult to praise or reward individual children in a group setting. It is a challenge, but more ways to do just that should be found in rehabilitative programs serving children. It is crucial to build in each child the confidence that can only come from feeling individually recognized and cared about.

In Africa, such praise, rewards, or singling out for special mention were not done, nor did the use of such tokens as pencils or stickers as rewards seem to be a practice. The focus was on the children's problems, not their strengths.

Indian informants say that they do praise children, but it is not clear whether it is the group or the individual who wins adult approval, or what form it takes. The most potent form of praise is specific to the child's actual accomplishment or contribution, rather than general, blanket remarks or praise for having stopped a negative behavior.[xc]

Having a constant primary caregiver facilitates the feeling of being important to someone. The longer that relationship has to develop, the more powerful an agent of positive change it can be for the child. In the closeness and safety of that relationship, the child can build enough trust to begin to share something of what is inside. Children have complex inner lives, very little of which is seen by adults. It is of enormous benefit to their future adaptation to be able to experience the give and take, the warmth, the energy, and the pleasure that can come from a

close relationship with a person one can count on -- for being on one's side, advocating for one's interests, and being willing to really listen. Above all, all human beings need to be understood.

In considering the term *psychosocial recuperation* of exploited children, one must consider the great divide between cultures that think of mental health as it relates to the separate self, and cultures that have more of a socio-centric view of the self. Individualistic psychotherapy promotes self-exploration and insight; the collectivist point of view tends toward harmony, integration into the family and other primary groups.[xci] This study has attempted to point the way to understanding how culture influences therapy, or the type of interventions deemed useful and appropriate in each country studied. But it must be understood that everything examined has been seen through the lens of someone trained to see children as separate encapsulated selves.

The individualistic model of psychotherapy was not apparent in the programs visited. In these more collectivist societies, where the family, especially siblings, the clan, and the village have more salience, children have weaker ties to the birth parents. Raising a child is more of a group project, and if the group becomes weakened by loss of leadership, civil unrest, internal conflict, economic desperation, or natural disaster, children become more vulnerable.

Collective approaches

Those interventions that have the effect of strengthening groups are most culturally appropriate. Almost all programs relied on some kind of group work. There were topical discussions, social learning groups, unstructured opportunities to chat, problem-solving, peer mediation, and even therapy groups, where children were expected to tell what had happened to them, though not to discharge intense feelings.

Many programs also offered parent groups and expected their participation. In Togo, PLAN-sponsored group work occurs in villages, with community organizers helping residents to form clubs to promote child protection and to prevent trafficking. The PLAN youth radio station program also involves and reaches out to whole communities.

Children are further helped to feel a part of the group through the regular incorporation into their day of unison expressions, such as chanting a welcome for outsiders, singing, praying, and recitation. In one such ritual at Bal Vikas Ashram, boys raised their fists as part of a song concerning their rights as children, and concluded by shouting slogans in unison that called on government to end child labor and for children to stand up for their rights. Another positive inspirational song written by the director of a recreational program was sung at the start of every gathering. Such unanimous activities served to create coherence and solidarity, and to draw in children who are more inhibited or shut down.

Children were also given jobs to do, reinforcing their early learning that they are duty-bound to participate in daily chores. In all centers, boys and girls equally had regular responsibilities for such things as keeping their area tidy, doing dishes and laundry, helping in the kitchen and assisting other children. One center expected children also to earn a little money out in the market. Sometimes it was important for children to contribute to their own support or find a

way, directly or indirectly, to pay back the center after they left. These practices helped children to feel good about themselves by contributing to the good of the community.

Individualistic approaches

So far this discussion has focused on some ways of helping children in accordance with the psychosocial care model described above. We turn now to how more individually-oriented approaches are put into effect -- the Rohner model of parent-child relationships and the Herman model of the effects of trauma. How relevant are these theories to the cultures of the two African countries, India or Haiti? In these cultures adults are more apt to pay attention to outward behaviors than to explore the interior life of the child.

There is some basis for believing that feelings are intricately linked with behavior: "Change your behavior, and you'll feel better." The implication is that it is too time-consuming and difficult to reconstruct the damaged insides; stick with what shows. What, however, does this allow for the consideration of internal psychological damage? Research has revealed that rejected children show a consistent constellation of negative personality characteristics, regardless of culture, though other factors may also be explanatory.[xcii] Two decades of work on the effects of trauma make a persuasive case that children who are traumatized are harmed in long-lasting ways. And these effects damage their personal relationships and standing in the community.

> Socially divisive forms of psychopathology invariably bring the individual into positions of conflict with group mates and lead to social isolation, retaliatory punishment and violence, and/or banishment. The result can be misery and suffering for the person showing the "psychopathology" as well as impaired biological fitness. And although many individuals who show such behavioral pathologies may have been abused, exploited, and generally mistreated (and their behavior the result of this), their sense of suffering and misery is often screened and concealed. Frequently, it is not easy to erase the impression that the 'afflicted persons' are following selfish interests, pursuits, and social agendas.[xciii]

The emphasis in the African and Indian programs appeared to be on conformity. Although many programs in these countries say they are fostering children's creativity through art projects, dramatic enactments, song, dance, and story telling, even in these creative areas, there are the telltale signs of working from a scripted template. Some examples were observed:

- When given drawing materials, children copied the clown on the crayon box or copy each other.
- A child was told what to draw by an adult, and then told whom the figures represent.
- A costumed performance for visitors was, for the most part, like an Indian version of a chorus line, with children all doing and chanting the same thing.
- Puppets were used didactically.

- No spontaneous pretend play was observed, nor were any toys in evidence that would lend themselves to that genre of activity so common to young children elsewhere.
- Fifty-five toddlers of working mothers were walking around in a day care center gazebo without anything to play with.

It is important to recognize that there can be a tension between social conformity and helping the individual child recognize and name his feelings, or have a strong sense of personal identity and boundaries. The membrane between individuals is thinner, more porous, in collectivist cultures.

Nevertheless, it is the individual who is hurt. The physical pain of being beaten, being cut by scissors, having fingers burned, hands smashed, vagina invaded, or the psychic pain of being criticized, humiliated, ignored, yelled at, or being given away accumulate in the recesses of the child's spirit. Intense pain is not forgotten. If it does not have a way to come out in the context of a benevolent relationship, it festers and corrupts the health and integrity of the organism. It gets sealed over with defensive layers installed by the mental gatekeepers of the psyche, and even foreshortens the life of that being.

