

Brothel-based female child sex workers in Cambodia:
Key health determinants and recommendations for change



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Abstract

Brothel based child prostitution in Cambodia is not a new phenomenon. The latest estimate, revealed nearly 2 000 child prostitutes currently residing in Cambodian brothels. Children are most often forced into sex work by an intermediary and suffer physical and mental abuse at the hands of their perpetrators or brothel owners.

The purpose of this review was to gain a better understanding of the children's key health determinants and their subsequent health problems. Recommendations for the Ministry of Health and Non-Governmental Organizations have been provided.

Information was obtained by way of a literature review of years 1988 to 2009. Key health determinants of this population were identified and presented as either macro-level factors, meso-level or micro-level factors, followed by communicable and non-communicable health problems. The document concludes with recommendations summarized into several categories: disease prevention efforts, accessibility and quality of health services and suggestions for future research.

The results revealed most child prostitutes suffer from either Human Immunodeficiency Virus or other types of sexually transmitted infections. They suffer multiple unplanned pregnancies, unsafe abortion and subsequent psychological illnesses. To worsen matters, there is a severe shortage of health services specific to child sex workers.

Improving the health of child prostitutes requires the general population to receive extensive education about child prostitution and how to prevent the spread of disease. An increase in the number of child friendly STI treatment centres, particularly those offering anti-retroviral therapy is required. Reproductive health clinics that offer safe abortion and post-abortive counseling should be accessible and available for children in brothels. Enabling this population to access health services will require the Ministry of Health to educate and motivate brothel owners.

Key words: child sex worker, Cambodia, brothel, HIV, STI, mental illness and prostitution and condom policy.

Abbreviations

AIDS – Acquired immunodeficiency syndrome
ART – Anti-retroviral therapy
AFESIP - Acting for women in distressing situations
BBSW – Brothel based sex worker
BV – Bacterial Vaginosis
CI – Confidence interval
CSEC – Commercial Sexual Exploitation of Children
CUP – Condom utilization policy
DFSW – Direct female sex worker
ECPAT – End child prostitution, child pornography and trafficking of children for sexual purposes
FHI – Family Health International
FSW – Female sex worker
GDP – Gross domestic product
HCV – Hepatitis C virus
HIV – Human immunodeficiency virus
HDI – Human development index
ILO – International Labour Organization
IUD – Intrauterine device
LARC – Long acting reversible contraceptives
MSM – Men who have sex with men
NCHADS – National Centre for Dermatology and Sexually Transmitted Infections
OCP – Oral contraceptive pill
OR – Odds ratio
PPP – Purchasing power parity
PWID – People who inject drugs
PWUD – People who use drugs
SH – Sweetheart
STI – Sexually transmitted infection
TB - Tuberculosis
UN – United Nations
UNAIDS – United Nations Development Programme
UNCRC – United Nations Commission for the Rights of the Child
UNICEF – United Nations International Children’s Emergency Fund
UN ESCAP – United Nations Economic and Social Commission for Asia and the Pacific
UNTAC – United Nations Transitional Authority in Cambodia
USAID – United States Agency for International Development
VCT – Voluntary counseling and testing
WHO – World Health Organization

Definitions

Cambodian - refers to people who live in Cambodia irrespective of their ethnic, linguistic and religious background and who are deemed “lawful” residents of Cambodia (Tarr & Aggleton, 1999).

Child – according to the United Nations Convention on the Rights of the Child (UNCRC), a child is any person under the age of 18 years. In Cambodia, the age of legal consent to sexual encounters is also 18 years, but is not enforced and children of younger ages often consent to sex without legal implications being placed on their client (UNCRC, 1996).

Commercial sexual exploitation of children (CSEC) – defined by the UN as “the use of a child for sexual purpose in exchange for cash or in-kind favours between the customer, intermediary or agent and others who profit from the trade in children for these purposes (parent, family member, procurer, teacher etc)” (UN, 2000, p.12). The basis of exploitation is the unequal power and economic relationship between the child and the adult.

Indentured sex worker – one who is bound to her brothel owner by a working contract and cannot leave the brothel until the contract has been carried out. The contract is most often bound by financial debts owed to the brothel owner.

Indirect female sex worker – a female who offers sexual services in a karaoke bar, truck stop or dance club.

Khmer – refers to those people living in Cambodia who speak Khmer and practice Theravada Buddhism. There are also Khmer Islam who consider themselves to be ethnic Khmer in all respects apart from the fact that they practice Islam (Tarr & Aggleton, 1999).

Long acting reversible contraceptives – include contraceptive methods such as hormonal implants, intrauterine devices and injections such as Depo-provera. Methods are temporary and are reversible.

Sex tourism - involves the travel of individuals from a country where sexual exploitation is illegal, to a country where children are “well-supplied” for engagement in sexual acts (US, 2009).

Sweetheart – “romantic partner” who does not live with the respondent. A sweetheart relationship does not necessarily involve sexual intercourse (non marital and non commercial). (NCHADS, 2004b).

UNCRC – UN Convention on the rights of the child is a signatory Convention that has been signed by all but two countries (Somalia and United States). The Convention aims to protect the rights of the child in order to prevent exploitation and abuse of children for sexual purposes, including child pornography. A Convention is not legally binding (UNCRC, 1996).

Glossary

Krarom Pomme – little apple

Meebon – Brothel owner

Mama San – Female brothel keeper

Meebaa – Ancestral spirits

Sangsaa – Boyfriend or girlfriend

Srey Kouc – Broken woman or “prostitute”

Yama or Yaba – Recreational drug (amphetamine), commonly crushed and smoked.

CHAPTER 1. INTRODUCTION

Prior to entering into the Master of International Health (MIH) program, I was a pediatric Registered Nurse (RN) in Canada for over 7 years (2001-2008). My desire to utilize my nursing skills and education in developing countries originated even before I had finished my undergraduate degree. Within one month of graduating as an RN, I went on a medical trip to Timisoara, Romania. I worked independently in two small villages and provided primary health care and education. Over the course of the next 7 years, I carried out 5 medical mission trips to Europe, Africa and Asia. It was a result of these trips that I developed a keen interest in the health of those in disadvantaged populations.

My interest also arose from working part time in public health research and through my years of volunteer work both in a pregnancy-counseling clinic and a drop-in center for sex workers. I became particularly intrigued by their poor health and lifestyle choices and desired to know what health determinants led these girls to their current situations. My time spent with the sex workers revealed that they not only had low educational attainment, but the majority suffered physical and mental abuse by clients, had either hepatitis C virus (HCV) and/or HIV and drug abuse. Poor nutritional habits were the norm, as were many unplanned, unhealthy pregnancies

In April of 2008, I traveled to Cambodia for another medical mission. It was there that I realized the need for health care services in the country and the children were even in greater need of medical care. Majority of persons that came to our clinic had never seen a health professional and were grateful for the smallest amount of care and medical treatment.

It was also during this trip that I bought a book titled, “Sex Slaves: the trafficking of women in Asia”, which described the extensive problem of sexual slavery among women and children. After reading this book, I realized the dire physical and mental health needs of young prostitutes. I performed a brief literature search on PubMed and CINAHL databases and discovered that there was a paucity of information on child sex workers in Cambodia and their most pertinent health needs.

As such, I came upon several questions for my thesis topic.

- What are the main determinants of health for brothel based child sex workers?
- What are the most pressing physical and mental health needs?
- What resources are currently available for these young girls?
- How can the country improve its health care resources specific to this population and as a result improve their overall health status?

From a personal perspective, I am also interested to discover how the health of Cambodia’s sex workers differs from Canada and what are the main differences both in the health determinants and health service accessibility.

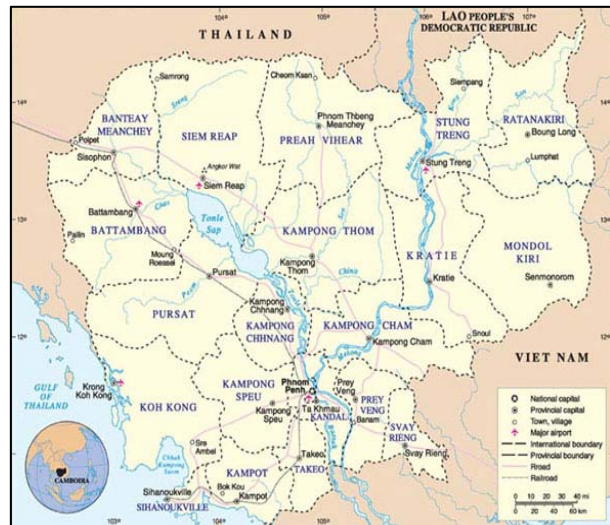
My aim is to provide recommendations for the Ministry of Health of Cambodia and NGOs in the region who cater to the child sex industry. In the near future, my goal (and dream) is to initially implement a medical clinic in Stung Treng province that will address the physical, mental and spiritual health needs of both indirect and direct sex workers in that region. I hope to begin with a pilot project, run by local Cambodian health care workers and expand the program based on the success and impact on health indicators.

CHAPTER 2. COUNTRY PROFILE

2.1 Land, population and administration

Cambodia has a total population of 14 197 000 people, of which over half are women (51%) and 44 percent are children (<18 years) (UNICEF, 2008). Cambodia is the most homogenous country in all of South-East Asia, as 90 percent of the country's inhabitants are indigenous Khmers (Leibo, 2008). The same number of individuals state their main religion to be Buddhism (Ross, 1987). The total area is over 180,000 sq. km and Thailand, Lao and Vietnam border the country itself on the west, north and east and southeast, respectively (Griffiths, 2003). The southern tip of Cambodia borders the Gulf of Thailand and for many years, has been a well-known port for tourist and militia groups, as well as a common port for commercial business. For administrative purposes, the country is divided amongst 20 provinces (Griffiths, 2003).

Figure 1. Map of Cambodia and provinces



Source: UNAIDS, 2008

2.2 Socioeconomic situation

Cambodia was affected tremendously by over two decades of civil war, and despite recent advancements both technologically and economically, it remains one of the poorest countries in the world. Cambodia currently ranks 131 out of 177 countries on the human development index (HDI) (UNDP, 2009) and is the poorest country in the Mekong Region (Leung, 2003). The Gross Domestic Product (GDP) per capita in 2008 was a mere \$2,727 (PPP), with 35 percent of Cambodians living below the poverty line (UNDP, 2009). Most impoverished persons are rural dwellers and not surprisingly subsistence farming is the livelihood for most Cambodians, particularly females (UNICEF, 2008). Women and their children are largely affected by low earning power and suffer the effects of poverty in the greatest way.

Despite Cambodia's growing market economy in recent years, the country is seeing a larger disparity develop between urban and rural populations. This disparity is particularly evident among educational attainment markers; over a quarter of the population aged 15 years and older are illiterate (26%) and only 30 percent of girls between 15 and 49 years attend school (UNDP, 2009). Most children who do not attend school inhabit rural areas and are subject to child labour in lieu of formal education. This low educational attainment, coupled with the cycle of poverty

and ill-health places young girls at high-risk of sex work, either in brothels or entertainment venues.

2.3 Health indicators

The health situation of Cambodia has been largely affected by the human immunodeficiency virus (HIV) epidemic that began in 1991 (UNAIDS, 2008). Incidence rates of HIV were extremely high at one point in time, but overall prevalence has decreased in the last decade from 3.3 percent in 1998 to 0.8 percent in 2008 (UNAIDS, 2008)¹. Despite these encouraging statistics, Cambodia is still considered to be harboring a concentrated epidemic because of high rates (>5%) among high-risk populations, particularly sex workers and persons who inject drugs (PWID) (UNAIDS, 2008).

The thousands of children suffering from HIV, coupled with limited access to anti-retroviral therapy (ART), are suffering greatly from poor nutrition. Because the WHO stated in 2008 (WHO, 2008) that malnutrition was a *major* problem for young Cambodian children, those with concurrent illnesses are at particular risk of morbidity and mortality. Child prostitutes are at even greater risk of malnutrition due to lack of control over their nutritional intake. Out of 1000 children born alive today, 91 will die before age 5 years and the life expectancy of survivors is a mere 59 years of age (UNICEF, 2008). Respiratory infections, such as Tuberculosis (TB) remain a common cause of morbidity for all Cambodians and are exacerbated by high rates of HIV. The 5 leading causes of morbidity and mortality among all Cambodians are listed in Table 1 (WHO, 2009) and a summary of most pertinent health indicators are listed in the Annex (3).

Table 1. Five leading causes of morbidity and mortality, 2000

Morbidity (rate per 100 000 population)		Mortality (rate per 100 000 population)	
Acute respiratory infections	7182.77	Malaria	4.75
Diarrhoea	2366.00	Acute respiratory infections	3.43
Malaria	987.70	Road accidents	1.40
Cough (of at least 21 days)	417.54	Tuberculosis	1.00
Gyneco-obstetrics	272.06	Meningitis	0.83

Source: WHO, 2009

¹ These decreasing rates has been thought to be caused in part by initial overestimations and better reporting and surveillance systems in recent years.

2.4 National health system

In the 1990s, a district health system was introduced in an effort to provide primary health care to greater distances throughout the country (WHO, 2009). The health reform involved creating a health coverage plan, allowing each district the financial means to operate decentralized services (WHO, 2009). Decentralization improved access for rural Cambodians. Most individuals are able to locate a health center within close proximity. There are now health centres in rural regions and a referral hospital for every 100 000 to 200 000 people (one per province) (WHO, 2008). Yet, despite improved access, the quality and comprehensiveness of services is lacking. As of late, the government of Cambodia was spending a measly 1 percent of its GDP (10.72%) on the national health care system!(UN ESCAP, 2002).

CHAPTER 3. STUDY RATIONALES, AIM OF THESIS, OBJECTIVES AND METHODOLOGY

3.1 Background of sex work in Cambodia and study rationale

Child prostitution is a severe violation to the rights of the child and “constitutes a form of sexual exploitation which involves coercion and violence against children and amounts to forced labour and a contemporary form of slavery” (UN ESCAP, 2007, p.7).

Globally, there are an estimated 2 million children involved in prostitution (World Vision, 2005) and Cambodia is no stranger to the problem. Known as a country that supplies ample numbers of children to provide sexual services, Cambodia continues to struggle with the elimination of child prostitution to the present day.

Sex work has not always been viewed as problematic for young women; in the early 1970's, the sex trade was a superb economic opportunity for women of all ages. The industry was booming, particularly near the commercial and tourist port in Sihanoukville . Popularity rose even further with the legalization of prostitution in this same port province (Hill & Heng, 2004). Yet, the times of legalized sex worked were short lived. The arrival of the Khmer Rouge party in 1974 brought with it the criminalization of sex work, and those found guilty were punishable by death. It was during this time that Cambodia would see complete elimination of all visible forms of sex work.

By 1979, the Pol Pot regime had ended, leaving an extremely unstable political situation. What was also lost was one-third of the total population, majority of whom were highly educated individuals. Families were displaced to the Thai border, livelihoods were lost, and the surviving population had little formal education. Lacking better economic opportunities, many women and their *children* were pushed into the sex trade as a means of survival. Cambodia would once again see a rise in the numbers of child prostitutes, most of whom were tied to brothels.

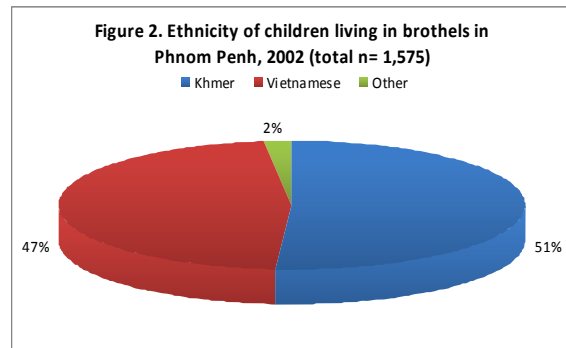
In 1991, Cambodia again saw an exponential rise in the numbers of sex workers. The end of the nearly two decades of civil war brought along with it the arrival of the United Nations Transitional Authority of Cambodia (UNTAC) (Whitworth & Moxon-Browne, 1998, Leung, 2003). The army brought 16 000 young men, in addition to an increased demand for sexual services. In response to this demand, the number of women and children in the sex trade rose from 6 000 to 25 000 within two years (Whitworth & Moxon-Browne, 1998). It was also this same year (1991) that Cambodia documented its first case of HIV and watched a massive epidemic evolve, primarily among sex workers and their clients (WHO, 2004).

