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Health Equity for All: Sexual and Reproductive Health Needs and Access to Health Services for Adolescents 10–17 Engaged in Selling Sex in Asia Pacific

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**SEXUAL AND REPRODUCTIVE
HEALTH NEEDS AND ACCESS
TO HEALTH SERVICES FOR
ADOLESCENTS UNDER 18 ENGAGED
IN SELLING SEX IN ASIA PACIFIC**



**HIV YOUNG
LEADERS FUND**

HIV Young Leaders Fund

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ACRONYMS

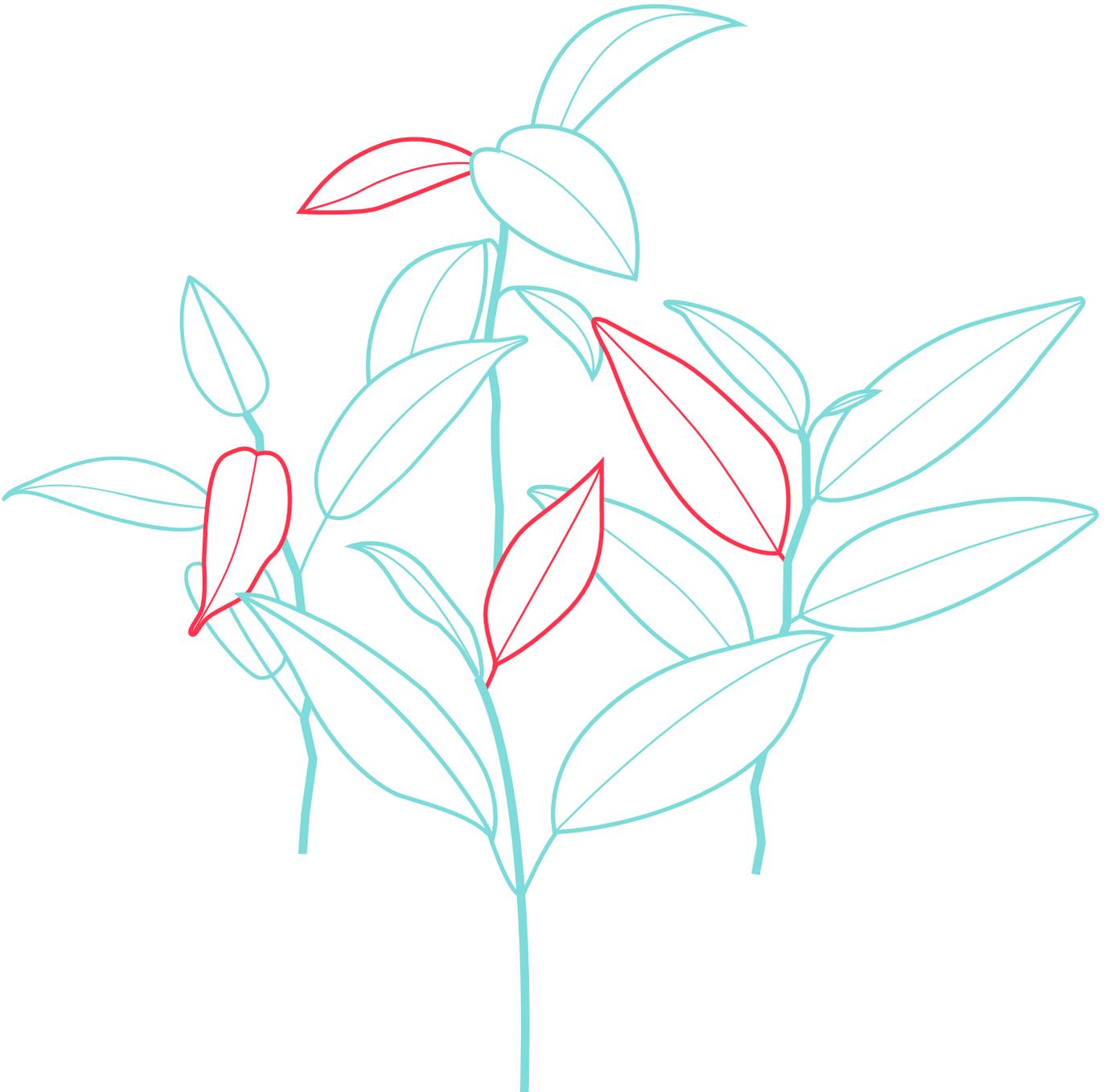
APN+	Asia Pacific Network of People Living with HIV
APNSW	Asia Pacific Network of Sex Workers
ART	Antiretroviral therapy
CRC	Convention on the Rights of the Child
CSE	Commercial Sexual Exploitation
CSA	Child Sexual Abuse
EAPRO	East Asia and the Pacific Regional Office
ECPAT	End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes
FHI	Family Health International
FSW	Female sex workers
HYL F	HIV Young Leaders Fund
ICPD	International Conference on Population and Development
IEC	Information, education and communication
ILO	International Labour Organization
IPPF	International Planned Parenthood Federation
MSM	Men who have sex with men
MSW	Male sex worker
OPSC	Optional Protocol on the Sale of Children, Child Prostitution and Child Pornography
PMTCT	Prevention of mother to child transmission
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary counselling and testing
WHO	World Health Organization

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BACKGROUND



1 BACKGROUND

Box 1: Terminology

The term “engaged in selling sex” is intended to be inclusive of all adolescents under 18 selling sex regardless of how they identify themselves, whether as young sex workers, victims of sexual exploitation, or local variations such as temple-dedicated *devadasis* as in some Indian states or as participants in “compensated dating,” known as *enjo-kōsai* in East Asia.

The approach to terminology adopted by this paper is based on the belief that health interventions must adapt to the specific programmatic needs of the many sub-populations of adolescents engaged in selling sex, many of whom do not attach an identity or status to their behaviour. The term “engaged in selling sex” is therefore meant to cover adolescents trading sex for a range of reasons, including: economic survival and family support; sexual initiative; or physical force, threat of force, or other coercion. “Selling sex” does not necessarily imply that the adolescents themselves receive pay or goods in return for the sex act, rather than a third party. The term also denotes any exchange of sex acts for money, food, shelter, or other resources, given that for SRH purposes this exchange is one and the same. Nonetheless, where a cited study uses different terminology, this review attempts to use the original term for purposes of research continuity.

Note: While some international legal documents refer to persons under the age of 18 engaged in selling sex to be commercially sexually exploited children (CSEC), young people and adolescents do not label themselves according to international legal instruments, and it is HIV Young Leaders Fund's position that we should not do so either. The young people HYLFF has worked with find the term “sexual exploitation” unrelatable and often stigmatising, in that it denies the complexity of young people's agency and development.

1.1 INTRODUCTION

This paper addresses the sexual and reproductive health (SRH)—including HIV prevention, care and treatment^a – and other health service needs of adolescents aged 10 – 17 engaged in selling sex in the Asia Pacific region. While the United Nations defines adolescents as 10 – 19, we purposefully focus on ages 10 – 17 due to the unique legal and policy implications faced by this age group as compared to older cohorts. In regards to terminology, the term “engaged in selling sex” is used for its inclusive and non-stigmatising connotations as well as the benefit of a behavioural description to tailoring programmatic interventions, as explained in Box 1.

Given the many and varied issues faced by this group, this paper’s analysis is narrowly tailored around three core issues: (i) health problems correlated with adolescent involvement in selling sex; (ii) access to SRH and other health services; and (iii) the response of formal and informal health and protection systems to address the SRH-related needs and rights of adolescents.

While the paper predominantly focuses on SRH and health services, we recognise that multiple systems, such as the social welfare and child protection systems, are organized around responding to adolescent needs. In addition, health issues arise from adolescent contact with health, law enforcement and child protection systems. Despite this, there has been little research into an integrated and comprehensive response for adolescents under 18 engaged in selling sex that cuts across programmatic silos. This paper therefore provides an initial outline for creating a more comprehensive response on the principle of “first, do no harm” – one that takes into ac-



This paper provides an outline for a comprehensive response on the principle of “first, do no harm” – one that takes into account each adolescent's unique motivations and circumstances in formulating an appropriate and minimal intervention across child protection and health systems, informed by the best practices of both.

^a SRH includes HIV treatment, prevention, care and support but also encompasses broader aspects of health related to the maintenance of a satisfying, safe and responsible sex life and the freedom to decide if, when, and how many children to have.

count each adolescent's unique motivations and circumstances in formulating an appropriate and minimal intervention across child protection and health systems, informed by the best practices of both. A by-product of the paper's tailored approach is a limited reach. The paper does not address child sex tourism, child pornography or the sale of children through marriage and adoption. Neither does it comprehensively deal with the literature on trafficking of children across borders. However, it is not possible to completely separate the discourses, and the review does examine trafficking where overlapping legal provisions or specific conceptual issues require. In addition, the review does not include discussion of criminal penalties to "end demand"—namely, by prosecution of purchasers or procurers of sex acts with adolescents—except to the extent that adolescents engaged in selling sex are themselves arrested under such charges. Finally, this paper addresses adolescents *already* engaged in selling sex, whether short- or long-term, and not those adolescents at risk of entry. However, many programme recommendations for SRH and other health-based interventions aimed at prevention for at risk adolescents may overlap with those aimed at adolescents already engaged in selling sex.

1.2 RATIONALE

While the research literature on the sexual and reproductive health (SRH) needs of adolescents under 18 engaged in selling sex in this region is limited, what we do know paints a stark picture. Multiple studies demonstrate this group is more vulnerable to sexually transmitted infections (STIs), HIV and other SRH concerns than older cohorts. This vulnerability is due to a multitude of reasons specific to adolescents under eighteen. Certain factors for vulnerability are behavioural or biological, such as more frequent and severe circumstances of initiation and involvement in selling sex, including physical force and lack of economic alternatives; the complexities involved in negotiating condom use; age and development; and biological differences, among others. However, still other reasons are rooted in systems, including legal and policy barriers to access SRH and other health services; increased contact with uniformed services such as police, resulting in harassment, physical and sexual abuse and arrest; and lack of youth-friendly HIV treatment, prevention, care and support and other SRH information and services, including for adolescents in detention.

Despite the clear vulnerabilities to SRH concerns for these adolescents in the Asia Pacific region noted above, this group is not being adequately reached with SRH, HIV and other related services. Reasons for the failed response in the region include: (i) the discordance between national laws in the Asia Pacific and international frameworks on child health and rights have inadvertently resulted in a confusing policy and program environment; (ii) the available spectrum of interventions to best improve health outcomes for adolescents under 18 engaged in selling sex at different ages and circumstances is not well known by many international, national and local stakeholders, and in some cases not supported through research; and (iii) the lack of agreed, specific policy and programme guidance on addressing the complex SRH and other health concerns of adolescents under 18 engaged in selling sex regionally and internationally.

Still other "systems" barriers and harms are more local and programmatic. Current initiatives are not always able to provide adequate and age-appropriate responses to the specific short and long-term SRH needs of adolescents engaged in selling sex. Typically health interventions that target sex workers over 18 generally do not address the specific needs of adolescents under 18 precisely because of law and policy barriers; and the majority of child protection interventions that target adolescents under 18 engaged in selling sex focus on removal from the sex trade rather than provision of harm-reduction services, including SRH and HIV treatment, prevention, care and support. In the Asia Pacific, police are documented to harass, physically and sexually assault, rape, extort, and steal from adolescents who sell sex. Given this reality, there is an urgent need to contribute to the evidence base and increase dialogue

around how to better protect adolescents engaged in selling sex with SRH and HIV protection, as well as harms perpetrated by protective or service related interventions.

Based on this rationale, the aim of this paper is to identify, review and synthesise existing research and guidance on reaching and reducing potential harms for adolescents under 18 engaged in selling sex in the Asia Pacific region, with a particular focus on their SRH and related health needs. It aims to:

- Assess what is already known about the needs of adolescents under 18 engaged in selling sex and relevant programmes to address their needs in the Asia Pacific region;
- Highlight case studies of good practices in regional programming and policies; and
- Identify research gaps which require further attention.

The paper is produced under the *Health Equity for All initiative*, which is part of a partnership – between the HIV Young Leaders Fund (HYLF); United Nations Population Fund (UNFPA) Asia Pacific office; United Nations Educational, Scientific and Cultural Organization (UNESCO) Regional Bureau for Education in Asia and the Pacific; United Nations Children’s Fund’s Regional Office for East Asia and the Pacific (UNICEF EAPRO); Joint United Nations Programme on HIV/AIDS (UNAIDS) Regional Support Team for Asia and the Pacific; Save the Children; Youth LEAD; and Youth Voices Count; as well as other civil society partners – to improve health information and services for adolescents affected by HIV in the Asia Pacific region.

The paper provides an evidence base for a set of policy and programme recommendations to be issued in 2014 on how to better reach adolescents engaged in selling sex with SRH services to reduce harm, improve their health and respect their rights. While the paper cannot address all aspects of these adolescents’ health and well being, we hope to encourage dialogue and further attention to these critical issues.

 **Given the reality of police harassment and assault for these adolescents, there is an urgent need to address the consequences of current law enforcement-based protective and service related interventions.**

1.3 METHODOLOGY

This paper aims to quickly synthesise existing evidence and identify critical issues for further exploration. The majority of the resources have been provided by the project partners, with additional materials identified through the writers’ own contacts and a web search of online databases such as AIDS Data Hub as well as of online journals like PubMed and websites of key organisations working on these issues. The paper was restricted to resources from the past decade (2002 - 2012), with the exception of international frameworks established before 2002.

The research process combined a rapid search technique using search terms such as ‘HIV’, ‘sexual and reproductive health’, ‘commercial sexual exploitation’, ‘laws’, ‘adolescents who sell sex’, ‘under-age’ and ‘young’, ‘children in detention’, ‘children and consent’, ‘maltreatment in shelters’, ‘child sexual abuse’. This was combined with an in-depth review of key documents with detailed analyses of issues relating to adolescents engaged in selling sex in the Asia Pacific region.

To the extent possible, the search specifically focused on resources related to *adolescents aged between 10 - 17* who sell sex. However it was sometimes necessary during the research process to extrapolate information from studies addressing a wider age group (such as up to 20 or 24 years) or broader demographic (such as young key affected populations). Given the overlap between common definitions

of a “child” (0 - 18) and “young person” (10 - 24), many studies addressing adolescents under 18 also address young people up to age 24.

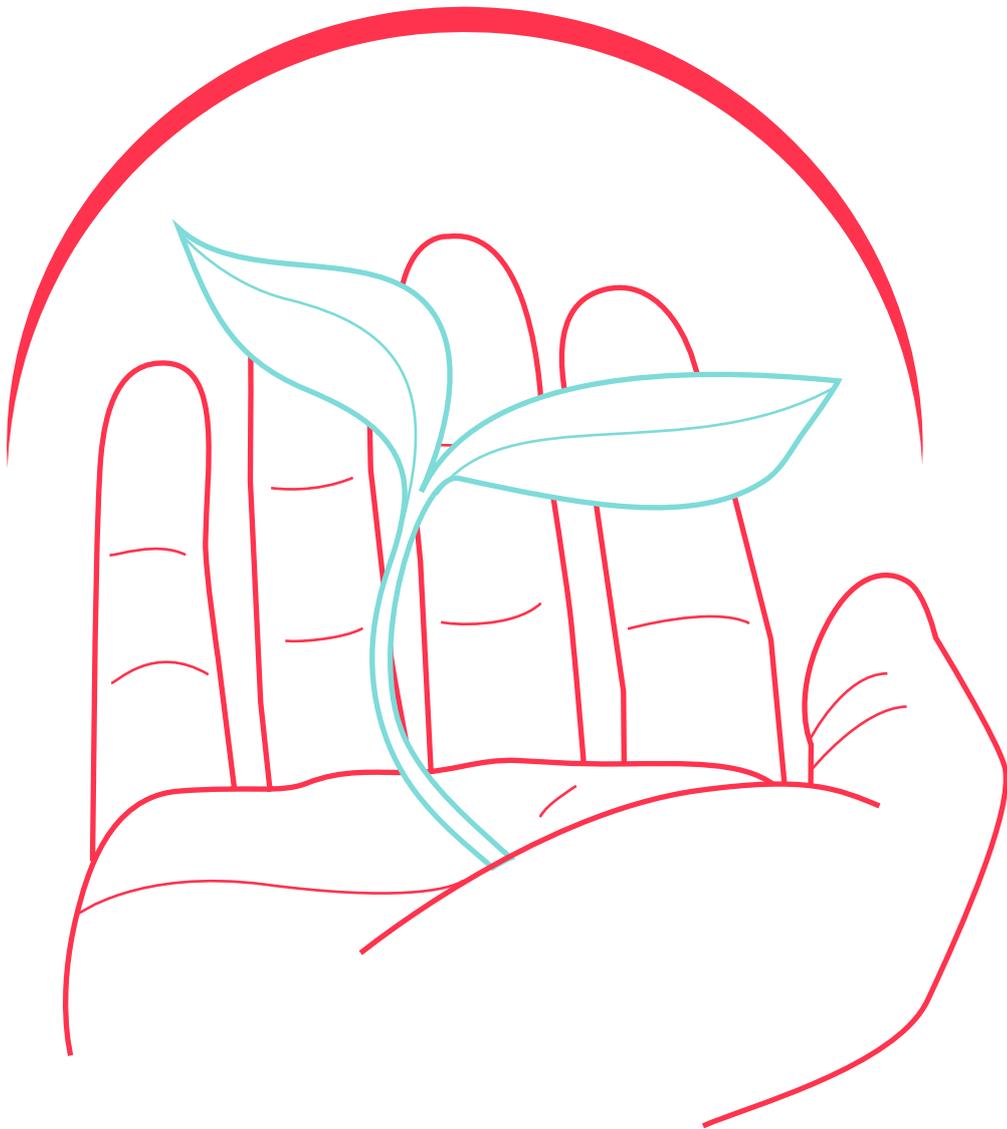
The review incorporates over 100 resources relating to South Asia, South East Asia and the Pacific¹ as well as resources from outside the region that contribute to conceptual understandings of the issues. In addition, legal documents pertaining specifically to national legislation in the Asia Pacific region on adolescents’ engagement in selling sex as well as on the rights of children and adolescents to access SRH and HIV related services were examined.

There were several limitations to the methodology. The paper was drafted with a modest budget and timeframe. As such, it does not constitute an exhaustive assessment of available research. However, it represents an important step forward—providing a synthesis and identifying issues for further exploration. Another challenge was the geographical area addressed by the review—with the Asia Pacific region being made up of culturally, economically and politically diverse countries. Within the subject of adolescents engaged in selling sex, this translated into a range of different legal contexts and societal ‘norms’—sometimes making it challenging to identify common themes and responses.

Yet another limitation is seen in the uneven regional coverage of the research literature. There is more readily available information from certain countries such as the South Asian countries and Viet Nam, Cambodia, Thailand and Indonesia, whereas the Pacific region is not covered as comprehensively. Further, resources looked at were only those available in English (whether as originals or translations). Finally, many resources, particularly for adolescents engaged in selling sex who were male or transgender, focused predominantly on HIV, rather than broader SRH and other needs.

2

**INTERNATIONAL LEGAL AND
CONCEPTUAL FRAMEWORK**



2 INTERNATIONAL LEGAL AND CONCEPTUAL FRAMEWORK

2.1 THE INTERNATIONAL LEGAL FRAMEWORK

Adolescents engaged in selling sex need a legal environment that ensures the fulfilment of multiple rights. This duality of needs can cause tension in practice where laws exist that intend to protect adolescents, but where the interpretation of the laws or specific provisions in the laws themselves sometimes commit affirmative harm and create barriers that prevent adolescents engaged in selling sex from accessing the services they critically need. This section of the review provides a brief summary of the international legal framework around child and adolescent rights in this context. For a discussion of domestic legislation in the Asia Pacific region which may both support and hinder access to SRH and other health services for adolescents engaged in selling sex, see Section 6.

A. UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD (CRC), 1989

The United Nations Convention on the Rights of the Child (CRC) was the first legally binding international instrument to set out the civil, political, economic, social and cultural rights of children—defined as persons under the age of 18, unless under the law applicable to the child, majority is obtained earlier.² The CRC entered into force in September 1990 and has been either signed or ratified by every UN Member State in the Asia Pacific region. It establishes the principle that the best interests of the child should guide all actions concerning children.³ It also iterates the rights of children to life, survival and development⁴ and to non-discrimination on any grounds including their “*race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.*”⁵ The Convention also guarantees the right to privacy, the right of children to express opinions freely in matters affecting them, and to have their views given due consideration.⁶

The CRC stipulates that children are entitled to protection from all forms of sexual exploitation and sexual abuse, including child prostitution,⁷ and the right to recovery and reintegration for child victims.⁸ The Convention envisions that such protection may take the form of prosecuting purchasers or procurers of selling sex or initiating proceedings against children themselves for their protection. In the latter case, such proceedings are tempered by the “minimum intervention” principle contained in Article 19, specifying that judicial measures are to be used only where appropriate, “*as a measure of last resort and for the shortest appropriate period of time.*”⁹ In this context, each child also holds the “*right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.*”¹⁰ Further, where children are affected by any judicial or administrative proceedings, the CRC specifically requires they be “*provided the opportunity to be heard... either directly, or through a representative or an appropriate body.*”¹¹ and any child who has been placed in protection or treatment for health purposes is entitled “*to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.*”¹² Importantly for many adolescents engaged in selling sex who are separated from their families and peer networks, the CRC also makes clear that every child deprived of liberty is also entitled to “*maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.*”¹³ These provisions are especially important for adolescents engaged in selling sex who face arrest as a condition to access services, or who are involuntarily committed to residential programmes or detention centres.

The Convention provides for children’s access to services that they might critically need depending on their specific situation and in accordance with their ‘evolving capacities.’ For example, it stipulates that children have the right to “the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.” However, regional policy guidance has further articulated these rights in the context of compulsory detention and rehabilitation centres in the Asia Pacific. The Joint U.N. Statement on Compulsory Drug Detention and Rehabilitation Centres and the UNICEF Position on Compulsory Detention Centres in East Asia and Pacific specifically treat compulsory detention and “rehabilitation” of adolescents engaged in selling sex as forms of punishment that must be abolished. In their place, the framework requires voluntary, evidence-informed and rights-based health and social services. Echoing these statements in the context of HIV, the Global Commission on HIV and the Law has advocated for the closure of compulsory detention or “rehabilitation” centres for persons engaged in selling sex, including adolescents, and instead recommended protection in safe and empowering family settings, selected based on the best interests of the child .

B. UNITED NATIONS SECOND OPTIONAL PROTOCOL TO THE CONVENTION ON THE RIGHTS OF THE CHILD (CRC) ON THE SALE OF CHILDREN, CHILD PROSTITUTION AND CHILD PORNOGRAPHY

The Optional Protocol (OPSC)^b expands upon the protection and due process guarantees of the CRC. The Protocol requires States Parties to adopt criminal penalties for the sale of children, child prostitution and child pornography to be treated as criminal acts by State Parties, as well as civil and administrative proceedings for seizure of instrumentalities used to commit or facilitate the offences described by the Protocol; jurisdiction and extradition; and mutual legal assistance. As noted in Section 1.1, however, the criminal prosecution of purchasers and procurers is generally outside of the scope of this review. Nonetheless it is worth noting for reference purposes that the Optional Protocol influenced adoption of the 1999 International Labour Organization, Worst Forms of Child Labour Convention, No. 182 and the 2000 Palermo Protocol in this regard. The Protocol also requires States Parties to adopt or strengthen prevention measures.

More importantly for this review, the Optional Protocol requires States Parties to adopt appropriate measures to protect the rights of child victims of the offences described “*at all stages of the criminal justice process*.”¹⁶ This particular provision iterates rights such as child-friendly legal proceedings; information as to rights, role, scope, timing, and progress of the proceedings as well as dispositions; due consideration to their views, needs, and concerns; privacy and confidentiality concerning their identity; and safety and protection against intimidation and retaliation.¹⁷ The Protocol also assigns to States Parties the duty to consider the best interests of the child victim as a primary consideration and to provide appropriate training to all those who work with child victims, among others.¹⁸ The Committee on the Rights of the Child has noted in this context that children and adolescents engaged in selling sex should not be treated as offenders, and that “double victimization” must be avoided.

The Optional Protocol’s focus on the rights of survivors in legal proceedings must necessarily be read in the context of the broader CRC framework discussed above, including that protective intervention should involve judicial measures only where appropriate, and as a last resort;¹⁹ that adolescents be provided legal assistance and the opportunity to be heard;²⁰ and that adolescents placed in protection or treatment for health purposes be provided a periodic review.²¹

^b This protocol was adopted in May 2000. As of October 2012, 115 United Nations Member States – including most, but not all, in the Asia-Pacific region - had signed it. Those who have not signed it are Kiribati, Marshall Islands, North Korea, Papua New Guinea, Palau, Singapore, Samoa, Tonga and Tuvalu. For more information: http://www.unicef.org/protection/files/Status_OPSC_and_OPAC_01_October_2012.pdf

C. THE COMMITTEE ON THE RIGHTS OF THE CHILD: GENERAL COMMENTS

The Committee on the Convention on the Rights of the Child (hereinafter: the “Committee”) has interpreted obligations of governments under the CRC in specific general comments, which have bearing on this review.^c For instance in General Comment 3 on HIV/AIDS, the Committee reiterates and expands upon several key principles relating to discrimination, the best interests of the child, and the right of children to participate in decisions related to their own health. The Committee acknowledges that all of children’s rights, civil, political, social, economic and cultural are affected by HIV/AIDS and recognises that *“adequate measures to address HIV/AIDS can be undertaken only if the rights of children and adolescents are fully respected”*²² General Comment 3 establishes that non-discrimination on the basis of ‘other status’ includes HIV/AIDS^d and also addresses gender based discrimination noting that this may limit access of girls to prevention and other services. It also emphasises the importance of children’s participation stating that, *“Interventions are found to benefit children most when they are actively involved in assessing needs, devising solutions, shaping strategies and carrying them out rather than being seen as objects for whom decisions are made”*²³

“As the Committee has noted on numerous occasions, children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgemental, do not require parental consent and are not discriminatory.” - General Comment No. 3 , HIV/AIDS and the Rights of the Child

The Committee’s General Comment 4 on adolescent health and development recommends health services for adolescents who are sexually exploited, including services to address STDs, HIV/AIDS, unwanted pregnancies, unsafe abortions, violence and psychological distress, within the right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity.²⁴ The Committee also notes that it *“is the obligation of States parties... to provide appropriate health and counselling services to adolescents who have been sexually exploited, making sure that they are treated as victims and not as offenders.”* The Committee also elaborates on Article 19 of the CRC to establish that States Parties are to take all measures to prevent and eliminate institutional violence, especially in regards to vulnerable adolescents such as those who are homeless or who are living in institutions. The Committee recommends legislation and administrative measures in relation to both public and private institutions for adolescents, as well as *“training and monitoring of personnel in charge of institutionalized children or who otherwise have contact with children through their work, including the police.”* Relatedly, the Committee notes that *“States parties have to provide special protection to homeless adolescents, including those working in the informal sector”* and in particular that *“States parties are required to (a) develop policies and enact and enforce legislation that protect such adolescents from violence, e.g. by law enforcement officials; (b) develop strategies for the provision of appropriate education and access to health care, and of opportunities for the development of livelihood skills.”*

The Committee on the Rights of the Child has called for legislation and administrative measures for monitoring and training of police and personnel in charge of institutionalised children.

