Global Health Coalition:

Summary & Strategy for the Future

2013

International Centre
FOR MISSING & EXPLOITED CHILDREN

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About Us

The International Centre for Missing & Exploited Children (ICMEC) is leading a global movement to protect children from sexual abuse, exploitation and abduction. ICMEC's work brings promise to children and families by: establishing global resources to find missing children and prevent child sexual exploitation; promoting the creation of national operational centers based on a public-private partnership model; building an international network to disseminate images of and information about missing children; providing training to law enforcement, prosecutors, judges, legal professionals, non-governmental organizations, and government officials; advocating and proposing changes in laws, treaties, and systems to protect children worldwide; conducting international expert conferences to build awareness, encourage and increase cooperation and collaboration between and among countries; and leading global coalitions to eradicate child pornography from the Internet and to attack child sexual abuse as a public health epidemic.

The Koons Family Institute on International Law & Policy (The Koons Family Institute) is the in-house research arm of ICMEC. The Koons Family Institute conducts and commissions original research into the status of child sexual exploitation and child protection legislation around the world and collaborates with other partners in the field to identify and measure threats to children and ways ICMEC can advocate change to help make children safer. The Koons Family Institute works to combat child abduction and child sexual exploitation on multiple fronts: by creating replicable legal tools, building international coalitions, bringing together great thinkers and opinion leaders, and creating best practices on training and the use of technology.

ICMEC gratefully recognizes the generosity of the following companies, without whom the Global Health Coalition would not be possible.

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Foreword

"For the first time in history, the health care industry is coming together to attack the public health crisis affecting today's youth that has resulted from the sexual abuse and exploitation of children.
This coalition will change the way the world responds to child sexual abuse and exploitation.
This is an important day, but it is just the beginning. We will add more companies and more health care leaders.
Our commitment is to build and execute a coordinated global attack on the hidden crisis of child sexual abuse and exploitation in the same way we have attacked other health crises."
Dr. Franz Humer, 11 October 2012, Zurich, Switzerland

In November 2011 the International Centre for Missing and Exploited Children, Il Telefono Azzurro, the Mayo Clinic and Bambino Gesu Pediatric Hospital convened a forum to examine the state of the world's children and the abuse of their rights in the Italian Senate in Rome. The attendees adopted a 20-point action agenda entitled "The Declaration of Rome." The first action taken as a result of the Declaration is the creation of a Global Health Coalition to address child sexual abuse and exploitation as a public health crisis.

Our goal is to utilize both proven and innovative models of prevention, intervention, and treatment to attack child sexual abuse and exploitation as a public health epidemic. Together with leading health care institutions and pharmaceutical companies, we aim to shape the future of the world's battle against child sexual abuse and exploitation.

Several crucial steps comprise the foundational stage of this Coalition, with recognition that the overall initiative may require years of investment and effort to achieve comprehensive impact. This is just the beginning.

Ernie Allen, *President and Chief Executive Officer*
International Centre for Missing & Exploited Children

Acknowledgements

We wish to thank the following members that comprise the Global Health Coalition for their fundamental support of this effort:

Pharmaceutical Companies

- Menarini, *Lucia Aleotti, Vice President of the Board*
- UCB Biopharma, *Dirk Teuwen, Vice President, Corporate Social Responsibility*
- Merck, *Jay Galeota, President, Hospital & Specialty Care for Merck & Co.*
- Almirall, *Jorge Gallardo, Chairman of the Board*
- Roche, *Franz Humer, Chairman*
- Forest Laboratories, *Howard Solomon, Chairman and CEO*
- GlaxoSmithKline, *Andy Wright, Director, Disease Programmes, Global Community Partnerships and Minne Iwamoto, Manager, Global Community Partnerships*
- Pfizer Inc., *Dr. Olivier Brandicourt, President & General Manager, Emerging Markets*

Health Care Institutions

- American Academy of Pediatrics, *Dr. Robert Block, Immediate Past President*
- Mayo Clinic, *Dr. Daniel Broughton*
- Bambino Gesu Children's Hospital, *Dr. Lucia Celesti*
- InterPharma, *Thomas Cueni, Executive Committee Vice-Chair*
- Fondation Merieux, *Dr. Christophe Longuet, Medical Director*
- Centers for Disease Prevention and Control (CDC), *Dr. James Mercy, Special Advisor for Global Activities, Division of Violence Prevention*
- Children's Hospital Cleveland Clinic, *Elaine E. Schulte, Professor & Chair, General Pediatrics*
- American Academy of Pediatrics, *Patricia Sprague, Executive Director, Prevent Child Abuse Pennsylvania PA Chapter*