Although the political situation in Cambodia has become increasingly stable, the growing market economy has been increasing the demand for sexual services. In recent years the booming tourism industry has brought 'sex travelers' who seek out the multitude of young (virgin) sex workers. As young as 5 years, most are smuggled illegally into the country, against their will (CATW, 2008). The UN (2000) states that countries in the greater Mekong subregion (Cambodia), are dealing with a rising problem of sexual abuse and sexual exploitation of

children. This problem is resulting in ‘severe physical and psychosocial’ health problems for many children of Cambodia today (UN, 2000, p.7). Such exploitation is not only a severe violation of the rights of a child, both to health and freedom, but lives are lost daily because of the abuse and maltreatment of vulnerable young children.

What is the magnitude of the problem in Cambodian brothels? The most recent estimate available, albeit somewhat dated, indicate there are approximately 1,874 child prostitutes living in brothels in Cambodia (Steinfatt et al, 2002).

Most child prostitutes are either of local Khmer descent or Vietnamese migrant workers (Figure 2). The majority of brothels remain concentrated in urban areas and two major red light districts, in Phnom Penh and in Battambang province, account for one-third of the total numbers of brothel based sex workers (Steinfatt et al, 2002).



Source: UN, 2000, Beyrer & Stachowiak, 2003, ECPAT, 2008, US, 2009

3.1.1 Study rationale

Two key factors that distinguish Cambodia’s sex trade from most other countries: First, most female prostitutes are very young, with nearly 30 percent being under 17 years of age (UN, 2000) and second, most are *forced* into ‘selling’ sex by those known to them (Leung, 2003). These young, vulnerable children are starved of their autonomy, including rights to health and freedom. As a result, thousands of children are exposed on a daily basis to life-threatening disease and maltreatment. In fact, many children are being used as “curative” treatment during a time of a massive HIV epidemic. Not surprisingly, the prevalence of HIV and sexually transmitted infections (STI) are much higher than national levels: as of 2005, approximately 3 percent of child prostitutes were infected with HIV (NCHADS, 2004a) and 16 percent harboured an STI (NCHADS, 2006). In addition to their physical illnesses, brothel based sex workers (BBSW) are often bonded to their brothel owner for extended periods and as a result, their rights to obtain medical care and formal education are severely restricted. Physical abuse and starvation is not uncommon and most of the children, if they do manage to escape the bondage of prostitution, will be psychologically scarred for years to come.

Female child sex workers in Cambodia are in need of greater attention. There is a dearth of research studying key factors influencing the health of young sex workers today. Specific knowledge of their most pertinent health needs is also unclear. Without this knowledge, providing appropriate health and medical services is difficult. It is not surprising then, that Cambodia documents few medical services aimed specifically at sexually exploited children who are suffering physical and psychological illness. In fact, these types of health services are virtually non-existent, thus preventing the young sex worker from receiving potentially life saving care and attention.

Addressing the young sex worker's key health determinants and subsequent health services is crucial to helping one achieve optimal long-term health and future potential. My hope is that this thesis will bring to light the most pertinent health needs of the young child prostitute. In addition, it is hoped that the recommendations provided to the Ministry of Health will be effective in improving the child's current and future quality of life.

3.2 Study Objectives

The overall objectives are to study the key determinants of health for underage sex workers who live and work in the brothels of Cambodia. This paper will unfold the impact of those determinants on the physical and mental health of prostitutes, and will be described as either communicable or non-communicable health problems. To conclude, I will provide recommendations to the Ministry of Health, of ways to improve the health of these children, through improved disease prevention and health service programs in the country.

3.3 Specific objectives

- Identify pertinent determinants of health for brothel based child sex workers in Cambodia, with emphasis on HIV and other common STIs.
- Identify current available services, with emphasis on reproductive health services within the public and private sectors.
- Recommend ways to improve disease prevention programs in Cambodia, as well as the quantity and quality of health services.
- Provide suggestions for future research within the area of child prostitution.

I wish to acknowledge that male prostitution is also a problem in Cambodia, with many boys working within the street based sex trade. Male sex workers however are not within the scope of this paper.

3.4 Study Questions

1. What are the key determinants of ill health for brothel based female child sex workers in Cambodia?

2. What are the most pressing health problems for the child sex worker?

3.5 Methodology

The methodological approach used for this literature review was as follows: First, a literature search was conducted, using data no earlier than the year 1988, unless it was relevant anthropological research. I was not able to limit journals to peer-reviewed research, due to the dearth of information on this topic. I restricted the chosen articles to brothel based sex workers. Although I attempted to include data only on girls under the age of 18 years of age, I was not able to consistently collect data on child prostitutes. Where necessary, I included data from girls between 15 and 19 years of age. In some situations, where data was sparse, I also included research from direct female sex workers (DFSW) who were older than 19 years of age and generalized the results, albeit a large limitation to my review. I focused my data collection entirely on Cambodia, although for background information, I reviewed several articles about DFSWs in surrounding countries such as Thailand, China and India. Search terms utilized were: child prostitute, sex worker, brothels, Cambodia and sexual exploitation. The following databases were searched: PubMed, POPLINE, Medline, Scopus, Google Scholar and the Child Trafficking site.

3.5.1 Search strategy

The second step in the review involved searching relevant websites. These websites were, the WHO, UNAIDS, UNDP, UNFPA, UNICEF, AFESIP, ECPAT, USAID, US government and World Vision. Third, I referred to three books, “The Road of Lost Innocence” and “Sex Slaves: The Trafficking of Women in Asia”, and “Khmer Women on the Move: Exploring Work and Life in Urban Cambodia”. Lastly, grey literature was accessed which included the “Cambodia daily” newspaper, as well as the BBC website that posted a short documentary on sex work in Cambodia.

3.5.2 Key words: child sex worker, Cambodia, brothel, HIV, STI, mental illness and prostitution and condom policy.

3.5.3 Limitations

I encountered two major methodological limitations while carrying out my review. First, I had anticipated communicating personally with local Cambodian NGOs. After multiple email attempts to connect with several individuals, contact proved very difficult. As such, I was not able to include reports from individuals who are directly involved in the sex trade in Cambodia. Second, as previously mentioned, there were very few studies aimed specifically at child prostitutes in Cambodia. As a result, I was forced to include multiple studies aimed at female sex workers (FSW) of over 18 years of age and in some situations, make generalizations to the younger population of sex workers. Thus, in the document, I often refer to “female sex workers” where age specific data was not provided. Most often, I utilized data from FSWs under 20 years and disaggregated the data as much as possible for each age group.

3.6 Presentation of the review

The results of this review will be presented systematically in the order of the framework presented in Figure 3. Beginning with a definition of a child prostitute, and an introduction to those involved in the sex industry, the results of the review will be presented as follows: first, macro-level factors, such as the laws, policies and the state will be outline, followed secondly by the meso-level factors such as the characteristics and working conditions of brothel based sex work, and ending with micro-level factors; individual choices and knowledge of health and education and how their health status is affected.

Figure 3

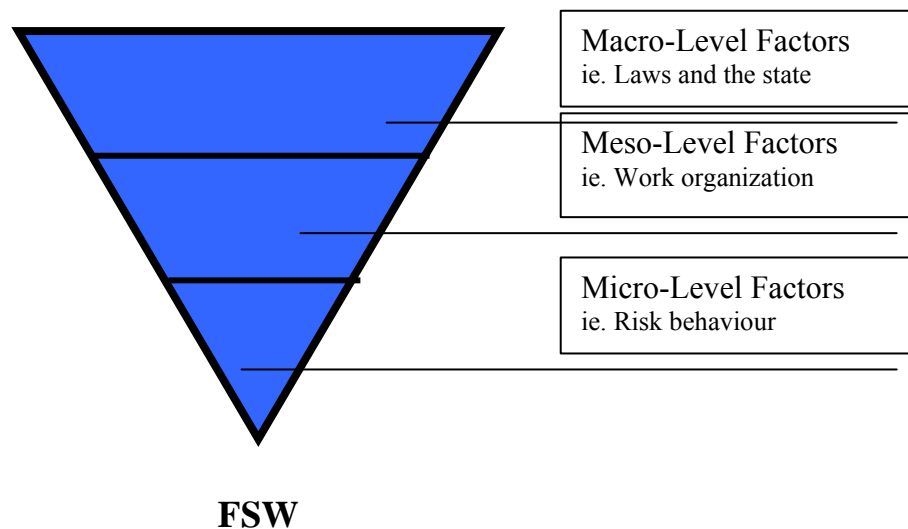


Figure 3 outlines the logic behind the presentation of this review.

Source: Pirkle et al 2007, WHO, 2009.

After outlining key health determinants, the impact of these determinants on the health of child prostitutes will be explained. These will be categorized into communicable, and non-communicable illnesses. To conclude, recommendations for improving the health of child prostitutes will be provided.

CHAPTER 4. DISCUSSION

4.1 Defining brothel based child prostitution

The actual definition of a child prostitute is any person, under the age of 18 years who “engages or offers services to a person to perform sexual acts for money or other consideration with any other person” (UN, 2000, p.12). A brothel based prostitute, also known as a ‘direct (female) sex worker’ is an individual who offers services from within a brothel, versus an indirect female sex worker (IDFSW) who is based in an entertainment establishment.

The semantics surrounding the term, ‘child prostitute’ has been a contentious issue in recent years. The term “prostitute” has been viewed as “vulgar” and “degrading” by women who sell sex and carries with it years of negative connotations. As a result, a “prostitute” is now commonly referred to a “(female) sex worker”, as a way to give credit to women who view selling sex as a form of higher employment.

For the purposes of this paper, I felt the term “sex worker” gave the idea selling sex is a form of work for underage sex workers and in a way, gives the impression that it is “acceptable”. But, as most would agree, children “selling sex” is against the UN Convention of the Rights of the Child (UNCRC) and should not be tolerated in any form. Some might take offense to the word “prostitute”, but it is for these reasons that I often refer to “child prostitute” instead of “sex worker”. For the same reasons, I would rather use the term “abuser” instead of client or customer, but for clarity and consistency of statistics, I was not able to maintain this terminology throughout the document. I apologize if the terms are frowned upon, or offend those involved in sex work *per se*.

4.2 The stakeholders in child prostitution

4.2.1 The young prostitute

The typical girl who can be found in a brothel will be, on average between 11 and 17 years of age² (UNICEF, 2008), uneducated and from a severely impoverished, rural background (Ohshige et al, 2000a, Willis & Levy, 2002, Beyrer & Stachowiak, 2003, Hill & Heng, 2004, WHO, 2004, Orchard, 2007, Derks, 2008, ECPAT, 2008). One study of 456 sex workers found that 91 percent of those interviewed were from rural areas and had migrated to Phnom Penh (Prybylski & Alto, 1999). Due to poverty and lack of better economic activity, these stereotypical ‘uneducated countryside girls’ (Derks, 2008, Nelson, 2008) are unable to attend school and head to the nearest city center (as reported by 90% of the girls in the UN study) (UN, 2000). Most will not leave the brothel until the family’s situation has benefited from her earnings.

² There have been reports of girls as young as five or six years of age, but the exact numbers are unknown and thought to be a small minority (Mam, 2008, IJM, 2008).

Family level factors also appear to influence one’s entrance into prostitution. One study found 80 percent of the girls were the eldest in their family, and over half were from lone-parent families (UN, 2000). Problems within the home, such as financial stress, chronic illness or death were found to push girls into prostitution. In addition, there were multiple reports of physical or sexual abuse at the homes of girls who ended up in brothels; girls reported deliberately leaving home because of maltreatment by their parents, relatives, or a partner (UN, 2000, Derks, 2008, Mam, 2008, UN ESCAP, 2008).

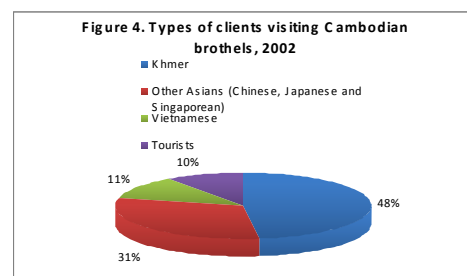
4.2.2 The recruiters (coercers)

The recruiter is often the key intermediary that brings girls into the sex trade. Usually, the intermediary is known to the child, either an aunt, parent or even a husband (Derks, 2008, Mam, 2008). In other situations, parents will sell their children out of ignorance because they are in need of money and are unaware of brothel conditions (Derks, 1998, UN, 2000, Brown, 2001, Marten, 2005). In one case, families in the Chiang Rai village had sold 61 daughters into prostitution for \$480 each, in advance for “future earnings” (CATW, 2008). In other cases, families or the girls themselves might be deceived and believe they are headed for work in a factory. Two studies on trafficking found that almost three-quarters of the girls reported being tricked and deceived by offers of other forms of employment (UN, 2000, Hill & Heng, 2004).

4.2.3 The customers (abusers)

In 2004, a national survey found that military, moto-drivers and police reported brothel sex workers as being the *most commonly* visited sexual partner (37% vs 31% vs 29% respectively) (NCHADS, 2004). Of this group, military men are most likely to frequent sex workers, particularly due to extended periods away from home. Migratory men are more likely to seek out FSWs when away from their partners (Verkuyl, 2002, Steinfatt et al, 2002, Sandoy et al, 2008a). Multiple concurrent relationships are common among men who use sex workers are an important bridge for the spread of sexually transmitted infections to the general population.

The most powerful customers are the high government officials. Although the exact numbers are lacking, these men alongside policemen have not only been linked to direct clients of the girls, but also to brothel ownership (UN, 2000, Bertone, 2004, Marten, 2005, Derks, 2008). The girls who cater to this group of men report being in difficult situations of power because of the level of status that these men hold. Most men who visit brothel based prostitutes are local Cambodians, followed by Asian migrants and tourists (Figure 4).



Source: Steinfatt et al, 2002

4.3 Macro-level factors

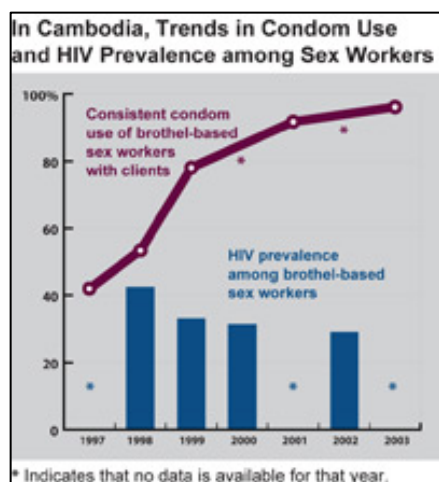
4.3.1 Laws, policies and the state, including legal challenges

Cambodia has been slow to evolve on the issue of child sexual exploitation. Most of the progress has been on the international agenda, and until recently, there has been very little independent movement by Cambodia. The first legislation that was directed at the problem of trafficking and sex work was established in 1949 with the UNCRC (Bertone, 2004) and there have been multiple legislations since that time, the most recent being in 2008. A summary of the various Conventions and legislations that Cambodia has been partial to are summarized in the Annex (Annex 2). A brief outline of the two most recent and most successful laws are outlined below, including challenges posed by the laws themselves.

4.3.1.1 Law #1 – The 100% Condom Use Policy (CUP)

The 100% Condom Use Policy (CUP), established in 1998, was seen as the first policy that successfully reduced HIV rates among sex workers. In the year of implementation, Cambodia was named as the country who would experience one of the “worst” HIV epidemics that was to hit South Pacific region (WHO, 2004, Derks, 2008,). The prevalence of HIV among sex workers was 44 percent, while the general population’s prevalence was 2.2 percent (UNAIDS, 2004). Established as an attempt to control the spread of disease between sex workers, the bridging population and the general public, the law mandated sex workers to use condoms for all sexual encounters. With the CUP, brothel owners were required to provide free condoms to sex workers and enable the women to go for mandatory monthly STI checks at government clinics (Marten, 2005). If the sex worker were found to harbor an STI, the brothel would be penalized, and after several hits, the brothel would be closed. The success of the policy is evidenced by a dramatic increase in condom use among sex workers, along with a large decrease in overall HIV rates in this same population (Figure 5).