The Committee on the Rights of the Child has also, in General Comment 10, provided important guidance on children’s rights in juvenile justice relevant to children and adolescents involved in state pro-

^c The Committee uses general comments to interpret obligations and guide governments on implementation of children’s rights under the Convention. These interpretations are considered to be authoritative but are not legally binding.

^d “The Committee interprets “other status” under article 2 of the Convention to include HIV/AIDS status of the child or his/her parent(s)”, ¶ 9.

ceedings.²⁵ In addition, various United Nations guidelines have been published that pertain to adolescents engaged in selling sex in this context, such as the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the “Beijing Rules”); the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (the “Havana Rules”); and the United Nations Guidelines for the Prevention of Juvenile Delinquency (the “Riyadh Guidelines”).

Related to this, General Comment No. 15, on the right to health, elaborates on these principles. The Committee has interpreted this right to include entitlements such as access to a range of facilities and goods as well as prevention, treatment, rehabilitation and palliative care services.²⁶ In addition the Committee stipulates that freedoms inherent in children’s right to health “include the right to control one’s health and body, including sexual and reproductive freedom to make responsible choices.”²⁷ Expanding further on this the Committee explains that children, in accordance with their evolving capacities should have access to confidential counselling without consent of a guardian or a parent. In addition, states should consider “allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.”²⁸

The Committee has also expanded certain key principles from the CRC in the context of the right to health. For instance they specifically mention that in this context, non-discrimination on the grounds of ‘other status’ must include “sexual orientation, gender identity and health status, for example HIV status.” In addition the committee has looked at children’s participation and suggested that this must include having their views taken into account “on all aspects of health provisions, including, for example, what services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes of health professionals...”²⁹

The above provisions are very relevant for adolescents engaged in selling sex, in terms of providing a rights-based framework, which can support their input on which information and services they need as well as their right to access those services.

D. INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (ICESCR)

Article 12 of the ICESCR specifies the right of all people to the highest attainable standard of physical and mental health. This has been expanded in General Comment 14 of the Committee on Economic, Social and Cultural Rights which in part addresses how this right applies to children and adolescents and stipulates that they must have the right to the enjoyment of the highest standard of health and access to facilities for the treatment of illness.³⁰ The Committee recommends to States Parties that they undertake to provide a supportive environment for adolescents that, “ensures the opportunity to participate in decisions affecting their health, to build life-skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make.”³¹ The Committee further states that youth friendly health care is critical if the right to health of adolescents is to be realised. This involves providing appropriate sexual and reproductive health services which respect privacy and confidentiality.

CONCLUSION

There are a number of other instruments that establish the rights of adolescents to sexual and reproductive health services.³² Although these are not legally binding upon states they do establish certain

international and regional commitments that states have repeatedly supported.^e These include ensuring for adolescents:

- Access to appropriate services and information related to sexual and reproductive health;
- Removal of legal, regulatory and social barriers to reproductive health, information and care for adolescents;
- Involvement and participation with design and implementation of programmes to reflect their specific priorities and needs;
- User-friendly non discriminatory services that effectively address their reproductive and sexual health needs taking into account their right to privacy, confidentiality, respect and informed consent;
- Promotion of education and information to reduce HIV amongst children.

These commitments were recently reiterated at the Asia Pacific Population Conference, wherein the draft declaration stipulates that states must “ensure that adolescents and young people, on an equitable and universal basis, enjoy the highest attainable standard of physical and mental health by providing them with access to youth-friendly sustainable health and social services without discrimination and judgment, including marginal groups, such as youth with disabilities, HIV and AIDS, ethnic minorities and other status.”³³ The inclusiveness of this provision which includes marginalization and ‘other status’ as prohibited grounds of discrimination is useful in terms of articulating the rights of adolescents to access services for adolescents from diverse backgrounds, including those engaged in selling sex.

2.2 KEY CONCEPTS

This section elaborates on key concepts informing the analysis of this paper.

CHILD PROTECTION

Child protection is defined as measures and structures to prevent and respond to abuse, neglect, exploitation and violence affecting children and adolescents.³⁴ At the level of state programmes, the child protection system typically has both a prosecutorial and custodial function. In the former role, the state system investigates and prosecutes perpetrators of exploitation and violence against children and adolescents, and initiates proceedings against children and adolescents who commit status offences or acts that would be crimes if committed by adults. In the context of the custodial function, the state system supervises children and adolescents in the child welfare system.

The international legal framework discussed in Section 2.1 clearly envisions child protection as an important framework for interventions affecting adolescents under 18 engaged in selling sex. What is less clear is what interventions qualify as child protection under this framework. For instance, the Convention clearly states that children and adolescents have the right to be protected from sexual exploitation and sexual abuse, including child prostitution, and the right to recovery and reintegration for child survivors.³⁶ However, the framework also situates these protective principles in the right to health, “minimum intervention,” and due process principles of the Convention, among others. These principles clarify that “protection” of adolescents selling sex also includes ensuring their safety from those harms attendant to the law enforcement and even the child protection system.



The international legal framework is clear—“protection” of adolescents selling sex includes ensuring their safety from those harms attendant to the law enforcement and child protection system.

^e For details regarding the specific commitments please refer to Godwin, J. ‘Laws and policies affecting young people’s access to sexual and reproductive health and HIV services in Asia and the Pacific’, (2013). UNESCO. Bangkok.

This review proceeds from the premises that child protection services are obliged to ensure adolescents' right to health and advance their SRH rights, and that child protection proceedings against children and adolescents must be mitigated by the "minimum intervention" principles of the Convention, specifying that judicial measures are to be used only where appropriate, as a measure of last resort, and that placements be undertaken for the shortest appropriate period of time, and subject to periodic review.³⁷ Conversely, the review recognises that rights-based SRH programmes and services should recognise the interrelated rights and protections of adolescents engaged in selling sex, and offer voluntary, low-threshold options for safe housing, treatment, and protection for those adolescents who desire it. This integrated approach is organised around the provision of on-going information and advice as desired by adolescents to assist them in making choices within the options that are available to them; opportunities to access safe housing; alternative care and protection if desired; alternative livelihood programs; educational opportunities and harm reducing services including access to condoms and safe and confidential testing for STIs and HIV, ART access, as well as clean needle provision and other services for adolescents who use drugs, among others.

EVOLVING CAPACITY OF THE CHILD

As noted in Section 2.1 above, the CRC includes the concept of 'evolving capacities' of the child, defined as any person under 18, and referring to the developmental changes that children experience as they mature, including progress in cognitive abilities and capacity for self-determination. The principle of evolving capacities focuses on capacity rather than age and takes into account the fact that, different environments, cultures and life experiences will affect how children develop in terms of their capacity to deal with diverse situations.

It has been suggested that the "*concept of evolving capacities is central to the balance embodied in the Convention between recognising children as active agents in their own lives, entitled to be listened to, respected and granted increasing autonomy in the exercise of rights, while also being entitled to protection in accordance with their relative immaturity and youth.*"³⁸

This principle is also related to the idea of the 'mature minor', a legal principle that recognises that some minors may be mature enough to understand the meaning and consequences of certain medical procedures and may therefore consent independently to them. This has bearing on this paper; for example access to HIV testing is vital for adolescents engaged in selling sex and some countries in the region have introduced this principle in statutory provisions relating to consent to HIV testing.³⁹

TRAFFICKING OF ADOLESCENTS

While not discussed in Section 2.1 concerning the international legal framework, according to the United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (commonly referred to as the Palermo Protocol), "*The recruitment, transportation, transfer, harboring, or receipt of a child for the purpose of exploitation shall be considered 'trafficking in persons' even if this does not involve*" the threat or use of force or other forms of coercion. Like the CRC, the Palermo Protocol defines a child as anyone under the age of 18. The Palermo Protocol and related legal instruments consider adolescents engaged in selling sex as trafficked persons regardless of how they define their involvement and even where no third party induced or regulates their involvement.

It is the position of this paper that research now demonstrates that it is not helpful to conflate the concept of trafficking with all situations of adolescents selling sex, given the diversity of situations and contexts. Such conflation makes it difficult to tailor programmes effectively for those who are trafficked and those who are not. There is also emerging evidence that the effect of related anti-trafficking legislation upon adolescents engaged in selling sex may restrict access to services related to SRH and HIV, as discussed in Section 6.1. Despite the “definitions” in international legal documents, to view all adolescents under 18 engaged in selling sex through a trafficking paradigm obscures the various realities and lived experiences involved with poverty and economic migration, complicating an understanding of why adolescents move within their countries and across borders. This influences interventions so that, for instance, government programmes may spend resources policing borders and preventing cross border migration rather than focusing on root causes in the adolescents’ communities of origin.

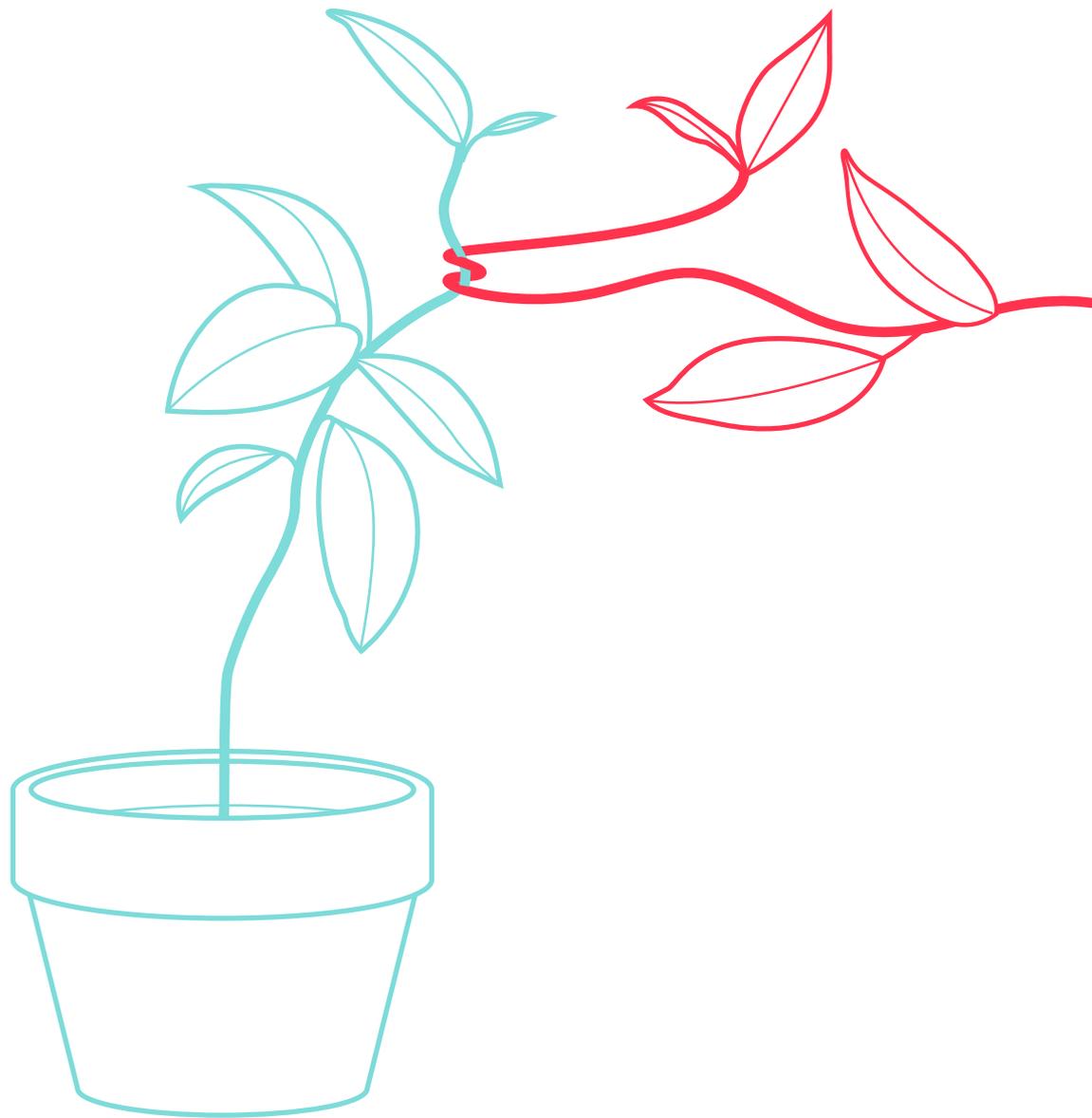


To view all adolescents under 18 engaged in selling sex through a trafficking paradigm obscures the various realities and lived experiences involved with poverty and economic migration, complicating an understanding of why adolescents move within their countries and across borders.



3

**SCALE AND NEEDS OF ADOLESCENTS
ENGAGED IN SELLING SEX**



3. SCALE AND NEEDS OF ADOLESCENTS ENGAGED IN SELLING SEX

3.1 POPULATION ESTIMATES OF ADOLESCENTS SELLING SEX IN THE ASIA PACIFIC

Box 2: Examples of data on adolescents who sell sex in the Asia Pacific region

Individual studies have found that that in:

- **Thailand**, a third of females who sell sex in massage parlours and brothels reported starting to sell sex under the age of 18.⁴⁰
- **India**, 40% of the three million women in the sex industry are under 18. In one study, 17 per cent of female sex workers reported starting to sell sex under the age of 15.⁴²
- **Nepal**, between 16% and 33% of females in the sex industry are below 18 years of age.⁴³
- The **Maldives and Papua New Guinea**, the median age reported among female sex workers was 17-19, as compared to 22-24 years of age in **Cambodia, Malaysia and Pakistan**.⁴⁴
- **Pakistan**, *hijras* (transgender persons) and male sex workers reported entering the sex trade at a mean age of 16.
- **Timor-Leste**, the age range of females who sell sex is 16 - 40 years.⁴⁵

Data from several countries in Asia Pacific – including Bangladesh, Cambodia, China, India, Indonesia, Laos, Mongolia, Myanmar, Pakistan, Papua New Guinea, the Philippines, Sri Lanka, Thailand and Viet Nam – clearly indicate the existence of adolescents under 18 engaged in selling sex. The prevalence of adolescents engaged in selling sex, however, is more difficult to measure. While data included in Box 2 provide an important starting point, they are also associated with a number of challenges and limitations. For example, different countries and/or institutions often use different definitions or methodologies to provide estimates, while many only address female adolescents engaged in selling sex and not male or transgender adolescents.

Even where inclusive research methods and definitions are utilized, in practice adolescents who sell sex are often excluded from, or self-select out of, many relevant surveys. One important reason for this is that researchers may be cautious about the ethics of involving adolescents under 18 in research or may be prohibited from doing so. In addition, the confusing and often punitive legal environment discussed in Section 6, as well as the treatment in some countries of all adolescents engaged in selling sex as trafficked, leads to them being hard-to-reach and ‘underground’, potentially unwilling to participate in research⁴⁶ or not granted access to researchers by third parties to the sale of sex, such as brothel owners.⁴⁷ If age of consent to sex in a country is high, it may also mean that adolescents lie about their age to avoid detection and so that they may access SRH services.⁴⁸

The limited data that reach a final report may also be compromised by research bias. The controversial nature of adolescent involvement in selling sex may skew researchers’ interpretation of data reported by adolescents. For example, a study in Thailand has noted for concern certain differences between a researcher’s own interpretations of engagement in selling sex and those given by the adolescents themselves.⁴⁹

As a result, data pertaining to size estimations of adolescents engaged in selling sex are extremely limited. However, some countries have begun including younger cohorts in the collection of data on



The confusing and punitive legal environment, and treatment of adolescents engaged in selling sex as trafficked, leads to them being hard-to-reach and ‘underground’, potentially unwilling to participate in research.

key populations^f such as for behavioural surveillance surveys.^g For instance, Pakistan (see Case Study 1) and Bangladesh (see Case Study 2) have carried out detailed national assessments of young people from key populations, including those engaged in selling sex. In countries where such data have not been collected, programmers face a major challenge in terms of being able to quantify and understand the issue. For example, a study of those aged 15 - 19 who sell sex in Kunming, China, found that limited data about the age group – such as their social characteristics, working context, sexual and drug-using risk behaviour, HIV and other STI prevalence and health-seeking behaviour – was a major limitation to designing effective health interventions.⁵⁰

CASE STUDY

1

HIV second generation surveillance in Pakistan – National Report Round IV-2011

This report provided national biological and behavioural information of key populations at risk of HIV that was gathered in Round 4 of Pakistan's Second Generation Surveillance. Since the previous rounds identified emerging HIV epidemics among high risk groups, the focus of Round 4 was to ascertain the spread of HIV among these groups and to understand any changes in behaviours that increase or decrease the risk of HIV infection.

How did it work?

- Key populations were mapped across 20 cities in Pakistan. Behavioural data were gathered from these population samples using a structured questionnaire covering socio-demographic information and risk behaviour indicators identified from the literature on HIV. Informed consent was obtained prior to conducting interviews. Biological data were gathered using the capillary "Dried Blood Specimen" (DBS) methodology.
- Results showed that 90 per cent of male sex workers (MSWs) were under 30 years of age, with 42.1 per cent between 13 – 19 years. On average MSWs reported starting sex work at an average age of 15.8. Condom use among MSWs varied according to age – younger people were less likely to use condoms than older people. MSWs under 20 years who did not use condoms and who relied on contacting clients on the street were also more likely to have experienced sexual violence.
- Forty per cent of MSWs were illiterate and 21.2 per cent had under 5 years of schooling.
- For female sex workers (FSWs), those under 20 reported higher rates of sexual violence. 13.6 of FSWs under 20 reported having been arrested. Younger FSWs saw more clients than older FSWs.

CASE STUDY

2

Mapping of most-at-risk children and young people, Bangladesh⁵¹

An extensive mapping of most-at-risk children and young people in Bangladesh published in January 2012 estimated that, in 20 districts, there were 5,820 male sex workers. A survey of 400 MSWs found that 37% were persons aged 10-18 years. The mapping also produced a similar map and set of data for female sex workers and transgender people. For example, a study of 400 transgender people found that 33% were aged 15-19 and, for about half of the whole group, selling sex was their main source of income.

^f According to UNAIDS 2011 Terminology Guidelines, "The term 'key populations' or 'key populations at higher risk of HIV exposure' refers to those most likely to be exposed to HIV or to transmit it – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients..."

^g See www.aidsdatahub.org for behavioural surveillance surveys and country profiles indicating that adolescents who sell sex are being included in data collection on key populations.

3.2 DEMOGRAPHICS AND CIRCUMSTANCES OF INITIATION AND INVOLVEMENT OF ADOLESCENTS

The review confirmed there is no one profile for adolescents under 18 engaged in selling sex in the Asia Pacific and that demographics and circumstances vary greatly. Adolescents engaged in selling sex experience a full range of motivations and reasons for their involvement in selling sex that can be positioned on a spectrum, or “continuum of volition” from sexual initiative to economic survival to physical force, which is in turn influenced by age, development and other factors.⁵² It is critical to know an adolescent’s unique circumstances along this spectrum so that SRH and health interventions can be tailored effectively.

It is worth noting that there is a significant evidence base that contributing factors exist that may predispose adolescents to initiate involvement in selling sex. Examples include those that are from poor families, are migrants, or displaced, those that are out of school; and those living or working on the streets or those that have been mistreated or abused.⁵³ Other factors enhancing adolescents’ vulnerability include discrimination based on belonging to an ethnic minority or other marginalised group or caste (such as in India); gender discrimination including discrimination against transgender adolescents; disability; and misuse of traditional practices such as child marriage.

Figure 2: Continuum of volition

Motivations or reasons for involvement in selling sex, including physical force or coercion



Weissman, et al. *Gender & Development* Vol. 14, No. 1, March 2006

MOTIVATIONS OR REASONS FOR INVOLVEMENT IN SELLING SEX, INCLUDING PHYSICAL FORCE OR COERCION

Multiple studies in different countries describe how adolescents report being involved in selling sex for a variety of reasons. Many adolescents report that they sell sex to escape poverty and meet financial responsibilities including familial support (especially in communities where there is a lack of other livelihood opportunities).⁵⁴ Some report being forced or coerced to do so by other people, including through trafficking.⁵⁵ Still others report additional non-monetary reasons for exchanging sex, referred to as transactional sex.⁵⁶ For example, adolescents might exchange sex for self-support needs, including food, alcohol, clothes, transport or drugs. Overall, some of their motivations may be the same or very similar to those of older young people (aged 18 - 24). However, some — such as selling sex to pay for school fees — are specific to their age. It should also be noted that selling sex might be a temporary response to specific needs, such as to earn money after a natural disaster.

Importantly for framing protective interventions, studies in the Asia Pacific region have found that not all adolescents engaged in selling sex experience physical force or the threat of force. A study in Thailand found that adolescents engaged in selling sex viewed their engagement in selling sex neither as a form of work nor a form of abuse, but instead as a way of fulfilling perceived obligations to their families.⁵⁷

Likewise, a study concerning adolescent boys engaged in selling sex in Bangladesh found that only 12% reported intimate partners that supported their involvement in prostitution, compared to 88% who did not.⁵⁸ Moreover, only 11.63% identified “pimps” as agents of enrolment; the vast majority of boys left their families to either provide economic support to their families [36%] or for a better life [34%].⁵⁹ A further study in Thailand found that different reasons for entry corresponded to three different groups of adolescents selling sex: those trafficked from neighbouring countries or the hill tribes; those who had been ‘debt-bonded’ into brothels on their own accord or with parental encouragement; and those who worked freelance.^{60 h} Similarly, a study of 580 people who sell sex in West Bengal, India, including some adolescents, found that: 68% had started selling sex primarily due to poverty; 24% had been forced through trafficking; and 8% had been forced by their spouse or a family member.⁶¹

There is some evidence that narratives of selling sex-as-exploitation have even resulted in inappropriate and harmful protective interventions.⁶² One study found that the “innocence lost” narrative obscured equally important aspects of adolescents’ involvement in selling sex, particularly familial relationships and responsibilities such as supporting families with a dramatically greater income than would be garnered from what is considered to be conventional child labour.⁶³

A study in Thailand among 14 – 25+ⁱ year olds found that the reasons for becoming involved in selling sex existed along a spectrum ranging from informed occupational choice at one end (the work is dangerous and unpleasant, but pays well) to being the outcome of family breakdown, violence or drug abuse at the other.⁶⁴ The study found that adolescents and young people who sell sex, particularly those under 20, tend to be at the latter end of the spectrum. A literature review that specifically examined the situation of boys engaged in selling sex in South Asia identified a developmental sequence or “*process by which a boy becomes involved in prostitution often involves a complex sequence of interlinked actors and events that isolate a boy from his family safety net and disempower him. The process may begin with sexual abuse in the home..... The boy’s vulnerability is often exacerbated by entry into unprotected labour situations and by family separation and migration.*”⁶⁵ The study also found that for boys separated from their families, the influence of peers and friends had an impact on their decision to sell sex as did factors such as addiction to tobacco or hashish.

Child sexual abuse (CSA) has also been identified as a factor in determining adolescents’ entry into selling sex, and may also serve as a motivation or reason for continued involvement.^j Some research posits that CSA causes changes in behavioural development. In an ILO–IPEC 2005 study in Mongolia of 91 women and girls engaged in selling sex under the age of 25, 19.8% said their first sex was rape. Similarly, in a qualitative study exploring the life stories of young women in Ho Chi Minh City, all of whom had been selling sex by or before the age of 15, some of the narratives related a cycle of physical abuse and rape from as early as eight years old, perpetrated by family members and boyfriends. These experienc-

^h According to this study, children who sell sex ‘freelance’ are “the ones most likely to have foreign customers. These children live with their families and sell sex as part of the overall family economy. For some children, selling sex is a rare occurrence done to supplement wages from others jobs; while for other children, it is a regular occupation and their main source of income. This category might also include those children living on the streets who sell sex on some occasions (“survival sex”) or girls who exchange sex with boys on the street in order to win their protection.”

ⁱ 230 of the respondents were aged between 14-24, the rest were 25 and above. The study does not state the upper age limit of respondents.