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- David Finkelhor, *Crimes Against Children Research Center, University of New Hampshire*
- Ronald C. Kessler, PhD, *McNeil Family Professor of Health Care Policy, Harvard Medical School*
- Dr. James Levine, *Professor of Medicine, Mayo Clinic*
- Dr. Winston Price, *Pediatrician, Former President of National Medical Association*
- Donna Sabella, Med, MSN, PhD, RN, *Assistant Clinical Professor, Director of Global Studies, Drexel University*
- Dr. Norman Sartorius, *former Director, Division of Mental Health, World Health Organization and former President, World Psychiatric Association*
- Dr. Raymond Schinazi, *Director and Professor of Pediatrics and Chemistry, Laboratory of Biochemical Pharmacology at Emory University*
- Dr. Michael Seto, *Director, Royal Ottawa Health Care Group, Canada*
- Suzanna Tiapula, *Director, National Center for Prosecution of Child Abuse*

Other Members

- Male Survivor, *Christopher M. Anderson*, *Executive Director*
- International Centre for Missing & Exploited Children, *Baron Daniel Cardon de Lichtbuer, Chairman Emeritus*
- Missing Children Europe, *Maude de Boer-Buquicchio, President*
- Together for Girls, *Michele Moloney-Kitts, Managing Director*
- Minnesota Department of Health, *Patty Wetterling, Program Director, Sexual Violence Prevention*

In addition, the staff of the International Centre for Missing and Exploited Children has been instrumental in the Coalition's development, in particular: Caroline Humer, *Program Director;* Sandra S. Marchenko, *Director, The Koons Family Institute on International Law & Policy*; and Eliza Harrell, *Marketing Manager.*

Points of view and opinions presented in this publication are those of the International Centre for Missing & Exploited Children and do not necessarily represent the official position or policies of the other organizations and individuals who assisted with the development of the Global Health Coalition.

Executive Summary

Researchers estimate that at least one in five girls and one in ten boys will be sexually victimized before 18 years of age, yet only one in three cases is reported. According to the United Nations, at least 1.8 million children are forced into commercial sex each year, 1.2 million children are trafficked, and 43% of trafficking victims are used for forced commercial sexual exploitation, of whom 98% are women and girls.

The estimated total health costs of child maltreatment exceed $124 billion per year, and when all costs, direct and indirect, are included the costs balloon to more than $500 billion per year.

The World Health Organization's World Mental Health Survey found that the majority of youth who experience sexual assault also experience other childhood adversities. Each additional childhood adversity adds to the aggregate risk of future mental disorder. The survey also found that sexual assault victims have double the risk of experiencing anxiety, mood, behavioral and substance disorders, and that this effect appears in equivalent ways in high, middle and low income countries.

Studies have found that child sexual abuse can lead to health disorders later in adulthood. A 2010 Mayo Clinic study found that a history of sexual abuse is associated with suicide attempts, post-traumatic stress disorder (PTSD), anxiety disorders, depression, and eating and sleep disorders. Sexual victimization changes a child's brain. It creates a risk of mental and physical health problems, including a risk of death from diabetes, cancer and heart disease later in life. The incidence of PTSD among child sexual abuse victims is estimated to be 35%, compared to 9% among non-sexual abuse victims.

The prevalence of pedophilia and hebephilia is estimated to be at least 1% of the male population, a prevalence level comparable to schizophrenia. There is some evidence of neurobiological impairments in pedophiles, but research is limited. Sex offenders are 4 – 5 times more likely to have been sexually abused themselves as children than the general population, and nearly 1 in 4 child sexual abusers is an adolescent.

There is progress, however. There are important international conventions, treaties and laws, and confirmed cases of child sexual abuse are actually declining. Yet, in this era of the Internet, the problem is actually getting worse. Reporting is poor; most victims are never identified; the services to treat the victims who are identified vary widely; prevention campaigns are not comprehensive and fail to reach most of the world's population; and most world leaders still do not view it as an important policy issue.

The world's primary response to child sexual abuse and exploitation has been through law and efforts by law enforcement – which are important. However, while leading international bodies like the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC) and others have taken important steps, there has been no comprehensive global effort by the health care industry to address child sexual abuse and exploitation as a public health crisis. An industry-wide collaboration is essential if we are to change the way the world addresses this problem and make progress.

There are proven prevention models from the world of health care that the Coalition should seek to emulate, including the global mobilization around the fight against HIV. While there are fundamental differences between a global campaign to combat a disease and one to promote the well-being of

children, we believe that there are areas of commonality and much we can learn from global mobilizations against HIV, SARS and other public health crises.