Figure 5. Trends in condom use and HIV prevalence among direct female sex workers (DFSWs) (1997 – 2003)



Source: PSI, 2007

Although the government claims that the CUP has been highly effective in reducing HIV prevalence rates, the success has not come without much criticism. First, it has been suggested that actual rates of HIV and STIs were initially overestimated because of a poor reporting system and sporadic, inadequate laboratory testing (Prybylski & Alto, 1999). Due to the selective record keeping and improved statistical programs, true prevalence rates might only now be surfacing.

Second, the 100% CUP has been criticized for being ineffective in monitoring brothel owners and for failing to impose sanctions on brothels that do not comply. Many claim that the law merely places blame on sex workers for the spread of HIV and STIs without holding clients accountable. They state that the true cause of low condom utilization among sex workers is a result of gender inequality and unequal power relations between clients and the girls (Derks, 2008).

Third, other critics claim that creating a policy that requires the cooperation of brothel owners is counterproductive because brothel owners are often intertwined with government work themselves (Derks, 2008). Corruption between these groups prevents sanctions from being imposed on the brothel owners themselves. Where the brothel owners are not directly involved with the government, the sex industry could be driven further underground as more brothel owners attempt to evade government sanctions (Derks, 2008). Some brothel keepers are already discovering ways to avoid restrictions placed on their brothel operations. By not giving the prostitutes adequate supplies of condoms, and preventing girls from attending the clinic because of legal repercussions, not all girls are benefiting from the 100% CUP. Subsequent low clinic attendance could be preventing the effective monitoring and effectiveness of the program.

4.3.1.2 Law #2 – The Suppression of Human Trafficking and Commercial Sexual Exploitation

The second most successful law, aimed at reducing the number of prostitutes working in brothels, was the Suppression of Human Trafficking and Commercial Sexual Exploitation. Instituted in February, 2008, this Law saw an increase in the number of brothel raids and a subsequent decrease in the number of underage sex workers (US, 2009). Although it is encouraging that convictions have largely focused on sexual exploitation, the trafficking convictions have been few. In fact, there were only 12 trafficking convictions in 2008, compared to 52 convictions the previous year (US, 2009). Although the government continues to give attention to the problem of trafficking for sexual purposes, consistently convicting involved persons remains a huge problem.

Despite an increase in the number of brothel raids, not all of these raids are legitimate or provide freedom for the girls. A recent report found that in 2008, prostituted women were being detained and abused physically by both the police and government officials (US, 2009). These types of “brothel raids”, where girls are simply taken to the police station, is not an effective means of suppression of prostitution and is not a viable long-term option. Police have also been known to coordinate brothel raids in advance with the brothel owners, as a means to evade punishment against both involved parties (UN, 2000, Beyrer & Stachowiak, 2003, Bertone, 2004, Derks,

2008). One source found evidence that brothel keepers are not being held responsible for their actions; after a brothel raid in a well-known red light district, Svay Por, 11 out of 34 brothel employees were released without penalty (CATW, 2008).

In other situations, the *meebon* will return to where the girls are being cared for and demand the return of their “commodities”. One incident was documented as follows:

A few weeks after her brothel was raided, the *meebon* decided to take the girls back to her brothel. She arrived several times at the shelter with three military police and three armed guards. She called over the fence to the girls who used to work in her brothel. When the girls came out, she convinced them to come back to her, telling them that if they stayed longer in the shelter the staff of the shelter would eventually kill them. Five of the girls, fearing this prospect more than working for their brothel madam, allowed themselves to be lifted over the fence and taken back to the brothel (Derks, 1998, [page not provided]).

The police, military and brothel keepers are intertwined, making the legal ramifications extremely difficult to enforce.

4.3.2 Cultural and religious views of sex workers

The Khmer word *srey kouc*, (“broken woman”) is an accurate depiction of how the majority of Cambodians perceive a woman involved in sex work today (Mam, 2008, p. 47). In fact, local Khmer custom dictates that brothels should cease to exist (Derks, 2008, Steinfatt et al, 2002) and rape should be treated as one of the “worst possible offenses” (Derks, 2008, Tarr & Aggleton, 1999). A well-known Khmer proverb “Men are gold, women are cloth” was explained by a former Cambodian sex worker, referring to the importance of a woman’s virginity in the Khmer culture:

The men look like gold. When it drops in mud we can clean it, but the women look like white clothes; when it drops in mud we cannot clean it to be white again.
(Brown, 2001, p. 246)

In South Asian cultures, brothel based sex work holds a great deal of shame. Most of these women and children often experience the greatest consequences of the “sexual double standard” that pervades these cultures (Brown, 2001, p. 246). Virginity is an extremely prized possession in South Asia and once a woman loses her virginity, she is forever “dirty” (Tarr & Aggleton, 1999). Yet, a man can have premarital or extramarital relations many times over without experiencing the same discord (Derks, 2008).

In addition to cultural judgment and disapproval, sex workers also experience negative consequences because of their religious beliefs. Buddhism places particular value on maintaining one’s virginity until marriage. According to the third Buddhist principle, a person is required to abstain from “sexual misconduct”, specifically referring to premarital and extramarital affairs

among women (Derks, 2008). If one disobeys, then the “*meebaa* will frown upon and punish fornication.” (Derks, 2008, p. 185). Child sex workers are particularly at risk of punishment from the *meebaa*; these spirits are especially concerned with preserving virginity of young women (Derks, 2008).

Once a girl enters prostitution, particularly those who are of Khmer descent, support from family and the community will be lost. Without this support, young girls often end up in even worse situations, particularly when they contract a chronic illness, such as HIV. High medical expenses coupled with low education and limited economic opportunity can have a huge negative impact on their future well-being.

4.4 Meso-level factors

4.4.1 Characteristics of brothel-based sex work

4.4.1.1 Number of clients per day

Most girls working in brothels have to be available for work 24 hours per day, regardless of their health status (UN, 2000). Due to long working hours and the lack of control over the number of clients they service, girls usually encounter between 5 and 11 clients per day (Prybylski & Alto, 1999, UN, 2000, NCHADS, 2004b, WHO, 2004, Talbott, 2007, Derks, 2008)

Ethnicity, particularly being of Vietnamese descent has been found to play a role in serving a higher number of clients, as many as ten per day. But, despite being in greater demand, these same Vietnamese girls find themselves better equipped to service larger volumes because of working shorter durations in the sex industry (Busza & Baker, 2004, Derks, 2008).

Working long hours while servicing many clients negatively impacts one’s healthy state (Prybylski & Alto, 1999, UN, 2000, Oshige et al, 2000b, Busza & Baker, 2004, NCHADS, 2004b). In particular, Oshige et al (2002b) found in their study of over 400 brothel based sex workers that ≥ 4 clients per day was significantly associated with a positive HIV status ($p < 0.0658$)³. These results are not surprising, considering a prostitute works nearly every day, and is exposed to an average of five contacts per day. This frequent exposure to clients creates *massive* power for both infection and spread of disease.

³ Significance found when controlling for confounders using multiple logistic regression analysis.

4.4.1.2 Age of clients

The national behavioural survey found that the majority of local men who use the services of brothel workers are older than 30 years (NCHADS, 2004b). Due to the sexual experience and longer exposure period to diseases, these men are a high risk of infecting the younger sex workers. The risk is particularly high when men are older and have sex with a younger prostitute. Sopheab et al (2003) found that the risk of HIV infection increased when men had a sexual encounter with a woman at an older age (<18 years, OR 1, 19-24 years OR 2.52, >25 years 4.19). The study suggested that older men were more likely to be authoritative and less likely to use a condom with young girls, thus placing themselves at increased risk of infection. Not surprisingly, these men were also more likely to report having symptoms of an STI in the previous year. Thus, young girls are at particularly high risk for contracting illness when with someone who is their superior, especially an older man who is more likely to harbor an infection.

4.4.1.3 Cost of sexual services and virgin status

The amount of money that a girl earns per sexual encounter⁴ has also been found to impact her health status. Although a slightly less important risk factor, Ohshige et al (2000b), found in their study that low-cost per sexual encounter was positively associated with HIV status, although the findings were not statistically significant. A low cost for a sexual encounter allows for greater affordability, thereby increasing the ability to service more clients per day and a greater number of exposures to infection.

Although cheaper sexual encounters will likely expose the prostitute to infections in greater frequency, men are also willing to pay larger sums to “de-flower” a virgin. Due to beliefs that a virgin can improve one’s health and vitality (Derks, 2008, Mam, 2008), there are children as young as five working in brothels (BBC, 2008). Not only are virgin girls at greater risk of contracting an STI because of increased tearing and bleeding, but brothel owners also contribute to their increased risk. *Kramom pommes (little apples)* have reported being forced by their *meebon* to feign one’s virginity in order to earn the brothel owner more money (Derks, 2008). The health risks for the young prostitute are heightened, particularly because the procedures are likely performed without proper sterilization of instruments, couple with unsanitary conditions of the brothel. One such method is for the cervix to be sutured multiple times (Mam, 2008), likely without attention paid to using sterile procedures. Another such technique is when the *meebon* takes blood from a vein in the girl’s arm and places it on a piece of cotton, which is then placed in the vagina (Derks, 2008). When the client penetrates the vagina, he will have traces of blood on his penis and falsely believe that he has had sex with a virgin (Derks, 2008). There is little evidence on the actual impact of this practice on the health of the girls and their clients, but it is

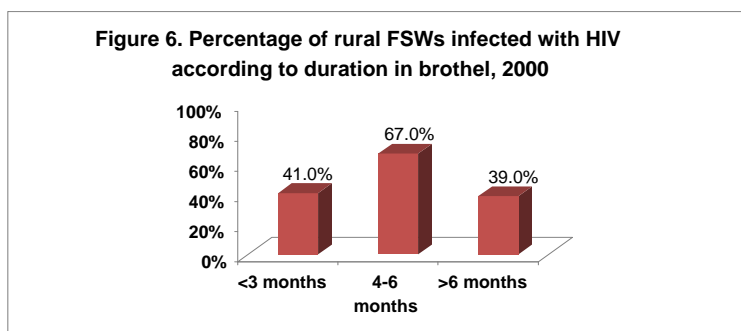
⁴As recent as 2008, it has been reported that brothels are charging a mere 2 to 4 USD per sexual encounter! (Prybylski & Alto, 1999, Sopheab et al, 2003, CATW, 2008). For non-Khmer girls - particularly those of Vietnamese decent – the price increases dramatically to between \$50 and \$4 000 USD (mean= \$300) (Busza & Baker, 2004, US, 2009).

safe to assume a high risk of exposure to blood-borne pathogens, especially HIV and Hepatitis C virus (HCV).

Whether one accepts very little money per sexual encounter or large sums, without barrier protection, the risk of HIV and other STIs is tremendous for the young prostitute.

4.4.1.4 Duration of employment in the brothel

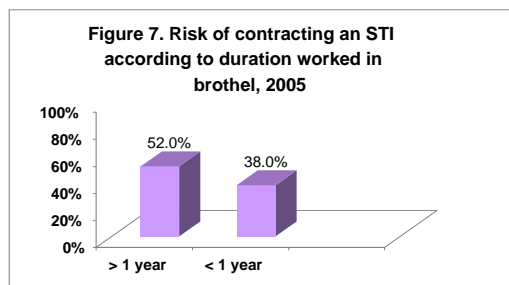
Duration of employment has been proven to have a considerable effect on the health of children in brothels. UNAIDS has suggested that brothel workers in South Asia are most likely to become infected within the first 6 months (UNAIDS, 2002), likely during the period that they are “de-flowered”. Yet, a study by Sopheab et al (2003) found the *longer* a woman worked in the brothel, the greater the risk of HIV. The study found that rural DFSWs working in the sex trade for 4 to 6



Source: Sopheab et al, 2003

months were significantly more likely to be infected with HIV (OR 2.86, 95% CI 0.77 to 10.66) (Figure 6). Further, a significant association was observed with duration of ≥ 2 years when a multiple regression analysis was performed. Yet, these findings do not clearly establish *when* the infection took place; many girls will either not immediately attend the STI/HIV clinic for testing or, they will wait until they are symptomatic, often months or years later than the initial date of infection. It is unclear whether girls are infected when they are younger and have thus, less negotiating power, but simply get tested at an older age, or when more experienced. This is especially likely due to the large number of older women who migrate to rural brothels when they are less attractive and more sexually experienced (Derks, 2008). These women thus, might report being infected later than the actual date

Younger girls who work longer than 6 months in a brothel also appear to be less likely to be infected with HIV, according to a study by Gorbach et al (2006). They found that women less than 20 years of age had *lower* levels (%) of HIV when working greater than 6 months, as compared to women >20 years. Contrary to the report by the UN, the author of this study suggested that the younger women (<20 years) were more likely to have negotiating power because of their youthful appearance and attractiveness and were thus, more likely to use a condom. Their explanation of these findings is inconsistent with other reports about young (virgin) girls and the lack of power to negotiate condom use.



Source: USAID, 2005

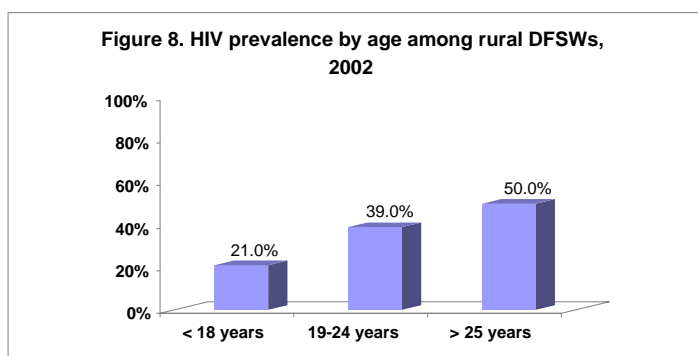
In contrast to the study by Gorbach et al, the risk of being infected with an STI other than HIV, appears to *increase* the longer one works in a brothel. USAID (2005) found that working for a year or more placed girls at significantly greater risk of contracting an STI other than HIV ($p < 0.001$) (Figure 7). These findings contradict the findings of the above study that showed increased condom use among those who spend longer periods in the brothel.

It appears the longer one works in a brothel, the more likely she is to be infected with HIV or another type of STI. It is logical that unless a sex worker consistently uses a condom, (unlikely among young girls), the longer the exposure period, the greater quantity of clients and thus, the greater the risk.

4.4.1.5 Size and location of the brothel

A relation between the number of women living in each brothel and sexual practices has been found in several studies. Even brothels that have one more person present, (8 vs 7.4 women per brothel) tend to have better security and more advocacies for condom usage (Gorbach et al, 2006). As a result, it was found that girls in larger brothels reported always using a condom, significantly more often than those residing in smaller brothels (OR 1.02, $p < 0.004$) (Gorbach et al, 2006). Perhaps it is also more likely that larger brothels have a greater number of older women who are willing to mentor the “new recruits”. The study by USAID (2005) reported that women in some of the large urban-based brothels offered to educate the younger girls about safe sex, condom utilization and negotiation. This type of “peer education” is known to be highly effective among sex workers and it is possibly more likely to occur in a larger centre.

Location also appears to be a determinant in one’s healthy state. One study found that rural-based DFSWs reported higher HIV prevalence rates than urban sex workers in Phnom Penh (Sopheab et al, 2003). And again, it was the women older than 25 years who were significantly



Source: Sopheab et al, 2003

more infected with HIV (Figure 8) than their younger counterparts. The study suggested that rates could be explained by a high turnover and migration of older, HIV infected women to rural areas. Yet, the higher prevalence of HIV in rural areas, along with the presence of older, more experienced women could also positively influence safe sexual practices among the younger girls. Unfortunately, there are no existing studies that have supported the potential association between rural

brothel workers, and efficacy of peer education on STI and HIV prevalence. As such, it could be suggested that young prostitutes are initially recruited to busy, urban based brothels and once infected with an STI, will migrate to lower class, rural establishments.

4.4.2. Characteristics of customers of sex workers

4.4.2.1 Condom use among military men, moto-drivers and policemen

Reported condom use by clients is encouraging. A recent study in 2003 revealed that nearly 90 percent of moto-drivers, military personnel and policemen had used condoms consistently⁵ in the previous three months (NCHADS, 2004b). Unfortunately, for those that use condoms regularly, effectiveness is not always a guarantee. One report found that despite consistent condom use among military and the sex workers (89%), 30 percent reported condom failure (Hopperus-Buma et al, 1995). Although this is much higher than the average breakage or slippage rate of 2 to 15 percent (FHI, 1994, WHO, 2003), it is an important reminder that simply surveying *reported* consistent use does not imply the method was effective with every sexual encounter.