Ongoing questions

A series of questions and issues that came up again and again have yet to find an initial consensus, much less a resolution. Specifically, we would point to these questions and issues:

- Understanding the child: how children feel, think, communicate and express their needs, and the caregiver's conception of the child and childhood.
- The nature of the role of the caregiver and other adults, how much "guidance" is needed in the healing process as opposed to the innate healing capacity of the child if allowed to live in a safe and supportive environment, including balancing the autonomy of the child against the authority of the adult.
- What is actually meant by *rehabilitation*, what the child's role in the healing process might be, what the role of counseling is, and what other important forms of support and care exist.
- How best to achieve reintegration: how to determine if it is appropriate in any given case, how to link repatriation to a child's right to decide his or her future, how to define and support the roles of the community and the family in reintegration.
- How we might engender professionalism and a high quality of care in contexts of significant shortages in economic and human resources.
- Challenges that reflect the cultural and socio-economic context: gender and caste; tribal, ethnic or class discrimination; stigma and discrimination against the sexually abused; and how to build for economic autonomy in an environment lacking opportunities and options.

We cannot answer all of these questions or resolve all of these issues, and we note that in the literature we found that other researchers were also calling for more extensive -- particularly longitudinal -- research in hopes of finding consensus on these issues.

Yet we saw first-hand remarkable individuals doing their best in difficult situations to help previously enslaved and abused children into healing and rehabilitation. From them we can distill a clear set of key themes and recommend appropriate and necessary actions, with some additional suggestions.

RECOMMENDATIONS

Key Theme: The setting for rehabilitation must provide safety, basic needs, and predictability, in a secure environment with opportunities for learning and play.

NECESSARY ACTION: All facilities serving formerly enslaved and exploited children should assess their ability to provide such a place. Clear and agreed-upon standards of care and reintegration should be established.

Key Theme: There is a distinct need for a case management system that includes recording the physical and emotional condition and needs of each child, monitoring the child's progress, and bringing to bear a coherent, consensus plan for the child's recuperative process.

NECESSARY ACTION: Staff training in assessment, case planning, appropriate roles and responsibilities, and record keeping will underpin a workable case management system.

SUGGESTION: Assessment should include a method of estimating a child's level of development and psychological status. (See Appendix A.)

Key Theme: Across the developing world, there is a significant shortage of both trained personnel and opportunities for staff training for agencies aiming to meet the needs of vulnerable children.

NECESSARY ACTION: Build up the human resource capacity of agencies, including the range of skills of all staff. More mental health practitioners trained in trauma recovery are particularly needed.

SUGGESTION: Short informational booklets about child development, the effects of trauma and rejection in simple language should be widely distributed among caregivers, parents, and community organizers.

SUGGESTION: Many manuals giving useful guidance on particular aspects of rehabilitation are now in existence. A simple manual on the rehabilitation of slaves is soon to be available from Free the Slaves. These manuals should be made available in appropriate languages free of charge to all relevant programs.

Key Theme: Children who have experienced loss, trauma, rejection and/or exploitation tend to have serious physical and emotional difficulties. They are best helped by compensatory relationships in which they experience warmth, trust, support and guidance.

NECESSARY ACTION: In the hiring process, screen candidates for capacity to work with children in a positive manner.

SUGGESTION: Child care shelters should make every effort to assign a single "go-to" person for each child, and to put in place structures that facilitate this relationship, including a way that they can stay connected after the child leaves.

SUGGESTION: Train staff to promote positive relationships among age-mates, by specifically teaching conflict resolution skills, the effect of one person's behavior on others, and culturally appropriate pro-social behavior.

Key Theme: The form and nature of the rehabilitative process must be located within the cultural and social context of the child. While increasing the capacity of agencies to provide rehabilitation and reintegration requires the establishment of structures and protocols applicable to all service providers in all countries, it also requires bringing local knowledge and practices into the rehabilitative process.

NECESSARY ACTION: Use materials that are universally applicable and based in the common needs of traumatized children everywhere, but adapt them to the local culture.

Key Theme: Reintegration is a considerable challenge, and its complexities must be addressed at the community level.

NECESSARY ACTION: Support community-based reintegration activities such as preliminary screening of families for willingness and suitability; making clear the need for strong family and community involvement; creating an "exit strategy" for the child at the start of the rehabilitation process; and providing favorable conditions for the child to return to, including economic support and educational opportunity.

NECESSARY ACTION: Carry on dialogue with communities to understand and identify solutions. It is not that the community does not know the risks to their children, but they do not necessarily appreciate the consequences (physical and moral) of these risks and hazards, or they may be conscious that the risks and hazards of remaining in the community could be worse. There are a lot of unspoken stories and taboos within a community and to engage them through a lengthy dialogue allows some of these taboos to break down. Communities are then in a better position to make appropriate decisions for their children.[xciv]

SUGGESTION: Provide training for income-producing activity with consideration of whether the skill is actually going to prove useful and ensure a livelihood. If there is already a surfeit of seamstresses, hairdressers, embroidery workers, or auto mechanics, children will have a hard time competing with adults who have established networks. The child then becomes a further drain on the community rather than adding to its economic viability. Other types of income-generating activity, especially those that do not rely on local customers, will serve the community and the child better.

CONCLUSION

We found that while levels of commitment, dedication, and energy were high, the general capacity for physical care and psychological rehabilitation of dramatically abused children was low across nearly all agencies. While some trained psychologists were available in some instances, few agencies had access to such professionals at all times. Moreover, while some materials are emerging to help, these are primarily directed at the "upper" or individual counseling end of the rehabilitative process.

However, from the success of the mother-figure in Haiti and other examples, we know that rehabilitation can be fostered at many levels within an agency. To that end, training is needed across agency staff in such areas as intake and information collecting, case management, social work, art and recreational therapy, nutrition and exercise, rights-based education, life skills development, guidance and life planning, family interventions and the fostering of peer activities.

Building standards of caregiving

We find that all agencies we visited are understandably doing better in some areas and worse in others. There is no perfect service provider, no agreed-upon perfect model for care and rehabilitation, no "magic bullet" to meet the needs of abused children. For that reason we look to the further elaboration and dissemination of basic standards of care for the rehabilitative process. John Frederick states:

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

Standards must be developed through consensus and conversation within the context of care, and including NGO and agency staff and directors, caregivers, experts in psychology, medicine, nutrition, exercise, law and social work, government representatives, donor representatives and the children themselves. At one level they are aspirations, but they are also more, for they are the baseline of protection for children who have already been harmed.

-

While we recommend that local cultural practices should be integral to the rehabilitative process, they cannot be allowed to overturn certain fundamental standards in care, such as prohibition of physical or corporal/psychological? punishment or any action that would deny the rights of the child. Frederick has outlined standards applicable to care for children who have suffered the worst forms of child labor:

> **Principles for the Child**
>
> - Basic human rights (genuine participation, privacy and confidentiality, right to family, and many others),

- Facilities and interventions are child-centered,
- Each child is provided individual case management,
- Children have access to the outside world, and
- Interventions are culturally appropriate.