The more general public health model of intervention development entails five key steps:

a) Determine the magnitude of the problem.

b) Identify the risk factors.

c) Develop and apply screening tests to identify families in which children are at high risk of victimization and individuals who are high risk for perpetration.

d) Identify, implement, evaluate, and as necessary, revise preventive interventions aimed at prevention of perpetration in high-risk segments of the population. Carry out parallel intervention research aimed at the prevention of adverse effects among victimized children.

a) Develop a program of dissemination and quality assurance of interventions shown to be effective.

After having evaluated the outcome data, the process begins again with reassessment and refinement of the data for each part of the intervention model. The public health model works. Yet, the key to its success is sound empirical, measurable data. Applying this model to child sexual abuse and exploitation today fails because we lack quality empirical data in four of the five categories. Thus, we need more science, more research, and greater understanding of this complex problem.

The Comprehensive Strategy

The Global Health Coalition will address this problem through a five-point plan:

- Promoting and/or conducting the epidemiological and clinical research described in the previous section of this document (two-stage approach).
- Improving victim recognition and identification through enhanced medical education and specialized training for health care workers
- Identifying gaps and improving services for victims worldwide
- Intervening earlier with victims at the highest risk of adverse outcomes
- Launching a comprehensive global prevention campaign

Each strategy point requires concrete action items, the details of each are outlined below.

Strategy for the Future

As seen above, The Coalition has developed a broad strategy to address the problem of child sexual abuse and exploitation more effectively and from a public health perspective. The following action items outline the detailed components of this strategy.

Promoting and/or Conducting Epidemiological and Clinical Research

Guided by the first three steps of the public health model, the solutions for this complex problem must be driven by science, and the first step in the quest for solutions is to understand and identify the magnitude of the problem. The problem of child sexual abuse and exploitation is complex and multi-faceted, including multiple sub-categories:

- Child molestation
- Commercial sexual exploitation of children
- Child sexual assault
- Intrafamilial prostitution of children
- Statutory sex offending
- Child sex tourism
- Child pornography offending
- Domestic minor sex trafficking
- Online sexual solicitation
- Self-exploitation
- Incest

One of our greatest challenges is the absence of uniform definitions and vocabulary. Without such a framework, professionals in different fields often make different assumptions about the problem, for example assuming sexual abuse involves penetration or that rape always involves physical force. It makes it impossible to compare findings from different sources and jurisdictions.

As a result, we are often confronted with apparent contradictions.

How can confirmed cases of child sexual abuse be declining in this era of the Internet when there is an explosion of child sex abuse images on the Internet, each of which requires a real child victim? Or when hospitalizations of children for sexual abuse are rising? How can the reporting of child sexual abuse be increasing when there is evidence that when children are abused and photographed, reporting drops to virtually zero?

Important research has been performed over the past 20 years, but much more must be done to provide better understanding of the true magnitude of the problem, and its true impact on a child's health and on global health. The lack of comprehensive research is not surprising given the scope of the problem and the relatively short time in which it has been recognized as an issue with public health ramifications.

We need epidemiological research grounded in science. We must measure the problem(s), and then use that research to drive action. Our approach to epidemiological research must be predicated on three steps:

(1) Public health surveillance of prevalence and distribution;

(2) Impact analysis of the adverse effects of child victimization, including both economic and noneconomic costs, from both the individual and societal perspective; and

(3) Evaluation research. What works, and what does not, to reduce prevalence and adverse effects?

A particular concern is #2. There is very little impact analysis on a global scale. We must undertake research to measure the personal and societal costs of child sexual abuse and exploitation, and the cost effectiveness of various interventions. Though an economic analysis does not address the non-economic human costs, this information is essential to inform policymakers about the economic costs and benefits of current and recommended policies and practices.

As we contemplate the epidemiological research needs, we must first identify the right questions, standardize definitions and measures, and consolidate and align our data. And it is important that any research agenda addressing the problem of child sexual abuse and exploitation include research in the neurosciences. Within the health care system, there are not even diagnostic codes for physicians to use for certain types of child sexual exploitation.

Action Item: The Coalition will convene a consensus panel of scholars and experts to arrive at agreed-upon, standardized definitions and review existing research to attempt data consolidation.

Action Item: The Coalition will advocate for the adoption of diagnostic codes for the sub-categories of child sexual exploitation for which there are no such codes today.

One of the primary challenges is that "research funding follows light and heat." There is "Research to Know" and "Research to Show." We need both. "Research to Know" provides empirical data that we use to make decisions. "Research to Show" provides information we can use to demonstrate to the public and policymakers that this is a serious problem and one that warrants significant increases in investment and allocation of resources.