Although it is encouraging to know that clients are using customers with sex workers, but it is less comforting to know that men reported “never” using a condom with a steady partner or sweetheart (Tarr & Aggleton, 1999). The pattern of inconsistent condom use with “trusted partners” is concerning, particularly because the most frequented customer of the sex worker - military men - also reported the highest incidence of STI symptoms (urethral discharge) in the previous year. They were also most commonly diagnosed with an STI (NCHADS, 2004b). Knowing that these men continue to have unprotected sex concurrently while visiting sex workers and do not have 100 percent condom use, the young prostitute is at particular risk of infection! And, to make matters more worrisome, 90 percent condom use by the customers could be inaccurate. This can be explained by the fact that case control studies assessing condom use are prone to recall bias by its subjects and the men are reporting falsely high rates of condom use. As such, the aforementioned results should be interpreted with caution and this bridging population should be continually targeted with education campaigns for the use of condoms.

4.4.2.2 Condom use among men who have sex with men (MSM)

The MSM group is one of the most important groups in the transmission of HIV/STIs. They not only prefer prostitutes over any other type of female partner, but they also have high-risk sexual practices and high rates of STIs. While one would expect that MSM only have sexual experiences with only men, over 60 percent of men in one study had had between 2 and 5 female partners in past year (FSW, casual partner, SH or female client)(NCHADS, 2006). In addition, MSM frequently have concurrent partners, both paying and non-commercial, increasing the spread of disease.

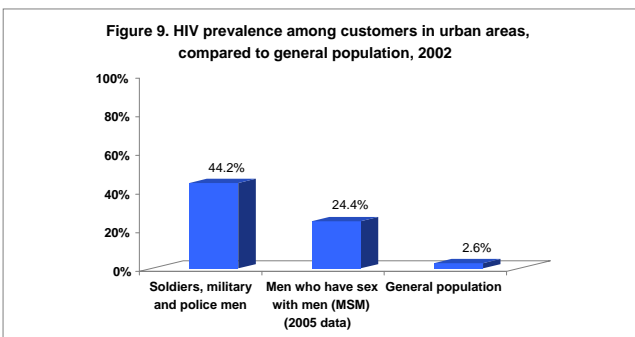
One well-known high risk sexual practice among MSM is anal sex. This type of sexual intercourse is particularly high risk for the spread of HIV and anal Chlamydia. Because men have the ability to have both insertive and receptive anal sex, they also hold the power to be

⁵ Consistent condom use defined as using a condom with every sexual encounter with a prostitute in the previous 3 months.

infected and spread the infection in the same day. This places sex workers at high risk of contracting an STI, being that receptive anal sex is the riskiest form (Pisani, 2008). Yet, only one in five men (MSM) consistently used a condom when practicing insertive anal sex⁶ (NCHADS, 2006). Without using condoms, the transmission of HIV and rectal STIs is very likely.

4.4.2.3 High rates of STIs/HIV among clients

High rates of STIs among the *clients* of sex workers are a major risk factor for FSWs' contracting HIV (Figure 9). The rate of HIV among the most frequent customers - soldiers,



Source: NCHADS 2004a, UNAIDS 2008

military and policemen – is shocking. These groups had reported an *increase* in prevalence rates from 19.1 percent in 1998 to 44 percent in 2002 (UNAIDS, 2008). These same men also have the highest rates of Chlamydia, an infection that is very common to DFSWs of all ages. In addition, policemen who tested positive for Chlamydia nearly always had a concurrent infection with gonorrhea or syphilis (USAID, 2005).

The reported high condom use, coupled with high STI prevalence paints a very confusing picture: Chlamydia rates are increasing among both clients and DFSWs, but HIV is not increasing among clients. Several explanations are possible: first, young girls (<20 years) are not being tested for HIV and actual prevalence rates are much higher. Second, as suggested previously, police and military men are reporting falsely high rates of condom use. Third, perhaps Chlamydia rates are preceding a sudden rise in HIV incidence rates, as because of synergetic effect of Chlamydia on HIV infection. And lastly, male clients are indeed using condoms 90 percent of the time with DFSWs, but are having condom-less intercourse with their spouses. I suspect the country could see a dramatic rise in prevalence rates within the general population in upcoming years.

As suggested in Figure 9, the MSM group is also reporting high rates of HIV. In addition, STIs are more common among older, more experienced men: STI prevalence among 25 to 29 year olds was 11 percent, while only 6 percent among the 15 to 19 year old group (NCHADS, 2006). Thus, as men become more sexually experienced, and have greater power over the young sex worker, they are not only more likely to harbor infection, but perhaps are more willing to have unprotected sex, as evidenced by increasing infection rates with age.

⁶ Results are with the exception of Phnom Penh (where condom use rates were higher).

4.4.3 Violence and maltreatment

Violence among girls living in brothels is not uncommon, and is perpetrated by clients, pimps and brothel owners (UN ESCAP, 2007). Injuries range from minor cuts and bruises, to death. A former child prostitute in Cambodia, Somaly Mam, describes her experience of violence within a brothel:

I know three girls who were killed. One time a girl was killed by a policeman who came in late one night. He wasn't a regular client and it was very late, about 2:00 am. This girl didn't want to go with him. She was sick. He was drunk. The yelling woke us all – 'Watch, all of you, because this will happen to you too one day if you don't obey' – and bang, she was dead (Mam, 2008, p. 57).

According to AFESIP, punishment of prostitutes today is far worse in recent years. Rescued brothel workers have reported getting "nails hammered into their skulls" or being "chained and beaten with electrical cables" (Mam, 2008, p.59). In one Phnom Penh brothel, a sex worker reported that if the girls took longer than 15 minutes to service a client, they would be beaten for providing 'unprofessional service' (Brown, 2001, p. 213). Other forms of torture are also utilized to impress fear upon the girls (Mam, 2008). If a girl disobeys the customer or the pimp, she might be tied up and have snakes and scorpions dumped on her (Mam, 2008). Although these reports cannot be immediately generalized to all Cambodian brothels, a large study by UN (UN, 2000) among women and girl prostitutes found similar reports. Thirteen percent of the subjects reported living like "animals", and stated that they were often neglected, left in "cages" and beaten with electrical wires. Most of the girls (85%) had received some form of abuse while living in brothels, most commonly in the way of being hit or kicked by clients or owners.

The recent conviction in 2008 of a foreign man revealed inexcusable behaviors of an adult abuser:

In a search of his home that led to his arrest, police found three minor female victims, aged 9, 10 and 11, as well as hundreds of pornographic images, including those of children engaging in sex acts, various drugs, children's clothes, and rope and cloth strips, which victims say (he) used to bind and gag them while he assaulted them (Poer, 2008).

Unfortunately, the abuse often occurs at a young age when they are likely energetic and trusting. This is also when they are developing physically, psychologically and socially (UN ESCAP, 2007) and are thus more likely to experience impaired development and psychological illness. The enslavement and trauma suffered is equivalent to torture – and the longer the exploitation goes on, the more health problems will be experienced (Bjerken, 2004). The trauma is likely to be highly underreported due to the difficulty of investigating child sex workers and fear of retribution by brothel owners. The brothels are also guarded 24 hours per day by security personnel, and remain 'hidden' and largely inaccessible by law enforcement officers.

4.4.4 Malnourishment

Girls often have food withheld as a form of punishment and several studies have reported that children living in brothels are starved or bonded when business is lacking (UN, 2000, Brown 2001, Willis & Levy, 2002, Mam, 2008, US, 2009.). Yet, they are caught in a bind because if business is good, obtaining adequate nutrition can be just as challenging. In the study by the UN (2000), it was found that most of the children were “undernourished” *and* overworked. When these undernourished children become infected with an STI /HIV or TB, their nutritional status deteriorates further.

Concurrent illnesses are known to impair one’s nutritional state. HIV and opportunistic infections such as TB can reduce appetite and subsequent food intake. In children, HIV impairs growth and development early on and thus, it is recommended that a child with mild, asymptomatic HIV infection ingest at least 10 percent more calories than a non-infected individual (World Bank, 2008). For those children with advanced HIV, the requirements are as high as 100 percent greater (World Bank, 2008). Tuberculosis (TB), with or without HIV infection is also detrimental to a child’s nutritional state. Malnutrition has been found to have a synergistic effect on the severity of TB. A small study among 30 children who were infected with TB showed a significant association between severe malnutrition and severe TB (Vijayakumar et al, 1990). When a child is suffering both illnesses, the risk of severe malnutrition is tremendous.

4.4.5 Unsanitary living conditions

Most girls’ sleep and work in crowded, small windowless rooms (Derks, 1998, Mam, 2008, Marten, 2005) and some rooms are simply divided by cardboard paper (Derks, 1998). One sex worker describes the conditions of a brothel:

Later that morning, I went to see the place – just a bare room, hardly big enough for the bed, and not even a proper door, only a curtain to shield it from the stairwell. It was like a lot of other rooms in Phnom Penh. There was a bare concrete floor and the blackened cooking fire as you walked up. There were many beds and rotting pallets made of woven grass. The place was filthy (and) the odor of sewage was overpowering (Mam, 2008, p. 56).

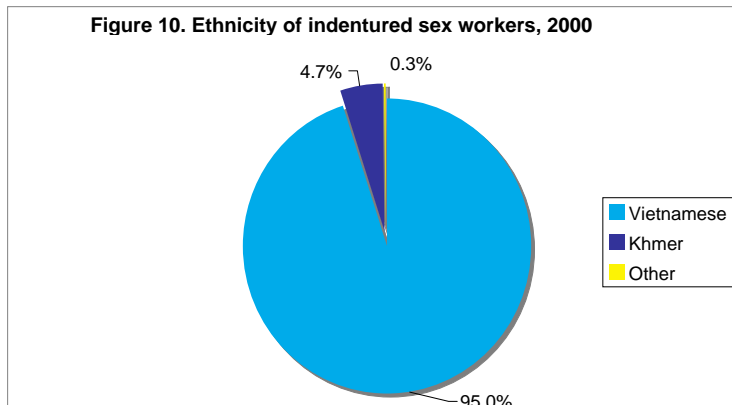
The WHO has described brothel conditions in Asia as a “combination of the worst facets of prison life with many of the features of refugee life” (WHO, 2006). The report states that in addition to poor nutrition, the squalid housing conditions make girls who live in brothels especially vulnerable to communicable diseases such as TB (WHO, 2006). Overcrowding and poor ventilation compound the problem and result in prime conditions for the spread of TB and other airborne diseases.

When girls live in the brothel, they place themselves at even greater risk of contracting disease. A study by Prybylski & Alto (1999), found that 63 percent of FSWs reported the brothel to be

their primary residence, and due to restricted mobility and lack of access to health care, the girls were more vulnerable to illness. In fact, 75 percent of Vietnamese workers who reported the brothel as their primary residence were found to be at significantly higher risk of contracting HIV ($p < 0.001$). Whether due to restricted mobility, limited access to condoms or health care, living and working in the same brothel was found to be a predictor of ill health.

4.4.6 Ethnicity

The impact of ethnicity⁷ on the health status of sex workers in Cambodia appears to be dependent upon one factor: whether one is indentured or not. For Vietnamese girls who are indentured, the risk of contracting an STI appears much greater. Several studies found that Vietnamese girls were more likely to be indentured and subsequently, they harbour less control



Source: Stienfatt et al 2002

over their circumstances, have difficulty communicating with clients and have greater difficulty in negotiating for safe sex. A study of prostitutes living in Phnom Penh brothels found of the one-third that were indentured⁸, with the majority being of Vietnamese descent (Figure 10) (Prybylski & Alto, 1999, Steinfatt et al, 2002, Derks, 2008). The study by Busza et al (2004), also found Vietnamese workers who were more likely to be indentured were at a greater risk of violence if they refused

to have sex without a condom. The language barrier, coupled with social and physical isolation from being bonded appears to negatively impact the rates of condom utilization (Rithy, 2004).

The study by Prybylski & Alto, (1999) also hypothesized that due to language problems, and subsequent social-cultural isolation, Vietnamese sex workers would be at greater risk of violence and less empowered to utilize safe sexual practices. But, surprisingly the study found the opposite result: Vietnamese girls were significantly more successful in convincing clients to use a condom compared to Khmer girls (75% versus 64.9% respectively, $P = 0.02$). Yet, the study was limited by selection bias as most Vietnamese chosen were able to understand and speak Khmer. In addition, it was suggested that Vietnamese subjects reported higher rates of condom use because of fear and retribution by brothel owners.

Although it is suggested that Vietnamese girls are more likely to be indentured, ethnic characteristics such as youthful appearance and lighter skin color have been found to have a

⁷ Ethnic studies have focused primarily upon Vietnamese versus Khmer prostitutes due to the majority of sex workers being one of these two descents.

⁸ These estimates include girls who either are presently indentured, or have been at any time in the past (Steinfatt et al, 2002).

positive impact on condom utilization rates. A study carried out among Vietnamese sex workers in a small STI clinic along the Thai border found consistent condom use (100%) with clients. The high rates of condom use were thought to be because Vietnamese women were *less* likely to be indentured and more likely to be younger and lighter in skin color, allowing for greater power to negotiate condom use.

In support of the above findings, one Vietnamese sex worker reported she was more apt to use condoms than Khmer girls:

Khmer women get more often sick because they don't think of sexually transmitted diseases when they are with their *sangsaa*, or when customers refuse to use condoms. The Vietnamese prostitutes finish ten boxes of condoms in a month, whereas Khmer prostitutes cannot finish even one (Derks, 1998).

Being of Vietnamese descent could increase one's risk of being indentured. Coupled with poor negotiation skills and language barriers, these factors appear to have the greatest negative impact on whether a sex worker has the capability to protect herself from an STI with use of a condom.

4.4.7 Illiteracy and low educational attainment

The link between low educational attainment, poverty and ill health has been well established (Guarcello et al, 2006). Children who reside in rural areas often have limited accessibility to educational institutions and are subsequently impeded from obtaining higher paying jobs (Kassouf et al, 2001, O'Donnell et al, 2005,). Not surprisingly, the drive to earn more money encourages children to enter into prostitution without having knowledge of when to access health care or how to protect themselves from STIs and HIV. In Cambodia, low educational attainment and illiteracy have been correlated with higher numbers of FSWs and is said to be a predictor of infection with HIV (Talbot, 2007).

In addition, diseases that result from STIs that have not been promptly treated, such as pelvic inflammatory disease (PID) have also been linked to females who have low levels of education (Sweet & Gibbs, 2002). There are many females in Cambodian brothels with little to no formal education, who are also at risk of these health problems. In the behavioural survey in 2003, nearly half of the DFSWs who were interviewed had *never* attended school (NCHADS, 2004b). In addition, knowing their their rights to health, education and freedom from sexual abuse and exploitation will be not be realized without formal education (Beyrer & Stachowiak, 2003, Orchard, 2003, Derks, 2008,).

4.4.8 Lack of accessible health care services: appropriate, affordable & accessible

It is imperative that services are appropriate for young, brothel based sex workers. This translates into non-judgmental staff, specially trained to deal with issues surrounding sex workers. As stated by the WHO (2004), most STI care seekers are ashamed for having contracted an STI and wish to be treated like any other clinic attendee. A study by Delvaux et al (2003) reported that in one reproductive health clinic in Sihanoukville, the FSWs reported feeling unwelcome and the staff did not know how to “deal” with the sex workers. The attitudes of those working in the health clinics influence whether girls choose to return to the clinic and will affect usage rates, particularly among young FSWs (WHO, 2002).

Affordability is the second issue. Most girls in Cambodia visit the pharmacies because doctors are too costly (UN, 2000, Derks, 2008). They tend to visit when their health problems have become more serious. Unfortunately, by this point the cost of their medical treatment will be even less affordable (UN, 2000). Brothel owners also dictate what medicines a sex worker can afford. When contracts are first signed, girls are required to pay in advance for their medicine (Marten, 2005, Derks, 2008). When the sex workers require medical treatment, the *meeba* will retrieve the medicines and then add interest on to the original cost (Brown, 2001, CATW, 2008). Large debt creates great pressure to return to work as soon as possible, often without the completion of (appropriate) treatment.