^j For further discussion of these linkages please see: “Commercial Sexual Exploitation of Children (CSEC) and Child Sexual Abuse (CSA) in the Pacific: A Regional Report”, 2006, UNICEF, UNESCAP and ECPAT; Rubenson, B., Hanh, L.T., Höjer, B. & Johansson, E. (2005). Young sex-workers in Ho Chi Minh City telling their life stories. *Childhood*, 12, 391-411; Child Sexual Abuse, Links to Later Sexual Exploitation/High-Risk Sexual Behavior, and Prevention/Treatment Programs, Kevin Lalor and Rosaleen McElvaney, 2010; *The Commercial Sexual Exploitation and Sexual Abuse of Children in Fiji: A situational Analysis*, Save the Children, 2006.

es sometimes culminated into selling sex due to coercion by the same abusers.⁶⁶ Researchers from this study posited that, *“Child sexual abuse is not a cause in and of itself of being prostituted, but a component of traumatic, negative development experience. Studies from prostituted juveniles point to those interviewed own views that being sexually abused as a child was a major factor in them later being prostituted.”*⁶⁷

NATURE OF INVOLVEMENT IN SELLING SEX

As with older people, the nature of selling sex varies for adolescents. These variations include: the sexual acts performed (such as penetrative and receptive anal sex for adolescent males or adolescent females selling sex); the location where sex is sold (such as on the street or in hotels, brothels, bars, industrial areas or beaches); and the ways of working (such as informal, individual or organised).⁶⁸ Again, however, there are some indications of dynamics that are specific to, or heightened for, adolescents. For example, a study in Thailand found that the younger members of the 14 to 25 and over age group studied were more likely to be freelance.⁶⁹ One study found that for boys selling sex in South Asia, common contact sites are the streets and bus stands, with sexual activities conducted in parks or hotel rooms. Some adolescent males who sell sex are also attached to shops, restaurants and bars, and this is where they contact clients. In Nepal, research found that younger women (under 20) who sell sex are more mobile than older people who sell sex, including because they have to move around to avoid being detected by the police.⁷⁰ This makes them harder to reach for SRH and other programmes.

The review found that there are often established hierarchies among those engaged in selling sex, such as according to age and class.⁷¹ In China, for instance, the lower rungs of the hierarchy, in terms of conditions, earnings and vulnerability to arrest, tend to be occupied by street workers or those who work from various sites (hotels, bars, beauty shops) and are contractually engaged by third parties. These women tend to be younger and poorer than those who manage to establish themselves independently and able to better determine their own price and location of work.

The review also highlighted how the selling of sex is dynamic within a country environment. As seen in Case Study 3 about Indonesia below, new trends emerge. Often, these trends reflect a country's changing socio-economic situation, such as increased consumerism. New technologies also evolve, such as with, in many countries, adolescents engaged in selling sex now using mobile phones and the internet to manage their work.⁷² These lifestyle changes bring both opportunities and challenges. For example, in Cambodia, one study found that changes to the working conditions and nature of selling sex for 15-29 year old females have increased their access to amphetamine-type stimulants (ATS) which in turn has led to them having more sex partners, higher levels of alcohol use and a higher risk of STIs.⁷³ This particular study concluded that ATS use is an *“important emerging risk exposure that should be integrated into HIV prevention interventions targeting this population.”*⁷⁴ The nature of selling sex can also change according to the clients involved. For example, in Bangladesh, a study of male sex workers, including adolescent males who sell sex, identified complex patterns of sexual behaviour, including having transactional, non-transactional, commercial, non-commercial, penetrative and receptive sexual relations. Also condom use varied according to the type of sexual partner.⁷⁵

CASE STUDY

3

Emerging forms of adolescents engaged in selling sex, Indonesia⁷⁶**SUZI**

Suzi left school at 14 for a factory job in Jakarta arranged by a neighbour. Once in the capital, the neighbour forced her to work as a tea-seller in a park where she serves clients, including providing sexual services. The neighbour keeps the money and gives her a salary. Suzi has a boyfriend (a military officer who is a client). She uses her income for food, clothes, make-up and medicines and sends money to her family. She has been sexually harassed by the police and government officers, verbally abused by her clients and had meals and salary withheld by her neighbour.

LILIS

Lilis is 15, from a middle class family, with a junior high school education. She is a **pecun** – a group of urban female adolescents, many of whom are students, who begin selling sex to earn the income and materials they require or desire. The term ‘pecun’ is not an identity but one imposed by researchers who have studied this lifestyle. Lilis began by hanging out at South Jakarta Mall with her older sister who introduced her to the pecun lifestyle. Initially, she would allow only touching and fondling by her clients to earn money for clothes, cosmetics, accessories and clubbing. Later, she began to engage in sexual relations. She now uses her earnings to live independently (at a boarding house with her sister).

CLIENTS (OR, PERSONS WHO PURCHASE SEX WITH ADOLESCENTS)

Clients, or persons who purchase sex with adolescents, include a cross-section of society in the Asia Pacific region. The paper found that clients also include other adolescents. A study in Sri Lanka found that local community members, business men, tourists and soldiers purchased sex from female adolescents under 18.⁷⁷ In a global study that included reporting from Viet Nam, commercially sexually exploited youth reported that customers were both local and foreign, and included state officials, private sector workers, young people from affluent families, Asian businessmen, and military and police men.⁷⁸ In a study from Nepal, the majority of clients were found to be small businessmen, government officers, internal migrants and army and police men, among others.⁷⁹

As seen from the studies sampled, uniformed services such as police and military officers are commonly clients of adolescents engaged in selling sex. This consistent finding – paired with data on the disturbingly high prevalence of police abuse and harassment of adolescents engaged in selling sex as discussed in Section 3.4 – raises important implications for health interventions targeting this population that rely on law enforcement action.

The research on the motivations of purchasers of sex from adolescents is not in complete agreement. According to the World Health Organization (WHO), in Asia, there are a notable number of clients who specifically demand children, with the premium age in many countries being 12-16 years.⁸⁰ On the other hand, a study in Thailand found that clients were predominantly local community members, and the age of the person was almost always irrelevant to all but a small minority of foreign clients.⁸¹ Relatedly, research on the proximity of adolescent involve-



The consistent finding that police and military officers are commonly clients of adolescents engaged in selling sex, paired with data on the high prevalence of police abuse and harassment of these adolescents, raises important implications for health interventions targeting this population that rely on law enforcement.

ment in selling sex to adult sex work locations frequented by clients of adult sex workers is also not clear. For instance, while nearly all policy discussions of child prostitution in Thailand refer specifically to the procurement of children for sexual purposes by foreigners, one study found that the majority of adolescents engaged in selling sex in Thailand see local clients, and are located not in tourist centres, but in brothels in rural Thailand or on the streets of urban cities.⁸²

As discussed in this section, some resources noted that adolescents and young people selling sex have a higher number of clients than older people who sell sex. For instance, in a study among 580 sex workers in West Bengal, India, those under 20 were found to have a higher number of clients (averaging 3.7 per day) than older people who sell sex.⁸³ This finding suggests that SRH services are extremely vital for adolescents selling sex.

3.3 INCREASED VULNERABILITY TO SRH CONCERNS, INCLUDING HIV AND UNINTENDED PREGNANCIES

Studies confirm that adolescents engaged in selling sex are more vulnerable than general young people to SRH problems, such as unwanted pregnancy, HIV and other STIs. As noted above, structural inequalities, lack of self-esteem, lack of agency, isolation and legal powerlessness of their position also leads to an inability to negotiate safe sexual practices leaving them more vulnerable to SRH concerns.⁸⁴ For example, research among 827 MSM and transgender people aged 15 - 24 in Thailand found high HIV prevalence (13 per cent) among the youth group as a whole, but even higher (15 per cent) among those that sell sex.

Studies indicate that adolescents engaged in selling sex are more vulnerable to acquiring HIV and other STIs than adults who sell sex. This can be due to a range of reasons, including that they may have a higher number of sexual partners; have more frequent unprotected sex with lovers, intimate partners or others, even if they use condoms with clients; work in more hidden/underground ways which decreases access to appropriate SRH and HIV services, including information on risks consequences and prevention, and peer outreach;⁸⁵ and more likely to use drugs.⁸⁶ Studies from India, Nepal and Thailand have found that initiation into selling sex prior to age 18 confers increased risk of physical and sexual violence and relates to a two to fourfold increase in HIV infection.⁸⁷ In India, research in specific regions has shown that young women who sell sex are more likely to be HIV-positive than the adult female sex worker population at large. A study among 580 females who sell sex in West Bengal found that HIV prevalence was the highest (24 per cent) among those aged 20 or below.⁸⁸

Similarly, a study of adolescents and young women who sell sex (average age of 18.2 years) in Kunming, China, found that younger age, early sexual debut, being isolated from schools and family, short duration in sex work, and use of illicit drugs were strong predictors for unprotected sex and the presence of STIs. Nearly three-quarters of the adolescents and young women (74 per cent) had STI symptoms in the past year. The majority reported a need for additional health knowledge (77 per cent), free condom distribution (51 per cent) and low-cost STI diagnosis and treatment services (54 per cent). The study showed that having access to condom promotion, free HIV counselling and testing and peer education were associated with lower levels of unprotected sex.⁸⁹ A study in Phnom Penh, Cambodia indicated that more informal, 'sweetheart' relationships with clients (where money is not always given) can decrease the likelihood of consistent condom use by adolescents engaged in selling sex.⁹⁰

Adolescents selling sex are also more likely to be biologically immature than adults who sell sex. For example adolescent girls have a developing cervix made up of unstable cells that are more vulnerable to

certain STIs.⁹¹ In addition, adolescent girls engaged in selling sex who are raped are more susceptible to genital injury following rape due to size and mucosal characteristics that are specific to the less-developed reproductive tracts of younger women.⁹² Similar biological factors may predispose to injury adolescent men and transgender people who sell sex.

There is little available research on the reproductive issues faced by adolescent females engaged in selling sex. Research suggests that adult female sex workers face high rates of abortion due to inadequate contraceptive services.⁹³ This finding suggests additional health harms posed by the abortions themselves, which may be self-induced in the event of denial of health services, lack of affordability, or an environment in which abortion is criminalised, as discussed in Section 5.1.

One study from Thailand, specifically explored the differing vulnerability of adolescents and young people (aged 14 - 19) who sell sex compared to those over 25.⁹⁴ Overall this study summarised the findings as follows:

- There is a strong association between early sexual abuse and sex work at young ages.
- Younger sex workers want to leave the sex industry more quickly.
- Younger sex workers have higher rates of illicit drug use.
- Sex workers aged under 20 earn the least, and 20-24 year olds earn the most.
- Young sex workers endure more abuse at work than older sex workers.
- Young sex workers have similar rates of condom use to older sex workers.
- Young sex workers have very low levels of knowledge about STIs and HIV.
- Young sex workers are less likely to be tested for STIs but not HIV.

VULNERABILITY DUE TO HIV-POSITIVE STATUS

As noted above, some evidence suggests that adolescents engaged in selling sex in the Asia Pacific are more likely to be HIV-positive than the adult sex worker population at large. More study is needed to confirm this finding, as well as research to determine whether SRH vulnerabilities increase adverse health consequences for this group. For instance, it seems likely that selling sex may expose immunosuppressed adolescents to increased risk of sexually transmitted infections at a higher rate than adult sex workers, given that adolescents report a higher number and frequency of clients.

Further research is also needed into the increased vulnerability caused by laws and policies on adolescents who sell sex and live with HIV. In the context of adult sex workers living with HIV in the Asia Pacific, it has been observed that sex workers living with HIV face increased family rejection, abuse and imprisonment from police; lack of access to antiretroviral therapy (ART) and related SRH services and counselling; refusal of access to ART for imprisoned sex workers; and, for migrant sex workers, HIV status can be grounds for deportation.⁹⁵ In addition, almost no research exists about whether adolescents living with HIV who also sell sex are accessing HIV treatment, care and support.

3.4 ADOLESCENTS EXPERIENCE HIGH RATES OF VIOLENCE AND ABUSE

Findings show that adolescents engaged in selling sex are more likely to experience physical and sexual violence than older peers—whether by police, managers, or others—and this violence acts as a direct

cause of sexually transmitted infection and unwanted pregnancy, as well as primary health consequences.⁹⁶ Data from a study of 815 women who sell sex in Thailand, showed that 25 per cent of those who were adolescents reported physical or sexual violence in the context of selling sex during the previous week alone. This can be compared to rates of 18 per cent and 12 per cent for those aged 18–30 and over 30, respectively.⁹⁷

The violence experienced by adolescents might be sexual and/or gender-based and perpetrated by intimate partners, clients or uniformed officers, most commonly local police but also military officers in cross-border regions.⁹⁸ In particular, this review found high levels of police harassment and abuse among adolescents engaged in selling sex in many contexts, which compounds the vulnerability of these adolescents to health issues. It also raises important — and as of yet, unaddressed — implications for health interventions targeting adolescents engaged in selling sex for “rescue” or removal which rely on law enforcement intervention. The existence of law enforcement violence is strongly supported by country level research. In an ECPAT study of adolescent males engaged in selling sex in Bangladesh, researchers found 48 per cent faced police harassment and abuse.⁹⁹ In an ECPAT study in Hyderabad, India, researchers also found that the police targeted adolescent males engaged in selling sex, with 30 per cent reporting being the target of police violence and 23.3 per cent reporting the police had arrested them in the past.¹⁰⁰ In a 2011 ECPAT country report on Pakistan, researchers noted that police conducted raids of bus terminals where adolescent males engaged in selling sex, participated in sexually abusing the boys and received contributions from managers or exploiters.¹⁰¹ These findings highlight the fact that adolescents do not merely face police attention for the purpose of arrest — but also the threat of police harassment, theft, physical abuse and rape, including by requesting sex in exchange for release from custody.

The widespread nature of police abuse likely makes the reporting of violent crimes against them impossible for adolescents engaged in selling sex who face violence by clients, procurers or intimate partners. Moreover, even where law enforcement does not specifically target adolescents engaged in selling sex, the fear of police abuse or arrest may cause adolescents to move beyond the reach of health services. For instance, in a 2011 ECPAT country report on Cambodia, researchers reported that multiple police crackdown operations resulted in the sex sector moving its activities underground.¹⁰²

The data also suggests that in some cases, the training of uniformed officers for victim identification and sensitivity in the Asia Pacific may have little impact. In a 2011 ECPAT report on Singapore, the researchers note that despite capacity building activities for a specialised police unit, the unit criminalised and deported adolescents engaged in selling sex rather than providing them with appropriate care and protection, only recognising the child as a victim in four out of 89 cases in 2009.¹⁰³ Likewise, in a 2011 ECPAT country report concerning Nepal, despite documenting increased sensitivity among police, researchers noted that in September 2008 police arrested hundreds of women and girls when cracking down on entertainment establishments in Kathmandu, but none were screened by the police and identified as victims of trafficking, and none of the women and children arrested were offered protection.¹⁰⁴ These studies did not measure whether harassment, rape, theft or other abuses accompanied these interventions.



Findings highlight the fact that adolescents do not merely face police attention for the purpose of arrest — but also the threat of police harassment, theft, physical abuse and rape, including the extortion of sex in exchange for release from custody.



3.5 MENTAL HEALTH, SOCIAL ISOLATION AND STIGMA

Persons during their adolescent years experience a critical stage in their physical and emotional development.¹⁰⁵ The context in which selling sex may occur compounds what, for many, is a very challenging time in their lives. The review indicated that the mental health impact on adolescents of selling sex is uncertain – it varies according to the individual, their developmental stage and their circumstances.¹⁰⁶ In addition, most studies have not been able to draw causative conclusions, given an adolescent engaged in selling sex may encounter multiple factors that lead to mental health issues, such as stigma and discrimination, institutional violence and social isolation.

Some adolescents report that selling sex brings increased employment, income and independence.¹⁰⁷ However, other studies¹⁰⁸ posit that a correlation exists between negative and long-term impacts and engagement in selling sex. These include: physical harm (such as STIs including HIV, pregnancy, unsafe abortion, drug use and injury); mental harm (such as anger, low self-esteem, guilt, aggression, depression, anxiety and suicide attempts); and social harm (such as stigma, marginalisation and isolation).¹⁰⁹

Several studies correlate selling sex with serious mental health concerns. Studies of programmes supporting the psychosocial well being of adolescents engaged in selling sex report the adolescents having feelings of shame, guilt and low self-esteem. Many feel unworthy of help, and suffer from nightmares, hopelessness and depression.¹¹⁰ These physical, mental and social impacts are also commonly reported among other vulnerable youth, such as street youth and young transgender and young men who have sex with men, which may reinforce psychosocial issues where adolescents share multiple identities. Once again, it is unclear whether these issues are caused exclusively or in part by institutional violence, social isolation, stigma, discrimination and/or selling sex.

In a study of 326 females who sell sex in Goa, India, 42% of those in the youngest age group (under 20) reported attempting suicide in the past three months. Those in older age groups were three to six times less likely to report a recent attempt.¹¹¹ Adolescents engaged in selling sex also generally experience and are less able to cope with high levels of stigma from their own communities as well as from society at large including the health care sector.¹¹² In a participatory action research study with adolescents on the streets of Davao City in the Philippines, children said the stigma of being on the streets was more pronounced for girls, as they are negatively labelled ‘buntog’^k, if not called ‘whores’ or ‘prostitutes’ outright by people in their communities.¹¹³ This may be exacerbated by additional levels of marginalisation, such as for those who also use drugs¹¹⁴ or transgender or third-gendered persons (such as with *hijras*^l in Pakistan¹¹⁵).^m As shown by research in Lao PDR, young, marginalised children and young people – such as those engaged in selling sex – often experience self-stigma, associated with feelings of shame and self-loathing. In response, they sometimes employ strategies aimed to protect their anonymity and reduce harassment. Paradoxically, these strategies, which are protective against social discrimination, increase their risk to HIV infection as well as their risk of exploitation and abuse.¹¹⁶ Clearly the external and self-stigma experienced by adolescents based on their engagement in selling sex can increase their vulnerability to SRH issues.



Evidence suggests the training of uniformed officers for victim identification and sensitivity in the Asia Pacific may have little impact in ending abusive practices.



^k Buntog is defined as a “a derogatory term referring to an adolescent boy or girl engaged in practice of ‘free sex’. The term is derived from the local vernacular, referring to a quail that flies from nest to nest.”

^l A culturally-specific transgender sub-population found in Pakistan, India and Bangladesh, many of whom identify as being neither male nor female, but as *hijra*.

^m See Case study 4: Bugoi, The Philippines.

Adolescents engaged in selling sex are often isolated from community networks. An assessment of 15-24 year olds in Lao PDR found that street-based children and young people were particularly isolated from both personal networks and services. Few disclosed that they were selling sex to their family or anyone in their village. Instead, they fabricated stories of working in restaurants or hotels in which the tips were good. The participants said their families, desperate for the income they provided, often did not question them. A smaller number said their families knew they were selling sex and did not prevent it because there were few other options for income.¹¹⁷ All of the young people surveyed were geographically separated from their parents.

Another interesting finding showed that families can also be affected by stigma. In areas of the Solomon Islands parents and families of adolescents and young people engaged in selling sex to men involved in the logging industry spoke about the effects of this on their families and the shame they felt about having a young child who was, for instance, pregnant.¹¹⁸

3.6 ACCESS TO EDUCATION, LACK OF DESIRED EMPLOYMENT OPPORTUNITIES AND AUTONOMY

There is evidence to show that low levels of education or school enrolment for adolescents can act both as a cause and a result of selling sex. Adolescents engaged in selling sex in the Asia Pacific commonly drop out or experience low levels of education prior to their involvement in selling sex. Nonetheless, a causal or correlative relationship between poor education and involvement in selling sex is not in evidence. For instance, in a study in Thailand, 76 per cent of children and adolescents engaged in selling sex had completed or were currently enrolled in primary school, and some had attended secondary school, indicating relatively high levels of educational attainment. On the other hand, in a study of child labour in the tourism industry in Cebu City, The Philippines, a total of 237 child workers were interviewed out of which 53 were children who sold sex. Seventy-four per cent of child workers had stopped going to school; 17 per cent had never reached high school.¹¹⁹

Findings reveal that selling sex is not simply associated with dropping out of school during involvement, but that selling sex may be a consequence of having dropped out of school due to poverty or discrimination. A study from Surakarta in Indonesia, for which interviews were conducted amongst 110 children who sold sex, found that they were particularly vulnerable to dropping out of school.¹²⁰ In comparison, a study in Bangladesh of sexually exploited male youth found that the large majority of youth aged 11 to 18 sampled were school dropouts. They reported this low level of education contributed to their entry, and that 46 per cent dropped out due to poverty.¹²¹ A study in Thailand found that, in comparison to their peers, MSM and transgender children and young people aged 15 - 24 who sold sex were less educated and more likely to have used drugs and be living away from their family.¹²² Gender and sexual orientation-based bullying and discrimination as a cause of MSM and transgender youth dropout has been well documented.

LACK OF DECENT OR DESIRED EMPLOYMENT OPPORTUNITIES

The low levels of education experienced by adolescents engaged in selling sex matches adolescent labour figures for out-of-school youth. Namely, one quarter of out-of-school youth are estimated to be involved in child labour worldwide.¹²³ In the Asia Pacific, 2012 data from the International Labour Organization on the situation of youth employment in Asia Pacific shows youth employment is domi-

nated by low wage, irregular and informal employment. For instance, in a study of Cambodia, employed young people had low-quality employment; specifically nearly 80 per cent had poorly paid and irregular employment, and nearly 100 per cent were informally employed.ⁿ

Some studies have shown that the majority of adolescents engaged in selling sex had prior employment experience, and that many left prior employment due to employer abuse, poor wages and failure to pay salaries on time. In a study in Bangladesh, 56 per cent of boys engaged in selling sex had prior employment experience before beginning to sell sex; nearly all had been previously employed as day labourers, domestic workers, retail workers or engaged in micro-businesses.¹²⁴ The comparatively high remuneration offered by selling sex, combined with low barriers to entry, may act as an incentive to engage in selling sex for adolescents in some contexts.

AUTONOMY AND ITS IMPACT ON ACCESS TO SERVICES

Adolescents engaged in selling sex may, as compared to other adolescents, lack the skills or access to resources to make their own decisions and reduce their vulnerability to HIV, STIs, unintended pregnancy and other health consequences. The effect lack of autonomy has on SRH and other health needs of adolescents is interrelated with other factors such as economic marginalisation and the experience of physical force or coercion. A study in Lao PDR found that generally younger and more inexperienced people who sell sex were vulnerable to coercion and more likely to be intimidated into not using condoms.¹²⁵ Lack of control also heightens women and girls' vulnerability in the following ways: use of rape as a means of coercing initiation into selling sex; inability to refuse sex; inability to use condoms or negotiate their use; substance use as a coping strategy; and inadequate access to health care.¹²⁶ Similarly, in Vietnam, being under 18 and selling sex has been found to be associated with lower frequency of condom use—a challenge that is compounded by the adolescent's higher number of sexual clients compared to their older peers.¹²⁷

Those adolescents engaged in selling sex who are mobile or in hard-to-reach locations are significantly underserved in comparison to adolescents in more stable venues. Research in China indicated that adolescents (averaging 18 years) who sell sex at higher-risk locations^o are significantly less likely to have received peer education, outreach services, free condoms or an HIV test.¹²⁸ A study in the Philippines found that 86 per cent of those under 18 engaged in selling sex in entertainment establishments and 97 per cent of those engaged in selling sex at cruising sites had never had a HIV test.¹²⁹

As noted, the already heightened health vulnerabilities of adolescents engaged in selling sex can be further aggravated by physical force or other coercion that reduces their autonomy. Research in Eastern India among females who sell sex — 46 per cent of whom had started to sell sex aged 16 - 20 years — indicates that, compared to those who were not trafficked, those who were trafficked were more likely to report having experienced violence (57 per cent compared to 15 per cent), and being HIV positive (13 per cent compared to 10 per cent).¹³⁰ Another study in India among girls and women aged 14 - 30 years found that those that had been trafficked lacked control over their movements and actions, increasing their vulnerability to HIV due to being unable to refuse sex, negotiate condom use or access health services.¹³¹

ⁿ ILO findings in 2012 showed that 13.1% of youth ages 15 to 24 in Southeast Asia and the Pacific were unemployed, meaning 86.9% were employed in some form. For details see International Labour Organization (ILO), *Global Employment Trends for Youth 2013: A Generation at Risk*, www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/publication/wcms_212423.pdf.

^o Participants at higher risk were those who walked the streets, worked in bars, small roadside guesthouses/hotels with managers or pimps, foot massage parlours, small saunas/bath rooms, barbershops, karaoke clubs, dancing halls and those who were self-employed (soliciting from the internet, a mobile phone or through a pimp).



Some studies have shown that the majority of adolescents engaged in selling sex had prior employment experience, and that many left prior employment due to employer abuse, poor wages and failure to pay salaries on time.



CASE STUDY

4

Bugoi, a 16 year old transgender who sells sex, the Philippines¹³²

Bugoi has been living in the alleys of Adriatico Malate in Manila, selling sex in the evening and then sleeping on the street or in a friend's house in the morning. Bugoi started selling sex at a very young age. Six months ago, she started smoking marijuana and taking methamphetamine (shabu), either orally or by snorting it, which she believed was safer than injecting. Her friends told her the drugs would boost her stamina while selling sex.

"Sometime our clients offer us the drugs and if we perform well, they give us extra pay and a shabu for free. Clients often prefer to use shabu before we have sex. I feel numb every time I use shabu, I don't care about what people say anymore, I just want to do the things I want to do. My body is full of energy. I've been arrested three times before because the police found marijuana on me. I was sent to prison for 16 days, where the adult inmates discriminated [against] me because I'm transgender People call me names like 'gay boy who use[s] drugs'. Whenever they say this I feel hurt inside. I still keep my poise and act normally, but I feel more alone now. I'm afraid one day my family will find out about my sex work and drugs. But I have no choice as I need to help my mother earn another day's living. I can't get the free HIV test because I don't want my mother to know what I'm doing and so I cannot provide the clinic with parental consent. So I have to go to Youth AIDS Filipinas Alliance (YAFA—a youth NGO—to ask [for a] consent letter from the volunteers. It's a hassle to do that when all I want is to know my HIV status and whether I have a sexually transmitted infection I'm being trained to become a peer educator to other young transgender people in sex work who also use drugs. I came to realize how important it is to share my knowledge with my peers about HIV as well as about our rights as young people. In my own little way at least I know I helped."