If we are to make real progress we must create a public groundswell that leads to action. We must build broad-based understanding that child sexual abuse and exploitation must be a priority public health issue.

Action Item: The Coalition will develop a prioritized research agenda emphasizing child sexual abuse and exploitation as a public health issue, and promote this agenda to potential partners and funders.

Action Item: The Coalition will promote research to identify risk factors for child sexual abuse and exploitation and develop screening tests.

Once the above action items are completed and epidemiological research has shown who is at high risk and what the risk factors are, additional steps will be necessary to expand the initiative into steps d and e of the public health model.

Action Item: The Coalition will promote and/or conduct research to identify and evaluate interventions, develop training to ensure that these interventions work and are used correctly and then develop dissemination strategies.

IMPROVING VICTIM RECOGNITION AND IDENTIFICATION THROUGH SPECIALIZED EDUCATION AND TRAINING

Child sexual abuse and exploitation is severely underreported. This can be remedied in part by ensuring that health care professionals probe for present or past abuse during patient visits to an office, clinic, or emergency room.

Yet, many health care leaders indicate that child sexual abuse and exploitation is not included in many medical and graduate school curricula (including nurses, and social workers) nor in in-service training for health care workers. Further, many health care professionals have not been taught to simply ask the question to children being examined about the possibility of sexual abuse.

It is imperative that students be educated not just at the medical school level. There must also be education at the collegiate level. And the training cannot be "one size fits all." The training must be adapted to the unique role of the particular professional being trained.

We must create a "No Wrong Door" policy, ensuring that every key person in a child's life knows what to do. The targets for this policy should include nurses, doctors, social workers, teachers and counselors. It also needs to include the primary care system, school systems and more.

Similarly, it is important that we "connect things," linking mental health with primary care, social services with medical care, the educational system with health care and social services, and law enforcement with all of the above. There is too little multi-disciplinary thinking and too few multi-disciplinary approaches in connection with child sexual abuse and exploitation.

Action Item: The Coalition will promote the inclusion of content on child sexual abuse and exploitation in the curricula of medical schools, nursing schools, schools of social work, schools of education, law schools and other schools producing child-serving practitioners. Such curricula will include a "what to do" component, instructing practitioners on actions to take if abuse is suspected.

Action Item: The Coalition will develop training modules for health care workers and other child-serving professionals. A key element of this training should be the promotion of collaborative care.

Action Item: The Coalition will create a certification program for institutions that meet required standards for best practices and worker training.

Of particular importance is that training advance the principle of collaborative care. For example, teachers are more likely to report student mental health problems when there is a system in place that allows the teachers to hand off the burden of dealing with the complications caused when a report is made. The same is true for primary care detection and referral for treatment of depression. When a collaborative care program is put in place in a primary care office and when it includes a protocol for handing off cases involving children with serious emotional problems to specialists, primary care detection skyrockets. When the collaborative care program is phased out, detection drops. Thus, we have to go beyond training in simply how to detect abuse. We have to develop a system that will facilitate and encourage reporting.

IDENTIFYING GAPS AND IMPROVING SERVICES FOR VICTIMS WORLDWIDE

In much of the world, systems for responding to disclosures are poorly developed. In many places nothing is done, but under worse circumstances children (and sometimes their families) are targeted with blame and stigma and sometimes physical harm. This means that in every environment there must be systems for responding to and protecting children in the wake of disclosures, systems that involve collaborative efforts of social service, health and law enforcement. The main goal of such systems should be to shield the child from further harmful contact with the perpetrator (in the best of circumstances interfering as little as possible with the child's other support systems). Another goal should be to minimize the stigma and possibility for retaliation by anyone against the child and family. Finally, a third goal should be to minimize additional harm to the child from the actions of authorities who become involved in the management of the case.

Action Items: Collation of best practices in child protection from around the world based on different models. Particular models that have been promoted because of their success include the Children's Advocacy Center model and the Confidential Doctor model.

Action Items: Promotion of research about the comparative impact of different child protection approaches, to inform decision makers about such issues as: appropriate circumstances for removing children from the home, incarcerating offenders after child disclosures vs. other legal control mechanisms, methods for promoting family support of the disclosing child, methods for insuring confidentiality about children's disclosure, and methods for making medical examinations, interviews, and court appearances more child friendly.

Action Items: Creation of a methodology for countries and communities to conduct an assessment of the gaps and failures in their response systems to child disclosures, and develop solutions to these problems consistent with their particular cultures, legal systems, health systems and social service systems.