Enabling a young prostitute to receive prompt and appropriate treatment is crucial for her recovery. A medical clinic that caters specifically to her needs is also a critical piece of the puzzle. Unfortunately, an assessment by the UN revealed a severe shortage of available medical clinics that cater to the needs of sexually exploited children (UN, 2000, Beyrer & Stachowiak, 2003). As a result, majority of the children are using other means to get their health care, which usually are not specifically targeting their needs (UN, 2000). When needing a more specific assessment for their symptoms, and a pharmacy will not suffice, girls are attending the local HIV/VCT clinic, followed by a private lab and the public hospital (UN, 2000). Unfortunately, these services are aimed at the general population’s health needs and are not specific to the types of infections that sex workers face.

In light of the limited health services for young prostitutes, I conducted a brief assessment of what services are available at the present time.

4.4.8.1 What services are available for sex workers?

In general, there is a lack of programmes specifically available for girls and young women in the sex trade (WHO, 2004, UN, 2000). The study by the UN (2000) found in one of the provinces, there were *zero* services for children. Two other provinces only had one service, which was not even pertinent to the health of children: a poorly equipped orphanage. Services specifically for sex workers of all ages are also inadequate. Sono et al (2004) summarized nicely the available

STI clinics in 4 Cambodian border provinces and found only 6 in existence. Less than half of health centres had integrated STI services, and those were not specific to sex workers, particularly not for those under the age of 18 years (Table 2). As of January, 2009, there were 13 Family Health Clinics with integrated STI services, but only available in 9 provinces! (FHI, 2009). As such, Table 2 provides an accurate depiction of what is also available in the remaining 3 provinces.

Table 2. STI Public health facilities and STI care in 6 provincial clinics

STI services	Province				Total
	Battambang	Svay Rieng	Prey Veng	Koh Kong	
STI clinics for sex workers	1	1	2	2	6
Minimum package of activities' health centers	57	37	62	8	164
Minimum package of activities' health centers with integrated STI care	25	27	13	8	73
Referral hospital	4	3	7	2	16
Referral hospital with integrated care	1	1	0	0	2
STI laboratories	0	0	0	0	0
STI clinic staff	5	5	10	9	29
STI clinic staff trained in:					
Syndromic management	5	5	8	9	27
STI management with speculum and lab	3	0	0	1	4
Sex worker management	3	2	6	6	17
Laboratory	2	1	4	3	10

Source: Sono et al, 2004

In recent years, non-governmental organizations (NGOs) have been increasing their contributions to the health needs of young direct and indirect sex workers. A review of NGOs that cater to the needs of sex workers are listed in the table below (Table 3). For organizational purposes, the assessment of services has been disaggregated into central Cambodia, followed by northwest, and west central regions. Most services are concentrated in urban centres, particularly Phnom Penh and Siem Riep and there is a need to expand services into outlying areas.

Table 3. STI services available for sex workers in Cambodia

Location of clinic	Organization	Type of clinic	VCT available	Life skills training
Central:				
Kandal Province:				
1. Phnom Penh	Pharmaciens Sans Frontiers	Mobile STI care (7 sites)	No	No
	Mith Samlanh Friends	STI/HIVcare for children	No	Yes
2. Svay Pak	Medicens Sans Frontiers	STI care	No	Yes
	Khmera	STI referral services	Yes	Yes
Northwest:				
Siem Riep province				
1. Siem Riep	The Rose Centre	STI Care	No	Yes
	Medicens Sans Frontiers	Transport and referral for STI care and cervical cancer	Yes	No
West central:				
1. Poipet and Sisophon (2 sites)	Medicens Sans Frontiers	STI clinic (2 sites)	No	No

4.5 Micro-level factors

4.5.1 Knowledge of HIV/STIs and the impact on the prevention of spread of disease

Sex workers' overall knowledge of HIV/STIs is impressive. The study by Prybylski and Alto (1999), assessed the knowledge levels concerning HIV/AIDS among 502 FSWs (62% were DFSWs, mean age, 22 years) and found the baseline knowledge level to be high (Table 4).

Table 4. HIV/AIDS and condom use knowledge, attitudes and behaviours of sex workers by place of residence (brothel versus non-brothel)

	Residence	Residence	P
	Brothel N = 316 (%)	Non-Brothel N = 186 (%)	
Can HIV/AIDS be prevented?			
Yes	96.8	96.8	0.97
No	3.2	3.2	
How can HIV/AIDS be prevented?			
Use condom	96.8	96.2	0.72
Other	3.2	3.8	
Want to use condom every time you have sex with a customer?			
Yes	95.9	98.9	0.06
No	4.1	3.8	
Ask all customers to use a condom every time have sex?			
Always	60.6	79.0	<0.001
Not always	39.4	21.0	
What to do if customer refuses to use condom?			
Not have sex	44.9	59.1	<0.01
Have sex without condom	44.0	32.3	
Other	11.1	8.6	

Source: Prybylski & Alto, 1999

In reviewing Table 5, it appears that both IDFSWs and DFSWs have high knowledge levels of HIV/AIDS and how to prevent infection. Yet, when the knowledge needs to be applied to safe sexual practices, the results are slightly less encouraging. Why were so many women not using condoms when they knew that it could protect them from infection (44%)? Perhaps one issue is the lack of negotiation skills. Even with a mandatory condom policy, it is known that many women are vulnerable to being convinced to have sex without a condom, particularly when skills to negotiate are missing. This problem is likely to be much higher among the young, vulnerable, prostitute.

In addition, the *perceived* risk of HIV infection is not affecting condom utilization. Nearly 20 percent of the FSWs thought they had zero risk of contracting HIV! Among those who perceived they were at risk and those who thought they were at no risk, condom utilization rates were the same ($P=0.30$). Similar results were found in a study by Ohshige et al (2000a), which revealed that education and knowledge about HIV did not have a positive impact on condom use or on the prevalence of HIV.

The inadequate knowledge of HIV and STIs among young prostitutes and migrant workers (ie. Vietnamese) is mainly due to illiteracy, low educational attainment and linguistic barriers (Prybylski & Alto, 1999, WHO, 2004). Not only is it also difficult to read pamphlets and other educational programs, but also comprehending the message will prove challenging. A shocking knowledge deficit was found in a recent study by the UNAIDS. Despite the mass media campaigns associated with the 100% CUP, as recent as 2004, nearly 50 percent of female respondents still believed they had a high risk of contracting HIV from a mosquito bite and one-third believed HIV could be spread by supernatural means (UNAIDS, 2004). Accurate information widely disseminated to both sex workers and the general population is key to reducing the spread of infection between these two groups.

Despite loopholes in the accuracy of their knowledge, sex workers appear to be more educated about preventing HIV than the young people in the general population (97% versus 49% of 15-24 year olds, respectively) (Prybylski & Alto, 1999, UNAIDS, 2008). If customers are not equally targeted with education campaigns, they might be lacking needed motivation to practice safe sex. The difficulty lies in educating the entire population, and targeting other high risk groups, such as MSM, persons who inject drugs (PWID) and military and police men. Nearly half of policemen thought they would never be at risk for contracting an STI, yet these same men had the highest reported rates of Chlamydia, Gonorrhea and Syphilis (NCHADS, 2006). As such, the importance of mass education to bridging groups and sex workers themselves is crucial to the success of disease prevention programs.

4.5.2 Utilization patterns for HIV/AIDS services

In light of the aforementioned section on accessible health services, it is evident that most Cambodians, whether or not in the sex trade, have extremely limited access to medical care. Utilization of HIV/AIDS services by both sex workers and their customers remains poor. Among both DFSWs and IDFSWs, uptake of voluntary counseling and testing (VCT) is not all bad, and even an improvement from the general population. In 2004, although only 50 percent of FSWs had ever been tested, 80 percent received their results (USAID, 2005). In fact, this was down from nearly 60 percent testing rates in the national survey among sex workers in 2003 (NCHDS, 2004a). But compared to all Cambodian females, where only 3 percent reported to ever have had been tested for HIV (UNAIDS, 2002), these rates are not all bad. Why are rates of HIV testing not improving when the availability of testing sites has increased in recent years? Finding an answer to this question proved difficult. One theory could be that stigmatization and fear of positive status is deterring individuals from wanting to get tested.

Despite mediocre rates of VCT uptake, a more recent study found that access and utilization of ART is improving in Cambodia. The institution of universal access by UNAIDS increased ARV uptake 10-fold, reaching coverage rates of around 32 percent of those needing between 2003 and 2005 (UNAIDS, 2006). In addition, with the help of Medicins Sans Frontiers (MSF), there are now multiple pediatric HIV treatment centres around the country and in 2005, there were 890 (out of 4 400, 20% coverage) HIV positive children receiving anti-retroviral treatment from these clinics (Marten, 2005).

4.5.3 Utilization patterns for STI services

There is little evidence examining patterns of STI clinic attendance by sex workers. One small study by Sano et al (2004) tracked STI clinic attendance by both indirect and direct sex workers in 4 border provinces in Cambodia. The data is not generalizable, as the study was limited to only 4 out of 26 provinces, and it did not disaggregate for age. It is therefore not possible to determine how many DFSWs under age 18 years are attending the clinics countrywide.

None-the-less, the study did find clinic coverage to be high among sex workers and accuracy of diagnosis and treatment was encouraging. Yet, in most provinces, clinic attendance by unregistered⁹ sex workers was less than optimal (Table 5). For those who were mandated to attend the clinic on a monthly basis, the results were more encouraging, except in Prey Veng province. It is unclear why the attendance was so low, but one factor could be the low number of STI integrated services in their health centres and the proximity to the multitude of clinics known to exist in the nearby capital province (Kandal). It is suggested that either the sex workers were making the trip to Phnom Penh for a wider range of services, or Prey Veng has a greater number of private or not-for-profit clinics in operation.

⁹ Unregistered sex workers were women who were not registered in the mandatory, monthly STI check-ups and thus, attended the clinic on their own will. Registered sex workers were those who were obliged by the condom utilization program to attend the clinic.

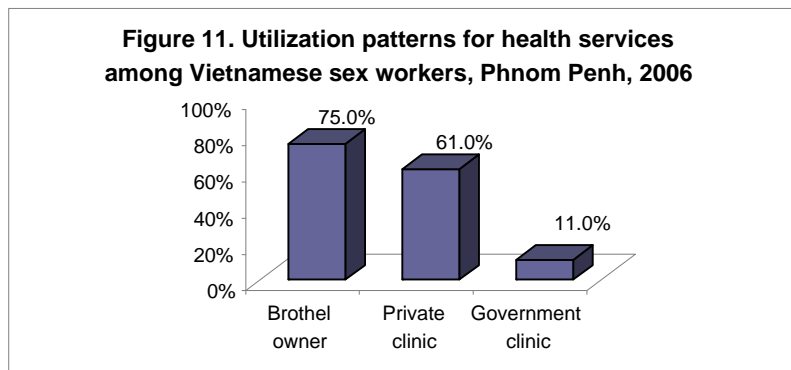
Table 5. Clinic and sex worker attendances, STI diagnoses, and treatment in 6 provincial clinics in the last 6 months

STI Attendances, Diagnoses, Treatment	Province				
	Battambang	Svay Rieng	Prey Veng	Koh Kong	Total
Average monthly attendance in last 3 months					
Total attendance (M+F)	257	76	290	310	933
Females in general pop.	117	27	96	112	352
Sex workers (direct + indirect)	21(8%)	12(16%)	142(49%)	155(50%)	330
Registered sex workers					
No.	0	29	228	155	412
Actual attendees in last month	0	22(76%)	126(55%)	148(95%)	296
STI cases in last month					
First visit	14*	6	35	38	93
Follow-up visit	3*	5	49	106	183
STI diagnoses and treatment					
All new STI cases in last month	99	49	42	155	345
Urethral discharge	24	13	8	36	81
Health centers out of stock of drugs >7 days in last 6 months	1	0	1	2	4

Source: Sano et al, 2004.

* At the time of the study, the 100% condom use campaign was suspended in Battambang so cases are in unregistered sex workers.

The study by Sono et al (2004) was limited by the exclusion of the multitude of NGOs that exist throughout Cambodia and did not account for other sources of treatment. The Cambodian STI survey found that more DFSWs were seeking treatment in 2003 than the previous two years and they reported using a combination of clinics, such as public and private clinics and NGOs (NCHADS, 2004b). Public clinics were the most popular choice among DFSWs (53% attendance) in 2003, but again this result could be biased because of the non-randomized sample group. In fact, several studies report that girls do not attend the public clinics as a first choice. The UN found that many girls were visiting a pharmacy near the brothel for treatment (UN, 2000) due to restricted mobility by brothel owners. These same girls had been found to be particularly fond of self-treatment with injectable antibiotics, which has recently been linked to the spread of HIV (Brown, 2001). Another study found that the brothel owner was most



Source: Gazin et al, 2006

commonly visited for health care treatment and government clinics were least popular (Figure 11). Therefore, depending on the sample population, including age and ethnicity, girls attended places that are convenient, affordable and efficient. The sources were mainly brothel owners, followed by private clinics and NGOs.

Another reason for poor attendance to clinics could be the sheer lack of time. Many clinics that are not geared for sex workers do not have times that are consistent with working hours for prostitutes. In addition, being required to provide services 24 hours per day makes it difficult to travel far distances to find a clinic. For those who are able to seek treatment most cannot even stop working to allow for completion of treatment! In the study done by the UN (2000), almost half of the girls were not able to stop selling sex during their last STI episode and of those who did stop, 16 percent abstained for up to 3 days.

Lastly, sex workers have trouble attending clinics because of restricted mobility. Brothel owners have been well known to restrict mobility of their workers because of fear of detection by local authorities (Busza et al, 2004). Even in cases where the girl is able to leave the brothel, she often cannot leave without an escort (Brown, 2001). Second, girls who are “new arrivals” to the sex trade are less likely than their veteran counterparts to be able to access health care. Large debts are most common in the first few weeks, and this is not only the time when girls are most restricted (Brown, 2001, Mam, 2008), but they are likely to be engaging in frequent, unprotected sexual practices or “deflowering” (Derks, 2008, Mam, 2008). As a result, they are at high-risk of exposure to communicable diseases, with minimal opportunity to access treatment. Migrant workers, who are more likely to be indentured to brothel owners are even less likely to be able to freely attend health clinics (Brown, 2001, Beyrer & Stachowiak, 2003, Marten, 2005). This

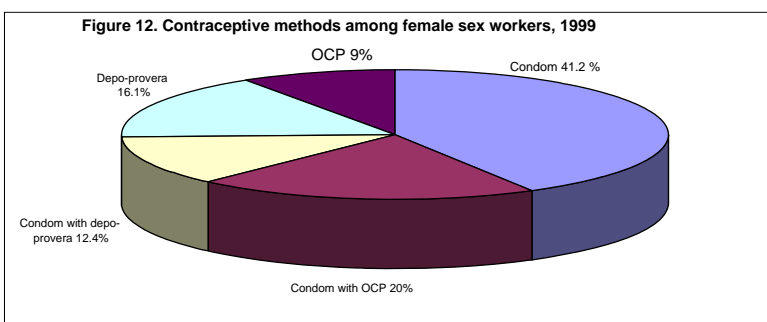
group consists mainly of Vietnamese workers, who are already restricted by a severe lack of culturally sensitive health clinics.

Encouraging sex workers to seek necessary medical care is extremely complex and challenging. Affordable, mobile health clinics, with hours that accommodate sex work are critical to providing accessible health care to this “high-risk” population.

4.5.4 Utilization patterns of contraception: all forms (excluding condoms)

Contraception and family planning is crucial in preventing unplanned pregnancies and unsafe abortions among sex workers. Unfortunately, the number of sex workers using some form of contraception is extremely low. A recent assessment of contraception utilization was carried out among nearly 700 sex workers at an STI clinic in urban Cambodia (Delvaux et al, 2003). It was found that only 5 percent and 1.6 percent of women in the two comparison groups were using any form of contraception. Although the study was limited by the small sample size of women under 18 years of age (<4%) and those residing in brothels, the findings were disappointing. Interestingly, all 700 subjects were at the clinic because of STI symptoms, suggesting the need for barrier contraception in addition to other forms of birth control such as the oral contraceptive pill (OCP) or intrauterine device (IUD). The results imply a need for varied methods, and further education, perhaps within the STI clinic, to increase the utilization of all forms of contraception.