Principles Guiding Care

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

Principles Guiding Basic Activities of the Rehabilitation Process

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

Kielland and Tovo, in grappling with the limitations of the current rescue, rehabilitation, reinsertion approach in Africa conclude:

> The prospects for "rescued" children are typically not good, especially in the long run, and evaluation reports have yet to identify the "right" approach on rehabilitation. The only element that seems to be a common denominator for successful projects is to have highly committed people involved...A good project worker is available to the traumatized child...24 hours a day and over a period of several years, and he or she feels a profound commitment to protecting and rebuilding the dignity of the child.[xcvii]

The commitment to protecting and rebuilding the dignity of the exploited child was abundantly evident in all the programs in this study. Again and again, those who have taken on the difficult work of restoring children to physical and psychological health spoke with compassion and understanding about the needs of their young charges and concern for their futures. A great many people are doing what they can, but there are not enough people and resources yet to provide for all the children who need help.

AFTERWORD: APPLYING WHAT WE LEARNED TO THE USA

by Marc Levin, Free the Slaves

One of the greatest challenges of conducting research in which social scientists from the Global North descend upon the Global South to observe and analyze a complex social phenomenon is to identify and account for the effects of culture upon *every* phase of the investigation. The history of developed-country interventions, be they nation-building, military, economic development, public health or even humanitarian relief, is rife with costly errors and injustice. When one ignores culture, opportunities abound for "getting it wrong."

Another challenge rarely met today is to search for insights that cross cultural boundaries. Some solutions to social problems that at first glance appear bound to a particular culture may, on closer inspection, contain the answer to the same problem that exits in very different cultural setting. We found this to be true throughout the study. The Global South has plenty to add to what Americans do successfully to rehabilitate and reintegrate child slaves and other youngsters who bear the open wounds that severe trauma inflicts.

We kept this challenge in the forefront of our thinking from the moment we drafted the proposal for this research project. We traveled to Côte d'Ivoire, Haiti, India and Togo determined to learn and assess what organizations are doing to rehabilitate and reintegrate former child slaves using a lens that would allow us to see the roles that value systems, worldviews, patterns of communication and relationships, and institutional and legal systems play. It did not surprise us to find that culture accounts for some differences, a few of them profound.

At the same time, we discovered some striking similarities between the study countries and the United States in how we think about the needs of traumatized children, what may work in restoring their lives, what stands in the way of success, what else we must learn and what should take place in the public policy arena. We raise some examples here, in part, to lessen the skepticism of many that solutions to difficult social problems can be applied successfully across cultures. More important, though, we hope this investigation will fuel the kind of international dialogue that generates powerful and definitive answers to questions like those that follow.

How effective are short-term interventions?

Many of the sites we visited reported that children in their care made dramatic social and psychological gains in a brief period of time, often less than one year. Until very recently, most mental health providers in the United States and Western Europe would have been incredulous.

The prevailing view since the 1920s, when the West first began to recognize and respond with psychosocial interventions to the needs of maltreated children, has been that it takes years to eradicate the effects of severe and prolonged trauma. Until the 1970s, this view shaped the training of mental health professionals and largely determined the design and financing of government-supported mental health and social service systems. Though far from dead or

seriously discredited, long-term models have given ground slowly over the past three decades to short-term approaches to treating all kinds of psychosocial problems.

Research into the efficacy of all forms of psychotherapeutic intervention and why they do or don't work for different populations is not definitive and has been controversial. But overall, the evidence that short-term interventions can be very helpful in treating trauma victims has been strong enough to make mental health educators incorporate them into the training of psychiatrists, psychologists and social workers. The promising results of new short-term interventions have also captured the interest of insurance companies and U.S. policymakers. Not surprisingly, government support for long-term mental health services is on the decline. Even less surprising, insurance companies have moved even more decisively to limit coverage for mental health benefits to acute care and stabilization .

In the countries we studied, public resources are so scarce that there is not much debate about whether short-term treatment can produce long-term benefits. There also appear to be no cultural barriers to implementing psychosocial or psycho-educational programs. We believe that we can learn a lot from the Global South's ability in certain circumstances to do a lot with a little in a short period of time. Further research on this is important.

Who can provide services?

As we prepared the *Guide To Decision-Making* (see Appendix A) we realized that the people we saw delivering services to children in the four study countries could make important contributions to current debates within the United States over who is qualified to deliver what kind of services to traumatized children. Though our *Guide* suggests a series of questions and interventions that caregivers with little or no prior training can use for crisis intervention and treatment planning, we recognize that some of what they already are doing to help children formerly in slavery or other worst forms of child labor must be responsible in part for the successes they report.

Residential treatment centers for children in the U.S. have always relied on people with little or no professional training to care for traumatized children. If you consult the institution's organizational chart you will see that they are working "under the supervision" of a credentialed mental health professional. But in fact they are the people on the front lines and are often called upon to make critical clinical decisions when the supervisor is at home sleeping or on weekends and holidays when the professional staff may on call but hard to reach.

Thus we have a curious contradiction at work in the U.S. On the one hand graduate-level training has been the minimal requirement for making critical and nuanced decisions about both crisis and long-term treatment of children who have been severely damaged. On the other hand, staff members who have much less professional training and, in some instances, none at all, are faced with providing minute-by-minute care. In some community settings the same dynamic is at work. Professional social workers may set care plans, but foster parents often are the ones that implement them.

As public resources and reimbursements for mental health care continue to shrink and the number of professionals who limit their practices to the private sector increases, the debate in the U.S. over who can and should do what becomes even more critical to resolve. Some research to date indicates that un-

credentialed providers can take on some of what had previously been deemed beyond their competence. But there is little agreement about the type and duration the training needed to give them the skills and ability to discern what to do and the kind of oversight needed to ensure that any risks to the children they treat are minimal.

Caregivers in the countries we studied, by necessity and in most cases de facto, have had little opportunity for debate. Further research into what they are doing well with and without credentials will help both the Global North and the Global South in restoring formerly enslaved and other traumatized children to the childhoods they deserve.

What makes for successful reunification?

The facilities we studied report mixed success and growing ambivalence about returning children to their birth parents. However they believe that, in virtually every case, it is in the best interest of the children to eventually place them in a community where they can thrive. Most caregivers in the United States share the same perspective. The question is when to do it and under what conditions.