CASE STUDY

5

Tip, a freelance 17 year old who sells sex, Thailand¹³³

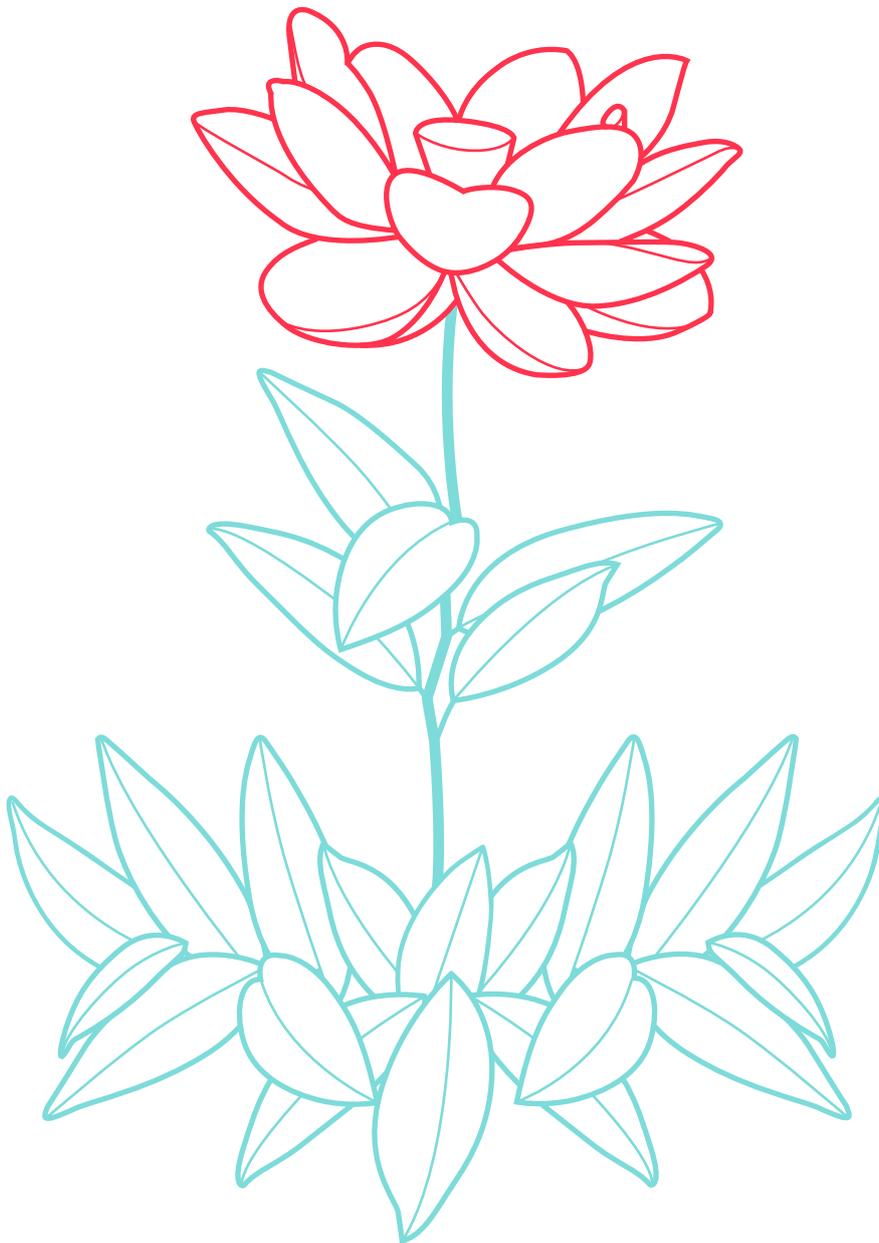
When she was 15, Tip was given alcohol and then raped by her brother's friend at a birthday party. After telling her parents about the incident, she moved in with the brother's friend. She dropped out of school and started work at a noodle stall, where she earned 200 baht per day. She gave birth to a child at age 16. Her boyfriend blamed her for not preventing the pregnancy. He became a drug user and stopped working, living off Tip's earnings. Tip argued with him about money and the baby and decided to move out. She became desperate to earn money for her baby.

Tip heard that sex workers were operating from the Royal Grounds, Bangkok. She went there to ask about work and a food vendor encouraged her to try. Tip earned 300 baht from her first client who refused to use a condom. After she had sold sex for several months, a friend suggested that she take a blood test. She went to an anonymous clinic run by the Red Cross Society and took a free HIV test. It was negative. Many of Tip's customers refuse to use condoms. Tip's current boyfriend also sells sex. Tip lives with the boyfriend and his mother. She works six days per week and earns about 15,000 baht per month. Her boyfriend's mother collects condoms from a nearby health centre and gives them to her and her boyfriend.

The above case studies illustrate how many adolescents engaged in selling sex need support related to additional vulnerabilities (such as harm reduction for those who inject drugs), as well as multiple general needs, such as in relation to their education and livelihood. Interventions must be cognisant of the different ways in which engagement in selling sex reinforces pre-existing or co-occurring vulnerabilities in adolescents and the need to address them comprehensively, as further outlined in Section 4.8.

4

**THE PROGRAMMING PERSPECTIVE:
WHAT WORKS FOR ADOLESCENTS
ENGAGED IN SELLING SEX?**



4. THE PROGRAMMING PERSPECTIVE: WHAT WORKS FOR ADOLESCENTS ENGAGED IN SELLING SEX?

The International Conference on Population and Development in 1994 (ICPD) and its subsequent Programme for Action established that sexual and reproductive health (SRH) are essential for adolescents. The Programme of Action specifies many programmes for SRH care in the context of primary health care that apply to adolescents engaged in selling sex, including: family planning; antenatal, safe delivery and post-natal care; prevention of abortion and management of the consequences of abortion; treatment of reproductive tract infections; prevention, care and treatment of STIs and HIV/AIDS; information, education and counselling, as appropriate, on SRH; prevention and surveillance of violence against women; care for survivors of violence; and appropriate referrals for further diagnosis and management.

There exist a number of useful, evidence-based resources that can be adapted to provide guidance for SRH and other health interventions for adolescents engaged in selling sex. However, there is no one set of agreed policy and/or programme guidelines available either internationally or in the Asia Pacific region, and there are also gaps in guidance for adolescents in certain contexts. With regards to information about successful programmes, there are few empirical data to assess the capacity of current HIV treatment, prevention, care and support and SRH programmes to reach adolescents and both protect them from STIs, HIV and other related issues or, for those living with HIV, provide them with ART. According to assessments, the majority of large intervention trials regarding prevention of HIV among female sex workers have excluded those that are under 18.¹³⁴

Researchers have suggested that another problem lies with the quality of research carried out by NGOs who frequently use *“quantitative methods on small samples of informants, producing unreliable ‘statistics’ that are generalized to large populations..... Samples tend not to be clearly identified, basic disaggregation of data, such as by gender or age, is often lacking.”*¹³⁵ Yet this data is critical, because, as mentioned above, large scale studies on adolescents engaged in selling sex are scarce.

4.1 AVAILABLE GUIDANCE

SRH AND HEALTH GUIDANCE RELATED TO ADOLESCENTS

Overall, findings showed that there is a lack of agreed-upon policy and programme guidance on addressing the complex SRH and other health concerns of adolescents engaged in selling sex – as opposed to young people in the general population or adult sex workers.¹³⁶

An exception, shown in Figure 3, is provided by programme guidance notes for South Asia developed by UNICEF, UNFPA, UNESCO, United Nations Office on Drugs and Crime (UNODC), WHO and Family Health International (FHI). The document uses the United Nations definition of young people (aged 10 - 24 years), children (up to 18) and adolescents (10 – 19). The first part of the guidance (focused on young sex workers) is based on suggestions from members of the Coalition of Asia Pacific Regional Networks on HIV/AIDS and including the Asia Pacific Network of Sex Workers. The second part (focused on young male and young transgender sex workers) is based on *The Truth about Men, Boys and Sex* – a publication developed by the International Planned Parenthood Federation (IPPF).

Figure 3: UN guidance on programs in South Asia for young sex workers¹³⁷**Young sex workers:**

- Reach out to young sex workers using their own friendships and networks. Use outreach to ensure 100% condom delivery.
- Work with entertainment establishment owners to encourage the promotion and provision of condoms in establishments where sex work may occur. Seek to partner on outreach programmes with establishment owners.
- Keep in mind that poverty is a key reason why young people sell sex;^p some young people may regard sex work as a viable source of income and migration to areas known for sex work as necessary for increasing their chances of work.
- Assist and empower young people by providing livelihood training, education and other skills in consultation.
- Provide access to counselling, testing, reproductive health and social support, and basic health care services through creative, innovative means such as the media (TV, radio, print, outdoor media), technology (text messages), and community educational initiatives in areas known for sex work.
- Create linkages to other services such as maternal and neonatal health and prevention of mother to child transmission (PMTCT) services for female sex workers; involve their male partners.
- Work with sex workers and relevant authorities to reduce harm including violence, rape, HIV and STIs.
- For those under 18, make sure they have access to information, services and condoms/lubricants to promote safe behaviours or if they wish, assist them in quitting sex work by providing necessary skills, re-integration with families if and where possible, and psychosocial counselling as part of child protection.
- Support the young sex worker to reach clients with appropriate information and referrals to services if required, and focus on promoting responsible client behaviour and the practice of safe sex.
- Encourage self-help groups to reach out to young people who sell sex. This is appropriate if young sex workers feel uncomfortable to speak out when they are with older more experienced workers. This will work better in some settings than in others.
- Make IEC materials appropriate to the needs and contexts. One example is the 'Smart Girl' materials from Cambodia which promote young women who protect themselves from disease as smart and looking after their health.
- Focus resources for programming on the locations where most young sex workers, their clients and their sexual partners can be reached.

Young male and young transgender sex workers:

- Build the knowledge base and capacity of male sex workers and their clients on correct and consistent condom use and non-penetrative safer sex to prevent STIs, HIV and unwanted pregnancies (the latter is often a concern for male sex workers with their female clients and partners).
- Provide primary health care and rights-based sexual and reproductive health and HIV services, through outreach work and mobile clinics. Special services that should be considered for male sex workers include access to condoms and lubrication, diagnosis and treatment of rectal and oral STIs, and counselling and medical support for transgenders who take hormones or seek sex reassignment surgery.
- Address stigma and discrimination, including thorough advocacy on the rights of sex workers, legal reform, working with the perpetrators of discrimination and violence, psycho-social support and legal options.
- Ensure sex workers' participation in developing, implementing and monitoring sexual and reproductive health and HIV programs.
- Lack of financial resources may be a barrier to reaching male sex workers, but stigma is often the greater obstacle. Sensitising project staff (from the project coordinator to the receptionists at the clinics) on the rights and needs of male and transgender sex workers usually needs to be the first step to implementing effective and rights-based programs. Staff should also have the skills and facilities to take accurate medical histories, conduct rectal examinations and throat swabs, and give specialised advice and counselling.

^p Poverty rarely exists in isolation – there are usually other contributing factors that compound the adolescent's likelihood of involvement in selling sex. Further, sometimes it is not a reason at all, e.g. the practice of enjo kosai ("compensated dating") in Japan and Korea.

As seen in Figure 4, a further exception is provided by policy and programme guidance by UNICEF, UNFPA and UNESCO which addresses young people up to 24 who sell sex (while acknowledging that some start while under 18). Again, the terminology of the original document is used.

Figure 4: Key elements for young people who sell sex¹³⁸

- 1. Avoiding sexual exploitation and promoting child rights for those under 18.** Children should not have to earn a living in the sex industry. They deserve an education and a safe and healthy lifestyle. Young people in sex work (not only those under 18) should be screened for the extent they control their own lives, including the decision to enter the sex trade, their say in the selection of their customers, the type of services that they provide and the income they generate.
- 2. Providing services to exit the sex industry.** If sex workers are under 18, in principle the law enforcement and social welfare sectors should take over; sex workers over 18 should be given the option, since relapse is common among those who are forced to quit. So-called 'rehabilitation' of young people that have been in sex work should focus on providing appropriate education and / or vocational training, where the child is based in her/his family or community or (as a measure of last resort) in institutions. They should have access to counselling and social support, health care, and all efforts should be made to avoid stigma and discrimination by upholding standards of confidentiality.
- 3. Reducing harm, including violence, rape, HIV and other STI, for young people who do not want to quit sex work.** Even if a sex worker is under 18, is not exploited or forced by an adult manager or 'pimp' but still refuses to quit, he or she should not be refused access to prevention services and health care.
- 4. Reducing demand for underage sex workers.** . Criminalising customers seeking services from underage sex workers may be more effective than focusing on curbing the supply of young sex workers, especially in countries where trafficking of young women and girls is common or where entry into the sex trade by 'dutiful daughters' to earn money for a poor family is implicitly appreciated or encouraged by segments of the population.
- 5. Establishing self-help groups for young people who sell sex.** This is appropriate if young people who are part of groups that consist of older sex workers feel discouraged to speak out.
- 6. Adapting IEC and messages for behaviour change.** These may need to be adapted to include language popular with teenagers; also the 'level' of information provided may need to be lowered for young sex workers, as they may have less basic knowledge and less experience than their older peers.

GUIDANCE RELATED TO YOUNG PEOPLE FROM KEY POPULATIONS AT HIGHER RISK OF HIV EXPOSURE

As represented by the examples in Annex 2, the paper identified many examples of programmatic and/or policy guidance on young people most at risk of HIV, including in the Asia Pacific region. These include adolescents under the age of 18 who sell sex, alongside those who, for example, are MSM, transgender and/or inject drugs. They provide very relevant input on the type of approaches and issues to be considered for all adolescents who are highly vulnerable and marginalised.

GUIDANCE RELATED TO ADULT SEX WORKERS

Similarly, as represented by the examples in Annex 3, the paper identified an increasingly strong collection of programmatic and/or policy guidance related to adult sex workers. For instance the *UNAIDS Guidance Note on HIV and Sex Work* provides clarification and direction on reducing HIV risk and vul-

¹³⁸ Poverty rarely exists in isolation – there are usually other contributing factors that compound the adolescent's likelihood of involvement in selling sex. Further, sometimes it is not a reason at all (e.g. practice of enjo kosai in Japan, Korea).

nerability in the context of sex work.¹³⁹ It is also built on human rights principles supporting the right of adults to make “informed choices about their lives, in a supportive environment that empowers them to make such choices free from coercion, violence and fear.” In addition the *Prevention and Treatment Of HIV And Other Sexually Transmitted Infections For Sex Workers In Low- And Middle-Income Countries: Recommendations For A Public Health Approach* developed by WHO, UNAIDS, UNFPA and NSWP in 2012 supports national public health officials, managers of HIV and STI programmes, civil society and health workers with good practice recommendations.¹⁴⁰

There is a need to recognise that, in certain circumstances, a 17 year old may have similar needs to an 18 year old in relation to SRH. As such this guidance for adult sex workers is included as an additional resource. In particular this resource can inform the development of programmes and policies that specifically address the practices, risks and vulnerabilities associated with adolescent engagement in selling sex.

4.2 SRH AND HIV CONCERNS

Several studies have identified a paucity of interventions sensitive to the SRH and HIV related needs of adolescents engaged in selling sex.¹⁴¹ Still others have emphasised that development of new approaches to identify and assist such interventions should be prioritised.¹⁴² A study in China among 493 adolescent (15 - 19) female sex workers found that this group has often been neglected by SRH strategies and services due to the traditional assumption that young people should be attending school with family support and abstaining from sexual intercourse. Seventy-seven per cent of the females surveyed reported a need for additional health knowledge and 50.8 per cent for free condom distribution. They also expressed a need for low-cost STI diagnosis and treatment services (53.7 per cent). Of the 148 who reported STI symptoms in the past year, only 25.5% reported seeking care at public health facilities. The study concluded that interventions do not sufficiently address the reality of the diverse social and contextual factors that affect female adolescents engaged in selling sex.¹⁴³

Where they do exist, programmes pay inadequate attention to the fuller spectrum of their health concerns, including SRH¹⁴⁴ since they are often focused on HIV and target adults. These latter emphases are likely an unfortunate consequence of donor requirements. In fact, adolescents engaged in selling sex may particularly benefit from integrated services that link SRH and HIV.¹⁴⁵ This is because such services may have the capacity to address a broad range of their personal and health-related needs. Examples of key components of SRH programs for adolescents engaged in selling sex include: condom provision (for example, with a study in China finding that those that did not receive condoms were 2.5 times as likely to have at least one STI);¹⁴⁶ and contraception, safe abortion and maternal care (for example, with a study in Thailand highlighting a significant unmet need for contraception—with high levels of risk of unwanted pregnancy).¹⁴⁷ Research in Lao PDR, found that just over a third of females who sold sex (of a sample of 912 women) — many of whom were adolescents and young people — had been pregnant, with 71 per cent of them having terminated a pregnancy.¹⁴⁸

In addition, with significant correlations between selling sex and the (both injection and non-injection) use of drugs,¹⁴⁹ adolescents engaged in selling sex may need services for drug-related education, hepatitis testing and treatment, addiction treatment options and harm reduction, such as needle and syringe programmes.¹⁵⁰ Research among 200 males (aged 15 and above) engaged in selling sex in Ho Chi



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Minh City, Viet Nam, found that younger people were less able than adults to understand SRH, reduce their risk behaviours and have an HIV test. It also found that males who sold sex in this context were a sub-group of MSM (an already highly marginalised group in the City) and showed higher levels of alcohol, drug use and high risk sexual practices than their peers.¹⁵¹ A study among 565 male street children (5 - 19 years old) in Lahore, Pakistan, found that, in the last three months, 40 per cent had exchanged sex for money, drugs or goods and nearly all had used drugs.¹⁵² In Hanoi, Viet Nam, a study comparing heroin using males aged 16 – 29, who sell sex, to heroin using males who do not sell sex, found that those who sell sex were more likely to have a history of forced sex and have multiple sources of complex sexual risk (such as a high number of different sexual partners and high rates of both penetrative and receptive sex). Adversely, they were less likely to have had an HIV test.¹⁵³ A study in Thailand found that MSM and transgender people aged 15 - 24 engage in multiple high-risk behaviours such as unprotected sex, multiple sex partners, sex work and drug use.¹⁵⁴

Some findings from research in Lao PDR¹⁵⁵ highlighted the need for further analysis, planning and provision of support to adolescents engaged in selling sex who are living with HIV. Such adolescents face an additional layer of challenges — such as intense HIV-related stigma — on top of their existing challenges related to being young, selling sex and perhaps also using drugs or being MSM or transgender. They need access to a full range of care, support and treatment services, such as ART, treatment adherence support, treatment education, co-infection and opportunistic infection diagnosis and management, and mental health support. If they are pregnant or have children they require an additional level of support including prevention of parent to child transmission services, access to respite or day care services and access to information related to childbirth, child rearing and nutrition. These all need to be both generally ‘youth-friendly’ and specifically sensitive to the needs of adolescents engaged in selling sex.

Where they cannot provide all services themselves, organisations need to establish referral systems for adolescents engaged in selling sex to other service providers. However, with some adolescents who sell sex likely to be fearful of government services and given that health workers are often not trained in the provision of non-judgmental, accurate, accessible, and/or non-discriminatory support,¹⁵⁶ careful attention is needed to the assessment and selection of such partners.



Careful attention is needed to the assessment and selection of partners in referral systems, given that adolescents who sell sex are likely to be fearful of government services and given that health workers are often not trained in the provision of non-judgmental, accurate, accessible, and/or non-discriminatory support



Figure 5: Promising approaches for linking HIV, SRH and child Protection systems¹⁵⁷

According to ECPAT research in Nepal and Togo, promising approaches for linkages include:

- Peer education programmes that include SRH services
- Community based approaches and peer networks, which are critical to getting children who sell sex into HIV testing and treatment, as well as to responding to their other immediate care needs.
- Structural interventions, which should include analysis of poverty, gender inequality, lack of economic livelihood options and discrimination. Structural interventions should also support marginalised children and their families to access government services and social security systems.

“The participation of children and young people is an effective entry point for addressing reproductive health issues and for strengthening the design and implementation of research and HIV/AIDS related programmes. With the appropriate support and training, empowered children and youth can act as key agents for change within their communities and through national level advocacy.”

4.3 TAILORING PROGRAMMES TO ADDRESS THE NEEDS OF ADOLESCENTS

As mentioned above, findings highlighted the need for programmes for adolescents engaged in selling sex to be age, behaviour and gender appropriate,¹⁵⁸ comprehensive and tailored to the needs of the individual adolescent.¹⁵⁹ Programmes also need to consider local contexts, including social and religious norms. Whatever services are provided, programmes need to be rights-based, supporting adolescents to take informed and good decisions about their health and well-being.¹⁶⁰ In some documents, such as that captioned in Figure 4, UN agency guidance has recommended that programmes should, in principle, aim to prevent first involvement in selling sex for those youth at risk and to provide alternatives to the selling of sex. However, for those who decide to remain, or do not wish to change their behaviour, this guidance suggests that programmes should focus on reducing harm and meeting the full needs of the adolescent.¹⁶¹

In addition, findings suggest that especially for HIV treatment, prevention, care and support it is critical that health interventions for this adolescent group not be limited to either traditional, school, hospital or clinic-based services. This finding is especially important in light of the likelihood that adolescents engaged in selling sex have or will drop out of school, as discussed in Section 3.6, or experience discrimination and denial of services from traditional health care providers. A recent UNICEF global systematic review found that a significant proportion of adolescents are underserved by school-based health services, and recommended that these should complement and not replace other health care services in the context of HIV treatment, prevention, care and support interventions. The review also found that adolescents require a tailored approach to access to HIV testing and counselling including out-of-facility services, opt-out provider-initiated testing, rapid testing, and testing within a tolerant environment.¹⁶³ Finally, the review found that interventions to increase HIV treatment access among adolescents living with HIV likely require models of care that combine treatment with supplementary nutrition programmes.¹⁶⁴

UNICEF's systematic review found that among HIV treatment, prevention, care and support interventions that targeted adolescents and youth, those in which adolescents created their own system or structure for intervention delivery were the only ones that had evidence of an impact on biological and behavioural outcomes.¹⁶⁵ The study also recommended community-based condom distribution strategies such as street outreach and peer distribution to increase access to condoms among adolescents, as well as provision of opioid substitution therapy to adolescents who inject drugs.¹⁶⁶

It is important to mention that SRH and HIV may not be an adolescent's main concern. A comprehensive approach involves addressing the spectrum of their health and protection needs — from food and housing, STI and HIV treatment, prevention, care and support, to their wider SRH and primary healthcare, social welfare, psycho-social well-being, legal, education and employment needs.¹⁶⁷ Programmes need to combine attention to the adolescents' behaviour, context and life stage



While UN agency guidance has recommended that programmes should, in principle, aim to prevent first involvement in selling sex, for those who decide to remain, or are unable to change their behaviour due to poor circumstances, this guidance suggests that programmes should focus on reducing harm and meeting the full needs of the adolescent.



Findings suggest that especially for HIV treatment, prevention, care and support it is critical that health interventions for this adolescent group not be limited to either traditional, school, hospital or clinic-based services. This finding is especially important in light of the likelihood that adolescents engaged in selling sex have or will drop out of school, or experience discrimination and denial of services from traditional health care providers



as an adolescent who has evolving capacities with attention to technical interventions (such as STI treatment and HIV testing) related to them selling sex.

In many contexts, specific programmes are needed for different groups of adolescents engaged in selling sex — especially those that experience physical force or coercion in their involvement, and may be less likely to access NGOs or peer outreach services. One study in China recommended that existing services for adult sex workers, such as drop-in centres, needed significant reorientation to be relevant and accessible to adolescents.¹⁶⁸ However, sometimes, parallel programmes are not necessary—as adaptations can be made to existing programmes.¹⁶⁹ For example, a study in Thailand concluded the SRH specific needs of youth need to be recognised – and better addressed - within general services for sex workers.¹⁷⁰

To meet the specific needs of younger cohorts, existing services for adult sex workers would need to emphasise to a greater degree certain pre-existing services in order to better address adolescents' disproportionate vulnerabilities, such as: free or subsidised shelter or long-term housing; substance use programmes; education grants; job placement and skills training; legal services; reintegration with the family if desired; and confidential psychosocial counselling including trauma and abuse counselling. In addition, specific groups of young people need context-specific programmatic adaptations; for example, to make existing programmes for adult transgender sex workers accessible for adolescents in these populations, special emphasis should be placed on youth development and empowerment to fight stigma related to sexual orientation and gender identity, as well as a greater emphasis on hormone access and safe-injection methods for transgender adolescents. In addition to providing services, staff would need more comprehensive training to prevent discrimination and homophobia, which deters many adolescents from accessing services to a greater degree than their adult counterparts.¹⁷¹

4.4 INCREASING COVERAGE OF SRH PROGRAMMES TO INCLUDE ADOLESCENTS

Findings emphasised the need for SRH programmes for adolescents engaged in selling sex to have adequate coverage — reaching a large enough number of such adolescents to, for example, protect adolescents from immediate harm and impact on SRH problems and HIV epidemics.¹⁷² According to a United Nations paper published in 2007, age and gender-appropriate HIV prevention and support services for young people — including adolescents engaging in high risk behaviours such as selling sex in Asia Pacific — should be scaled-up to reach 80 per cent in 2015 to have an impact on the HIV epidemic.¹⁷³ At present, the extensive challenges to meeting that target include that without comprehensive and disaggregated data on the size, needs and challenges of vulnerable populations, it is difficult to establish a baseline, identify appropriate indicators and assess progress.¹⁷⁴ Currently, there appears to be low coverage of specific SRH programmes for adolescents engaged in selling sex.¹⁷⁵

However some of the programmes identified for this paper noted the number of adolescents engaged in selling sex that they have reached. One example is the SMART girl programme in Cambodia (see Case Study 6), which was also able to indicate coverage since it had an estimated population size. The 18,000 or more young women who sell sex (including those who are adolescents) that it has reached represents more than half of the entertainment workers⁹ in the provinces where it works.¹⁷⁶

⁹ The term 'entertainment workers' refers to women employed in the entertainment sector, e.g. beer promoters, karaoke singers, massage workers and hostesses in bars and restaurants who may also sell sex 'directly' (as their main means of income) or indirectly (to supplement income some of the time).