While in much of the world there are inadequate services for child sexual abuse victims, there are hopeful developments. Many victims do get better. For example, while sexual abuse victims are affected by PTSD at a rate four times that of the general population, many victims manage to remain relatively unscathed emotionally, a testimony to the enormous resilience of the human spirit. Further, there are new treatment interventions that are producing impressive results for victims who develop significant emotional problems.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a treatment model that is helping large numbers of sexual abuse victims. Fifty percent of PTSD victims recover within two years. The other 50% tend to have to deal with chronic illnesses. TF-CBT is an evidence-based therapy that has proven successful for children and adolescents with trauma, including symptoms of PTSD, fear, anxiety, depression, externalizing behaviors, sexualized behaviors, feelings of shame and mistrust.

TF-CBT is low cost, highly effective, and its use is now reaching beyond the developed world. For example, health care workers are now being trained to use TF-CBT in Sub-Saharan Africa with great results. This proven intervention is being accepted and utilized in diverse communities and can be utilized successfully by social workers. TF-CBT is one possible treatment that merits further study and examination.

There are a number of preventive and early intervention programs for people exposed to trauma. However, one of the major challenges is that limited resources prevents providing treatments to all of those who need them.

> **Action Item: The Coalition will review evidence-based treatments and determine an optimal mix and match strategy based on evidence of differential need and differential effectiveness. One promising option which the Coalition will consider is promoting expanded global use of TF-CBT.**

It is also important to recognize and anticipate that sexual abuse victims are prone to risky behaviors, and are vulnerable to teenage pregnancy, HIV, additional sexual assaults etc. The primary challenge is to destigmatize what happened to these victims, and to convey that it is acceptable to get help.

One of the principal gaps in responding to the trauma experienced by victims is the lack of coordination across disciplines. Many professionals are most comfortable in their "primary zone," and do not reach out to or interact with professionals from other disciplines. In treating victims this focus on "connections" is highly important and must be promoted.

There are particular gaps in services and inadequate recognition of the harm for child pornography victims. They have been violated and their privacy has been violated. Over subsequent years, they must be assured that others will not continue to violate them through voyeurism, and that they will be safe. They also require disease surveillance, mental health treatment and attention to neurodevelopmental disruption.

Child victims of sexual abuse and pornography may also be victims of family prostitution, cyber-enticement, sex tourism, commercial child sexual exploitation and self-exploitation, as well as physical abuse and neglect. This pattern is referred to as polyvictimization.

Victims of commercial sexual exploitation are 28 times more likely to be arrested in their adolescent years than those who have never been child sexual abuse victims. Options for secure residential treatment for these victims are inadequate around the world. These victims need housing, rehabilitative education and mental health treatment. Often they need substance abuse treatment, reproductive health management, and management of related medical problems including tuberculosis, hepatitis, traumatic brain injury, etc.

One attractive model is Dr. James Levine's Child Escape refuges in India, Africa and elsewhere for the rehabilitation and education of children rescued from commercial child sexual exploitation and human trafficking.

Interventions can be made at a number of levels and can be directed either at preventing victimization, preventing perpetration, and/or reducing the risk of adverse effects among rescued child victims. Some interventions can be at the individual level, community level or at the societal level. It is essential that the Coalition consider these types of interventions broadly and examine and identify models at all levels.

> **Action Item: The Coalition will examine programs and interventions and explore the replication of successful models, such as Dr. James Levine's Child Escape refuges in India, Africa and elsewhere for the rehabilitation and education of children rescued from commercial child sexual exploitation and human trafficking.**

One of the encouraging interventions with sexual exploitation victims is online therapy. A Swedish study reported that one hour of web-based therapy met the victims needs better than traditional clinic-based counseling. It enables victims to save face and be more motivated in treatment. The principal arguments for such web-based therapy are that it is accessible, anonymous and affordable.

This is a growth area and is especially important for stigmatized situations like being a victim or a perpetrator of sexual abuse. However, the effectiveness of these programs varies widely as a joint function of focus and facilitation by a professional. The programs that have some phone or in-person contact between a live therapist-coach and the patient work better than the ones that exclusively rely on the patient to go to a web site and to work through the materials on their own.

It is essential that there be a serious effort to review all of the off-the-shelf therapies and undertake a systematic comparison to see which ones the Coalition can and should support. The Coalition could consider convening a group of clinical experts to conduct a review of existing programs and then design a proposed evaluation to compare the relative effects of the programs that appear to be the most effective.

Action Item: The Coalition will evaluate the use of web-based therapies for certain victims of child sexual abuse and exploitation, particularly for group therapy in remote areas.

From a broader perspective, there is much we can learn from the HIV experience. There are behavioral aspects in addressing both. And in the HIV experience a key goal was to empower the victims and give them a voice. The health care industry learned to work not just with the individual but with the community. The Coalition believes that we can adapt a great deal from the HIV experience.