In the United States the criteria for unification usually involve a parent's financial stability and gainful employment, (though recent court decisions have, based on sound research, severely limit those criteria from being used in decisions to *remove* children from parents.) If financial means were a test for reunification in the countries we studied, few children would ever live with their parents again. Our study did not include gathering data on how well children fare when they return home. Comparing what makes for a successful short- and long-term adjustment in the Global South will help solidify the basis upon which traumatized children should be reunited and what needs to be done to prevent re-victimization.

How can local communities aid in rehabilitation and prevention?

As services to traumatized children became professionalized in the United States, support for children at the community level began to decline. Though other factors also contributed to the decline in collective aid at a neighborhood or village level, "civilians" increasingly made their contribution to the welfare of children by dutifully paying their taxes. Recently the trend has begun to reverse. State and county child welfare departments, prompted in many cases by federal funds, have been reaching out aggressively to widen the circle of concern and services for children in trouble of all kinds, including youngsters suffering from the effects of severe trauma. It is not uncommon now to see schools, law enforcement, recreation programs, neighborhood associations, community centers religious congregations, Kiwanis Clubs and Chambers of Commerce involved as volunteers in formulating and participating in aftercare plans to help youngsters thrive at home.

Once again the Global South has a lot to teach us about how to do this and do it effectively. Our work with Free the Slaves in supporting grassroots antislavery groups in Ghana, Haiti, India and Nepal has shown in dramatic fashion what local, non-professional people can do, with little or no money, to prevent trafficking, generate resources that lead to stable and empowered communities, make reluctant governments accountable for removing children from slavery, and

taking children whose lives have been shattered and mentor them from victim to human rights advocate. We need to know more about how they do it and do it so well so their success can be translated and implemented effectively throughout the developed world.

How can governments of the Global South and Global North work together to prevent child slavery?

Slowly but surely, governments throughout the world are awakening to the problem of child slavery in their own country and to the fact that our modern global economy contributes to the supply and demand for child slaves (and adults, too). Antislavery activists, some of the same people who are running the facilities we studied, are beginning to link up. They are concerned with pooling resources to rescue and rehabilitate former slaves and strengthen communities to resist and repel traffickers who take their children. In just the past year, Free the Slaves' partners in South Asia have decided that it is time to move in concert to enter the policy arena in their own states and countries to eradicate slavery and restore its victims.

But efforts on the supply side address only one half of the child slavery equation. What countries are doing on the demand side, where slave-made products are consumed, is the other half. It will take bilateral and multilateral commitments to solve the problem. We know of no compelling research that analyzes the circumstances under which economic, social and political benefits would accrue to governments that work in concert to stop child slavery at both its source and destination. Once governments are convinced that it is in their interest to stop slavery, rehabilitation will no longer be necessary.

APPENDIX A

GUIDE TO DECISION-MAKING IN THE CARE OF CHILDREN EMERGING FROM THE WORST FORMS OF CHILD LABOR AND OF SLAVERY

When children emerging from enslavement, the worst forms of child labor, or commercial sexual exploitation arrive at a care facility for protection, stabilization and, eventually, reintegration into a community, the caregivers face a daunting task. They must provide services to young clients whose lives have been shattered and whose needs are vast and complex — and do so with very limited resources and, in most cases, very little training. The regrettable fact is that these children cannot wait for a perfect crisis intervention and stabilization system, so we have focused on interventions that are not highly resource dependent.

Over our decade of work on modern slavery, service providers have made it clear that they are looking for practical tools and guidance. Reviewing the existing intervention literature, we were struck by the likely value of a simple guide focused on the immediate actions needed in the first "make-or-break" weeks after children arrive at a shelter. That critical period will most likely determine the extent and quality of their long-term recovery.

Several colleague organizations have been generous in sharing their work, and we have drawn especially on the ECPAT *Training Guide for The Psychosocial Rehabilitation of Children who have been Commercially Sexually Exploited,* and the ILO-IPEC *Child-friendly Standards and Guidelines for the Recovery and Integration of Trafficked Children*. These, however, place major emphasis on the lengthy multi-faceted processes of rehabilitation and community integration.

With this guide to decision-making, Free the Slaves intends to add significantly to the knowledge of what providers must attend to immediately, so as to make the rehabilitation process to take hold later on. The guide should be seen as a starting point rather than a finished product—a first step toward a fully field-tested tool. We welcome feedback both from organizations working with children and from other researchers.

There are few "if/then" propositions among the interventions we propose. In the case of the first two sections, *Establishing a safe living environment* and *Physical care and health,* each action stands alone and need not be part of a series to achieve its crisis-reduction and stabilizing effects. The third section, *Psychosocial assessment,* was developed with awareness of most caregivers' lack of formal mental health or social work training and the absence of experienced clinical professionals in the areas where most slaves are freed. Traumatized children present complex clinical challenges. Yet even in countries where social service and mental health care systems are well-developed, foster parents, group home staff, shelter workers, and others with limited formal training are relied upon to provide frontline and critical therapeutic care.

We see the highly dedicated people we interviewed as possessing the same capabilities. Thus, the interventions we have suggested that they undertake as part of their psychosocial assessments are indeed therapeutic in and of themselves, and carry little risk to the children sitting before them in tremendous shock and pain.

1. Establishing a safe environment

Children who have been enslaved or who have suffered the worst forms of child labor should be placed in a child-friendly environment that protects them from further abuse by those who have exploited them, potentially including some members of their family, the media, community members, and abuse from staff or visitors to the shelter. Children must feel that the environment is one that supports them, not one that is punishing them.

- A child who has been enslaved, trafficked, or subject to the worst forms of child labor should not be held in detention at any time.

- A child should not be held in an institutional care facility inappropriate to their age and needs for an indefinite or extended period of time, unless there is no other alternative.

- If there is an immediate external threat to the child from any person who might attempt to find the child while in care, the child will need to be moved to a place of safety.

- Each child should be protected from all forms of neglect, physical and psychological abuse (including verbal abuse) at all times, and treated with respect.

- The child's sense of security should help inform security measures. For some children the presence of walls and barriers is reassuring; for others, security provided through the people caring for them, rather than through bars on the windows, reduces their sense of being incarcerated.

- Each should have their own bed or sleeping area and, if resources permit, separate areas for eating, sleeping, studying and recreation.

- The child should be able to influence their environment in some fashion. For example, children should be allowed to decorate designated areas of the facility.

- A child should have access to legal help, especially to prevent deportation or being charged with crimes related to trafficking and, later, for filing a criminal and/or civil complaint against the trafficker or person who held the child in forced labor.

- Children should not suffer discrimination on the basis of age, sex, nationality, race, language, religion, ethnic or social origin, birth or other status.