CASE STUDY

6

SMARTgirl Programme^r (supported by FHI 360), Cambodia¹⁷⁷

Where do they work? Through 6 local NGOs in 9 provinces

Who do they support? Females who sell sex, including some who are young

How do they work?

- Reinvigorating HIV prevention among females who sell sex by changing how they see themselves, celebrating them as smart for their HIV prevention efforts rather than as bad because they sell sex.
- Emphasising the integration of family planning information and services with HIV – because 17-26% of entertainment workers in the country had abortions in the preceding 12 months. The programme also emphasises condom use with regular partners as part of HIV risk reduction.
- Supporting referrals to HIV testing and counselling, reproductive health and STI treatment centres, with referral cards to track service use. Using a positive, fun, modern and trustworthy tone in the messages. Using quarterly themes (such as alcohol and drug use), working with peer educators and using group discussions.
- Reaching more than 18,000 women, of an estimated number of 35,000 entertainment workers in the provinces, and tracking referrals and condom distribution.
- Recognising that some of the young women are selling sex in part to support drug use – and, therefore, operating drug support groups and planning to offer needle and syringe programs.
- The Cambodian Government has announced that it is introducing a new national sexual health model and standard procedures, based in part on the SMARTgirl approach.

Difficulties in increasing coverage include that adolescents engaged in selling sex who are mobile, street-based or in hard-to-reach locations often cannot access traditional health care services. A further difficulty is sometimes found in relation to recognition of and identity of adolescents engaged in selling sex. Research in Samoa found that adolescents and young people who sell sex are hard to identify as they are 'hidden' as a social group.¹⁷⁸

Increasing the availability of mobile services and other ways to bring health care into locations where adolescents live could prove useful. In addition, adolescents engaged in selling sex could potentially be provided access to SRH and other health services through currently existing social protection programmes, such as those that provide cash and food allowances. One study, comprised of a social protection mapping in nine countries of the region⁵ detailed mostly government run initiatives specifically related to children affected by HIV and AIDS.¹⁷⁹ The programmes largely had national coverage and were focused on health insurance, education, cash transfers for families living beneath a certain income level, cash for food schemes, access to drugs and livelihood initiatives for caregivers. While most countries in the study were implementing a cash and food scheme for children living and working on the streets, adolescents engaged in selling sex do not seem to be specifically covered in any of the schemes. Indeed the report acknowledges that *"social protection for key affected populations...is lacking in the region. Of the reviewed programmes, only a handful focused specifically on these highest-risk groups"*¹⁸⁰ In addition a review of this mapping study showed limited evidence of SRH interventions within the programmes. Integration of SRH and other health services for adolescents engaged in selling sex could also prove helpful in increasing coverage; integration would mean an adolescent could have multiple health needs addressed at one service centre.

^r For a video introduction to the SMARTgirl Programme, see <http://www.youtube.com/watch?v=d60UMhBZNQo>.

⁵ Bangladesh, Cambodia, China, Indonesia, Nepal, Pakistan and Papua New Guinea, Thailand, Vietnam.

4.5 MENTAL HEALTH

Programmes also need to address the mental health needs of adolescents engaged in selling sex. For example, a study of young MSM and transgender people in Thailand, including some who sell sex, concluded that more information and action is needed on mental health and self-efficacy.¹⁸¹ Findings from different parts of the child protection sphere showed a significant shift in terms of approaches for working with children experiencing trauma, low self-esteem, depression or risk behaviours due to harmful sexual encounters and violence. There is a shift away from therapeutic approaches[†] to ecological models which emphasise the interacting dimensions of inter-personal relations of family, community, the socio-economic context and cultural environment as factors that impact on the physical and mental health and well being of the child and thus also on the recovery and healing process when a child is harmed and protection has failed.[‡] Although some of these findings are from studies related to children in conflict situations, they may provide some insight and guidance into ways forward for interventions related to the mental health needs of adolescents engaged in selling sex.[‡]

CASE STUDY

7

Save the Children, Viet Nam¹⁸²

Where do they work? Viet Nam

Who do they support? Young females who live on the street, including some who are children

How do they work?

- Developing an operations research/intervention project – based on a model combining inter-personal communication with effective referral to services. The project builds on the ‘continuum of volition’ model, which illustrates how programmes must recognise the young woman’s specific situation. For example, protection may be the priority for girls being coerced to sell sex, while education, health services and economic opportunities may be the priorities for those motivated to sell sex primarily for economic reasons.
- Working primarily with female street youth who are usually controlled by and in debt to their manager, with some of the young women working out of cafes or bars. Many of the young women migrated to the city looking for jobs and started selling sex to support themselves. Most were 17 or older when they became involved, but some started as young as 13. Most of the girls are not willing to test for HIV because of the stigma associated with testing, as well as the associated fear and lack of options for care and support.
- Training and supporting 15 paid peer educators, who had a high level of street credibility and were not using drugs, to work with 100 girls and young women selling sex. The peer educators led structured discussions for groups, using a well-tested curriculum that addresses gender roles, street life, condom negotiation, substance abuse, expressing emotions and violence. The peer educators were available via cell phones and street contact to follow up with the young women in their daily lives, including referrals to health services and condom distribution. The peer educators themselves received support from social workers and social work students.

[†] These have usually emphasised psychotherapy, counselling, cognitive development therapy (sometimes referred to as talking therapies) in combination with creative and relaxation based therapies such as, drama, art, dance and play focused on the individual.

[‡] For further discussion please see ; and M Fazel, & Stein, A. , ‘The Mental Health of Refugee Children’, *Archives of Disease in Childhood*, 87/5 (2002).

[‡] For details please see Timothy P. Williamsb Theresa S. Betancourt, Sarah E. Kellnerd, Joy Gebre-Medhinc, Katrina Hannd, Yvonne Kay-iteshongae, ‘Interrelatedness of Child Health, Protection and Well-Being: An Application of the Safe Model in Rwanda’, *Social Science & Medicine*, 74/10 (2012), 1504-11. Donatien De Graaff Brechtje Kalksma-Van Lith, Eveline Jansveld, Ans De Jager, ‘State of the Art Psychosocial Interventions with Children in War-Affected Areas’, (Amsterdam War Child 2007).

- Social workers providing case management for service referrals, including issues relating to pregnancy, employment and re-connection with family (if this was considered a positive thing to do).
- Identifying valuable lessons, such as that: peer education could reach street girls selling sex and was effective in encouraging appropriate behaviours to reduce risk; calling the project 'youth programming' was more effective than calling it a 'sex worker project'; and having caring adults working with the peer educators and the young women was also important. Recognising that, while the young females were not always ready to make life changes, services and support needed to be available for when they were.

CASE STUDY

8

Service Workers in Group (SWING), Thailand¹⁹²

Where do they work? Bangkok, Pattaya and Samui

Who do they support? Males, females and transgender people of any age who sell sex

How do they work?

- SWING staff identify volunteers who sell sex at each establishment to act as contact persons and help with activities. The greatest obstacle for reaching those under 18 is their illegal status. Employers are often reluctant to grant access to under-age workers. SWING tries to overcome this by building up good relations with employers.
- Offering foreign language classes, non-formal education, workshops at sex establishments, solidarity activities, life skills camps, group support for people living with HIV, counselling, and health information and referrals.
- Involving those selling sex in the implementation of activities, as much as possible.
- Designing activities directed at younger people who sell sex to emphasise basic health knowledge, including protection from STIs, HIV and pregnancy – as they have extremely limited knowledge about such things.
- SWING staff distribute free condoms to establishment employers and giving them out at their offices.
- Staff use every opportunity they can to promote condom use among sex workers.

CASE STUDY

9

World Vision, Thailand¹⁸⁴

Where do they work? Pattaya

Who do they support? Young at-risk people in the community, including children and young people who sell sex

How do they work?

- Providing a centre and maintaining a friendly atmosphere so that the children and young people feel welcome.
- Providing occupational training and counselling, plus scholarships for non-formal education.
- Organising therapeutic activities such as music, art and recreation.

- Encouraging HIV testing if people have not been tested already.
- Enabling the children and young people themselves to help organise the activities. Relations between the children and young people and staff are very good. The centre has become a home and meeting place.
- Planning to work with the owners of sex work establishments to protect children's rights.
- Records indicate that around 70 children and young people use the services regularly. About 90% are boys and almost all are aged under 18. All have experienced substance abuse of some kind and most have had symptoms of STIs. Five are known to be living with HIV and are receiving ART. Many of the others do not want to be tested.

As reflected in the Case Studies 6-9, the key characteristics of services for adolescents engaged in selling sex are that they should be low-threshold, voluntary and confidential, non-judgmental, accessible, and in places and times that suit the intended populations. Gaps in data available on these programmes also reveal a need for more comprehensive documentation of the implemented interventions to include more detailed information on the scope of the programmes, numbers reached, duration of operation and lessons learned.^w

4.6 DELIVERY OF PROGRAMMES FOR ADOLESCENTS

Evidence suggests that adolescents engaged in selling sex benefit from a combination of service delivery methods.¹⁸⁵ Community Support Concern and Homeopathic Association of Pakistan (HMAP) – working with female, MSM and transgender young people who sell sex in the Punjab, Pakistan – have found it important to combine youth-friendly drop-in centres with outreach.¹⁸⁶ The latter is particularly important for adolescents engaged in selling sex. This is because, while generally being ‘underground’ and sometimes opting for self-medication rather than accessing mainstream health facilities,¹⁸⁷ they are often willing to receive support in the location where they sell sex, such as entertainment establishments.¹⁸⁸ A study among young MSM and transgender people in Thailand found that those who sell may actually be more likely to use condoms than other young people – in part, because they are targeted by outreach activities.¹⁸⁹

Adolescents engaged in selling sex may lack supportive companionship. As such, peer education is another important intervention acting as a source of information and support and simply someone to talk and relate to. As shown by the experiences of Fulmaya in Nepal (see Case Study 10), it can be critical to building trust among and providing support to adolescents who sell sex.¹⁹⁰



The importance of combining safe, youth-friendly drop-in centres with peer-based outreach is particularly important for adolescents engaged in selling sex because these adolescents are often willing to receive support from peers in safe locations or the location where they sell sex, such as entertainment establishments.

CASE STUDY

10

Fulmaya, 16 year old girl who sells sex, Nepal¹⁹¹

“I started [working] in a guesthouse when I was 15. I was at school, but since my family situation was not good, some of my friends said if I wanted to earn some money I could try sex work. My parents don't know what I do. They think I am going out with friends. I am not at school any more. Community mobilisers came up to me one day during their outreach, and with them I started going to VCT clinics. If I had been alone I wouldn't go,

^w For details on additional ‘drop in centre’ style NGO interventions specifically for boys that sell sex in five countries of South Asia see John Frederick, 2010 (full reference endnotes). This document also includes a section on limitations of documentation and evaluation of existing programmes.

but with them I felt comfortable. At the centres, I got information on condoms and that if a condom ruptures I should get tested. Before meeting them, I didn't know about HIV or STIs.

There are different types of clients. Some want to use condoms, but I don't know if that is due more to avoid pregnancy. A few don't want to use condoms. Some clients agree to use condoms in the beginning, but start bargaining or change their minds once we get into the room. If this happens, I try to negotiate. I am afraid of getting HIV because I worry I might transmit it to my family and they might get discriminated [against] within the community. I don't think prevention campaigns really work - they don't reach out to young female sex workers, as often we do not come out to access the information, and if we do it doesn't speak to us. I am trying to help others, telling them how to use condoms properly and encouraging them to get tested and counselled. I want the government to provide more opportunities for young people to work. I want to make a difference. I am fed up with the police and I hate the clients' misbehaviour and violence. Governments and agencies should really try to address this. We have self-respect and don't want others to hurt us."

Research among 565 male street children and adolescents aged 5 - 19 in Lahore, Pakistan, highlighted the vital importance of peer support, street outreach and drop-in centres to reach those who sell sex.¹⁹² A study in Lao PDR found a connection between outreach and peer support by civil society organisations and improved knowledge of risk, self-esteem and access to health services for adolescents and young people (15 - 24 year olds) who sell sex. However, it also found that such adolescents and young people would not access health services or programmes on their own. They would, however, attend with the help of a friend or supportive adult – although many indicated that they did not have those sorts of friends. The Lao PDR study noted that adults with whom adolescents engaged in selling sex interact (such as older sex workers) might also play an important role in delivering and linking them to services. Indeed the study recommended programmes to encourage older people from key affected populations to take care of the younger people.¹⁹³ Nonetheless, the current legal and policy environment reflects harsh penalties for any adult sex workers implicated in providing material support to an adolescent engaged in selling sex, as discussed in Section 6.

As discussed earlier, despite significant differences among adolescents (in terms of their cognitive, physical, emotional and social development), programmes are largely not age-disaggregated and do not address the specific needs of adolescents who sell sex.¹⁹⁴ Services need to be sensitive to marginalised adolescents. As noted, this would include: using an entry point that is relevant to the lives of marginalised adolescents (for example, not just government clinics or schools); having staff with appropriate knowledge, attitudes and skills including language skills since the adolescents may be migrants and therefore linguistically diverse;^x providing physical and emotional safe spaces; using appropriate and creative methods; being located in appropriate locations and open appropriate hours; being affordable or free; providing both generic adolescents' services (such as professional counselling) and specific ones related to their high risk (such as STI screening); and providing appropriate commodities (such as condoms, lubricant and modern, long-lasting contraceptives) and distributing them through relevant systems.¹⁹⁵ A study in Nepal indicated that the methods of medical intervention could also make a difference, such as with oral HIV testing being easier for adolescents.¹⁹⁶

A number of studies also highlighted the increasing need to incorporate the use of communication technology into support for adolescents engaged in selling sex.¹⁹⁷ For example, a study in Timor-Leste

^x It is necessary to recognize that staff, in outreach centres, also need protection from prosecution and guarantees of immunity to carry out their jobs effectively. Many staff work in highly stressful conditions occupying a grey area legally which may also deter them from recording or promoting their services.

 Older sex workers may play an important role in delivering and linking adolescents to services, but the current legal and policy environment reflects harsh penalties for any adult sex workers implicated in providing material support to an adolescent engaged in selling sex.

found that the most frequently used avenue for women who sell sex (aged 16 - 40 years) to meet clients was through mobile phone contact.¹⁹⁸ Programmes for younger cohorts should also look at providing access to basic health care services through creative, innovative means such as the media (TV, radio, print, outdoor media) and technology (text messages).

There are certain challenges related to the types of providers of services for adolescents engaged in selling sex. For example, there can be a lack of understanding among service managers and providers about how and why the SRH needs of vulnerable adolescents, such as those who sell sex, differ from other adolescents.¹⁹⁹ This may be related to service providers' own perceptions of 'morality' or cultural norms being transgressed. Services may lack human resources with adequate time, capacity and training to meet the multiple needs of adolescents engaged in selling sex.²⁰⁰ More generally, issues of privacy and respect can be particularly important. In Lao PDR, a study found that lack of confidentiality was a serious barrier to access to services for adolescents and young people from key affected populations, including those that sell sex.²⁰¹ These adolescents and young people often have a preference for stand-alone services to address their specific needs. This preference is often informed by negative experiences of accessing mainstream services where their identity has been revealed or their confidentiality breached.²⁰²

4.7 INVOLVING ADOLESCENTS IN PROGRAM AND POLICY DESIGN

Many of the resources included in the review indicated the need to involve adolescents engaged in selling sex in the design, development and implementation of programmes and policies that affect them. One obstacle to this is the reluctance of some sex worker networks to include younger cohorts, due to the intense stigma these networks already experience and fear of being prosecuted for providing material support to adolescents to sell sex under domestic legislation discussed in Section 6. A further challenge is that adolescents who sell sex do not always self-identify with the terms used in the child rights, SRH or HIV policy worlds—such as 'sex worker' or 'commercially sexually exploited'. As such, advocacy messages do not necessarily reach them or encourage their involvement.²⁰³ Lack of adequate knowledge, information or skills may also block effective participation. Legal issues — such as age of consent and criminalisation — also contribute to the lack of a 'voice' for adolescents who sell sex to describe their situation and be involved in improving it.²⁰⁴ These also affect policy makers and programmers who do not know how to reach these adolescents. Programme interventions and adolescents themselves may rely on young people – aged 18 and above – to speak on their behalf.

The existing participatory interventions found by this review refer to children who are survivors of commercial sexual exploitation, recruited from shelters where government officers have placed them. For example, ECPAT's Youth Partnerships Project (YPP)[†] is an initiative wherein child survivors of commercial sexual exploitation and children considered to be at high risk for trafficking and/or exploitation (adolescents under 18 and older young people) engage in activities against commercial sexual exploitation. In South Asia, YPP members recruited from shelters in Kolkata, India and Dhaka, Bangladesh carry out research they have conceived and planned to better understand the needs of children in these locations.²⁰⁵ The project has also developed peer support programmes in schools to share information related to prevention of sexual exploitation. YPP youth trained in media and advocacy skills are reaching out to local communities through awareness campaigns related to prevention of trafficking but also to care and support for survivors by working with trained caregivers and local organisations to give them the tools to provide quality psychosocial care for child survivors. Findings from these projects have revealed that children and adolescents supported and encouraged to participate start to take on

[†] For details of ECPAT's Youth Partnership Project in a global context see <http://www.ecpat.net/child-youth-participation>.

new roles in their communities, helping to raise awareness, supporting others and mobilising action. It also challenges the stereotypes and prejudices that people hold against them, as well as building resilience and addressing discrimination.²⁰⁶

Findings revealed scarce data on programmes encouraging participation and leadership among adolescents who are currently engaged in selling sex. One exception may be found in the advocacy activities of Integrated Community and Industrial Development Initiatives (INCIDIN) from Bangladesh, which works closely with the children's organisation Child Brigade. Child Brigade advocates for the rights and protection of children living on the street in Bangladesh. Child Brigade has conducted child leadership activities in which young activists organise children currently living on the street, including those selling sex, collect information about the violation of their rights, identify key issues for advocacy and sensitise other children to their rights.²⁰⁷

Aside from these examples, though, findings revealed that limited progress has been made in terms of the substantive participation of adolescents in many countries. Even among these initiatives it is clear that adolescents engaged in selling sex are often grouped with adolescents "at risk" of selling sex, raising questions of the appropriateness of recommendations. Additionally, there is a need for greater dialogue — involving adolescents themselves, alongside stakeholders that bring different priorities to the table, such as anti-trafficking, HIV, and adult sex worker organisations — to ensure the perspectives of adolescents engaged in selling sex are represented in policy decisions.²⁰⁸

Regional research shows a gap in the participation of adolescents engaged in selling sex

An East Asia and Pacific regional review suggested that there is still an identified need to "create structures to support effective participation of children and youth on issues that concern them, including commercial sexual exploitatio... children and youth were rarely consulted during development of policies and programmes concerning them. When they received opportunities to participate, they were generally brought into the process in a haphazard and token manner".²⁰⁹

A similar review for South Asia noted that "The children and young people of the region have been active and determined in their actions, and governments, NGOs and agencies have recognised this by consulting with them and including them in consultations and programmes. Some specific mechanisms, such as Children's Clubs, have formalised the participation of children and young people. In some countries there is a National Children's Task Force or another mechanism for regular consultation with children. Importantly children have been involved- or have led awareness raising actions, peer initiatives and peer outreach and counselling actions".²¹⁰

4.8 TOWARDS AN INTEGRATED APPROACH

Figure 9: The need for constructive dialogue between HIV and child protection

"Beyond the vast under-representation of adolescents in the literature on sex work and HIV, there is another force that has led to this long-standing inaction – **the often intolerant relationships and lack of dialogue between, on the one hand, HIV prevention professionals and sex workers' rights advocates and, on the other hand, anti-trafficking and children's rights advocates.** This conflict has stemmed from perceptions of child protection advocates that HIV prevention efforts turn a 'blind eye' to adolescents present in sex work in order to facilitate condom-use promotion. Conversely, HIV prevention practitioners often view those working to detect and assist adolescent FSWs as 'abolitionists' who are working to end all sex work based on their belief that it is inherently abusive It is clear that continuing

to ignore the existence or needs of adolescent FSWs will limit the ability of public health agents to prevent the spread of HIV, as it these adolescents who are most likely to be infected and to transmit the virus via unprotected sex. It is also clear that far greater attention and resources must be directed to the development and implementation of programs and policies that prevent this large scale and horrific abuse of children across the globe.”

Adolescent Female Sex Workers: Invisibility, Violence and HIV, Global Child Health, Jay Silverman, Harvard School of Public Health, 2010

Although this review has mentioned the need for ‘comprehensive services’ and an ‘integrated approach’ several times over the course of this document, we found a lack of clarity in published literature as to what this would look like in the context of adolescents engaged in selling sex. The child and adolescent health and protection systems in each country are made up of a collection of nested institutions organised around a similar purpose: ensuring the fulfilment of child and adolescent rights. Achievement of these systems’ overall purpose depends in part on the effectiveness of coordination and cooperation among the different parts of the system.² This integrationist or “systems approach” to child protection recognises that “*a child protection system does not work in isolation. Rather, it involves, engages and intersects with other systems, including, health, education, social welfare and social protection*”.²¹¹ The same can be said of the health system’s integration of child protection services. Nonetheless, little published literature addresses this issue, there are few programmatic interventions dealing with this group of adolescents in the Asia Pacific, and the programmatic documentation that does exist is insufficient to form an adequate evidence base.

The lack of research literature and programmatic models on an integrated approach is due in part to the difficulties presented by different strategic pathways to intervention embraced by health and protection systems for this group of adolescents. Typically, country-level social and health systems rely on voluntary, low-threshold interventions, while pathways to child and adolescent protective intervention often rely on mandatory reporting, arrest in the name of protection by law enforcement, state custody proceedings, court supervision and compulsory placement in residential treatment or detention centres. From the perspective of many health service providers to adolescents engaged in selling sex as well as adult sex worker peer service providers, then, the issue of systems integration with child protection raises a concern of forced medical treatment and collaboration with state systems that perpetrate violence against adolescents in this group and sex workers more generally. At the same time, child protection systems may envision voluntary health service provision as an inadequate model in this context, especially for adolescents who sell sex by reason of physical force or coercion, as well as adolescents for whom SRH is not their primary concern.

Despite the programmatic tension, many recent studies maintain the need to enhance integration of health systems within and across the child welfare and protection system²¹² especially with reference to linkages between SRH and HIV programming.²¹³ For instance, a recent study on the subject of integrating issues of children affected by HIV and AIDS into child protection systems identified a significant gap in relation to SRH, HIV and protective interventions.²¹⁴ Indeed, from a rights based perspective as well, where all rights are equal, the integration of services is essential.^{aa}

This paper proposes a solution to the integration gap from the perspective of SRH and other health services in child protection systems that are both “horizontal” and “vertical.” A horizontal integration

² For a detailed discussion on this see Save the Children, ‘A ‘Rough Guide’ to Child Protection Systems’; (2009). and S. J. Leischow, Et. Al., ‘Systems Thinking to Improve Public’s Health’, *American Journal of Preventive Medicine*, 35/2 (2008).

^{aa} It is worth adding that health and child protection systems do not offer a complete answer to the rights-based needs of adolescents engaged in selling sex. Other, interrelated needs of this adolescent group include adequate short- and long-term affordable shelter options, living wage alternatives to selling sex, harm-reducing drug treatment services, legal support, mental health services, child care, nutrition, education, counselling and, if desired, opportunities to exit selling sex and be repatriated with family, among other services.

would ensure that voluntary shelter and residential treatment referrals and options are offered, with informed consent and without discrimination, to adolescents engaged in selling sex who access SRH and HIV services. At the same time, vertical integration would guarantee that adolescents who engage in selling sex who are detained in state custody in the child protective, juvenile justice, and adult criminal systems are provided SRH and HIV treatment, prevention, care and support without discrimination.

It is worth noting that, in the initial stages of this paper, health systems stakeholders expressed doubt that full integration could occur on the assumption that such integration would require the mandatory reporting of adolescents engaged in selling sex to government officers and, through them, the initiation of court proceedings. However, under the interpretation of the international framework advanced by this review in Section 2, child and adolescent protection and health systems need not be in conflict on the issue of state involvement. As discussed in Section 2.1, international legal documents such as the Convention on the Rights of the Child, as well as guidance such as General Comment 10, the Beijing Rules, Havana Guidelines, and Riyadh Guidelines, emphasise that interventions involving state proceedings be taken in the last resort. Importantly in the context of adolescents engaged in selling sex, the Riyadh Guidelines includes examples of alternative measures to court proceedings and recommends community based interventions as well as decriminalisation of status offences. In all cases early preventive interventions with reliance on low-threshold and voluntary services are promoted over involvement of the justice system. In this way, the solution to the integration gap proposed by this paper already tracks emerging international law and policy guidance.

While few models of such an integrated approach exist, some related guidance has been advanced in the child protection context. The table below, excerpted from the 2013 Inter-Agency Task Team on Children and HIV paper “Building Protection and Resilience: Synergies for child protection systems and children affected by HIV and AIDS” shows how one HIV programme component can be used to illustrate practical entry points so that the two systems can work together to provide a more comprehensive response for adolescents.

Figure 10: Making HIV systems child protection sensitive

HIV component	Entry Point for integrating child protection
Adolescent HIV treatment and support	<ul style="list-style-type: none"> • Include referral pathways for suspected abuse, violence, exploitation or neglect in health-sector mandates and guidelines; • Include adolescent-specific gender-based violence within adolescent HIV care and support programmes; • Include abuse and violence prevention and referral for support within child/adolescent HIV testing and counselling and sexual and reproductive health; • Include care and support for HIV-positive adolescents living in alternative care settings, especially residential and other forms of institutional care.

The table below captures information from this paper’s research findings presented in the context of child protection case worker management; it highlights possible interventions that can be taken by different agencies. It also shows the intersectionality of needs faced by adolescents involved in selling sex, illustrating how SRH and HIV services are part of a wide range of interventions required to provide for their rights. Nonetheless, the table is necessarily limited in that very few adolescents in the Asia Pacific have access to a case worker.