Low rates of contraception as stated above, could be a result of limited availability and lack of education programs on family planning (WHO, 2004). A study done by Kirby (Kirby, 2003) identified successful sex education programs that positively impacted the use of contraceptives among adolescent subjects and found only *one* successful program in all developing countries. This compared to four successful programs in the United States alone. Education on teen sexuality and prevention of STIs should be encouraged in addition to easily accessible contraception. Combined efforts are more likely to increase contraceptive use, while also preventing the spread of diseases and unplanned pregnancies.



Source: Prybylski & Alto, 1999

A more positive trend of contraceptive use was identified in the study by Prybylski & Alto (1999)¹⁰. Despite a large proportion of the sample being young, brothel based sex workers, surprisingly over 95 percent of respondents claimed to be using family planning methods. The effectiveness of

¹⁰ Although the study by Prybylski & Alto (1999) was carried out several years prior to the institution of the 100% CUP, the data is presented as an indication of contraceptive *preference* by FSWs before condoms were mandated.

these types of contraception is unclear, due to the high rate of unplanned pregnancies reported in the previous year (20%). Of those reported methods, the most popular was condoms, followed by the OCP (Figure 12). Although these results are encouraging, these two methods require strict adherence for their effectiveness and even with typical use¹¹, failure rates (as defined by accidental pregnancies) are 14 and 5 percent for the condom and OCP, respectively (WHO, 2003). Due to high reported pregnancy rates in the Prybylski & Alto study, it is likely that despite high rates of utilization of any one method, their effectiveness was counteracted by improper and inconsistent usage. Again, mass education of sex workers and the general population is critical for improving overall effectiveness.

4.5.5 Utilization patterns of contraception: condoms

Condom utilization among all sex workers in Cambodia has been a hot topic since the institution of the 100% CUP more than a decade ago. Yet, as previously mentioned, if condoms are not used perfectly, preventing unplanned pregnancies and protecting oneself from STIs is much less likely. Condom failure per se is thought to be unlikely (WHO, 2000), and greater emphasis is placed on *consistently using* the condom with each sexual practice. The following paragraphs outline utilization patterns among FSWs, as well as problems with the use of condoms.

Reported condom use between sex workers and their clients is encouraging. Overall, most women reported consistent condom use among clients (80-90%), but when having sex with boyfriends or sweethearts, women rarely used a condom (Gazin et al, 2006, USAID, 2005). In a recent survey by USAID (2005), only one in five DFSWs said they had used a condom in the past month with their SH. Some of the women said they “trusted” their sweethearts, and others wanted to use a condom, but were convinced not to use one (NCHADS, 2004b, Derks, 2008). What is worrisome is these SHs are known to be the bridging population between sex workers and the general population. Having concurrent relationships without consistently using condoms, places both their partners and themselves at high risk of infection or unplanned pregnancy.

Other girls reported having a desire to use a condom, but not having the choice to willingly protect themselves. A study by USAID (2005) found 67 percent of brothel-based girls had been forced into not using a condom or had been beaten with an electric cord (Marten, 2005). Girls who are indentured are in the worst position because they have no power over their brothel owner and are often vulnerable, young, naïve and without education (WHO, 2004, Marten, 2005). As stated by one sex worker:

Most drunk partners and those who carry a gun sometimes threaten us. With drunken partners, we try to please them and then put a condom on for them. With gunmen threaten us, we sleep with them without a condom because we feel worried about being shot (WHO, 2004, p. 5).

For sex workers who do hold the power to negotiate with a client, many girls do not always feel they can harbour the discussion with their clients (Mam, 2008). It is evident that simply

¹¹ Typical use is when the user does not always follows instructions for use exactly (WHO, 2003).

instituting a condom policy does not suffice when girls do not feel they are safely able to discuss the issue with clients. For those that are young, indentured and vulnerable, there is even greater risk of infection, pregnancy and violence.

4.5.6 Drug and alcohol ingestion

Globally, it has been estimated that 90 percent of child prostitutes abuse alcohol or other substances (Willis & Levy, 2002). The WHO (2002) states opiate addiction is a serious health problem among sex workers. Not surprisingly, there are reports of brothel owners who intentionally give alcohol to the young sex worker, to purposely disinhibit their intentions and appease the customer (Brown, 2001). Although only one study documented actual drug use, the national survey found 7 percent of girls living in brothels were using *yama* or *yaba* on a regular basis (NCHADS, 2004b). One sex worker in Tuol Kok said:

We smoke for fun – it makes us happy. You're not afraid of anyone when you are smoking (Stubbs & Bunley, 2002).

An alarming trend among prostitutes, this amphetamine is being smoked at higher rates in recent years. One study found that amphetamines are the most commonly used drug among sex workers (Gazin et al, 2006). The irony is that in many developed countries, females are pulled into sex work in order to feed a drug habit. And yet in Cambodia, it seems girls enter into the sex trade because of poverty and subsequently are addicted to drugs as a means to cope with their circumstances. As one author stated, “girls will use drugs as a way to overcome their fears and unhappiness over what they do for a living” (Brown, 2001, p. 215). Although young brothel based sex workers cannot often afford to use drugs, it is often this trauma from the early years that will motivate girls to abuse substances later on in life (Brown, 2001).

Not only might there be riskier behaviour, but the girls might be more likely to comply and less likely to enforce the use of a condom (Pisani, 2008). The issue of substance abuse is important when sexual practices are being considered and should be taken into consideration when planning education and interventions for sex workers and their clients.

4.6 Impact of Brothel based sex work on child sex workers

Based on the aforementioned studies, the impact of sex work on female child sex workers will be described as either communicable disease or non-communicable health problem. The list does not encompass the full realm of health problems that this population faces, but outlines the most pertinent and serious health threats.

4.6.1 Communicable diseases

4.6.1.1 Human immunodeficiency virus (HIV)

Child prostitutes are exposed to HIV very soon after commencing sex work. Many factors greatly influence their risk of exposures and these are: long working hours, multiple daily exposures to STIs, difficulty negotiating condom use and substance use. As a result, majority of children will be infected within their first year of work. By the time these children are “rescued” from brothels, it is estimated that as many as 90% of *children* will be HIV positive (Willis & Levy, 2002, ECPAT, 2008). More accurate statistics, revealed in 1999 in the province of Sihanoukville that nearly 60 percent of the 700 sex workers were HIV positive, with one-third of those being children (N = 122 children)! (Mitchell, 1999). These numbers are likely much higher due to restricted mobility to health care and VCT clinics by brothel owners. If all children were free to receive testing and treatment, the actual numbers would likely exceed the 33 percent found to be infected in the above study¹².

The hundreds of children who are infected with HIV in Cambodian brothels are not only at risk of associated morbidities, but also risk not receiving necessary medical care. The lack of HIV treatment centres tailored to children places these children at high risk of death within a very short time. In addition, once infected, these children can no longer “earn money” for their brothel owners and sadly, find themselves without life skills, money and a healthy future.

4.6.1.2 Sexually transmitted infections (STIs)

In addition to HIV, child prostitutes are at high risk of contracting multiple other STIs, most often Chlamydia. In fact, Cambodia has one of the highest prevalence rates of STIs among FSWs, with as many as 82 percent of child prostitutes found to harbouring an STI at any one time¹³ (Ohshige et al, 2000b). This compared to a global prevalence of 5 percent among young people in Asia (Willis & Levy, 2002). These high prevalence rates are not all surprising when one considers the high number of clients, the many condomless encounters with sweethearts and the lack of complete STI treatment. In addition, anatomical differences place females at *four* times greater risk of infection as compared to males, due to larger surface area for infection (WHO, 2004).

Which STIs pose the greatest problems for child prostitutes? Chlamydia, and to a less extent Syphilis and Gonorrhoea are responsible for the greatest number of infections. Chlamydia trachomatis is the most common STI diagnosed among DFSWs, causing nearly 60 percent of all

¹² As of 2007, over four thousand children were said to be infected with HIV (UNICEF, 2008). If 90% of children are infected (as suggested), then over 1600 brothel based child prostitutes have HIV in Cambodia.

¹³ The subjects in this study were Khmer speaking prostitutes, preventing the inclusion of Vietnamese migrant workers. Due to this selection bias, and the fact that Vietnamese workers have been found to have higher rates of condom use and lower rates of HIV and STIs, actual prevalence rates could be slightly lower if Vietnamese FSWs were included.

infections¹⁴ (USAID, 2005). Unfortunately, it is also this STI that has been found to increase transmission of other STIs, mostly HIV, Syphilis, and cervical cancer. In the study by Ohshige et al, (2000a), FSWs who were diagnosed with Chlamydia had a significantly higher rate of HIV. Syphilis has also been found to be positively associated with higher rates of HIV infection (Richens, 2006, WHO, 2004). Considering the high rates of Chlamydial infection among clients, such as military men and police, the risk of HIV infection among these groups and transmission to the girl sex worker is likely.

Although Chlamydia has long been one of the most commonly diagnosed STIs among Cambodian sex workers, the country has seen outbreaks of Syphilis in recent years. Particularly among DFSWs in the northwestern provinces, the prevalence rates are between 4 and 7 percent, compared to <1 percent in the rest of the country (NCHADS, 2004b). The high rates of STIs among policemen, could be the reason for such outbreaks. The issue of rising prevalence rates of STIs is an urgent issue that needs to be addressed in the near future. If STI rates are not controlled, it is only a matter of time before HIV rates increase because of the synergetic infections between STIs and HIV.

4.6.1.3 Human papillomavirus (HPV)

HPV is an increasingly common STI that is worrisome because of its cancer causing abilities. In fact, its two most common cancer causing strains, 16 and 18, cause about 500 000 cases of cervical cancer annually across the globe (WHO, 2007). What is worse, it is thought that majority of individuals will acquire HPV at some point in their lives, which translates into thousands of child prostitutes who will also become infected during their time in the brothel (WHO, 2007). In fact, global estimates suggest one in two child prostitutes become infected with HPV during their stint in the sex trade (Willis & Levy, 2002).

Child sex workers are at particular risk of HPV due to their early sexual debut and multiple sexual partners (Willis & Levy, 2002, WHO, 2007). The risk is highest immediately after the initiation of sexual activity (WHO, 2007), which is particularly problematic for the young prostitute who is indentured and is severely restricted from leaving the brothel for a health assessment. Cervical cancer is more likely when HPV infection is not detected early on, and cellular dysplasia occurs. Not only due to restricted mobility, but Cambodia, as in many developing countries, lacks proper HPV diagnostic equipment (WHO, 2004). As a result, HPV has become the leading cause of cancer among women in developing countries and nearly half of all cases will prove fatal (WHO, 2008).

Being infected with HPV as well as Chlamydia and HIV has been found to increase the likelihood of developing cervical cancer from HPV (Castellsague & Munoz, 2003). Histological changes known to be caused by Chlamydia infection, along with immune suppression caused by

¹⁴ The study was limited by the lack of disaggregation of age and location of sex work, making it difficult to generalize the results to children in brothels.

HIV (WHO, 2007) increase the risk of cervical dysplasia and subsequent carcinoma. The many young sex workers in Cambodia who are infected with Chlamydia, are at a higher risk of both HIV and cervical cancer, particularly when the infections are not treated promptly.

4.6.1.4 Pelvic inflammatory disease

Female child prostitutes are at extremely high risk of developing PID. This population is known to access pharmacies for treatment and as a result, receive improper or incomplete treatment for STIs; a major contributing factor to PID. Also known as ‘salpingitis’, this disease occurs from improper or missed treatment of either Chlamydia, gonorrhea or bacterial vaginosis (BV) (Mead et al, 2000, Sweet & Gibbs, 2002, Bjerkan, 2004). Left untreated, the infection ascends to the fallopian tubes and causes scarring and blockages, leading to infertility in 40 percent of cases or ectopic pregnancies (WHO, 2008, Mead et al, 2000). Mortality rates from ruptured these ectopic pregnancies, or ruptured pelvic abscesses is between 3 and 8 percent (Sweet & Gibbs, 2002). Not surprisingly, these risks for young women in the sex trade contribute greatly to the high maternal mortality rates in Cambodia.

Risk factors of PID among sexually active teenagers worldwide, is “young age” - mostly due to inconsistent condom use and multiple partners (Mead et al, 2000, Sweet & Gibbs, 2002). These characteristics also commonly found among young, brothel based sex workers. One study reported that as many as 70 percent of girls with acute salpingitis were under the age of 25 years and two-thirds reported their first case of PID before the age of 19 years (Sweet & Gibbs, 2002). Having a high number of partners, with inconsistent condom use also increases one’s risk; a woman who has greater than 10 lifetime partners (less than one prostitute might have in a week) is three times as likely to report a history of PID than those who have only one partner (Mead et al, 2000, Beyrer & Stachowiak, 2003).

4.6.2 Non-communicable health problems

4.6.2.1 Septic abortions and complications

Due to limited family planning services, many girls become pregnant within a short period of time. Willis and Levy (2002) estimated that in the absence of birth control, the risk of a girl sex worker becoming pregnant is 90 percent within one year. A pregnant sex worker is considered “bad business” and is often encouraged to have an abortion (Brown, 2001). As a result, there is a high prevalence of abortions, particularly among young and inexperienced sex workers. A study done by the USAID (2005) found that 54 percent of the 508 FSWs interviewed had already had an abortion and 15 percent reported having had three or more abortions (both direct and indirect sex workers). Not surprisingly, 80 percent had had an abortion within the last year, suggesting high risk of maternal related health issues in both the young and older sex workers.

Abortion related health problems are many, and pose greater problems in Cambodia, due to the lack of available registered abortion clinics (Hill & Heng, 2004). Besides the single NGO that

provides the procedure, the only other providers are government clinics, which are unaffordable for most impoverished girls (Hill & Heng, 2004). Being indentured to their brothel owners pushes girls to find the cheapest way to terminate an unwanted pregnancy. In addition, because the brothel owner allocates the funds, he or she also influences the time and place of the procedure (CATW, 2008). Often times, this procedure will take place in an illegal setting, with high rates of mortality. One estimate suggested that 20 to 25 percent of abortions among Cambodian women resulted in death (Hill & Heng, 2004). Other complications such as bleeding, infection and sepsis are also likely (Beyrer & Stachowiak, 2003, UN ESCAP, 2007). In fact, Delvaux et al (2008) found that one in five women in Phnom Penh and Sihanoukville had had a previous abortion that was likely to have been unsafe because of their low socio-economic status. In the previous reporting year, it was also found that nearly 20 percent of these abortions were performed by an unqualified health worker. These factors are likely to increase the risk of infection, hemorrhage and death. A Cambodian brothel worker describes the lack of care and concern by her brothel keeper when she became pregnant:

The mama-san was so angry when she found I was pregnant. She gave me some medicine and it made me vomit a lot but the baby didn't come out. She tried this three times. Then when my stomach got so big that the customers started to talk about it she took me to a doctor and I had an abortion. The baby had been in my stomach for about five months. I went back to the brothel the same day and after four days I started entertaining the clients (Brown, 2001, p. 218).

Considering the unruly conditions of the brothels these girls inhabit, the cleanliness of the procedure and disposal of blood and body fluids is likely to be inadequate. As a result, both the pregnant girl and the person performing the abortion could be at high risk of exposure to blood-borne pathogens and subsequent infections.

4.6.2.2 Depression, suicide and self mutilation

Many child prostitutes suffer acute mental health problems such as depression, psychosis and self-mutilation (Willis & Levy, 2002, Brown, 2001). A study by the UN reported that Cambodian children also suffered from feelings of low self-esteem, despair and had no concern of their circumstances (UN, 2000). To cope with their depressive thoughts and feelings, many turned to substance abuse and attempted suicide. In fact, Willis & Levy (2002) reported that, worldwide, as many as 70 percent of children in the sex trade will attempt suicide at some point.

Regular beatings contribute to behavioural problems, which are mostly in the form of anger and aggression (UN, 2000). This finding was supported in the study by Busza et al (2004), who found that the girls were dissatisfied with their work because of violence by local police and brothel owners. They also complained of ill health because they had not fully appreciated the risks they might face when first "recruited" for sex work.

The involvement of family members in the recruitment process was also a factor in depressive symptoms. Girls reported a lack of trust by family members who had deceived them (UN, 2000,

Busza et al, 2004), further contributing to feelings of anger and despair. The girls were so unhappy, that if given the chance, majority stated they would immediately return to their homes if given alternative forms of income (UN, 2000).