- A child's right to privacy should be respected and protected at all times.

- Each child should be made aware of their rights as well as their responsibilities within the shelter and within the larger community.

- Children should be provided an orientation as soon as possible to the facility and have the way of life and routines of the shelter home explained to them.

2. Physical care and health

- If seriously ill or injured, the child must be taken for medical or psychological treatment immediately. Following this, if further treatment is needed, a written plan should list the actions that staff need to take to arrange such treatment.

- All children will need a full medical evaluation as soon as possible, including dental and reproductive health. In many cases they will require ongoing medical care. According to UN guidelines, the child should not be subject to mandatory HIV/AIDS testing. Ensure the child's understanding of and consent to any medical tests that are needed.

- The child will need healthy, nutritious food and clothing that is appropriate to the climate and to their daily routine.

- Many of the children will come with disabilities and special needs that must be attended to. These include high levels of agitation, fear and distress despite all attempts to comfort them, chronic pain, severe withdrawal, hallucinations, and great difficulty in making themselves understood or even in speaking. Pregnancy will entail heightened anxieties.

- Many children will show signs of treatable malnutrition. These include being underweight, night blindness, chronic fatigue or an inability to focus their attention.

- Proper light, heat and ventilation are important to building and maintaining the child's health.

- Children need opportunities to make friends, learn to live and play cooperatively with other children, and to engage in regular physical activity.

3. Psychosocial assessment

From the moment that the child arrives at the facility, caregivers must begin the process of assessing the child's condition and needs. Information collected at this time will be crucial to planning the care and rehabilitation of the child.

At the same time, it must be remembered that a child who has suffered extreme exploitation may not be able to clearly explain their needs or their experiences. Time will be needed for the child to come to trust caregivers, and ideally a familiar, warm person (addressed here as 'you') will work closely and reassuringly with the child through this process.

The overall assessment will take at least two weeks, and possibly as long as a month.

Basic considerations:

- Begin to assess and record the child's condition and needs as soon as the child arrives at the facility.

- Make sure that you respect the privacy of other children by not attaching names to examples of what other children have told you.

- Tell the child why you are gathering information and what will be taking place in terms of his care during the time the child will be staying at the facility.

- Determine if the child knows their name, age, family and place of origin, as well as the conditions and locations in which he or she was held against their will and forced to work.

- Do not rush or pressure the child to give information. Help the child to feel comfortable and collect information at the child's pace. If the child becomes distressed, give the child the chance to stop for the day and reassure the child that you will keep him or her from becoming frightened or overwhelmed.

- Encourage the child to voice their own preferences, wishes and plans for the future and to ask questions. This should include trying to get an understanding of the likely safety of returning the child to their family, and whether it is safe to contact their family with information about the child's presence at the facility. At a later stage, it will be important in most cases to meet with the family and community to determine whether returning home is the safest and best option for the child.

- Collect and record facts and evidence about traffickers, other exploiters and all crimes committed against the child.

- If at all possible, have those conducting the assessment be of the same cultural background and able to speak the child's preferred (native) language. If not, provide interpreters who are trained and experienced in dealing with child victims of trafficking.

The interview itself:

- Before interviewing the child, in order to get the fullest, most reliable answers, take plenty of time to make the child as comfortable as possible. One way to increase the child's comfort level is to do an activity that requires no response, such as showing a picture book or how something works, or chatting about other children and their experience at the facility.

- No two children who have been through the worst forms of child labor or slavery have reacted or been affected exactly the same way. So, you may need to try more than one way to gain their trust and participation. For example, some children become very anxious with eye contact or physical contact. Other children find gentle touching to be comforting. Use a relaxed, soft voice.

- You will want to know about and record as much as you can about the following:

1. The child's level of fear, anxiety, sadness, agitation and inhibition.

2. Problems they have with thinking clearly and paying attention.

3. The ways in which the child relates to others, whether hesitantly, aggressively, fearfully, overly affectionately, or perhaps not at all.

- Set a context for your questions. For example, you can say that sometimes children who come to the shelter tell you how they feel and that doing so helps them to feel better.

- You can further help the child to talk about him- or herself and ask you questions by telling them some of the things that other children have told you and say that you wonder if some of them are true for him or her too.

- Once the child is relaxed and feels safe, he or she may tell you a lot of what they are feeling without your having to prompt them.

- What they have to tell you may take many interviews to come out. As they develop trust in you, they may feel more able to give you an accurate version of what happened.

- Write down as much as you can after the interview. It is helpful to review those notes before you start the next session with a child.

Encouraging children to talk about feelings

Here are some examples you can give of what other children have sometimes told you. Remember not to rush or feel you have to include everything on this list.

1. I get scared often.

Explore whether the child is still scared or less scared since they came to the shelter. Explore what they are currently scared about and reassure them that they will come to feel better.

The following can be used in a similar way.

2. I feel like talking to the other children.

3. I feel like eating meals.

4. I cry or feel like crying every day.

5. Sometimes I get so angry I might really hurt someone or something.

6. I have trouble sitting still.

7. I don't like to be around adults.

8. I have trouble understanding what people are telling me.

9. I have very strange thoughts and dreams that scare me sometimes.

10. I go to sleep easily at night.

11. I am a good person.

12. I expect my life to get better.

13. Sometimes I think it would be better if I were not living anymore.

14. I have to watch out all the time to protect myself from others.

15. I can't stop worrying.

APPENDIX B

CHILD CARE PROGRAMS AND ORGANIZATIONS CONTACTED

Agency and informants	Population served and nature of center	Services offered	Ages and numbers of children served, and staffing	Additional notes
Côte d'Ivoire				
MESAD (Le mouvement pour l'education la santé et le developpement) Kouassi Konan, President Ake Michael, Psychologist	Shelter for children engaged in professional training or attending school Drop-in centers serving Street children Orphans Children in conflict with the law Poor children 1500 children served in 6 years, mostly boys ages 10-17	Shelter 6 neighborhood clubs and listening centers Psychosocial support Medical care Apprenticeship support Computer training Socialization Reinsertion	1500 children in 6 years, mostly boys ages 10-17 44 staff of which 12 volunteers, 27 paid, 5 contracted	They would rather not have girls but there is nowhere else for them. Psychologist was conducting staff training.
BICE – Côte d'Ivoire (Bureau international catholique de l'enfance) Director	4 centers and 4 projects for Street children Abused children Girls in domestic servitude Living with mothers in detention Handicapped Victims of war	Shelter Apprenticeships Psychosocial support Medical care Legal aid Schooling Recreation Reinsertion	In 2002, several thou children 49 paid staff, including 2 psychologists. Also 12 volunteers, 9 interns	
BICE – Centre Sauvetage Psychologist Project Director	Trafficked children Sex abused Runaways Forced marriage Child soldiers Domestic servants Lost children	Shelter Psychosocial support Medical care Reinsertion	50 in residence Drawn from the staff of BICE center above	Minimum equipment
Soeurs Salesiennes de Don Bosco Soeur Vicky, Project Director of the center	Girls: Abused Street children At risk Parents unable to provide for	Shelter Literacy Schooling Vocational training Sports, arts Socialization Reinsertion	30 beds for girls ages 9-15 Neighborhood children use play facilities after school 22 nuns living in the compound Each girl has a *tantine*	Clean, tidy, attractive milieu, warm ambiance