Figure 11: Possible integration based on the case worker model

Vulnerabilities of adolescent selling sex	Socio-Legal Services and Protections	Primary/adolescent health services	SRH and HIV services
<p>Tenuous/absent/harmful primary adult support and care. Weak social support systems.</p> <p>Economic/social deprivation or one of violence, neglect, abuse in family/ social context community.</p>	<p>Case worker assesses individual adolescent’s situation and relationships; eco/physical/social conditions and identifies needed supports for adolescent/family.</p> <p>Knowledge building among case workers on adolescent participation concepts and skills including measures for participation and integration of the adolescent views and opinions in matters affecting them.</p> <p>Individual casework serves as basis for planning interventions, identifying intersecting vulnerabilities and seeking viable allies and supports for restoration of rights of the adolescent including connection to family if in the adolescent’s best interest.</p> <p>Case worker maps and plans for the development /strengthening of adolescent’s social support network (family members, peers, community agents, other relevant social actors and institutions- i.e. undertakes service mapping.</p>	<p>Case-worker/health worker may refer an adolescent to an adolescent health programme or adult health programme for specific and/ or co-existing health care needs, including SRH.</p> <p>Child-health programmes are often geared to younger children with no specialised interventions for adolescents while public health programmes may not offer adolescent-focused SRH services particularly targeting adolescents engaged in selling sex.</p> <p>Caseworkers identify adolescent/public health programmes with SRH services including for adolescents selling sex.</p> <p>Adolescent advocate- (akin to ad litem) worker promotes the interests and rights of adolescents engaged in selling sex within the health, welfare and child protection systems (which often work through complex vertical programmes) for a comprehensive response to their needs.</p>	<p>Where the need for SRH information and care is identified, case workers may link the adolescent to health providers with SRH programmes if these exist and are accessible to their age group.</p> <p>Vulnerable adolescents, including those selling sex consistently indicate need for support & accompaniment to access SRH services.</p>

These initial models serve as templates for integrated services. However, for effective implementation to occur certain critical elements must be in place. These key elements are discussed below:

Operationalising co-ordination: Systematic co-ordination in these areas requires core changes in current services. To move towards an integrated response, child protection, SRH programmes, HIV service providers and collaborating programmes would assess their relative capacities and chart appropriate courses for operational collaboration. This could potentially make it easier for adolescents engaged in selling sex to claim services to which they are entitled. Some key factors that affect co-ordination include; laws and policies, governance, regulation, oversight, skilled human resources, funding, functions for service delivery and knowledge research and data collection.²¹⁵ Findings revealed that some specific measures have been taken in the Asia Pacific region but more work needs to be done.^{bb cc}

Laws and policies: As we have seen, the interpretation of the legal framework is critical in framing both health and protective services on a model of “minimum intervention.” A voluntary, low-threshold model, when paired with residential treatment options for those adolescents who desire it, may nonetheless operate with some difficulty depending on the legal context of specific countries. This paper has noted with concern the high prevalence of physical and sexual violence perpetrated by uniformed services affecting adolescents engaged in selling sex, which raises important concerns regarding the safety of law enforcement-based interventions. This is in part a global failing: international legal frameworks pertaining to the engagement of adolescents in selling sex have yet to provide for an alternative to law enforcement interventions. Even where alternative legal regimes exist, many countries in the region have yet to clarify the interaction between punishment and protection: in Australia an effort has been made to clarify the interaction between Penal Law offences relating to child prostitution and the Child Protection Law.²¹⁶ Studies of individual country laws in the region encompassing all the modalities that typify adolescent engagement in selling sex in each country should therefore be undertaken in tandem with programmatic surveys of actual services involvement and state custody conditions in residential and detention centres. Special attention is needed to monitor country compliance with the principle of “minimum intervention,” and the prioritisation of preventive services.

Governance, regulation and oversight: Various countries have established specialised bodies with a mandate to advance child rights and protection. One example is the Indian National Commission for Protection of Child Rights. These structures can be mobilised to represent the interests and protect the rights of adolescents selling sex, including to access SRH and HIV services. Similar bodies with differing purposes and levels of authority for ensuring delivery of child protection services against standards exist at other levels.^{dd} These types of oversight structures have also been established at all administrative levels including the community, to plan, coordinate, implement and monitor programmes and policies on child protection. Many of these can provide models of coordination and opportunities for integration of initiatives for adolescents selling sex.

Skilled human resources: Various countries in the region provide specialised training for personnel from all agencies (health, law enforcement and social service) that are involved in providing direct services or receiving referrals for services needed by vulnerable adolescents including those engaged in selling sex.^{ee} Specific manuals have also been developed to enhance the core curriculum of training insti-

^{bb} These measures are highlighted in the CSEC literature from the region.

^{cc} There is a growing focus on examining measures for integrative approaches linking community level initiatives including SRH for vulnerable children to the broader CP system i.e. Guy Thompstone Leonora Borg, Corinne Davey, Sarah Thomas De Benitez, Bill Bell,, 'Child Protection Systems: Challenges and Opportunities for Addressing Specific Issues Faced by Children', A discussion paper prepared for the global conference: Protecting Children Better: Theory And Practice Of Child Protection (2012).

^{dd} See terms of reference for the governing board and secretariat of South Asia Initiative to End Violence Against Children, SAIEVAC.

^{ee} See UNODC Project Childhood Training, http://www.unodc.org/southeastasiaandpacific/en/Projects/2010_08/project_childhood.html

tutions to better prepare line personnel for public service.^{ff} Such opportunities can be used to increase knowledge and skills for responding to the needs of adolescents selling sex. Such training should be expanded to accountability and monitoring of law enforcement officer interactions with this population.

Quality standards for delivery of services: A number of agencies have developed tools to build capacity and standards for quality child protection responses to address the complex decisions related to care and protection of adolescents engaged in selling sex, including case management, assessment, reporting and referral.²¹⁷ Increasingly such training is provided to multi-sectoral teams of government and non-government agencies to promote analysis and exchange across institutional structures and interrelated functions and to lay foundations for integration.²¹⁸ These tools promote quality and standardisation across organisations in ways that are relevant and useful for those working on the SRH concerns of adolescents engaged in selling sex.²¹⁹

Knowledge, research and data collection: Services for vulnerable adolescents including adolescents selling sex are often provided by NGOs whose data collection and information systems are not integrated with each other or with the formal child welfare and child protection system. While increased integration in knowledge management and data collection is desirable from a research perspective, this integration is not advised without rigorous confidentiality protections. Namely, data must not be connected to individual case files; no identification information should be written down; no names shared with third persons; and all original records containing such information should be destroyed after they are analysed. The Sex Workers and HIV Implementation Tool (SWIT) published by WHO, UNFPA, UNAIDS, The World Bank, and the Global Network of Sex Work Projects (NSWP) provides clear recommendations around ways to map the size and practices of sex workers which could be replicated in the context of adolescents.²²⁰

Unfortunately, data protection measures including specialised software and tools as well as guidelines and protocols used by statutory agencies to strictly protect sensitive case information and stratify levels of authority to input and access case information remain highly limited across countries in the region. Even where available, the lack of systematisation of indicators and methods of data collection and analysis across programmes serving adolescents impedes appropriate use and exchange of information to guide responses. Initiatives to enhance the capacity of NGOs in this regard have been undertaken in several countries of the region including in Cambodia, Thailand and Indonesia. The introduction of data collection tools and information management skills in NGO programmes has ensured the integration of information from these sources into national datasets. In this way they have increased the visibility of the problem and enabled efforts for improved response.²²¹ Findings highlighted the lack of information on adolescents engaged in selling sex and although the above initiatives were focused on data collection for trafficked women and children, such initiatives provide models for integration of data from small service providers and its use in local decision making.

CASE STUDY

11

Self-regulatory boards

The sex worker organisation Durbar Mahila Samanwaya Committee (DMSC), a 65,000 strong collective in 49 branch committees of sex workers in Kolkata, India, has established 33 Self-Regulatory Boards (SRBs) since 1997 throughout West Bengal. The purpose of the SRBs is to regulate entry to sex work by systematically screening all newcomers to sex work sites, primarily brothels, to identify underage girls and trafficked women and connect them to alternative placements and comprehensive services.²²²

^{ff} See, for instance UNICEF and India Department of Women and Child Development, 'Manual for medical officers dealing with child victims of trafficking and commercial sexual exploitation,' 2005.

The SRBs are public-private partnerships composed of 10 to 12 members: at least half of the members are from the sex work community, and the remainder includes local doctors, lawyers, government officers and others.²²³ Within these local boards, DMSC involves Social Welfare Officers, State Women's Commission members, Integrated Child Development Services (ICDS) and other government functionaries to the extent possible.

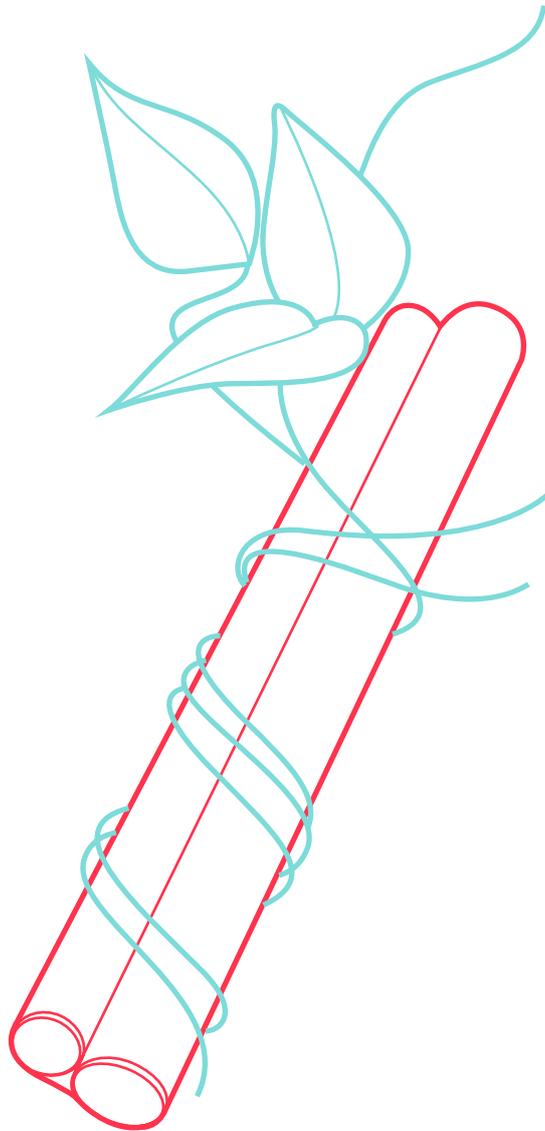
The SRB model has been identified as a best practice in rights-based interventions in connecting adolescents under 18 and trafficked adult women to comprehensive service.²²⁴ A WHO and UNFPA funded research review in 2013 of 15 years of SRB data found that between 2009 to 2011 alone, 2,195 persons were screened by SRBs, providing 170 (7.7%) minors and 45 (2.1%) unwilling adult women to assistance and follow-up.²²⁵ The study noted also that DMSC-led interventions account for over 80% of successful 'rescues' reported in West Bengal, and connected the work of the SRBs to a decline of 25% to 2% proportion of minors in sex work in the Sonagachi red light district between 1992 and 2011.²²⁶ At the same time SRB operations reduced the incidence of police raids in Sonagachi from 162 in 2003 to 22 in 2009.²²⁷

The SRB review process involves multiple stages. The first stage involves systematic screening of newcomers to local sex work sites. Peer educators visit local sex work sites in their districts daily, and accompany any newcomers to the clinic or drop-in centre where the local SRB meets. Where a newcomer is identified at night, they are brought to a short-stay home where they may spend the night prior to the SRB review. A counsellor then explains the SRB process and fills out an intake form with the person identified. The SRB members then conduct an in-depth interview to determine the person's circumstances and motivations for entry. Where age is in doubt, a bone age study is conducted by X-ray. Where the SRB determines the newcomer is underage, they are assisted and accompanied for a confidential and safe return home, where their family circumstances are assessed. Where family abuse is in evidence or return is not possible, placement of the underage woman in a government-run, NGO, or DMSC run shelter or home is arranged. Importantly, where underage women are placed in shelters, DMSC conducts periodic reviews every three months to assess the person's security and living conditions, and to intervene if needed to improve arrangements.²²⁸

The SRB approach is not limited to brothel sites, as Ashodaya Samithi has successfully adapted the model to the conditions in Mysore and surrounding districts of Karnataka, where 89% of sex workers solicit in public places and bring clients to hotels or lodges.²²⁹ The relevance of the model also extends outside of South Asia: the replication of the SRB model has been noted in Brazil and in Thailand.²³⁰

5

**LESSONS LEARNED FROM POLICY AND
LEGAL ENVIRONMENTS FOR ADOLESCENTS
ENGAGED IN SELLING SEX**



5: LESSONS LEARNED FROM POLICY AND LEGAL ENVIRONMENTS FOR ADOLESCENTS ENGAGED IN SELLING SEX

5.1 DOMESTIC LEGAL AND POLICY ENVIRONMENT FOR ADOLESCENTS

This section represents the analysis of a variety of resources — including codified domestic legislation, state agency guidance, regulations and NGO monitoring reports — to assess to what extent domestic laws and policies in the Asia Pacific region may either support or hinder access to SRH and other health services for this adolescent group. This review merely undertakes a survey of relevant laws and policies; insufficient research has been conducted to evaluate the impact of such laws and policies across the region. An impact assessment is complicated by the intersectional nature of legal regimes affecting adolescents engaged in selling sex: the penal regime as reflected by the adult criminal and juvenile justice systems; and the child protective regime comprised of state custody proceedings encompassing abuse and neglect and status offences. Nonetheless, to the extent that country-monitoring reports include such information, this paper attempts to address them.

The distinction between penal and child protection law is also increasingly blurred by domestic “safe harbour” legislation that carves out exceptions to prostitution-related offences to prevent persons under 18 from being charged as offenders, as recommended by the Committee on the Rights of the Child and discussed above in Section 2.1. However, at the country level many such laws and policies merely divert adolescents arrested by uniformed services such as police to state custody. Without comprehensive evaluation, it is difficult to say whether these developments actually prevent arrest from first occurring, or merely divert adolescent arrestees to residential, detention or rehabilitation centres and expose them to law enforcement violence discussed in Section 3.4 in the process. Given the difficulty of classifying such laws and policies under groupings such as penal or protective, this review categorises all such laws and policies in relation to whether they appear to support or hinder access to SRH and other health services for adolescents engaged in selling sex, noting that further analysis is needed.

While little comprehensive evaluation exists, the evidence base is increasing. In particular, ECPAT’s database of monitoring reports contains important information related to adolescents engaged in selling sex in 40 countries in the Asia Pacific region. Other studies examine a specific selection of countries and their legislation and these can be useful references.⁸⁸ In addition, the recently published UNESCO report, “*Laws and policies affecting young people’s access to sexual and reproductive health and HIV services in Asia and the Pacific*”²³¹ examines a broad range of legal and policy issues that shape young people’s access to HIV and SRH services within countries of the Asia Pacific region. This document is highly relevant in that it provides an analysis of various laws in the region, which both support and hinder young people’s access to these services. Although it does not specifically focus on adolescents who sell sex, it includes the concerns of young people from key populations at higher risk of HIV exposure including young people selling sex, young men having sex with men and transgender people and young people injecting drugs. The below analysis draws heavily on this report.

Important resource

Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people’s access to sexual and reproductive health and HIV services, UNESCO 2013

Available at: <http://unesdoc.unesco.org/images/0022/002247/224782E.pdf>

⁸⁸ See for instance, Bhardwaj and Diwan, 2012 as well as Frederick John, 2010 (IRC) in the end notes.

5.2 LAWS THAT MAY HINDER ACCESS TO SERVICES

The review uncovered a broad range of laws and policies that not only act as barriers to access to SRH and health services for adolescents engaged in selling sex, but also affirmatively place adolescents at risk of harm from uniformed officers and health providers. The paper reveals that despite some commonalities, each country in the region has a different legal response – in terms of the number of relevant laws, what they address, who they apply to and how they balance issues of protection and rights. Furthermore, in many contexts, national laws and policies appear to be open to the risk of being misinterpreted or abused in practice, for example by the police or judiciary. Overall, there is a need for further research and dialogue to envision a legal environment that would comprehensively protect the rights of adolescents engaged in selling sex.

ANTI-PROSTITUTION LAWS

A range of legal approaches designed to control or eliminate adult sex work can present barriers to accessing health services for adolescents engaged in selling sex especially for those who continue to sell sex after turning 18. Criminalisation of sex work is generally accompanied by punitive law enforcement; confiscation of condoms which are used as proof of solicitation; criminalisation of clients; licensing or registration; mandatory, compulsory or coerced testing for HIV; lack of labour and social security rights; denial of identity documents and citizenship rights; and compulsory detention and rehabilitation.²³²

The barriers discussed above are often further exacerbated by additional legal constraints related to the age of children (such as consent for medical services)²³³ or behaviour (such as homosexuality and injecting drug use).²³⁴ Most of the countries in Asia and the Pacific criminalise sex work or activities associated with the sex industry, such as soliciting or keeping a brothel. Vagrancy and public order laws are also used to arrest sex workers especially if they work on the streets, in parks, at bus or train terminals or other public spaces.²³⁵ The 2012 Global Commission on HIV and the Law report concluded that multiple different types of legal measures – including criminalisation of sex work – increase the vulnerability of adult sex workers and reduce their access to services. It recommended a wide range of legal measures, including the repeal of laws that prohibit adults to buy or sell sex, the prohibition of mandatory testing of sex workers and measures to stop police harassment.²³⁶

As discussed in Section 2.1 on the international framework, some countries have adopted “safe harbour” provisions in the case of adolescents who are charged with prostitution-related offences. New Zealand’s Prostitution Reform Act, 2003 explicitly protects persons under the age of 18 years from prosecution as a party to any of the prostitution related offences. According to Section 23(3) of the Act, “[n]o person under 18 years of age may be charged as a party to an offence committed on or with that person against this section.” Further research is needed to verify to what extent these provisions prevent first arrest from occurring, or merely divert adolescent arrestees into child welfare or juvenile justice systems.



A broad range of laws and policies not only act as barriers to access to SRH and health services for adolescents engaged in selling sex, but also affirmatively place adolescents at risk of harm from uniformed officers and health providers.



CHILD PROTECTION LAWS RESULTING IN PUNISHMENT, INVOLUNTARY REHABILITATION AND DETENTION, OR REMOVAL OF CHILDREN OF ADOLESCENTS ENGAGED IN SELLING SEX

As discussed in Section 2.1, the principle that children and adolescents are entitled to protection from CSE is to be balanced against the legal principle of “minimum intervention” and the Joint U.N. Statement on Compulsory Drug Detention and Rehabilitation Centres, among other legal documents, as applied to adolescents. These sources treat compulsory detention and “rehabilitation” as forms of punishment that must be abolished. In their place, the framework requires voluntary, evidence-informed and rights-based health and social services.

Nonetheless, domestic legislation in the Asia Pacific region does not reflect the position of international law and policy guidance against involuntary rehabilitation. In many countries in the Asia Pacific, domestic law and policy provides for involuntary rehabilitation in certain circumstances. The compulsion of institutional rehabilitation often exists in cases of repeat offenders, while non-institutional rehabilitation may be offered for younger adolescents or those who are not repeat offenders. For instance, Viet Nam’s Decree 178/2004/NĐ-CP dated Oct 15th, 2004 includes guidelines for the execution of a number of regulations in the Ordinance on Prostitution Prevention, stating that children who have permanent shelters and are regular sex workers from 14 years-old upwards will receive education and rehabilitative measures at their own localities; those who are regular sex sellers from 16 years-old upwards and have already received education and rehabilitation measures or do not have permanent shelters will be sent to rehabilitation centres for between three to eighteen months.²³⁷

In some countries, these laws may be enforced differently across gender lines. For instance, in a study in Ho Chi Minh City, Viet Nam, male adolescents and young people who sold sex did not report being sent to a rehabilitation centre where adolescent women sex workers are sent.²³⁸ Indonesia’s Child Protection Act 2002 specifies the obligation of the state to provide special protection in the form of institutional and non-institutional rehabilitation efforts, confidentiality, preventing stigmatisation of the child, providing physical, mental and social safety guarantees and ensuring access to information regarding the development of the legal proceeding.

The tension between protection and punishment also exists between protective legal frameworks that are not actually implemented at the level of policies and programmes, especially when laws do not disaggregate the experiences of children and adolescents. For instance, Thailand’s 2008 anti-trafficking law states that applicable criminal law relating to prostitution or immigration cannot be used against someone who has been trafficked.²³⁹ Yet a UNICEF EAPRO study in 2009 documents the implementation gap for adolescent migrants in Thailand, including those who sell sex, observing that anti-trafficking interventions have resulted in:

“unreasonably long placement in shelters result in children and others sometimes being held against their will, while those who have learned to navigate the ‘system’ shape their replies to the police to avoid the shelters, which is significant in itself, and opt for quick deportation via the [Immigration Detention Centre]. The questionable ‘protection’ services offered in the shelters and the lengthy stay against the wishes of the children leave the Thai Government, at best, open to charges of effectively providing a more friendly but lengthy form of deportation service for irregular migrants.”²⁴⁰

Findings reveal that current law and policy guidance on child protection interventions for adolescents engaged in selling sex in Asia Pacific pays insufficient attention to the problematic consequences of arrest-based interventions aimed at compulsory detention and rehabilitation. Even in guidance opposing criminal or administrative punishment of children and adolescents engaged in selling sex, such documents do not clarify whether this includes opposition to arrest-initiated and compulsory rehabilitation.²⁴¹ Further research is needed to identify the extent and scope of the problem.

It is important to note that child protection laws and policies are applied in some cases to deprive a sex worker parent – including an adolescent engaged in selling sex who is also a parent – of the right to parental care and custody merely for presence in a brothel or at another work venue.²⁴² The lack of birth documentation and identification systems for children of sex workers, as well as their discriminatory exclusion from such systems, may broaden the reach of such laws. In Bangladesh’s Children Act of 1974, Section 32 empowers a Probation Officer or Police Officer to bring a child before the juvenile court if any child is found in the company of a sex worker, living in or frequenting a brothel, and in cases in which the child is not the child of a sex worker in the establishment or is “likely to fall into bad associations or to be exposed to moral danger or to enter upon a life of crime.” Similarly, Sri Lanka’s 1998 amendment to the Penal Code²⁴³ added a specific section on sexual exploitation, which is open to a wide interpretation. Section 360b established penalties for any person who allows a child to be on any premises for the purpose of “causing the child to be sexually abused or to participate in any form of sexual activity or in any obscene or indecent exhibition or show” as well as a person who acts as a procurer of a child for sexual intercourse or “any form of sexual abuse”, by means of influence, threat, violence or provision of money or benefits to the child or his/her family.

INDIA CASE STUDY



The Juvenile Justice (Care and Protection) Act, 2000

This Act makes a distinction between children in conflict with the law and children in need of care and protection but “effectively criminalizes both by putting them under the jurisdiction of the criminal justice system”.²⁴⁴ Children are sent to either ‘observation homes’ or ‘juvenile homes’ but in both cases, these are closed institutions wherein children are completely deprived of their liberty. Often before the children are separated they stay in the observation homes together so adolescents who may have committed serious offences are housed with much younger children who have been picked up because they have been abused or neglected.

Standards of care are generally deficient in the homes and children perceive the option of entering these homes as a threat. Reports have documented severe neglect, overcrowding and abuse including sexual abuse and rape of the children in these homes. As one report mentioned, “In sharp contrast with the ambitious goals outlined by the Indian government in the Juvenile Justice Act, the life of children who have the misfortune of ending up there [in the homes] is frequently more horrifying than the family environment they escaped and often more wretched than the life on the streets from which the government supposedly rescued them.”²⁴⁵

In terms of the law and its impact on HIV and AIDS, this Act with its focus on institutionalisation has contributed to increased vulnerability of children. The fact that children’s mental and physical well being in terms of health, nutrition and care is seriously neglected in these homes is exacerbated by the fact that they may be sexually active without any access to HIV prevention services and that they may be exposed to a higher likelihood of sexual abuse from older children or caretakers.

MANDATORY REPORTING

Some countries have mandatory reporting laws, which require adults, often those engaged in child and adolescent health services, to report any known cases of adolescents engaged in selling sex to social services or the police. These reporting laws may put health service providers and others in a difficult position, when access to confidential health care for an adolescent may intersect with child protection or other legal guidelines,²⁴⁶ as well as the stated wishes of the adolescent.

For instance in Australia, under the *Children and Young Persons (Care and Protection) Act 1998*, health workers are legally obliged to make a report to the Department of Community Services if they have reasonable grounds to suspect a child under the age of 16 is at risk of harm from abuse or neglect, interpreted to include engagement in selling sex. If the child is 16 or 17, this legal obligation does not hold but health workers may make a voluntary report if they suspect harm, without breaching confidentiality regulations.^h

In light of Section 3.4's findings related to the prevalence of violence by uniformed services against adolescents engaged in selling sex as well as poor conditions of compulsory rehabilitation and detention centres discussed earlier, a case worker may conclude that the benefit of SRH and other health services for a given adolescent engaged in selling sex is outweighed by the collateral consequences of mandatory reporting.