Action Item: The Coalition will study the global response to HIV as a model for designing and implementing a global campaign against child sexual abuse and exploitation.

PREVENTING THE DEVELOPMENT OF PERPETRATORS

It is understood that the origins of perpetrator behavior lie in developmental experiences, and some adult perpetrators begin their career of activity during childhood itself. A considerable amount of work has been done about how to respond to signs of developing sexually injurious behavior during childhood to short-circuit such behavior before it becomes established. There are now many evidence-based treatment programs for children with sexual behavior problems and for juveniles who commit sex offenses that reduce re-offending to very low levels. Much more needs to be explored about how to transfer such programs to other cultural contexts where sexual behavior in children is difficult to discuss. This is a task where health care professionals, because of their esteem and ability to discuss sensitive topics with children and families may play an important role.

Work is also needed to explore how to prevent the development of abusive behavior in other populations with some increased offending risk including children with conduct disorder, children with cognitive impairments, aggressive children, bullies, and victims of sexual abuse. There is reason to believe the provision of sexual information and education about norms of appropriate behavior can be helpful, but such activities are problematic in many cultures.

Action Item: Developing programs to provide treatment and education to at risk youth groups in ways that are consistent with the cultural practices of sexually conservative cultures.

Nearly 1 in 4 child sex abusers is an adolescent, and sex offenders are 4 to 5 times more likely to have been sexually abused as a child than the general population. Thus, as we focus on doing more for the victims, one of the most important things we must do is to keep those victims from becoming offenders themselves.

The DSM IV (Diagnostic and Statistical Manual of Mental Disorders) classifies pedophilia and hebephilia as diseases. While most offenders are not pedophiles, some research has identified neurobiological impairments in pedophiles in particular, including changes in the brain.

Yet, there is a clear exercise of free will. The typical offender is methodical, patient, plans his approach to prospective victims, grooms the victim and is careful to avoid detection. So, this is not usually compulsive behavior beyond the control of offenders.

Nonetheless, some victims go on to become offenders. If we are truly going to help victims, we must keep those at highest risk of becoming offenders from doing so. A large proportion of young offenders show psychiatric symptoms and diagnoses. However, there is a shortage of studies on effective interventions for young sex offenders. We must explore effective interventions for young offenders against children, and evaluate the comparative effectiveness of various treatments in preventing recidivism.

It is difficult to reach potential offenders because of cultural barriers. There is enormous stigma associated with pedophilia and hebephilia. Penalties have increased and there is little tolerance or empathy for this kind of behavior. Most offenders are not identified until they have a problem with the law. And because of low reporting, most offenders do not make it into the criminal justice system. There are striking parallels with alcoholism or depression.

In order to prevent child sexual abuse and exploitation, we must focus on those who have not yet offended against a child. Systems need to be created that enable someone who is beginning to fantasize about having sex with a child to reach out for help. Yet, most potential offenders will not tell anyone that they are experiencing such feelings for fear that they will mark themselves for life, and jeopardize their freedom and their future.

A variety of approaches to inhibit offending are worthy of exploration including general media messages to potential offenders, increased publicity about the likelihood of detection, internet self-help messages and programs connected to pornography sites, new parent education, school based parent education, training for youth organization workers and volunteers, and bystander mobilization.

A model of particular interest to the Coalition is the Prevention Project Dunkelfeld in Germany. One percent of men have sexual fantasies directed towards children. While the cause of sexual preference disorders is largely unknown, many men have difficulty living with their sexual preference. Since most child sex abusers were themselves abused as children, the focus of any effort to intervene before a potential abuser abuses a child should be on the victims themselves. The Dunkelfeld Project provides confidential treatment free of charge for individuals who have a partial or exclusive sexual preference in terms of pedophilia or hebephilia and seek therapeutic help. The Dunkelfeld Project emphasizes that everyone is responsible for their own sexual behavior, but seeks to provide therapy for men with a sexual preference disorder to help them act responsibly.

Another alternative is the U.S. Military One Source program which offers online, telephonic and in-person counseling to military personnel dealing with a variety of stress-related issues. It guarantees

confidentiality but advises those being counseled that Military One Source consultants have a duty to report threats of harm to self or others, family maltreatment (spouse, child, etc.), substance abuse and illegal activities. Nonetheless, it provides a vehicle through which men experiencing psychological stress can reach out for help without stigma.

Action Item: The Coalition will review the data and results from the Dunkelfeld Project in Germany to determine whether that concept or other concepts like the US Military One Source program could be replicated as an option to provide help without stigma for sexual abuse victims and others who are beginning to fantasize about sex with children and may have a sexual preference disorder.