HOPE Worldwide Project of International Churches of Christ Lucille Konan, Director Ekrakou Romain, Educateur Nina Toyo, Sunday School Coordinator Julien Toyo, Accountant	Orphans Children affected by AIDS	AIDS prevention Psychosocial support Neighborhood support groups (Club des Amis) Home visits Food distribution	1000 per year ages 5-17	Special training in active listening, good at getting children to open up
CEIJA (Centre d'écoute et d'insertion des jeunes d'Adjame) M. Phillipe, Director Educateur	Neighborhood children Some adults	Employment referrals Consultation Recreation	Unknown by agency Director, psychologist, educateur, comptroller	No place for counseling Barren 3 old video games
Togo				
WAO Afrique Centre Esperance Cleophas Mally, Director Dede Houedakor, Center Coordinator	Short term transit center Trafficked girls Victims of abuse	Mediation Recreation Reinsertion	100 girls per year ages 6-17 Coordinator Social worker Social work assistant Nurse Two cooks Gardener Guard Psychologist once a week	
DGPE (Direction générale de la protection de l'enfance) Bossa Salimatour Bonfoh-Ali, Directrice, Child Protection	Trafficked children	Short-term hostel Literacy Apprenticeships Sensitization of family Reinsertion	55 boys per year staffing unknown	Government agency directly involved in child protection work
Terre des Hommes Centre Oasis Frederic Baele, Togo Delegate Prof. Gnansa Djassoa, Psychologist	Trafficked children Abused Runaway Lost	School on site Apprenticeships Reinsertion Follow-up	775 children in 2004 ages 0-18 17 educateurs and social workers doctor child psychiatrist nurse administrators	

CAJED (Comité d'aide aux jeunes en difficulté) Boniface N'tapi, Coordinator	Street children Porters	School fees Apprenticeships	9 boys ages 8-14 2 paid(?) staff	Children come and go freely
Centre la Providence Soeur Pascaline, founder and director Educateur	Shelter and day program Sex workers	Shelter Vocational training Health and sex education Literacy	25 girls in shelter 10 in day program ages 12-17 8 staff who work in teams of two to do outreach on the street	
AD – Togo (Action développement) Tsevi Adomayakpor, Executive Secretary Edwige Kuwonu, Project Coordinator	Trafficked children Street children Children in conflict with the law	Literacy School fees Vocational training Loans to parents Group work Neighborhood action Reinsertion	30 per year two on-call volunteer psychologists nurse	Parents' school. Conducting needs assessment of the Quarter. Selling weavings and liquid soap
PSI – Togo (Population Services International) Soeur à Soeur program Marie Yawo, Project Coordinator	Drop-in program for girls Sex workers	Creative activities (pottery, bead work, drama) Vocational training Domestic arts Medical, STD, HIV testing Day care for babies	50 girls per week for activities Ages 10-24 14 per month for professional training 4 paid staff 8 volunteer *animatrices* On-call psychologist	
CLORED (Centre de loisirs et de reeducation pour les enfants) Ben Koami Dewouna, Executive Director Two educateurs	Shelter Street children	School on site Group work Apprenticeships Reinsertion	Ages 6-17 2 teachers 2 assistants 2 guards Sub-office head Assistant Psychologist Doctor and gynecologist on-call	Signed contracts required. Want child to repay either directly or indirectly by supporting apprentices
BICE Franck Aziakh, Project Director Alda Segia	Residential center Child porters Street sweepers	Mothers' group Home visits Sex education Loans Skills training reinsertion	25 porters 12 girls, ages 14-18 Several animateurs 4 child care social worker psychologist	Advocating laws against use of child porters
AIDES (Action international pour le développement	Shelter Street children Orphans	Outreach Lunch for non-residents School fees	27 children, ages 6-17 18 this year	Good play area.Teacher from another program was

économique et social) Espace Fraternité Chile Mack Adodo, Executive Director		Medical care Reinsertion	Educateurs Psychologist bi-weekly	leading session with mixed age group before lunch.
2M FEED (Mission mondiale pour la femme et l'enfant dèsherité) Odile Sessou, Présidente	Shelter Orphans Abandoned Abused Extreme poverty	School on site Adoption Religious education Reinsertion	20 children, ages 2-16 Volunteer sociologist, Night time resident	Supports center through her couturier business
ANGE (Les amis pour une nouvelle generation des enfants) Gabriel Kossi Amouzou, Executive Director M. Klake, Animateur	Drop-in center Street children Jailed children	Schooling Twice weekly drop-in recreation Getting children out of jail and into project	Not clear President, secretary, treasurer, 6 animateurs	Executive Director had advanced training, including active listening
UNICEF Farida Noureddine, Child Protection Officer	Interngovernmental agency. Current priorities: Trafficking, AIDS, sex abuse, violence			
CARE Claudine Nensah-Awute, National Coordinator	NGO Priority: Trafficking			
PLAN Bel Aube Houinato, Director of Programs Stefanie Conrad, Country Officer	NGO Political action Working to establish minimum standards of care			Ten-year plan: Healthy start Learning for life Protection of the child
India				
SARC (Social Action and Research Centre) Ranjana Gaur, Director Aparna, Coordinator	Shelter and community program Women and children survivors of domestic violence, slavery in domestic work, and forced prostitution	Rescue Legal aid Counseling Shelter, food, clothing Medical care Education Human rights training Vocational training Job search Family reunification Awareness raising Women's community organizing against violence	65 children ages 2-17 over last two years Team of volunteers to do case work and field work	Small, informal Children lodged with director