AGE OF LEGAL CAPACITY TO CONSENT TO SEX

Laws related to the age of legal capacity in various contexts are sometimes problematic with relation to access to services. One relevant area is the age of consent to sex, which differs widely across countries in the Asia Pacific Region ranging from 12 to 18. For example, it is 13 in Japan, 14 in China, 15 in Thailand, 16 in Malaysia, 17 in Indonesia, and 18 in Viet Nam and the Philippines.²⁴⁷ The regulations relating to age of consent are usually framed within criminal law provisions on 'statutory rape' which forbid sexual conduct with a person below the age of consent, but lay down variables which affect the definition of the offence such as that the person should not be in a position of trust or authority, the maximum age difference between partners, and the specific sexual practices to which consent can be given. For example, in Thailand, the age of consent to sex is 15 for both genders but if a person is below 18 and has sex with a person aged between 13 - 15, this will not be considered statutory rape. In India, the age of consent is 16 but for boys for same sex sexual activity it is 18.ⁱ

Findings highlighted a range of diverse responses that countries have on this issue and which may complicate the understanding of individuals and service providers on how to deal with sexually active children and their health needs in general. Indeed, legal activists have suggested that, "*statutory rape laws must balance the objective of protecting younger persons in situations of vulnerability, while not interfering with their ability to access sexual information and engage in sexual behaviour appropriate to their ages and evolving capacities.*"²⁴⁹

^h See *Children and Young Persons (Care and Protection) Act 1998*, section 23-29 cited in *Working With Young People Ethical and Legal Responsibilities for Health Workers*, 2005, NSW Association for Adolescent Health

ⁱ See Section 277, Penal Code, 1956 (Thailand) and the judgment in *Naz Foundation (India) Trust v. Government of Delhi and another WP(C) No.7455/2001* [Delhi High Court], Date of Decision: 2nd July, 2009 which decriminalised consensual same sex but only between adults defined as those over 18.



Under the current legal and policy regime, a case worker may reasonably conclude that the benefit of SRH and other health services for a given adolescent engaged in selling sex is outweighed by the collateral consequences of mandatory reporting.



AGE OF LEGAL CAPACITY TO CONSENT TO MEDICAL INTERVENTIONS

Laws determining the age at which children and adolescents may consent to medical interventions may negatively impact on access to SRH and other health services.^{jj} National laws usually include a provision allowing consent to testing or treatment to be given by a parent or legal guardian of a person who is below the age of legal capacity.²⁵⁰

In some countries, an exception may apply that allows persons under 18 to exercise consent independent of their parents or guardians, provided certain conditions are met. These conditions usually refer to the ‘mature minor’ principle recognised in both international and certain national law, which recognises that “minors may give an effective lawful consent to medical treatment if they have sufficient maturity to understand the nature and consequences of the treatment.”^{kk}

National law in countries such as Fiji, Viet Nam, the Philippines and Cambodia contain specific provisions in legislative codes addressing the age of consent to HIV testing. The approach varies widely, with some stating categorically that no one under the stipulated age can be tested without a guardian’s consent and others referring to the minor’s best interests and the mature minor principle. Ages of consent also vary ranging from 13 in Papua New Guinea, 14 in Lao PDR and the Federated States of Micronesia to 18 in the Philippines. The draft HIV Bill pending in India suggests that children should be able to consent to testing by the age of 12.

Even where country level laws or policies in Asia Pacific are supportive of HIV testing for adolescents, no laws or policies uncovered by the review provide for exceptions in the case of adolescents living with HIV. Adolescents allowed to take an HIV test without parental consent and test positive then face the barrier of parental consent to HIV treatment.

Consent to HIV testing²⁵¹

Fiji: *HIV/AIDS Decree 2011*, Section 29(2)(b). A person below the age of 18 may consent to a test, if, in the opinion of the person administering the test, “the minor is capable of understanding the nature and consequences of an HIV test.”

Cambodia: *Law on the Prevention and Control of HIV/AIDS (1992)* Article 19: A person below the age of 18 may consent if “the guardian’s consent cannot be obtained and a test is in the minor’s best interests.”

Viet Nam: *Law on HIV/AIDS Prevention and Control of 2006*, Article 27: “HIV testing of persons less than 16 years old...may only be conducted when there is written consent of his/her parent or guardian.”

The Philippines: *Philippine AIDS Prevention and Control Act of 1998*, Section 15, “Such consent shall be obtained from the person concerned if he/she is of legal age or from the parents or legal guardian in the case of a minor.”

As governments continue to craft responses to these issues and will likely include some requirements or conditions of parental consent, it is also important to urge clarity for adolescents for whom parental or guardian consent is not an option such as those that live on the streets and/or those that sell sex and do not want their families to know. As UNICEF 2009 HIV counselling guidelines explain, “most laws and

^{jj} It is worth noting that adolescents selling sex may also be restricted from accessing confidential HIV testing and treatment for those living with HIV, as well as other services, not just because of age, but also marital status and nationality/migration status.

^{kk} *Gillick v West Norfolk and Wisbech Area Health Authority [1985] 3 All ER 402.*

*policies are unclear or ambiguous and sometimes conflicting about HIV testing of minors, in particular about who is authorized to give informed consent and under what conditions. In some cases, age at which a minor may give consent to test is actually higher than the legal age for which they can consent to sex, consent for marriage, termination of pregnancy, or voting rights. Laws and policies on consent do not often give consenting rights to informational caretakers or medical staff, an issue in terms of HIV testing in case of orphans, abandoned infants, and street children”.*²⁵²

AGE OF LEGAL CAPACITY FOR CRIMINAL RESPONSIBILITY

Another relevant aspect of age related laws is the age of criminal responsibility or the “*age at which, according to the law, a child is considered capable of committing a crime and therefore old enough to stand trial and to be convicted of a criminal offence*”.²⁵³ Adolescents whose behaviours are criminalised by laws relating to involvement in selling sex, homosexual conduct and drug use may be prosecuted under laws in countries that set a low age of criminal responsibility.

As discussed in Section 2.1, the Committee on the Rights of the Child has emphasised that adolescents engaged in selling sex are not to be treated as offenders. The Convention would seem then, in principle, protects adolescents from being prosecuted for criminal offences relating to their engagement in selling sex. However, further research is needed on whether this principle has been fully implemented on the ground in countries that have adopted similar domestic legislation, such as New Zealand. In addition, as discussed above, decriminalisation of criminal offences does not necessarily insulate adolescents from arrest for engagement in selling sex, as arrest may be utilised to divert adolescents to detention and involuntary “rehabilitation.”

The full decriminalisation of adolescent engagement in selling sex is especially a concern for those adolescents with intersecting vulnerabilities; for instance, whether boys having sex with boys or men in a commercial context can be prosecuted under homosexuality laws. Findings of the Innocenti Research Centre revealed that, “*In several countries of South Asia, the police use antiquated sodomy laws to punish homosexual behaviour. Afghanistan, Pakistan and Sri Lanka all have laws forbidding ‘immoral’ sexual practices, and the police frequently use these laws to punish boys sexually exploited in prostitution and homosexuals*”.²⁵⁴

BIRTH AND IDENTITY DOCUMENTATION LAWS AND POLICIES

In many countries in the Asia Pacific region, laws, policies and practices restrict the access of different groups of people to identity papers, which in turns restricts access to services and other rights. For example, many countries restrict the rights of sex workers to identity documents, which in turn restrict property and inheritance rights, freedom of movement and access to education, health care, housing, banking, voting, birth registration of children and access to social and health services including HIV treatment and support.²⁵⁵ The little research that exists confirms these restrictions are also often applied to adolescents who sell sex. For instance, a study in Viet Nam found that lack of identification papers traps male youth and adolescents aged 15 – 24 selling sex in a cycle of poverty given that they are unable to enter formal employment, acquire shelter or access social and health services.²⁵⁶

In a similar fashion, transgender adolescents selling sex face a lack of gender recognition that compounds this reality in Asia Pacific, in that a majority of countries in the region restrict or deny change in legal gender status or identity documentation.²⁵⁷ This presents important privacy issues for many

transgender people, and makes them more vulnerable to discriminatory treatment when entering contracts in employment, housing, goods or services; encountering security forces checking their ID; travelling through immigration points; and voting.²⁵⁸ Even in countries where gender recognition is available, it may be subject to onerous conditions such as undergoing gender affirming surgery, lack of a criminal record, informing direct relatives, and/or divorce.²⁵⁹

TRAFFICKING AND RESTRICTIVE MIGRATION LAWS AND POLICIES

As noted in Section 2.1, international legal frameworks consider adolescents under 18 who sell sex as victims of trafficking. Many governments in the region have enacted anti-trafficking laws used to prosecute purchasers and procurers of sex sold by adolescents. In some cases, such laws provide for non-prosecution of those who have been 'trafficked'. However, the *“legal position of young people who sell sex independently may be unclear if the circumstances do not fit the relevant legal definition of trafficking i.e., if there is no other person (a trafficker) coercing their involvement in selling sex.”*²⁶⁰

In addition, trafficking frameworks often call for large-scale 'raid and rescue' operations (Cambodia, India, Malaysia, the Philippines and Thailand). Adolescents rounded up in these raids may enter the juvenile justice system or be forcibly detained in "rehabilitation" homes or shelters. One UNICEF study of 22 countries in the Asia Pacific region found that *“Child victims of sexual exploitation, trafficking, abuse and violence at home, school and institutions are also reported to be subject to criminal procedures in some countries. As a result, many children are being held in police custody and detention without sufficient cause. Contrary to international standards and national legislation, some children are: detained with adults; kept in unhealthy conditions; subjected to inhuman treatment; not provided with access to education; and detained for lengthy periods of time.”*²⁶¹ Some shelters and detention centres do not appear to provide quality health care services to adolescents and studies have documented an increased risk of HIV transmission and drug and substance abuse for detained adolescents.²⁶² Adolescents in detention or shelters are vulnerable to sexual abuse and ultimately poorer health outcomes than if they had not been institutionalised,²⁶³ illustrating the fact that sometimes systems designed to protect children may end up harming them.

 Adolescents in detention or shelters are vulnerable to sexual abuse and ultimately poorer health outcomes than if they had not been institutionalised, illustrating the fact that sometimes systems designed to protect children may end up harming them.

As mentioned in Section 2.2 of this report, to avoid arrest, detention or 'rescue' adolescents who sell sex may go underground, work freelance and avoid all social services, heightening their vulnerability to violence, harm and severe health consequences. In Cambodia, the closure of brothels — as part of anti-human trafficking laws in 2008 — led to a significant shift in the nature of sex work, with those who sell sex, including adolescents, now largely working on the streets or in illegal brothels, which increases their vulnerability and also makes them harder to reach.²⁶³ A study in China documented how a legal crackdown on adolescents who sell sex led to their marginalisation and migration and impeded health workers from providing continuous services.²⁶⁴ It is clear that there are undesirable and unintended consequences of the implementation and enforcement of anti-trafficking and child protection laws. It is imperative that the implementing mechanisms of anti-trafficking laws are redesigned to establish minimal and effective interventions for adolescents engaged in selling sex that do not multiply harm.

Evidence shows that restrictive measures put in place to manage migration have not deterred would be migrants but rather have sometimes resulted in higher levels of vulnerability for them.²⁶⁵ For instance, following reports that female migrants from Myanmar were being forced into sex work, the

government prohibited females under the age of 25 from travelling without a legal guardian. This led to girls and women's migration shifting underground with increased payments to intermediaries to procure the passports, visas or other travel documents. In addition, the actual travel was facilitated through more difficult, less used and remote terrains, thus further heightening susceptibility to harm or abuse along the way.²⁶⁶ Similar trends have been reported from other countries such as Nepal and Bangladesh, where the portrayal of all adolescents on the move as trafficking victims has caused them to be seen only as victims of crime; as a result, government interventions may focus on the criminal aspect to the detriment of programming to address adolescent needs prior to and after migration.²⁶⁷

CENSORSHIP AND PUBLIC ORDER LAWS

Another category of laws that can hinder access to services for adolescents engaged in selling sex include censorship and public order laws. These are sometimes enforced broadly so as to interfere with health promotion efforts such as distribution of safe sex information at clubs or venues, or dissemination of health promotion information via Internet sites targeting specific populations such as young MSM or sex workers such as in Malaysia and China.²⁶⁸

UNCLEAR EVIDENCE ON PENAL LAWS TARGETING CLIENTS AND PROCURERS OF SEX WITH ADOLESCENTS

Penal laws and policies targeting clients (or "purchasers") and procurers of sex with adolescents are the norm in the law and policy literature on CSEC. To date, there has been little analysis of the impact of such measures on adolescents engaged in selling sex or adult sex workers who live or work in proximity to adolescents, or on the impact of such penal laws and policies on access to SRH and other health services.

Given that such laws may put adolescents in increased contact with uniformed services, and the documented abuse adolescents often face from uniformed services, more research is needed to evaluate the impact of such laws on adolescents engaged in selling sex in the Asia Pacific, but this review noted several areas of concern.

Such laws may be applied to adolescents selling sex as purchasers and procurers for activities incidental to their involvement in selling sex and even self-support, such as the sharing of work locations, resources, and customers. The same adolescents may also be prosecuted under such laws because they purchase sex from peers or attach fees to referrals to customers. In a study in Ho Chi Minh City, Viet Nam, all male adolescents and young people who sold sex reported that selling sex was not their sole source of income, specifically that they also earned from stealing, acting as managers for other youth and participating in street-based work such as shoe-shining.²⁶⁹

To the extent that laws reflect an understanding that adolescents engaged in selling sex may purchase or procure sex with other adolescents, the approach is punitive and not protective. For instance, Sri Lanka's 1998 amendment to the Penal Code recognised the reality that children themselves can be hired or coerced into procuring other children for prostitution. It criminalises any person who "hires, employs, persuades, uses, induces or coerces a child to procure any person for illicit sexual intercourse". Unfortunately,



"End Demand" laws targeting purchasers and procurers of sex with adolescents may disturbingly be applied to adolescents selling sex as purchasers and procurers for sharing work locations, resources, and customers. The same adolescents may also be prosecuted under such laws because they purchase sex from peers or attach fees to referrals to customers.



²⁶⁹ See India Case Study in Box.

ly, there is no reference to lessening the penalties for this offence if committed by adolescents and it is up to the magistrate to decide if a child is to be held criminally responsible if they are aged between 8 – 12.

Advocates for the expansion of such laws in the Asia Pacific region have noted that these laws are sometimes inconsistent, and lack a specific focus and clear definitions on the myriad forms of sexual exploitation a child might be subject to. For instance, in South Asia, the Innocenti Research Centre found that laws are “constrained by the interpretation of sexual exploitation either in the context of trafficking or in the context of brothel-based prostitution”.²⁷⁰ These laws often fail to distinguish fully between adults and adolescents and do not necessarily address those selling sex on the street or within the workplace, while also rendering them less applicable to boys, who are less involved in selling sex through brothels. For instance, Pakistan’s Suppression of Prostitution Ordinance^{mm} criminalises prostitution, does not distinguish between adults and children and does not cover boys at all. The laws may also define different age categories, such as in Nepal’s Children’s Act of 1992, passed with the aim of “protecting the rights and interests of children” and includes a prohibition on involving a child in an “immoral profession”,ⁿⁿ although children are defined as those under the age of 16. These advocates also maintain that such laws and policies contain few references to forcing someone into prostitution through psychological coercion, taking advantage of the child’s vulnerability or coercing the parent or guardian, thereby leaving out offences related to the process by which children may begin to sell sex.²⁷¹

LAWS THAT CRIMINALISE ABORTION

As noted in Section 3.3, adolescent women engaged in selling sex in the Asia Pacific experience unwanted pregnancies and undergo abortions, often in unsafe conditions. The existence of laws and policies criminalising abortion in the Asia Pacific appear even more threatening to adolescents engaged in selling sex, who face extensive prison terms in many countries for undergoing abortions. In countries such as Afghanistan, Bangladesh, Sri Lanka and Timor-Leste, abortion is permitted only to save the mother’s life, and a range of restrictions are placed on abortions in many other countries. Only a few countries in the region allow legal abortions on request – Cambodia, China, Mongolia, Nepal, Singapore and Viet Nam.²⁷²

LAWS RELATED TO GENDERED OR SEXUAL BEHAVIOUR AND/OR THAT CRIMINALISE HOMOSEXUALITY

Laws that criminalise the sexual behaviour of adolescent men who have sex with men and transgender people can lead to harassment from law enforcement officers and heightened stigma and discrimination. Fear of arrest, discrimination and being “outed” based on such laws may deter adolescents who are male or transgender from accessing services and obtaining condoms and lubricants that could protect their health. Nineteen countries of Asia and the Pacific have laws on the statute books and/ or religious laws that in effect criminalise male-to-male sexual conduct.²⁷³ Seven also criminalise sexual relations between females.^{oo} In some countries in Asia Pacific such as Afghanistan, Malaysia, Samoa and Tonga, laws may criminalise gender expression through outlawing cross-dressing as impersonation of the other sex, as anti-religious or indecent behaviour.²⁷⁴ As discussed above, these laws may also be substituted as proxy charges in domestic contexts where adolescent engagement in selling sex has been decriminalised.

^{mm} Pakistan Suppression of Prostitution Ordinance, 1961

ⁿⁿ Children’s Act, Nepal, 1992, Section 16

^{oo} For details of the countries with this legislation please see ‘Laws and policies affecting young people’s access to sexual and reproductive health and HIV services in Asia and the Pacific’, UNESCO, UNFPA, UNICEF, UNAIDS and UNDP, 2013, Pg 49.

LAWS THAT CRIMINALISE DRUG USE, POSSESSION AND SALE

In many countries in the Asia Pacific, laws and policies reflect a harsh environment for adolescents using drugs. The legal and policy environment is relevant to the many adolescents engaged in selling sex who also use drugs, as established in Section 4.2. The harsh penalties surrounding drug use, possession and sale cause adolescent drug users to avoid treatment for fear of being reported to government officers and detained in compulsory detention or “rehabilitation” centres. As discussed in Section 2, these centres violate international legal principles whether applied to people who use drugs or people who sell sex.

As of 2010, 25 countries in the Asia Pacific region retained the death penalty for drug possession or abuse. Many other establish extensive prison sentences for drug use. For instance, Indonesian law includes a maximum penalty of death for drug dealing, and a possible 15 years in prison for drug use. The law and policy environment stands at counter purposes to guidance for adolescents who inject drugs. For instance, a recent UNICEF systematic review recommended provision of opioid substitution therapy to adolescents who inject drugs,²⁷⁵ yet in some countries in Asia Pacific, methadone and/or buprenorphine maintenance treatment is unavailable or illegal.



Laws that regulate or punish gendered or sexual behaviour may also be substituted as proxy charges in domestic contexts where adolescent engagement in selling sex has been decriminalised.



LAWS AND POLICIES THAT CRIMINALISE OR DISCRIMINATE ON THE BASES OF HIV STATUS OR TRANSMISSION

A number of countries in the Asia Pacific region have enacted provisions that criminalise HIV exposure, transmission or non-disclosure, including Australia, Cambodia, China, Marshall Islands, Singapore and Viet Nam.²⁷⁶ According to the U.N. Global Commission on HIV and the Law, harms of such laws may include “*the additional stigma generated by criminal prosecutions and associated media attention, reluctance of people to come forward for testing and treatment as a result of fear of prosecution, and selective enforcement of laws against sex workers, migrants and MSM. Criminal sanctions can be a disincentive to HIV testing and disclosure. Contrary to the HIV prevention rationale of such laws, they may actually increase rather than decrease HIV transmission.*”²⁷⁷

In some countries in Asia Pacific, the existence of mandatory STI and HIV testing and lack of confidentiality for testing has been found to result in discrimination, termination from both sex work or other employment and violence.²⁷⁸ For migrant sex workers in the Asia Pacific, HIV status may also be used as grounds for denial of entry and deportation.²⁷⁹ While these findings were made in the context of adult sex work, these laws and policies may affect adolescents engaged in selling sex to an equal or greater degree.

5.3 LAWS THAT MAY SUPPORT ACCESS TO SRH AND OTHER HEALTH SERVICES

This section focuses on laws and policies specific to the rights of adolescents to access HIV and SRH services including anti-discrimination laws, laws that prohibit breach of confidentiality in delivery of health services and laws specifically conferring rights to access HIV and SRH services. Where age-related laws and policies could not be uncovered, the review includes laws and policies applicable regardless of age.

Policies in several countries in the Asia Pacific stipulate standards of health service delivery for adolescents ensuring access to services that are “confidential, do not require parental consent, are affordable or free of charge and accessible in a variety of settings.”^{pp} These have implications for adolescents who sell sex because they support a concept of state obligation to provide certain services to all people on a non-discriminatory basis while protecting their rights to privacy. These laws properly enforced and implemented could have a significant impact on health seeking behaviour of these adolescents. For instance, National HIV laws in PNG and Fiji provide that it is unlawful to deny any person access to the means of protection from HIV including condoms, lubricant and syringes.²⁸⁰ In Cambodia, people living with HIV have a right to free primary health care according to the national HIV law.²⁸¹ In Sri Lanka, all citizens have a right to access basic services provided by the State; this can be interpreted to cover health services.²⁸² India, Indonesia, Papua New Guinea and Thailand have also established programmes to help ensure that law enforcement does not act as an obstacle to HIV treatment and prevention.

In other countries, certain laws and policies may include both supportive and hindering approaches to accessing SRH services, especially where provisions restrict access to these services. For instance, in China the legal right to free family planning services is only available to married people²⁸³ and in Indonesia people must be married or engaged. However, in Indonesia, the right to information and assistance is not constrained by age.²⁸⁴ A contrasting example of a law that may contribute to an environment of entitlement to certain health services for adolescents is the Reproductive Health Act of The Philippines, which although signed into law by the President of the Philippines is now under review by the country’s Supreme Court. While the law maintains abortion is illegal, it also attempts to address the rights of adolescents to access reproductive health services.^{qq}

A recent joint UN report titled *Sex Work and the Law in Asia and the Pacific* notes that supportive laws, policies and practices in the HIV response and protection of the human rights of sex workers include: court judgments recognising that sex workers’ human rights are guaranteed under national constitutions; policies addressing access to state services and discouraging police harassment and abuse of sex workers including the confiscation of condoms; and legislation such as the prohibition of compulsory HIV testing, and protection against discrimination and breach of confidentiality.²⁸⁵ Adolescents could also benefit from the above provisions which could reduce their interactions with law enforcement and protect their rights to confidentiality, among other.

 Policies stipulating standards of health service delivery that include confidentiality, affordability, accessibility, and waiver of parental consent laws, properly enforced and implemented could have a significant impact on health seeking behaviour of these adolescents.

CASE STUDY

12

Supportive policies promoting access to SRH and other health services for adolescents who sell sex^{rr}

Cambodia’s *National HIV and AIDS Strategic Plan 2011-2015* is an example of a policy that targets young key affected populations (YKAPs). The plan includes provisions for the development and implementation of interventions that are age-appropriate, gender-equitable, and accessible to disabilities, to address the needs of young EWs (entertainment workers / sex workers) and other YKAP. It also focuses on young people who are most likely to or already are engaging in behaviours that put them at risk for HIV transmission and recommends the development of policy, legislation and strategies to provide an enabling environment for YKAP’s access to services that they need.

^{pp} For instance Lao PDR’s National Reproductive Health Policy.

^{qq} Legal proceedings in the Supreme Court have delayed implementation of this act.

^{rr} For an overview and examples of key components of many national policies in the region related to HIV, SRH services and adolescent health and youth policies, please see **Law and Policy**, Pg 64-75 (full reference in endnotes)

PNG's *National HIV and AIDS Strategy, 2011-2015* notes that young people are vulnerable to HIV as a result of lack of access to youth-friendly SRH services and education. The strategy identifies particularly vulnerable young people, including those “exchanging sex, those who are illiterate, street youth, and young men and women living with HIV.” It also specifically calls for legislative reform (including on laws that criminalise sex work and same sex practices) to reduce stigma and discrimination and improve the environment for effective HIV and AIDS prevention, treatment and care.

In **Indonesia** the *National Policy and Strategy on Adolescent Health (2004-2009)* provides that the government and the community are obliged to support and create a conducive environment for adolescent reproductive health (ARH). Services must be provided without discrimination including to marginalized groups. Importantly, this policy provides that the provision of health services should be carried out at all locations where young people are, both in school and outside of school, including on the streets, refuge and work.

The Responsible Parenthood and Reproductive Health Act, 2012, The Philippines²⁸⁶

This Act takes a human rights based approach and guarantees for all persons, “the right to equality and non-discrimination..... the right to sustainable human development, the right to health which includes reproductive health, the right to education and information, and the right to choose and make decisions for themselves in accordance with their religious convictions, ethics, cultural beliefs and the demands of responsible parenthood.”²⁸⁷ This Act prohibits discrimination on the grounds of age, which is a positive provision but also requires a letter of consent from parents if patients are under the age of 18, which is restrictive. However, the rights of young people are reiterated in the Implementing Rules and Regulations which state that “*reproductive health care must include adolescent and youth reproductive health guidance and counselling at the point of care, and age and development-appropriate education and counselling on sexuality and reproductive health, and age and development-appropriate reproductive health education for adolescents in formal and non-formal educational settings*.”²⁸⁸

Anti-discrimination laws which prohibit discrimination against any person in health care contexts can be helpful, particularly if the legislation “*specifies the prohibited grounds of discrimination to include age, marital status, HIV status, health status, disability, pregnancy, sexuality, gender or gender identity*.”²⁸⁹

The Draft Constitution of Fiji of 2013 includes all of the above grounds in its non-discrimination guarantee.²⁹⁰ Other countries specifically address non-discrimination in health services on the grounds of HIV status.²⁹¹ However, very few countries specifically prohibit discrimination on the grounds of age. Exceptions are Australia’s Age Discrimination Act 2004, which makes it unlawful to discriminate “*on the basis of a person’s age including in access to facilities, goods, services, premises, requests for information and the administration of government laws and programs*.”²⁹² Thailand’s Constitution also mentions that discrimination based on age is unlawful.²⁹³ As noted above, the Philippines Act also includes language that broadly prohibits discrimination and also provides for the State to eradicate discriminatory laws and policies if they hinder a person’s access to reproductive health rights.²⁹⁴

Non-discrimination guarantees are useful in establishing a specific environment supporting the rights of all people to access certain services. However, they often exist within National Constitutions as part of chapters on fundamental rights and are enforceable against the State but not private parties. In addition, even where specific enacted laws prohibit discrimination, other provisions may exist in conflict

with these. So, for instance, Indonesia's *Health Law* states that every individual shall have the right to "determine his/her reproductive life and to be free from discrimination, coercion and/or violence",²⁹⁵ but as noted above, in reality this only applies to married or engaged people.