Today, there are few resources available for youth who are not already involved in mental health or social services, especially if they have not disclosed. Some of them may be struggling with sexual feelings about children that may be connected to their own sexual victimization, a situation that is so highly stigmatized that they cannot talk to their parents or a trusted adult such as a teacher.

It may be possible to mitigate the risk of offending for the first time if we can reach these at-risk youth. One possible option is the creation of an interactive, multi-media, youth-friendly website with information links and the opportunity for anonymous online chat with trained operators. The website would not have to focus on sexual perpetration, since sexual and nonsexual offending often co-occur. There could be different modules for different kinds of risky behavior, including risky sexual behavior for unwanted pregnancy, sexually-transmitted illnesses, HIV, aggressive behavior, substance misuse and sexual offending.

Action Item: The Coalition will study the feasibility of a special web-based resource for child sexual abuse victims who are at-risk of later perpetration.

LAUNCHING A COMPREHENSIVE GLOBAL PREVENTION CAMPAIGN

The cornerstone of the Coalition's effort to end child sexual abuse and exploitation is prevention. The world must invest in prevention for the first time. Prevention begins with awareness. These are crimes that are not well understood and that most people think do not occur in their own communities. Overwhelmingly, the victims are hidden and do not report.

As the Coalition considers how best to proceed in addressing this global problem, it is essential that any global awareness campaign be staged and entail specific actions for people around the world to take.

Action Item: The Coalition will carefully plan and then implement a staged, strategic global awareness campaign, enlisting the support of leaders of the health care industry, policy makers, religious institutions, and respected leaders from around the world.

Nonetheless, there are steps the Coalition can take while we develop those data. Primary prevention means stopping maltreatment before it happens through addressing the conditions that make it possible. It would involve education and awareness building; empowering those who see suspicious behaviors to report, even when the apparent abuser is someone close; developing techniques to intervene earlier with those at risk of becoming perpetrators; and addressing societal norms and root causes.

Action Item: The Coalition's global awareness campaign should include educational efforts urging the public to report as a first step in identifying abuse and setting in

motion a process of intervention. An essential element of such a campaign will be public education directed at prospective offenders, urging them to get help now.

Prevention also entails risk reduction; i.e., focusing on groups at risk for victimization, providing them with information and empowering them so that they can recognize, resist, and escape; and focus on those at greatest risk of becoming perpetrators.

There is a considerable body of prevention education programming targeted at children of different ages and their families. The evaluation of these programs does show that they impart prevention concepts, increase reporting, and change child behaviors, although it has not yet been established that they reduce the incidence of abuse. Health professionals can be of great assistance to promoting the adoption of such educational programs.

Action Item: Research to develop and improve these programs should continue. Among the challenges are: Making such programs more developmentally specific to children of different ages; learning how to incorporate such learning in other more general prevention programming aimed at children (safety education, health education, violence reduction) to increase the likelihood that it will be adopted by schools and health programs; and adapting such programs to a variety of cultural contexts.

The U.S. Army has implemented an excellent program for female soldiers aimed at developing strategies to reduce sexual assault victimization. Such a program could possibly be adapted for children, or to provide information for parents regarding how to talk to their children. The Coalition should review and consider this program and other possible models.

We must also address the demand for sex with children. For the "entrepreneurs" behind commercial sexual exploitation, it is easy, low risk and enormously profitable. Children are commodities for sale or trade. And the customers do not match society's stereotype. They tend to be businessmen, lawyers, doctors, teachers, coaches, religious figures, etc. One way to stop maltreatment of a child before it happens is to shut down the demand.

Action Item: The Coalition's global awareness campaign will include a message to those who use children for sex that their acts are crimes, damage the children, and that we are unleashing a global effort to stop their behavior.

In the Western world, we are seeing increasing sexualization of younger children in advertising, media, etc. Governments and industries, like the advertising sector, can do more to ensure that their policies and practices do not promote the sexual exploitation and victimization of children.

The prevention of child sexual abuse and exploitation also requires changing social norms. Among the norms with some recognized association with sexual abuse include ones that devalue the status of women, promote violence in child rearing, and ignore the rights of children. Social norms interventions have produced behavioral change by encouraging people to reduce risky behaviors like smoking, drinking, driving under the influence or without seat belts, etc. We need to foster an environment that makes the sexual abuse or exploitation of a child unacceptable.

Action Item: The Coalition will seek to foster dialogue about what society believes in and stands for, and to focus attention on the way in which the world is normalizing and effectively, legitimizing, sex involving children.