		Training of police and other justice officials and NGOs Research and documentation		
Bal Vikas Ashram (run by Diocesan Development and Welfare Society) Rajneesh Kumar Radev, DDWS TIP Uttar Pradesh State Manager	Shelter Boys, mostly enslaved in rug weaving Other industries: sari making, brickworks, hotels, shops, railway station, begging	Rescue Legal aid, securing compensation Shelter, food, clothing, Medical care Counseling Education Human rights training Vocational training Family reunification Preventive work in home communities Awareness raising in destination communities of trafficked children	336 children since 2000, license for 60 beds 69 boys ages 6-17 rescued in last 6 months 13 paid staff: manager, supervisor, coordinator, 2 teachers, 3 vocational trainers cook 2 gardeners, guard, driver	Emphasizes work with receiving community
Mukti Ashram **Balika Ashram** Suman, Director Consultant	Shelter Bonded laborers formerly engaged in rug waving, domestic work, agriculture, brickworks	Shelter, food, Medical care Counseling Vocational training Literacy Reintegration	6000 boys and girls since 1991 ages 6-18 16 paid staff: 2 teachers counselors training instructor manager cook watchman contracted medical practitioner	
Haiti				
FMS (Foyer Maurice Sixto) Wenes Jeanty, Executive Director J.P. Elie, Executive Secretary Marie Pascal Douyon, Social Worker Mami Georges Rameau	Afternoon drop-in program Restavecs: boys and girls in domestic servitude FMS also has shelter, not included in study	Schooling Vocational training Community sensitization Medical and dental care Summer camp Recreation Follow-up	450 children 75% girls ages 4-17 16 full-time staff 16 part-time staff, including 10 teachers, social worker executive secretary director	Two visits, observed children at play and in an art lesson.

Timkatek Père Simon, Director Fritz, Manager	Shelter and drop-in Boys of the street	Schooling Seek foster homes	40 boys sheltered 125 daily total attendance ages 12-18 Director Female Coordinator Manager 6 teachers 2 cooks 2 launderers janitor 2 volunteers to monitor lunch and discipline	Observed lunch, children playing cards, watching TV
FCCM (Fonds communautaire de credit mutual) Frère Sainvistal Pierre, Director Nadege Simon, Secretary and administrator	Shelter and drop-in Restavec girls Boys in external program	Schooling Health care Vocational training Recreation Child rights AIDS education Religious instruction	60 girls sheltered 300 boys and girls in external program 2 animators 2 social workers 2 cooks 2 launderers 2 cleaning women secretary accountants translator janitor 4 religious leaders	In dangerous Carrefour district Observed children in singing game, at lunch
Sister Marthe Vonrompay	Restavec girls	Advocacy	48 girls	Information based on phone interview

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[xvii] A. Ibrahim-Tanko and K. Owen, Labour Migration Patterns and Child Trafficking from the upper-East Region of Ghana, August, 2005, p. 6.
[xviii] Ibid, p. 6.
[xix] See WAO-Afrique, 1997, Child Trafficking in Togo: Prospective Study – Lome, Vogan and Cotonou.
[xx] UNICEF, p.101
[xxi] PLAN, For the Price of a Bike: Child Trafficking in Togo, 2005, p.9.
[xxii] See M. Tovo, "Togo: Overcoming the Crisis, Overcoming Poverty: A World Bank Poverty Assessment" (Washington, D.C.: World Bank, 1996), p. xiii.
[xxiii] International Programme on the Elimination of Child Labour (IPEC) and ILO, "Combating trafficking in children for labour exploitation in West and Central Africa: synthesis report based on studies of Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Gabon, Ghana, Mali, Nigeria and Togo (Geneva: ILO, 2001), p. 6
[xxiv] "West and Central Africa: United Nations Integrated Regional Information Network (IRIN) focus on regional efforts against child trafficking," IRIN, March 27, 2002, at www.irinnews.org/print/asp?ReportID=19693, p. 2. At the time of the meeting Aho was Togo's director of the Department for the Protection and Promotion of the Family and Children, which is part of the Ministry of Social Affairs. In 2002, she was appointed Minister of Public Health, Promotion of Women and Child Protection.
[xxv] Human Rights Watch, Borderline Slavery: Child Trafficking in Togo, 2003
[xxvi] E.M. Abalo, "Problématique du trafic des enfants au Togo: Rapport d'enquête" (Lomé: ILO-IPEC, 2000), p. viii.
[xxvii] Veil L. " The Status of Child Trafficking for Economic Exploitation in West and Central Africa" UNICEF, 2000
[xxviii] Human Rights Watch, Borderline Slavery: Child Trafficking in Togo, 2003, p 46.
[xxix] World Development Indicators database, August 2005.
[xxx] Human Rights Watch, The *Small Hands of Slavery: Bonded Labor in India*, 1996.
[xxxi] HRW, The Small hands of Slavery:Bonded Labor in India, Sept 1996 p2; see also: HRW, Small Change:Bonded Child Labor in India's silk Industry. New York, HRW 15(2) p.6.