Most young sex workers will be at high risk to experience depression and hopelessness because of their indebtedness and loss of freedom in life.

4.6.2.3 Post-traumatic stress disorder (PTSD)

The stress and trauma that child prostitutes suffer because of sexual exploitation places them at tremendous risk for developing PTSD. Being difficult to diagnose (ECPAT, 2007), and requiring the skills of qualified health care personnel, PTSD is thought to be largely underestimated among this population. As a result, there is a paucity of data specific for sexually exploited children of Cambodia. The few statistics that have been offered are generalized to children worldwide. Two reviews estimated that nearly 70 percent of children in the sex trade exhibit signs of PTSD (Willis & Levy, 2002, Beyrer & Stachowiak, 2003). Symptoms include sleep disturbances, numbing to the current situation, flashbacks and nightmares and heightened levels of anxiety (UN ESCAP, 2006). In her biography, Somaly Mam (2008), reported that girls who had been rescued from brothels, who had also reported being chained and beaten with electrical cables had “gone completely mad”. The lack of mental health services for those suffering from PTSD lowers the odds of recovering from such experiences, particularly as vulnerable young children and should be a priority health care issue.

CHAPTER 5. CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

There are thousands of young girls enslaved in Cambodian brothels, and all are denied human rights, dignity or respect. These girls suffer from both physical and psychological effects of maltreatment and abuse. HIV and other STIs are common and complications of these infections can compromise their reproductive health. Infertility, cervical cancer and ectopic pregnancies are the most common and serious reproductive complications. As well, due to limited access to contraception, young prostitutes endure multiple unplanned pregnancies, many of which end in unsafe, high-risk abortions.

Although the 100% Condom Use Policy has helped reduce overall HIV prevalence rates among registered sex workers, many young girls do not necessarily benefit from the policy. Lack of negotiation skills and limited access to government STI clinics means that young prostitutes are not empowered to make proper choices or receive appropriate treatment for infections.

To further compound the problem, Cambodia lacks the necessary health centres equipped to deal specifically with the needs of sexually exploited children, particularly those clinics that offer mental health services. The needs of these vulnerable young girls must be addressed specifically and urgently.

Cambodia needs to take action to prevent more children from suffering physical and mental health problems and there are several key recommendations the country needs to consider:

- STI prevention strategies need to be aimed at all social groups, and not just sex workers and their clients. Men and women are not using condoms as they should and this issue should be addressed promptly.
- Men are not returning for their VCT results and could be unknowingly spreading HIV. Providing financial incentives as motivation to return for results should be considered.
- Brothel owners should be educated and motivated to allow prostitutes to leave the premises for medical treatment.
- Most importantly, there need to be dramatic increases in the numbers of child friendly treatment centres, especially those catering to the needs of children infected with HIV and suffering from psychological trauma. Because there are limited STI clinics outside of Phnom Penh, the number of clinics in Red Light districts in Battambang and along the Thai border should be increased.

The monitoring of these recommendations should be contracted by an NGO, one which can carry out audits of programs and evaluate their efficacy. Currently, Family Health International (FHI) is tied closely with the STI clinic operations for sex workers and works alongside the National

Centre for Dermatology and STIs (NCHADS) to provide these services. An example for evaluating the efficacy of new STI clinics could be to observe increases in attendance rates, and witness overall decreases in STI incidence among young sex workers.

Below, the aforementioned recommendations will be outlined in greater detail, and are geared specifically for the Ministry of Health and Cambodian NGOs. The recommendations are both realistic and achievable, and aim to improve the overall health and well-being of the thousands of female child prostitutes who are enslaved in the brothels of Cambodia.

5.2 Recommendations

Based on above study results, four recommendations are provided. These recommendations offer key strategies of how to improve the health and well-being of child prostitutes in Cambodia. Additionally, I have provided several suggestions for future research possibilities.

5.2.1 Improve STI prevention efforts

1. Tailor condom promotion strategies to each social group.
 - MSM – mass education about importance of condom use during anal sex.
 - PWID/PWUD – drug prevention programs and education about negative impact of drugs on condom utilization rates.
 - Military/Police – increase condom utilization between sweethearts and spouses.
 - Moto and truck drivers – increase availability of condoms, utilizing the PLACE¹⁵ method.
2. Advocate for peer education within brothels. Elect a spokesperson(s) within the brothel who will teach “new recruits” about HIV/AIDS, prevention techniques and accessible health clinics.
3. Teach girls negotiation skills with regard to condom use through the use of seminars at STI clinics.
4. Provide monetary incentive (ie. 5 USD per consultation) to brothel owners to allow prostitutes to attend STI clinics for seminars and education.
5. Adopt harm reduction approach for the prevention of spread of disease. Consider decriminalizing prostitution for women older than 18 years and provide widely available programs to protect sex workers from infection and maltreatment by the greater population (Study successful brothel operation in Amsterdam).

¹⁵ The PLACE method encourages the distribution of condoms at locations where high-risk sexual encounters are likely to occur (Ie. truck stops, restaurants, petrol stations) (Sandoy et al, 2008b).

5.2.2 Increase numbers who attend VCT centres and return for results

1. Provide financial incentives (ie. 5 USD per visit) for people to attend VCT centers and return for results.
2. Provide mass media education and promotion of the importance of VCT for *all* individuals, and not solely high-risk persons.

5.2.3 Improve accessibility and quality of health services

5.2.3.1 Increase overall numbers of health clinics and services

1. Create 15 pilot mobile STI clinics outside of Phnom Penh and along the Thai border.
2. Establish 10 drop-in centres where currently there are very few: 5 in Northeast Cambodia and 5 in Southwest region. Drop-in centres will provide snack programs, education and mobile health services.
3. Add 10 clinics that offer safe, affordable abortion services particularly geared for FSWs.
4. Initiate public-private partnerships to implement STI clinics where public clinics and/or funding are lacking.
5. Increase the number of VCT centers around Cambodia, particularly among hard to reach, rural populations.
6. Increase the number of pediatric specific HIV treatment centers, particularly geared for the multitude of child prostitutes who are HIV positive.

5.2.3.2 Modify clinics to cater specifically for the needs of young sex workers

1. Improve clinic accessibility for sex workers (Ie. location, hours of operation, low cost).
2. Implement a pilot project to assist those who struggle with drug or alcohol addiction. Utilize private sector if necessary.
3. Increase the number of health professionals that are able to offer culturally and spiritually sensitive mental health services for both Khmer and Vietnamese sex workers.
4. Train staff to understand how to deal with sexually abused and exploited children.

5.2.3.3 Improve the quality of health services

1. Appoint external auditor to monitor and evaluate the quality and accuracy of STI diagnosis and treatment.
2. Ensure uninterrupted supply of high quality (male and female) condoms and drugs at all health facilities.

3. Use the syndromic approach and treat all women for *C. Trachomatis*, *N. Gonorrhoeae* and *Bacterial vaginosis* due to the high prevalence of asymptomatic infection (WHO, 2000).
4. Provide sufficient Vietnamese translators at specific STI clinics throughout Cambodia.
5. Improve partner notification and contact tracing to prevent the “ping-pong” effect and reinfection of previously treated sex workers.
6. Expand birth control options. Make available a wide range of contraceptives, including long acting reversible contraceptives (LARC) that don’t require daily administration.

5.2.4 Include spiritual and cultural perspectives in health promotion and education

1. Encourage Buddhist leaders to promote safe sexual practices through sermons and community meetings.
2. Integrate faith based care into existing clinics and seminars, particularly accommodating most common religions of Cambodia’s sex workers (ie. Buddhism, Christianity).
3. Gather input from the community at “town hall” meetings, where individuals can suggest new ideas pertaining to respectful treatment of sex workers and safe sexual practices.

5.2.5 Suggestions for future research

1. Evaluate the effectiveness of the 100% CUP. Much money and human resources are involved, but is it really working? Are the *youth* in brothels benefiting from this program? Research should also consider what effect gender inequity has on condom utilization, as well as low educational attainment and risk perception. A cross sectional study could be utilized with questionnaires both in Khmer and Vietnamese language to measure risk perception, as well as biochemical markers of HIV and Chlamydial seroprevalence.
2. Determine the extent of mental illness upon girls who have been sexually exploited into brothels with qualitative analysis and focus group discussions. Currently, there is a paucity of evidence available to quantify the extent of the problem, as well as inconsistent measurement tools among psychiatric services within Cambodia.
3. Determine the nutritional status of children living in brothels, with comparison to their similar aged children who are living in rural areas – both with similar demographics and healthy states, utilizing a case control study and anthropometric measurements.

Annexes

1. Summary of research studies (n=17)

Study	Author(s)	Year of study	Methods	Sample (n)	Ages (years)	Strengths	Limitations
Knowledge, attitudes and practices concerning HIV/AIDS among sex workers in Phnom Penh, Cambodia.	Prybylski & Alto	1994	Face-to-face interviews	502	15 to 46 (mean 21.6y)	Large, randomized study.	Focused only on uneducated, rural sex workers – selection bias
Young people and HIV in Cambodia: meanings, contexts and sexual cultures	Tarr & Aggleton	1995 to 1996	Qualitative study among urban and rural sex workers and clients	281 people	13 to 26y	Included FGD's and individual interviews.	Occurred before institution of 100% CUP, so results not as applicable to present situation. Respondent bias – young people collecting data could prevent true reports of behaviours.
UN qualitative needs assessment of youth in the greater Mekong subregion	UN	1998 to 1999	Qualitative semi-structured interviews	54 sexually exploited children	<18	Focused solely on exploited underage sex workers. Qualitative method.	Small sample size.
Behavioural and serological risks among female sex workers in Cambodia	Ohshige et al (a)	1999	Questionnaires and serological testing for HIV, Chlamydia and Syphilis	143 direct and 94 indirect FSWs	15 to 33 years (mean 20.3y)	Quantitative data to control for confounders and serological testing to reduce reporting bias.	
Cross-sectional study on risk factors of HIV among female commercial sex workers in Cambodia	Ohshige et al (b)	1999	Cross-sectional survey	440 DFSWs in two red light districts	15 to 33 (mean 20.1 and 20.3y in two regions)	Concentrated among brothel based workers. High response rate (95% and 91% in two regions).	Lack of randomization of subjects and 97 percent were Cambodian due to language barriers
Rural sex work in Cambodia: work characteristics, risk behaviours, HIV, and syphilis.	Sopheab et al.	2001	Interviews and serological HIV testing.		(mean 24y)	Large study, involved both direct and indirect workers. Had both clinical and qualitative data collection.	
An evaluation of STI case management in health facilities in 4	Sano et al.	2002	Enumeration, interviews with clinic staff, STI	108 interviews (44 sex workers)	N/A	One of few studies to review the current health facilities geared	Only studied 4 out of 26 (6.5%) provinces, thus difficult to generalize to country

border provinces of Cambodia			register.			toward reproductive health and sex workers	situation.
HIV Sentinal Survey	NCHADS	2003	Serologic HIV testing.	2, 411 DFSW	Not provided	Large sample size of both indirect and direct FSW Also interviewed clients of sex workers Serological testing for accuracy of results. Randomized sampling.	Unable to randomly sample subjects for regions where sample size was less than 150 persons.
Sexual behaviour among sentinal groups	NCHADS	2003	Questionnaire	1308 DFSW	Mean age 23y	Randomized cluster sampling	
USAID	USAID	2004	Cross-sectional survey	1,079 DFSW	>15 years (80% were <30y)	FSWs were randomly selected, reducing bias.	Sentinal sites non-randomized
Trafficking and health	Busza et al	2004	Face-to-face interviews and focus groups	100 Vietnamese migrant workers	Not provided	Able to reach brothel based sex workers and utilized Vietnamese speakers to reduce misinterpretation.	Small sample size, difficult to generalize.
Patterns and behaviors among direct and indirect female sex workers across Cambodia's 5 major cities	Gorbach et al.	1997 to 2003	Face-to-face interviews	245, 804, 792, 569 and 822 (over 5 years) both direct and indirect FSWs		Large sample sizes. Uni and Multi variate analyses done to control for confounders	
Female prostitutes in Phnom Penh, Cambodia: changes in knowledge, attitudes and practices between 2000 and 2004.	Gazin et al.	2000 to 2004	Face-to-face interviews	131 direct and indirect FSW	Mean age 22.9 and 25.5 in respective years	Studied over 4 years to offer trend analysis.	Small sample size and only based in one major urban center making it difficult to generalize to other red light districts.
The need for family planning and safe abortion services among women sex workers seeking STI care in Cambodia.	Delvaux et al.	2000	Chart review, key informant interviews and focus groups.	2,332 direct and indirect sex workers	Unknown	Large sample size and both quantitative and qualitative data	Only one site was utilized and non-randomized data collection could bias results.
Commercial sex workers: Victims, vectors or fighters of the HIV epidemic in Cambodia?	Martin	2005	Semi structured interviews and focus group discussions (FDGs)	22 STI clinic attendants	Mean age 22y (only one under 18y)	Involved both IDFSW and DFSWs	Selection bias – all subjects were STI clinic attendees. Small sample size.
Integration of comprehensive	Delvaux et al.	2002 to 2005	Chart review of medical	2224	16-47y (3.6%)	Large sample population.	Not generalizable to child prostitutes; only

abortion-care services in maternal and child health clinic in Cambodia			records at abortion clinic.		were under 18y)		3% of sample was brothel based and 4% were between ages of 15 and 19 years.
Cambodian STI survey	NCHADS, FHI, ADB, CDC	2005	Face-to-face interviews	1081 FSW, 623 Police, 547 MSM	15 to 30+ years (mean 25y)	Both IDFSW and DFSWs Large sample size Cluster sampling Multiple clinical testing	Non-randomized subjects.

2. Overview of laws and legislations pertaining to Cambodia's sex industry

Legislation or Convention	Year instituted	Successful ¹⁶	Legally binding, yes or no	Comments
United Nations (UN) Convention for the Suppression of the Traffic in Persons and Exploitation of the Prostitution of Others	1949	No	No	
UN Convention on the Rights of the Child (UNCRC), article 34 and 39	1949	No	No	
Suppression of the Kidnapping and Trafficking/Sales of Human Persons and the Exploitations of Human Persons	1996	Yes*	No	Criticized for failing to comply with minimum standards
100% Condom Use Policy (CUP)	1998	Yes	N/A**	
ILO Convention on Elimination of Worst Forms of Child Labor (ratified all 7 by 1999)	1999	Unknown	No	Delayed implementation due to decades of civil war and poor infrastructure
Trafficking Victims Protection Act	2000	Yes	No	
The Trafficking Protocol	2003	No	No	
The Suppression of Human Trafficking and Commercial Sexual Exploitation	2008	Yes	No	

**N/A = Not Applicable

¹⁶ Successful was defined according to literature that stated the legislation was able to reduce the numbers of child prostitutes, hold guilty persons accountable by law or reduce the prevalence of STIs among female sex workers.