Implementation

In order to develop a methodical implementation of this strategy, the Coalition outlined the following framework, grouping the action items by short-term (advocacy, education and proven concepts), medium-term (prevention, building global awareness, and implementing certification protocols) and long-term (research and replicating specific interventions) timeframes. Below are details of each:

Short Term Actions (6 – 12 months):

- The Coalition will convene a consensus panel of scholars and experts to arrive at agreed-upon, standardized definitions and review existing research to consolidate current data.
- The Coalition will plan a staged global prevention/awareness campaign.
- The Coalition will advocate for the adoption of diagnostic codes for the categories of child sexual exploitation for which there are no such codes today.
- The Coalition will promote the inclusion of content on child sexual abuse and exploitation in the curricula of educational institutions of medicine, nursing, social work, education, law and others producing child-serving practitioners. Such curricula will include a "what to do" component, instructing practitioners on actions to take if abuse is suspected.
- The Coalition will develop training modules for health care workers and other child-serving professionals. A key element of this training should be the promotion of collaborative care.
- The Coalition will study the global response to HIV as a model for designing and implementing a global campaign against child sexual abuse and exploitation.
- The Coalition will review evidence-based treatments and determine an optimal mix and match strategy based on evidence of differential need and differential effectiveness. One promising option of which the Coalition will promote for expanded use globally is Trauma-Focused Cognitive Behavior Therapy (TF-CBT).
- The Coalition will evaluate the use of web-based therapies for certain victims of child sexual abuse and exploitation, particularly for group therapy in remote areas.
- The Coalition will collate best practices in child protection from around the world based on different models. Particular models that have been promoted because of their success include the Children's Advocacy Center model and the Confidential Doctor model.

Medium Term Actions (1 – 2 years):

- The Coalition will launch a staged, strategic global awareness campaign, enlisting the support of leaders of the health care industry, policy makers, religious institutions, and respected leaders from around the world. The campaign will include educational efforts urging the public to report as a first step in identifying abuse and setting in motion a process of intervention; will include content directed at prospective offenders, urging them to get help now; and will include

strong messages that using children for sex is a crime, damages children, and that the Coalition will unleash a global effort to stop this behavior.

- The Coalition will undertake a global effort to change social norms, including fostering dialogue about what society believes in and stands for, and focusing attention on the way in which the world is normalizing and effectively legitimizing sex involving children.

- The Coalition will design and implement a certification program for institutions that meet required standards for best practices and worker training.

- The Coalition will develop a prioritized research agenda emphasizing child sexual abuse and exploitation as a public health issue, and promoting epidemiological research to potential partners and funders.

- The Coalition will promote research to identify risk factors for child sexual abuse and exploitation, and develop screening tests.

- The Coalition will promote and/or conduct research to identify and evaluate interventions, develop training to ensure that these interventions work and are used correctly, and then develop dissemination strategies.

- The Coalition will promote research about the comparative impact of different child protection approaches, to inform decision makers about such issues as: appropriate circumstances for removing children from the home, incarcerating offenders after child disclosures vs. other legal control mechanisms, methods for promoting family support of the disclosing child, methods for insuring confidentiality about children's disclosure, and methods for making medical examinations, interviews, and court appearances more child-friendly.

- The Coalition will create a methodology for countries and communities to conduct an assessment of the gaps and failures in their response systems to child disclosures, and develop solutions to consistent with their particular cultures, legal systems, health systems and social service systems.

- The Coalition will develop programs to provide treatment and education to at-risk youth groups in ways that are consistent with the cultural practices of sexually conservative cultures.

Long Term Actions (2 – 4 years):

- The Coalition will review data from the Dunkelfeld Project in Germany to determine whether that concept or others like the U.S. Military One Source program can be replicated to provide help without stigma for sexual abuse victims and others who fantasize about sex with children and may have a sexual preference disorder.

- The Coalition will examine programs and interventions to explore the replication of successful models, such as Dr. Levine's Child Escape refuges in India, Africa and elsewhere for rehabilitation and education of children rescued from commercial sexual exploitation and trafficking.

- The Coalition will study the feasibility of a special web-based resource for child sexual abuse victims who are at-risk of later perpetration.

- The Coalition will research to develop and improve prevention education programs targeted at children of different ages.

Conclusion

Child sexual abuse and exploitation is a massive, complex and overwhelming problem worldwide. The Global Health Coalition will not solve this problem overnight. It must identify short-term and long-term goals. And it must determine what success looks like and work toward achievable, measureable goals. It must also identify ways to test and evaluate concepts, some of which may not have obvious linkages to child sexual abuse, such as testing model foster care programs to make a child less vulnerable to childhood adversities. Our goal is to determine what works and what will make the world's children safer and less vulnerable. As the Chairman said, "today we begin."

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