[xxxii] The United Nations Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practices Similar to Slavery, 1956, defines debt bondage as "the status or condition arising from a pledge by a debtor of his personal services or those of a person under his control as security for a debt, if the value of those services as reasonably assessed is not applied towards the liquidation of the debt or the length and nature of those services are not respectively limited and defined."
[xxxiii] IPEC, Subregional Information System on Child Labour, accessed at http://www.ilo.org/public/english/region/asro/newdelhi/ipec/responses/india/index.htm.
[xxxiv] U.S. Department of State, Country Reports on Human Rights Practices-2002: India
[xxxv] See for example: USDOL TDA 2004 report on India available at:http://www.dol.gov/ILAB/media/reports/iclp/tda2004/india.htm
[xxxvi] Human Rights Watch, *Small Change: Bonded Child Labor in India's Silk Industry*,2003, p. 78.
[xxxvii] UNICEF, State of the World's Children, 2006
[xxxviii] Harman, Danna, "From Brooklyn to Haiti: US Cop brings skills, heritage", Christian Science Monitor, 20 January, 2006
[xxxix] UNICEF funded study done by Institut Psycho-Social de la Famille, 1998, cited in Restavek No More, National Coalition for Haitian Rights, p 16
[xl] Limye Lavi Foundation, "Background and Context", Proposal for Partnership to Free the Slaves, March, 2005.
[xli] Ibid, p 60
[xlii] Rohner, www.cspar.uconn.edu/intro to PARTheory
[xliii] Rohner, R, Private communication, 3/06. Rohner pointed out that in social science, the 25% predictive power of PARTheory is two and a half times greater than any other known variable.
[xliv] Judith Herman, *Trauma and Recovery*, 1977, pp. 74-75.
[xlv] J. Herman, p. 108
[xlvi] J. Herman, p.121
[xlvii] L. Terr, p. 37
[xlviii] L. Terr, p. 63
[xlix] L. Terr, p. 101
[l] Seedat S, Nyamai C, Ngenja F, Vythilingum B, Stein DJ. (2004) Trauma exposure and posttraumatic stress symptoms in adolescents:A schools' survey in Cape Town (South Africa) and Nairobi (Kenya). British Journal of Psychiatry, 184:169–175, 2004
[li] S. Kaplan, p. 24.
[lii] Arnston, L. and C. Knudson. 2004. "Psychosocial Care and Protection of Children in Emergencies: A Field Guide." Save the Children. p.14.
[liii] Wessells in Handbook of Culture, Therapy and Healing, Gielen, Fish and Draguns, eds. p 328
[liv] UNICEF, Working with children in unstable situations: A guiding manual for psychosocial interventions, (2002) p 24.
[lv] Save the Children, Ibid, p16.
[lvi] ILO-IPEC Trafficking in Children-South Asia, *Specialized Training Manual on Psychosocial Counseling for Trafficked Youth*, April, 2002,
[lvii] Aide aux orphelins et enfants vulnerable d'Afrique,World Bank Institute, Washington, DC, September 2005
[lviii] Although job descriptions vary from center to center, a rough approximation of the duties of various staff positions would be as follows. The "animateur" is at the lowest rung of the professional ladder and is responsible for leading group activities such as drawing or sports and keeping on eye on things. The "educateur" has a higher level of education and training and may teach classes or have primary responsibility for a group of children. He may meet with them on a weekly basis to go over their projects The "assistante sociale" has a university diploma or professional certification and in general is in charge of the intake process and record keeping. The "agente de promotion sociale" may do outreach to families, get histories, and check out the home that the child may go back to. The "agente sociale" welcomes visitors, teaches crafts such as knitting, or plays with the children.
[lix] Email message from M. Konan, 27 Jan, 2006 – The quoted excerpt reads in the original: "Notre programme ayant demarer en Août, il est un peu tôt pour avoir une estimation correcte des éffectifs d'enfants issue des plantations. A ce jour nous avons documenter une dizaine d'enfants (des Garçons) qui disent avoir travailler dans des plantations de CaCao. Le problème n'ayant pas été documenter avant cette date il serait prétentieux de donner des chiffres avant au moins une année d'activités."
[lx] See Endnote 58 for a description of the role of the "educateur".
[lxi] Free the Slaves, Recovering Childhoods: Combating Child Trafficking in Northern India, (2005) p.72.

[lxii] The following quotations are from: Suman, Director of the Mukti Ashram, "Note on Institutional background and Program Information" by correspondence, October 2005.
[lxiii] Professeur Gnansa C. DJASSOA, personal communication.
[lxiv] Rajneesh Kumar Radev, Bal Vikas Ashram report, p 8.
[lxv] A. Kielland, M. Tovo, *African Child Labor: the Facts and the Faces*, p 90.
[lxvi] Film footage, FTS
[lxvii] UNICEF, State of the World's Children 2006, p. 51.
[lxviii] Professeur Gnansa C. DJASSOA, personal communication.
[lxix] Suman, private communication, Dec. 6, 2005.
[lxx] Erik Erikson's stages, summarised by D. Elkind, *Erik Erikson's Eight Ages of Man*, New York Times Magazine, 1970.
[lxxi] Suman, Mukti Ashram report, p. 8
[lxxii] Legrand Bijoux, *coup d'Oeil sur la Famille Haitienne* p.46
[lxxiii] Ibid, p 48. "They readily give away their children into adoption or into servitude to just anyone."
[lxxiv]" They should have a certain nobility when approaching their food."
[lxxv]J. Herman, p. 108
[lxxvi] L. Terr, Too Scared to Cry: How trauma affects children, and ultimately us all. 1990, p.46.
[lxxvii] Bal Vikas Ashram investigator, Rajneesh Kumar Radev, personal correspondence, 12/3/05.
[lxxviii] Rajneesh Kumar Radev, Free the Slaves research notes, p, 9
[lxxix] Herman, p. 133.
[lxxx] John Frederick, reporting on the level of development of mental health awareness in Asian programs serving child sex workers says "with the exception of a few NGOs, no facility uses trained clinicians for assessment, ongoing counseling or any except extreme psychological problems, if then. With returnees from India, PTSD is hard to assess as such, although is clearly evident in about 5% of the cases. Symptoms of complex trauma are evident, as many present with severe depression, severe social alienation, aggressive behaviors, refusal to speak, etc. Suicidal threats and attempts occur (and the suicide rate of women of childbearing age in Nepal is very high, in any case.) However, with the exception of one organization (CVICT), no facility has the capacity to identify or address PTSD, and would not understand or be able to address complex trauma." Email correspondence, dated August 1, 2005.
[lxxxi] Telephone interview with consultant Jean Plaisir.
[lxxxii] Kielland & Tovo, p. 156.
[lxxxiii] Frederick Baele, Terre des Hommes, Togo, personal interview, Lome, Togo, October, 2005.
[lxxxiv] F. Baele, Terre des Hommes, private communication, December, 05
[lxxxv]Unpublished film interview at Bal Vikas Ashram, conducted by FTS, August, 2005.
[lxxxvi] Kielland, private communication, December '05.
[lxxxvii] Kielland & Tovo, p. 161.
[lxxxviii] Meillasoux, in Schlemmer,ed. P.320.
[lxxxix] To help with such activities, we recommend an ECPAT publication compiled and written by Colin Cotterill, *Ideas Bank of Creative Activities for Children at Drop-in or Residential Centres (Low budget activities for non-literate children).* Available online at www.ecpat.net
[xc] Rudolf Dreikurs, M.D, & Loren Grey PhD *A Parents' Guide to Child Discipline (1970,* Hawthorne Books). p. 28; see also: Felice Kaufman, PhD, *Family Education: What your Child Needs to Know,* www.familyeducation.com/experts/advice
[xci] Gielen, Fish & Draguns, p.382.
[xcii] Ronald Rohner, Abdul Khaleque, &David Cournoyer, *Parental Acceptance-Rejection Theory, Methods, Cross-Cultural Evidence, and Implications,* Journal of the Society for Psychological Anthropology, (September 2005, Vol 33, No. 3) p.300
[xciii] "Culture and the origins of psychopathology" Horacio Fabrega, Jr. in Handbook of Culture, Therapy and Healing, p. 27
[xciv] K. Owen, ibid.

[xcv] John Frederick, quoted in ILO-TICSA, Creating a Healing Environment, Vol. 1, Proceedings, John Frederick (ed.) 2002, p. 40.
[xcvi] John Frederick, quoted in ILO-TICSA, Creating a Healing Environment, Vol. 1, Proceedings, John Frederick (ed.) 2002, p. 42.
[xcvii] Kielland & Tovo, p.157.