3. UNICEF country health indicators, 2007

Basic indicators

Under-5 mortality rate (per 1000 children)	91
Infant mortality rate (per 1000 children)	70
Neonatal mortality rate (per 1000 live births)	48
Life expectancy at birth (years)	59

Nutrition

% of infants with low birthweight, 200-2007	14
% of under-fives (2000-2007) who are suffering from: underweight (NCHS/WHO ref. pop): moderate & severe	36
% of under-fives suffering from: stunting (NCHS/WHO): moderate and severe	37

HIV AIDS

Estimated adult HIV prevalence (aged 15-49) (%)	0.8
Estimated number of people (all ages) living with HIV (thousands)	75
Mother-to-child transmission, estimated number of women (aged 15+) living with HIV (thousands)	20
Pediatric infections, estimated number of children (aged 0-14) living with HIV (thousands)	4.4
Prevention among young people, HIV prevalence among young people (aged 15-24), male	0.8
Prevention among young people, HIV prevalence among young people (aged 15-24), female	0.3
Prevention among young people, % who have comprehensive knowledge of HIV, 2002-2007, male	45
Prevention among young people, % who have comprehensive knowledge of HIV, 2002-2007, female	50
Prevention among young people, % who used condom at last higher-risk sex, 2002-2007, male	84

Education

Youth (15-24 years) literacy rate, 2000-2007, male	90
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Youth (15-24 years) literacy rate, 2000-2007, female	83
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Demographic Indicators

Population (thousands), under 18	6247
Population annual growth rate (%), 1990-2007	2.3
Crude death rate	9
Crude birth rate	26
Total fertility rate	3.2

Source data: UNICEF, 2008

References

- Bertone, A., 2004. Transnational activism to combat trafficking in persons. *Brown Journal of World Affairs*, 10(2), pp.9-22.
- Beyrer, C, & Stachowiak, J., 2003. Health consequences of trafficking of women and girls in Southeast Asia. *Brown Journal of World Affairs*, 10(1), pp.105-117.
- Bjerkan, L. ed., 2004. A life of one's own: Rehabilitation of victims of trafficking for sexual exploitation. *Fafo*, pp.31-38.
- British Broadcasting (BBC), 2004. [Online] Cambodia's child sex crack down. *BBC Online*, [internet] 4 February. Available at: <http://news.bbc.co.uk/2/hi/asia-pacific/3458581.stm> [Accessed 17 June 2009].
- Brown, L (2001). *Sex Slaves: The Trafficking of Women in Asia*. Virago: London, England.
- Busza, J, Castle, S, & Diarra, A., 2004. Trafficking and health. *British Medical Journal*, 328, pp.1369-1371.
- Busza & Baker, 2004. Protection and participation: an interactive programme introducing the female condom to migrant sex workers in Cambodia. *AIDS Care*, 16(4), pp.507-18.
- Coalition Against Trafficking in Women (CATW), 2008. *Cambodia: trafficking*. [Online] Available at: <http://www.catwinternational.org/factbook/Cambodia.php> [Accessed 18 June 2009].
- Castellsague, X, & Munoz, N., 2003. Cofactors in human papillomavirus carcinogenesis-role of parity, oral contraceptives and tobacco smoking. *Journal of National Institute of Monography* 31, pp.20-28.
- Delvaux, T, Soeur, S, Rathavy, T, Crabbe, F, & Buve, A., 2008. Integration of comprehensive abortion-care services in a maternal and child health clinic in Cambodia. *Tropical Medicine & International Health*. 13(8), pp.962-969.
- Delvaux, T, Crabbe, F, Seng, S, & Laga, M., 2003. The need for family planning and safe abortion services among women sex workers seeking STI care in Cambodia. *Reproductive Health Matters*, 11(21), pp.88-95 .
- Derks, A., 2008. *Khmer women on the move: exploring work and life in urban Cambodia*. Hawaii: University of Hawaii Press.

Derks, A., 1998. *Trafficking of Vietnamese women and children to Cambodia*. International Organization for Migration & Centre for Advanced Study (IOM/CAS), Cambodia. Ch.2&3.

ECPAT, 2005. The psychosocial rehabilitation of children who have been commercially sexually exploited. [Online] Available at: <http://www.ecpat.com/EI/book.asp?id=19> [Accessed 12 May 2009].

ECPAT. 2008. Combating the trafficking of children for sexual purposes, questions and answers. [Online] Available at: <http://www.ecaptcambodia.org/index1.php?pn=2> [Accessed 9 May 2009].

Family Health International (FHI), 2009. Letter of Agreement between NCHADS and FHI, Cambodia. 05 January. [Email] (Personal communication, 20 April 2009).

Family Health International (FHI), 1993. Condom breakage and slippage. [Online] Available at: <http://www.FHI.org/en/RH/Pubs/factsheets/breakslip.htm> [Accessed 10 July 2009].

Gazin, P, et al., 2006. Female prostitutes in Phnom Penh, Cambodia: changes in knowledge, attitudes and practices between 2000 and 2004. *Medical Tropics*, 66(2), pp.157-61.

Gorbach, P, Sopheab, H, Chhorvann, C, Weiss, R, Vun, M., 2006. Changing behaviors and patterns among Cambodian sex workers: 1997-2003. *Epidemiology and Social Science*, 42(2), pp.242-247.

Griffiths, C., ed., 2003. *Laos & Cambodia*. Singapore: Apa Publications GmbH & Co.

Hill, P, & Heng, L., 2004. Women are silver, women are diamonds: conflicting images of women in the Cambodian print media. *Reproductive health matters*, 12(24), pp.104-15

Hopperus-Buma APPCC, Veltink, R, Van Ameijden, E, Tendeloo, C, Coutinho, R., 1995. Sexual behaviour and sexually transmitted disease in Dutch marines and naval personnel on a United Nations mission in Cambodia. *Genitourinary Medicine*, 71, pp.172-5

Human Rights Watch, 2009. On the margins [Online] 21 January. Available at: <http://www.hrw.org/en/reports/2009/01/21/margins> [Accessed May 8, 2009].

International Justice Mission (IJM) (2008). [Online] Available at: <http://www.ijm.org/video/viewcategory> [Accessed 17 June 2009].

Kirby, D., 2003. Interventions directed at adolescent sexuality issues in developed and developing countries: evidence of what works. [Online] Available at: <http://www.paho.org> [Accessed 10 July 2009]

- Leibo, S., 2008. *East and Southeast Asia*. WV, USA: Stryker Post Publications.
- Leung, P., 2003. Sex Tourism: the case of Cambodia. Ch. 13. *Sex and Tourism: Journeys of Romance, Love and Lust*. New York: Haworth Press.
- Mam, S., 2008. *The Road of Lost Innocence*. New York, USA: Spiegel & Grau.
- Marten, L., 2005. Commercial sex workers: victims, vectors or fighters of the HIV epidemic in Cambodia? *Asia Pacific Viewpoint*, 46(1), pp.21-34.
- Mead, P, Hager, W, & Faro, S, eds., 2000. *Protocols for Infectious Diseases in Obstetrics and Gynecology*. 2nd ed. Mass., USA: Blackwell Science, Inc.
- Mitchell, N., 1999. The HIV/AIDS project in Cambodia: the 100% condom policy. [Online] Available at: <http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s39251.htm> [Accessed 16 June 2009]
- National Center for HIV/AIDS, Dermatology and STDs, 2004a. HIV Sentinel surveillance (HSS): results, trends, and estimates. [Online] Available at: <http://www.nchads.org/index.php?id=16&lang=en> [Accessed 9 May 2009].
- National Center for HIV/AIDS, Dermatology and STDs, 2004b. Sexual behavior among sentinel groups, Cambodia. [Online] Available at: <http://www.nchads.org/Publication/BSS/BSS2001.PDF> [Accessed 9 May 2009].
- National Center for HIV/AIDS, Dermatology and STDs, 2006. Cambodian STI survey 2005: Key risk behaviours and STI prevalence. [Online] Available at: <http://www.nchads.org/Publication/dissemination/SSS%202005%20Eng.pdf> [Accessed 9 May 2009].
- nSWP (2007). Network of sex work projects. [Online] Available at: <http://www.nswp.org/safety/100percent.html> [Accessed 7 July 2009]
- Nelson, K., 2008. Study first to profile women trafficked for sex. *The Cambodia daily*. [internet] Available at: <http://www.afesip.org/uploadfile/medianews/pic424.jpg> [Accessed 18 June 2009].
- Ohshige, K., et al 2000a. Behavioural and serological human immunodeficiency virus risk factors among female commercial sex workers in Cambodia. *International Journal of Epidemiology*, 29, pp.344-54.
- Ohshige, K., et al 2000b. Cross-sectional study on risk factors of HIV among female commercial sex workers in Cambodia. *Epidemiology of Infectious Diseases*, 124, pp.134-52.

- Orchard, T., 2007. Girl, woman, lover, mother: Towards a new understanding of child prostitution among young Devadasis in rural Karnataka, India. *Social Science and Medicine*, 64, pp.2379-90
- Pirkle C, Soundardjee, R, & Stella, A., 2007. Female sex workers in China: vectors of disease? *Sexually transmitted diseases*, 34(9), pp.695-703
- Pisani, E., 2008. *The Wisdom of Whores*. Toronto: Penguin Group.
- Poer, L., 2008. Swift conviction for US citizen who violently abused children in Cambodia. [Online] Available at: http://www.ijm.org/releases/2008/5_29_08_-_Michael_Pepe_conviction_FINAL.pdf [Accessed 18 June 2009].
- Population services international (PSI), 2007. [Online] <<http://www.psi.org/resources/pubs/cambodia2.pdf>> [Accessed July 15, 2009]
- Prybylski, D, & Alto, W., 1999. Knowledge, attitudes and practices concerning HIV/AIDS among sex workers in Phnom Penh, Cambodia. *AIDS Care*, 11(4), pp.459-472.
- Richens, J., 2006. Sexually transmitted infections and HIV among travelers: A review. *Travel Medicine and Infectious Disease*, 4, pp. 184-195.
- Rithy, P., 2004. Prevention of HIV/AIDS among Vietnamese sex worker in Phnom Penh, Cambodia. [Online] Available at: <http://www.aegis.com/conferences/iac/2004/D11169.html> [Accessed 7 July 2009].
- Ross, R., ed. 1987. Cambodia: A country study. Washington: GPO for the Library of Congress. [Online] Available at: <http://countrystudies.us/cambodia/> [Accessed 15 June 2009]
- Sandoy, I, Dzekedzeke, K, Fylkesnes, K., 2008a. Prevalence and correlates of concurrent sexual partnerships in Zambia. *AIDS and Behaviour*. 10(1573), pp.3254
- Sandoy, I, Seter, S, Fylkesnes, K., 2008b. Lost opportunities in HIV prevention: programmes miss places where exposures are highest, *BMC Public Health*, [Online]. 8(31), Available at: <http://www.biomedcentral.com/1471-2458/8/31> [Accessed 14 June 2009].
- Sano et al., 2004. An evaluation of sexually transmitted infection case management in health facilities in 4 border provinces of Cambodia. *Sexually Transmitted Diseases*, 31(12), pp.713-718.
- Sarkar, K, Bal, B, Mukherjee, R, Niyogi, S, Saha, M, & Bhattacharya, S., 2005. Epidemiology of HIV infection among brothel-based sex workers in Kolkata, India
- SihanoukVille General Hospital, 2009. Sihanoukville General Hospital. [Online]. Available at: <http://www.hospital.sihanoukville-cambodia.com/mainpages/generalhospital.html> [Accessed 16

June 2009].

Silverman, J, Decker, M, Gupta, J, Maheshwari, A, Patel, V, Raj, A (2006). HIV prevalence and predictors among rescued sex-trafficked women and girls in Mumbai, India. *Journal of acquired immune deficiency syndrome*, 43(5): 588-93

Sopheab, H, Gorbach, P, Gloyd, S, & Leng, H., 2003. Rural sex work in Cambodia: work characteristics, risk behaviours, HIV, and syphilis. *Sexually Transmitted Infections*, [Online]. 79:e2 Available at: <http://www.stijournal.com/cgi/content/full/79/4/e2> [Accessed 13 May 2009]

Sopheab, H, Morineau, G, Neal, J & Chhorvann, C., 2005. 2005 Cambodia STI prevalence survey. USAID. [Online] <http://www.nchads.org/Publication/SSS/SSS%202005.pdf> [Accessed 15 May 2009].

Steinfatt, T, Baker, S, & Beesey, A., 2002. Measuring the number of trafficked women in Cambodia: 2002. [Online] Available at: <http://slate.msn.com/Features/pdf/Trfcamf3.pdf> [Accessed 15 May 2009].

Stubbs, F & Bunley, M (2002). Big rise in methamphetamine use observed. *The Cambodia Daily*. [internet] Available at: http://www.camnet.com.kh/cambodia.daily/selected_features/yama.htm [Accessed 15 June 2009]

Sweet, R & Gibbs, R., 2002. *Infectious diseases of the female genital tract* 4th ed.. Lippinott Williams & Wilkins: Philadelphia

Talbott, J., 2007. Size matters: the number of prostitutes and the global HIV/AIDS epidemic. *PLoS ONE*, 2(6): e543

Tarr, C, & Aggleton, P., 2007. Young people and HIV in Cambodia: meanings, contexts and sexual cultures. *AIDS Care*, 11(3), pp.375-84.

United Nations AIDS (UNAIDS), 2008. Epidemiological fact sheet on HIV and AIDS: Cambodia, 2008 update. [Online] Available at: www.who.int/hiv [Accessed 17 June 2009].

UNAIDS, 2004. 2004 report on the global AIDS epidemic. [Online] Available at: http://www.unaids.org/bangkok2004/GAR2004_pdf/UNAIDSGlobalReport2004_en.pdf [Accessed 25 June 2009]

UNAIDS, 2004. Women in Mekong faced with higher rates of HIV than men. [Online] Press release. Bangkok, March 8, 2004. Available at: [Accessed 17 June 2009].

United Nations Development Programme (UNDP), 2007. Cambodia annual report. [online]. <<http://www.un.org.kh/undp/docman/View-document-details/218-UNDP-Annual-Report-2007.html>> [Accessed 16 June 2009].

UNDP, 2009. 2007/2008 Human development report: Cambodia [Online] Available at: http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_KHM.html [Accessed 14 May 2009].

UNCRC, 1996. Sexual exploitation and the rights of the child: an overview. *United Nations Publication*, E.96, XIV.7.

United Nations ESCAP, 2002. Economic and Social Commission for Asia and the Pacific: annual report 26 April 2001-22 May 2002. [Online] Available at [www.unescap.org/EDC/English/AnnualReports/2002\(58\).pdf](http://www.unescap.org/EDC/English/AnnualReports/2002(58).pdf) [Accessed 8 August, 2009].

United Nations ESCAP (Economic and Social Commission for Asia and the Pacific), 2007. Commercial sexual exploitation of children. [Online] Available at: www.unescap.org/esid/Gad/Issues/CSEC/index.asp [Accessed 16 June 2009].

United Nations, 2000. A qualitative needs assessment of exploited children and youth in the greater Mekong subregion. [Online] Available at: [Accessed 20 May 2009].

United Nations International Children's Emergency Fund (UNICEF), 2008. Cambodia statistics. [Online] Available at: http://www.unicef.org/infobycountry/cambodia_statistics.html [Accessed 9 May 2009]

United Nations Family Planning Association (UNFPA), 2008. Cambodia: Giving Reproductive Health a Place in the Dharma. [Online] Available at: http://www.unfpa.org/culture/case_studies/cambodia_study.htm [Accessed 16 June 2009]

USAID, 2005. 2005 Cambodia STI prevalence survey. [Online] Available at: www.nchads.org/Publication/SSS/SSS%202005.pdf [Accessed 19 June 2009].

USA Department of State, 2009. Trafficking in persons. [Online] Available at: <http://www.state.gov/g/tip/rls/tiprpt/2009/index.htm> [Accessed 17 June 2009].

Verkuyl, D, (2002) *Family planning as part of reproductive health, including the HIV/AIDS aspects, in Zimbabwe and Southern Africa*. The Netherlands: FEBO Druk BV

Vermund, S & Yamamoto, N (2007). Co-infection with human immunodeficiency virus and tuberculosis in Asia. *Tuberculosis*, 87(Suppl 1): S18-S25.

Whitworth, S, & Moxon-Browne, E., ed, 1998. *Gender, Race and the Politics of Peacekeeping*. Basingstoke: Macmillan Press: 176-191.

Willis, B & Levy, B., 2002. Child prostitution: global health burden, research needs, and interventions. *The Lancet*, 359, pp.1417-22.

WHO (2000). Effectiveness of male latex condoms in protecting against pregnancy and sexually transmitted infections. [Online] Available at: <http://www.who.int/mediacentre/factsheets/fs243/en/> [Accessed 14 May 2009].

WHO (2002). Guidelines for the management of sexually transmitted infections in female sex workers. [Online] Available at: <http://www.wpro.who.int> [Accessed 6 April 2009].

WHO (2004). Women, girls, HIV & AIDS. [Online] Available at: <http://www.who.int> [Accessed 7 April 2009].

WHO (2007). Cambodia: HIV/AIDS epidemic and response. [Online] Available at: <http://www.who.int/Cambodia.html> [Accessed 7 April 2009].

WHO (2008). Cambodia: health situation. [Online] Available at: http://www.wpro.who.int/countries/2004/cam/health_situation.htm [Accessed 30 June 2009].

World Bank, 2008. Internationales en matiere de vih/sida, nutrition et securite alimentaire: synthese des recommandations. La Banque Internationale: Washington, USA.

World Vision (2005). The child sex tourism project. [Online] Available at: <http://www.worldvision.org/content.nsf/learn/globalissues-stp> [Accessed 28 June 2009].