India and Non-Discrimination

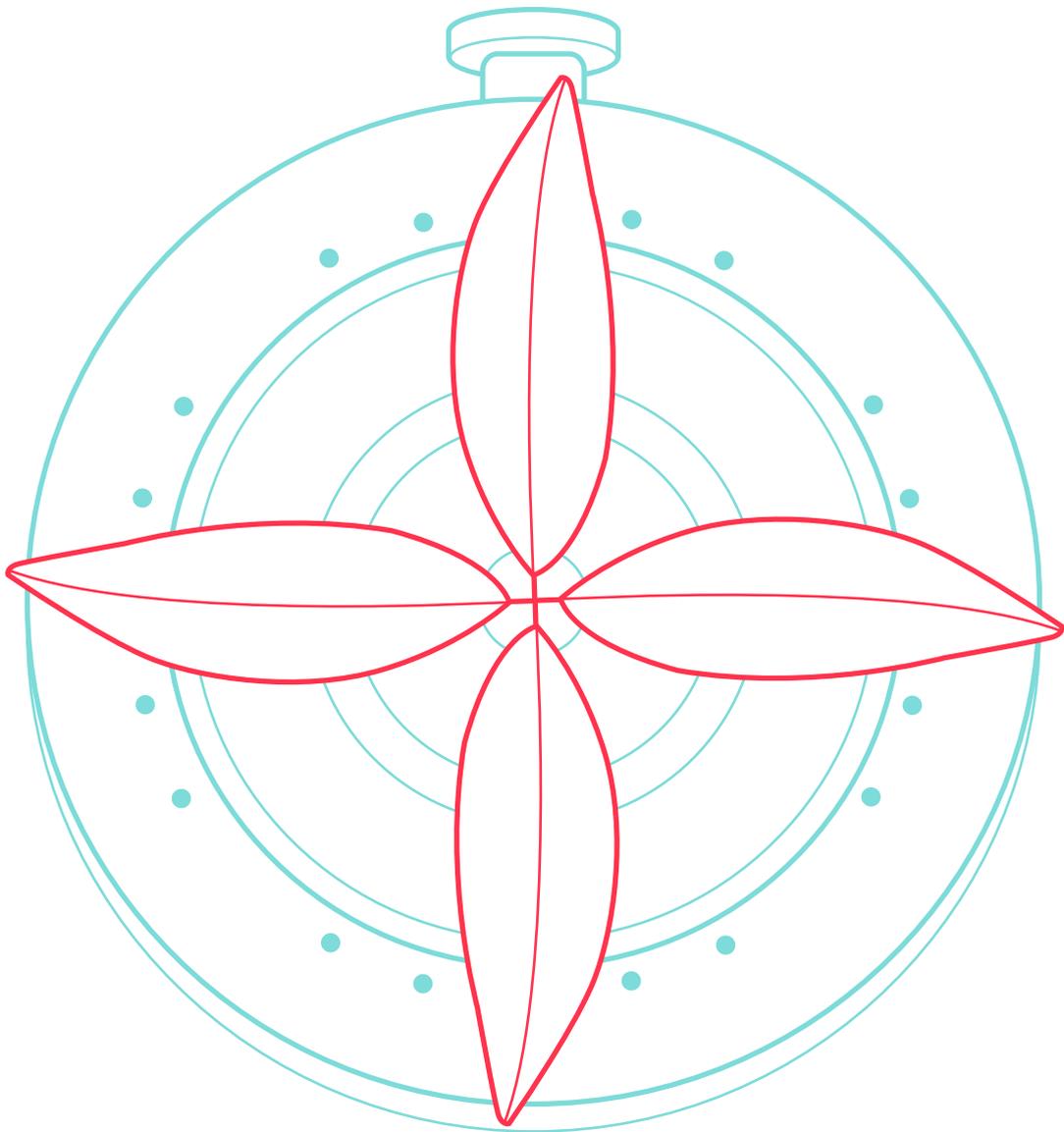
Article 14 of the Indian Constitution guarantees equality for all people "before the law or equal protection of the laws within the territory of India". This principle is further extended in *Article 15*, which prohibits discrimination on various grounds including race, religion, sex, caste or place of birth. *Article 21* of the Constitution of India recognises every individual's right to life and liberty, which the Supreme Court has held includes the right to health.⁵⁵

However, these fundamental rights guarantees are enforceable against the state not private actors. This means that discrimination in private health care is unregulated. The pending 2007 HIV/AIDS Bill has addressed this lacuna with its comprehensive provision that specifically prohibits discrimination related to HIV/AIDS in public & private spheres including healthcare employment, travel, insurance, housing, education etc.

⁵⁵ In 1991, in *CESC Ltd. vs. Subash Chandra Bose*,⁵⁵ the Supreme Court relied on international instruments and concluded that the right to health is a fundamental right and that Article 21 forms the basis of this right.

6

WHERE DO WE GO FROM HERE?



6. WHERE DO WE GO FROM HERE?

Across Asia Pacific, adolescents under 18 engage in selling sex in a variety of contexts and circumstances. Despite the clear evidence that adolescents appear to comprise a significant percentage of people who sell sex in many places, and that adolescents are often more vulnerable to SRH concerns, few documented programmes in the region focus on providing adolescents with a package of comprehensive services to meet their unique and intersecting needs.

As demonstrated in Section 2, adolescents under 18 have the right to access confidential health services, regardless of whether they sell sex. Yet although international and domestic legislation reflects a supportive position on access to SRH and other health services for adolescents engaged in selling sex, national policy and programmes may not reflect the written law. Even where supportive policies exist, *“there is a significant gap between the policy intent of promoting access to services, and the reality of services on the ground.”*²⁹⁶ The challenges include: lack of national action plans; poor coordination among stakeholders; lack of strong legal frameworks or legislation that implements and enforces rights mentioned in the policies; resource constraints; police practices; lack of clarity caused by conflicting laws; and persistence of religious and cultural norms which prevent adolescents’ access to services.

Also, unfortunately, as pointed out in Figure 9, the response to adolescent health and rights has become mired in politics – one in which the problems are either ignored or fall somewhere between the different domains of the SRH and child protection worlds. In addition, this paper notes with alarm the documented harms adolescents engaged in selling sex experience from state programmes and policies including health, child protection, law enforcement and other systems which are supposed to protect – not violate – their human rights.

There is a strong need to increase dialogue between health, child protection, social welfare and other systems at the global, regional and national level to ensure both government and non-governmental services operate with a rights-based and comprehensive approach to better support adolescent well-being. Systems must also be established to better document when rights are violated, and allow adolescents to address these violations.

In addition, this paper demonstrates that adolescents under 18 engaged in selling sex urgently need access to tailored programmes which address multiple vulnerabilities and are available to adolescents outside of traditional healthcare services. Key programmatic SRH and health elements include: comprehensive sexuality education; access to condoms, contraception, safe and confidential testing for STIs and HIV including through street and peer outreach; HIV treatment, including prevention of vertical transmission and related care, treatment for opportunistic and co-infections; safe abortion and maternal care; and harm-reducing services such as clean drug equipment and methadone treatment for adolescents who inject drugs. SRH and health services should be interwoven with other voluntary services, as requested by adolescents – including supportive housing, education, job skills training, mental health services, reunification with families, legal services and protection as desired. Peer support is also urgently needed to provide adolescents with a way to discuss their issues and create their own solutions.

While there is clearly enough information to support programme pilots and existing programmatic adaptations, there is still much we do not know about the needs of adolescents who sell sex. Research is



This paper notes with alarm the documented harms adolescents engaged in selling sex experience from state programmes and policies including health, child protection, law enforcement and other systems which are supposed to protect – not violate – their human rights.



needed to elucidate the programme models to support such adolescents that are not only effective and rights-based, but have the potential to be scaled up; collect data on existing programmes on capacity, coverage, length of programme and lessons learned; and conduct better population size estimations to understand the scale of the issues in different countries. Research is also needed on the impact of different laws and policies to elucidate how they support or hinder adolescent access to health and other services.

Furthermore, few initiatives actually engage adolescents under 18 *currently* engaged in selling sex in conversations about their realities and recommendations for addressing their needs. To further the conversation on these topics, HYLFF and partners also convened a series of community consultations across the region in late 2013 to better understand the SRH needs for adolescents and young people who sell sex. In November 2013, HYLFF brought together young people for a regional consultation where they made recommendations for improving the SRH response. HYLFF will release the findings of these youth-led processes in mid-2014, in the hope to begin shifting the overall dialogue on these issues towards one that puts adolescent realities, voices and demands at the forefront of the response.



SRH and health services should be interwoven with other voluntary services, as requested by adolescents. Peer support is also urgently needed to provide adolescents with a way to discuss their issues and create their own solutions.



ANNEX 1: DEFINITIONS OF AGE GROUPS AND KEY TERMS

Figure 1: Definitions of age groups and key terms

DEFINITIONS OF AGE GROUPS

CHILD

According to Article 1 of the Convention on the Rights of the Child (CRC): “A child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.”²⁹⁷

ADOLESCENTS

According to the United Nations, those aged 10-19 years.

YOUNG PEOPLE

According to the United Nations, those aged 10–24 years.²⁹⁸

YOUTH

According to the United Nations, those aged 15-24 years.²⁹⁹



DEFINITIONS OF KEY TERMS

ADOLESCENTS UNDER 18 ENGAGED IN SELLING SEX

Adolescents under 18 engaged in selling sex, for purposes of this paper, are persons aged 10 - 17 years who exchange sex acts for money, food, shelter, or other resources. The term is inclusive of adolescents involved in selling sex for a range of reasons: such as economic survival and family support, physical force, threat of force, or other coercion. “Selling sex” does not necessarily imply that the adolescents themselves receive pay or goods in return for the sex act, rather than a third party.

COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN (CSEC)

The Convention on the Rights of the Child (CRC) in Article 34 does not distinguish between sexual abuse and sexual exploitation. The Convention understands CSEC and sexual abuse as:

- “The inducement or coercion of a child to engage in any unlawful sexual activity.
- The exploitative use of children in prostitution or other unlawful sexual practices.
- The exploitative use of children in pornographic performances and materials.”³⁰⁰

According to the Stockholm Declaration and Agenda for Action adopted at the First World Congress against Commercial Sexual Exploitation of Children, CSEC comprises sexual abuse by the adult and remuneration in cash or kind to the child or a third person or persons. It is considered a fundamental violation of children’s rights, a form of coercion and violence against children, and amounts to forced labour and a contemporary form of slavery.³⁰¹

The definitions usually contain a stipulation that a second party needs to benefit. For instance UNICEF states that sexual abuse becomes sexual exploitation when a second party benefits – through making a profit or through a quid pro quo – through sexual activity involving a child.³⁰¹

²⁹⁷ While there are no universally accepted definitions of these age groups, the United Nations understands the age categories as below and applies these in their documentation, reporting and programming. See UNFPA, *Adolescent and Youth Demographics, A Brief Overview*. <http://www.unfpa.org/webdav/site/global/shared/factsheets/One%20pager%20on%20youth%20demographics%20GF.pdf>

³⁰⁰ This definition is from the Stockholm Declaration and Agenda for Action adopted at the First World Congress against Commercial Sexual Exploitation of Children, Stockholm, Sweden, 27-31 August 1996.



CHILD PROTECTION

According to Save the Children, child protection is defined as measures and structures to prevent and respond to abuse, neglect, exploitation and violence affecting children.³⁰²

CHILD SEXUAL ABUSE (CSA)

According to ECPAT International, CSA can be defined as contacts or interactions between a child and an older or more knowledgeable child or adult, such as a stranger, a neighbour or a relative, where the child is being used as an object of gratification for the abuser's sexual needs. The abuser may use force, threats, bribes, trickery or pressure.³⁰³

SEX WORKERS

According to United Nations guidance: "Sex workers include female, male and transgender adults and young people (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally It is important to note that sex work is consensual sex between adults, which takes many forms and varies between and within countries and communities. Sex work may vary in the degree to which it is more or less 'formal' or organized."³⁰⁴



UNIFORMED SERVICES

According to the United Nations, uniformed services are defined as police, military and other law enforcement, such as customs, navy, immigration and corrections officers. In many regions, "uniformed services have been recognized both as a key population at higher risk of HIV exposure and as important partners in the response to AIDS. Interventions addressing uniformed services are considered a major opportunity for promoting behavioural change, especially reducing stigma and discrimination and preventing violence against the populations most vulnerable to HIV."³⁰⁵

TRAFFICKING

There are different definitions as to what constitutes trafficking. Two that are important to note for the paper are:

1. The United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, articulates trafficking in Article 3 as the: "Recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."³⁰⁶
2. The Palermo Protocol further stipulates that "The recruitment, transportation, transfer, harboring, or receipt of a child for the purpose of exploitation shall be considered 'trafficking in persons' even if this does not involve any of the means set forth; and child is defined as anyone under the age of 18".



ANNEX 2: GUIDELINES ON PROGRAMMING FOR YOUNG PEOPLE AT HIGHER RISK OF HIV EXPOSURE

Note: The following provides examples of guidelines and recommendations for programmes to support adolescents and young people (under 18 years) who are at higher risk of HIV exposure. They have the potential to inform policy and program guidelines specifically for those aged 14-17 who sell sex in the Asia-Pacific region.

Key principles for responses for most at risk adolescents and young people aged under 18 – from *Responding To The HIV Prevention Needs of Adolescents and Young People in Asia: Towards (Cost-) Effective Policies And Programmes*, UNICEF, UNFPA and UNESCO, 2007

1. From a rights perspective, all children have the right to be free from sexual or other forms of exploitation, and they have the right to good health (which is compromised in case they use drugs or expose themselves to STI or HIV). As a matter of principle, therefore, children should not be engaged in risk behaviours for HIV; policy frameworks for HIV prevention among young people should make a distinction in those who are legally ‘children’ (i.e. under 18) and deserve social service assistance and ‘rehabilitation’, and those who are legally ‘adults’ and deserve access to prevention and care services.
2. At the field level, however, a certain level of pragmatism is necessary for those who are younger than 18. Those who are engaged in male to male sex or sex work and who are not coerced or exploited should have access to age- and gender appropriate STI care, VCT, prevention information and condoms and lubricants if they cannot be persuaded or assisted to quit or delay these behaviours. For drug users, principles of harm reduction apply, similar as those that apply to adults.
3. Any response – be it in policy or programming – should include consultation of children involved and their care givers, if they have any; any intervention should have the best interest of the child in mind.
4. There is a need for the development and implementation of adolescent friendly/age specific policies that ensure their rights to better health and social protection, and that their basic rights as children are not impeding their access to such services.

Core elements for effective responses to young people most-at-risk – from *Young People Most at Risk of HIV*, Interagency Youth Working Group, U.S. Agency for International Development, UNAIDS, Inter-Agency Task Team on HIV and Young People and FHI, 2010

- Collecting and disaggregating data by age, in addition to sex, which is important for advocacy, policies, and the development and monitoring of programmes.
- Developing and implementing policies that protect vulnerable young people, decriminalising the behaviours that place them most at risk, and ensuring that most-at-risk adolescents can access the services that they need.
- Training services providers, both those who work with most-at-risk populations and those who work with vulnerable groups of young people, so that they are better able to meet the specific needs of most-at-risk young people.
- Making effective links between services and communities: with parents, schools, youth, civil society, religious and community leaders, and others.
- Involving young people as advocates and as peers to make contact with, and provide outreach to, vulnerable and most-at-risk young people.

Elements of a youth-friendly approach – from *Programme Guidance Notes: HIV Prevention Among Most At Risk And Especially Vulnerable Adolescents And Young People in South Asia*, UNICEF, UNDP, UNESCO, UNODC, WHO, FHI, 2010

- Providing a range of accessible, appropriate, and affordable services for adolescents and young people – including those most at risk for HIV.
- Skills and technical expertise of health staff, including counselling for young people on sensitive issues of reproductive health, contraception, drug use, pregnancy and HIV.
- Hygienic, safe and private facility with necessary technical commodities available.
- Information and referral opportunities for young people.
- Procedural issues that respect privacy, confidentiality and voluntary participation, and treat each young person with dignity, respect and without discrimination.
- Allowing young people the choice to make free and informed choices in matters related to their health and sexuality, and providing opportunities for participation and involvement in decisions affecting them.

A one-stop shop:

- A youth-friendly approach to health services means that a service centre attempts to be a one-stop shop where an adolescent or young person can go to one place and find a full range of appropriate health services.
- Ideally the most comprehensive services will provide a place for young people to hang out and be involved in activities they like, interact with other young people, get basic necessities like clothes and food, and feel a sense of friendship and belonging.
- A one-stop shop can provide a safe space for young people most at risk

Practical and non-judgemental approaches:

- Focus on promoting safe behaviours and providing the necessary tools (i.e. condoms, lubricants, clean needles and syringes) rather than focusing on what they do (i.e. sex work, male to male sex, injecting drugs) and making judgements about their behaviour.
- Avoid moralising and promoting specific views. Consider alternative perspectives and provide best options based on engagement with every individual's health and social welfare needs.
- For those under 18, focus on providing a protective environment and linkages with child protection programmes (if these are appropriate) while remembering to provide them with information, skills and services to remain safe.

A focus on behavioural change and prevention of HIV transmission:

- Since multiple behaviours together contribute to increase risk, behaviours can be targeted through many levels to achieve the best results. Key behavioural change strategies for consideration include:
 - Increasing knowledge about how to protect oneself from HIV infection.
 - Promoting access to and use of condoms and, especially for MSMs and transgender people, water based lubricants.
 - Providing suggestions for alternative and non-penetrative sexual acts.
 - Encouraging access and use of services, for example methadone maintenance, HIV.
 - Counselling and testing for HIV, diagnosis and treatment of STI, use of antenatal and reproductive health services.
 - Promoting positive attitudes to condom use which will encourage safer sexual practices.
 - Delaying onset of intercourse if possible.
 - Assisting young people to get appropriate skills for other form of employment or education if they wish to change their work.
 - Improving enrolment in treatment programmes for STIs or HIV.
 - Promoting harm reduction strategies including providing clean needles and syringes to reduce sharing.
 - Focus on the importance of adherence to ARV drugs

Key interventions for effective responses for young people in all epidemic contexts - from *Inter-Agency Task Team on HIV and Young People: Guidance Brief: HIV Interventions for Most-at-Risk Young People*, Inter-Agency Task Team on HIV and Young People



- Information on HIV prevention and treatment (in a form they can understand).
- Condoms.
- Harm-reduction services (if injecting drugs).
- Services for the prompt diagnosis and treatment of STIs.
- Counselling and testing for HIV, with referral to HIV treatment, care and support services if HIV positive and HIV-prevention, counselling if HIV-negative.

Minimum package for most at risk young people for HIV – from *Programme Guidance Notes: HIV Prevention among Most at Risk and Especially Vulnerable Adolescents and Young People in South Asia*, UNICEF, UNDP, UNESCO, UNODC, WHO, FHI, 2010



- Information on HIV/STI, sexual and reproductive health including safe abortion.
- Voluntary counselling and testing services for PMTCT, STI and HIV, and pregnancy.
- Condom promotion/distribution including lubricants.
- Needle/syringe exchange programmes with access to clean needles and syringes.
- Harm reduction services.
- Outreach services with referrals to a variety of health and protection service options.
- Life skills training.
- Psychosocial/mental health care/counselling services which should include family counselling, treatment and care.



ANNEX 3: GUIDELINES ON PROGRAMMING FOR ADULT SEX WORKERS

Note: The following summarises examples of guidelines and recommendations for programmes for adults (18 years and over) who sell sex. They have the potential to inform policy and programme guidelines specifically for adolescents who sell sex in Asia Pacific.

Recommendations on programmes for adult sex workers – from *Prevention and Treatment of HIV and Other Sexually Transmitted Infections for Sex Workers in Low and Middle-Income Countries: Recommendations for a Public Health Approach*, WHO, UNAIDS, UNFPA and NSWP, 2012

Good practice recommendations:

1. All countries should work toward decriminalisation of sex work and elimination of the unjust application of non-criminal laws and regulations against sex workers.
2. Governments should establish anti-discrimination and other rights-respecting laws to protect against discrimination and violence, and other violations of rights faced by sex workers in order to realise their human rights and reduce their vulnerability to HIV infection and the impact of AIDS. Anti-discrimination laws and regulations should guarantee sex workers' right to social, health and financial services.
3. Health services should be made available, accessible and acceptable to sex workers based on the principles of avoidance of stigma, non-discrimination and the right to health.
4. Violence against sex workers is a risk factor for HIV and must be prevented and addressed in partnership with sex workers and sex worker led organisations.

Evidence-based recommendations for adult sex workers:

5. We recommend a package of interventions to enhance community empowerment among sex workers.
6. We recommend correct and consistent condom use among sex workers and their clients.
7. We suggest offering periodic screening for asymptomatic STIs to female sex workers.
8. We suggest offering female sex workers, in settings with high prevalence and limited clinical services, periodic presumptive treatment for asymptomatic STIs.
9. We recommend offering voluntary HIV testing and counselling to sex workers.
10. We recommend using the current WHO recommendations on the use of antiretroviral therapy for HIV-positive general populations for sex workers.
11. We recommend using the current WHO recommendations on harm reduction for sex workers who inject drugs.
12. We recommend including sex workers as targets of catch-up HBV immunization strategies in settings where infant immunization has not reached full coverage.

Key elements of a response in the context of adult sex work – from *The HIV and Sex Work Collection: Innovative Responses in Asia and the Pacific*, UNAIDS, UNFPA and Asia Pacific Network of Sex Workers, 2012

- Community mobilisation and organisational development of sex worker-led organisations and networks.
- Peer outreach, and education and drop-in services, including linking or providing services within sex worker-specific programmes such as for sexually transmitted infections (STIs), voluntary testing and counselling (VTC), and family planning.
- Promotion of and access to male and female condoms and water-based lubricants, including strategies to ensure demand, access, utilisation and supply — particularly in sites where sex work takes place — community awareness and acceptance of condom use and empowering sex workers to negotiate condom use.
- Access to the full range of sexual and reproductive health (SRH) services to meet the needs of sex workers

and their clients. This includes diagnosis and treatment of STIs; the full range of contraceptive methods and counselling to prevent unintended pregnancies; access to antenatal, delivery and post-natal care, including access to antiretroviral drugs for mothers and to prevent vertical transmission.

- Access to alcohol and drug-related harm reduction, including needle and syringe programmes and opioid substitution therapy.
- HIV voluntary testing and counselling.
- Access to HIV treatment, care and support.
- Preventing and addressing violence.
- Preventing and responding to stigma and discrimination, including in health care settings, through stigma reduction strategies, community legal education and access to legal services.
- Economic empowerment programming that expands choices for control over financial resources and generation of additional or alternative income.
- Advocacy and leadership building to reform laws, policies and law enforcement practices that undermine rights and impede an effective response and to promote protective laws, policies and practices that support effective responses.

Components of a new generation of programmes for adult sex workers – from *HIV in Asia and the Pacific: Getting to Zero*, UNAIDS, 2011

A comprehensive, rights-based, multi-sectoral and multi-partner approach is needed. It should feature:

- Sex workers' meaningful involvement in the design, implementation and assessment of programmes that are intended to benefit them.
- Support for sex workers' attempts to organise themselves collectively; partnerships with law enforcement authorities (particularly at a local level), and human rights training to reduce violence and harassment.
- Access for sex workers to legal assistance and other means to seek redress if their rights are violated.
- Programmes that promote safe working conditions for sex workers and access to social security through the workplace.
- Prevention programmes that include sexual reproductive health services, quality counselling and testing, treatment of HIV, and other sexually transmitted and opportunistic infections; and access to alcohol and drug-related harm reduction, including needle and syringe programmes and opioid substitution.
- Programmes to identify and reach men who buy sex, and greater effort to promote male responsibility for the sexual and reproductive health of their spouses, other intimate partners and families.

ENDNOTES

¹ As defined by the United Nations - <http://www.un.org/Depts/Cartographic/english/htmain.htm>. Countries: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka, Cambodia, China, Cook Islands, Fiji, Indonesia, Kiribati, Korea, People's Democratic Republic of Lao, Malaysia, Marshall Islands, Micronesia (Federated States of), Mongolia, Myanmar, Nauru, Niue, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Thailand, Timor-Leste, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam.

² *Convention on the Rights of the Child*, United Nations General Assembly, 20 November 1989.

³ CRC, Article 3.

⁴ CRC, Article 6.

⁵ CRC, Article 2.

⁶ CRC, Article 12.

⁷ CRC, Article 34.

⁸ CRC, Article 39.

⁹ CRC, Article 37(b).

¹⁰ CRC, Article 37(d).

¹¹ CRC, Article 12, § 2.

¹² CRC, Article 25.

¹³ CRC, Article 37(c).

¹⁴ CRC, Article 24.

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¹⁶ OPSC, Article 8.

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¹⁹ CRC, Article 19, § 2.

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²⁸ Ibid. Section III, Para 31

²⁹ CRC Comment 15, Section E, Para 19

³⁰ UN Committee on Economic, Social and Cultural Rights (CESCR) (2000), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

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The UN General Assembly Political Declaration on HIV and AIDS of 2011

The International Conference on Population and Development (ICPD) Programme of Action of 1994, ICPD+5, and ICPD+10

The Beijing Platform for Action of the Fourth World Conference on Women of 1995, Resolutions of UN ESCAP on HIV and AIDS of 2010 and 2011

The UN Economic and Social Commission for Asia and the Pacific (ESCAP), Fifth Asian and Pacific Population Conference Plan of Action on Population and Poverty of 2002.

The Association of South East Asian Nations (ASEAN) Declaration of Commitment on HIV, and the ASEAN Human Rights Declaration of 2012.

The South Asian Association for Regional Cooperation (SAARC) Social Charter of 2004.

The Pacific Regional Strategy on HIV and Other STIs 2009-2013.

The Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities, including Condoms 2008-2015.

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³⁴ sca.savethechildren.se/PageFiles/3189/child%20protection%20definition%20OSC.pdf.

³⁵ CRC, Article 34

³⁶ CRC, Article 39.

³⁷ CRC, Article 37(b).

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