

Linkages *between*
HIV/AIDS and the **Commercial**
Sexual Exploitation of Children
in **Africa**



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Table of Contents

2 Acknowledgements

3 Acronyms

4 Preface

7 Research Methodology

9 Section 1: HIV/AIDS Protection Mechanisms Available for Vulnerable Children,
Children Exploited in CSE and/or Affected by HIV/AIDS in Africa

18 Section 2: Linkages between CSEC and HIV/AIDS in Africa

31 Section 3: Conclusions and Recommendations

38 Bibliography

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Acronyms

ARV: Antiretroviral
ART: Antiretroviral Therapy
CBO: Community-Based Organisation
CSE: Commercial Sexual Exploitation
CSEC: Commercial Sexual Exploitation of Children
OVC: Orphans and Vulnerable Children
PLWHA: People Living with HIV/AIDS
STI: Sexually Transmitted Infections
VCT: Voluntary Counselling and Testing

Preface

The AIDS pandemic has decimated families, disintegrated community support structures and increased poverty, especially in Sub-Saharan Africa, which presents the highest infection rates globally, and where young people are particularly affected. African children have been forced to take on unimaginable responsibilities, such as providing for entire households in the context of economies that lack the channels to provide basic livelihood opportunities even for adults, putting them at high risk of entrapment in commercial sexual exploitation and thus contracting and further spreading the disease.

Further disaggregation of the estimated three million HIV infected children below the age of 15 in Sub-Saharan Africa¹ identifies two modes of infection: infants affected through mother-to-child transmission and children infected through contaminated bodily fluids and other high risk contact/behaviours. It is established that the HIV-infected infants will become symptomatic within one year and that 50-60 per cent will die within the second year.² However, in addition to the 40 per cent that survive, another proportion is

infected well after weaning through infected bodily fluids and other high risk contact/behaviours. With a significant proportion of these children below the age of those expected to be engaged in sexual contact, the question remains as to how many of these children have actually been infected with HIV as a result of sexual abuse or exploitation. Indeed, this concern is supported by the reportedly rapid increase in the number of children sexually exploited and that the age of these victims is becoming younger. In Togo, for example, children as young as seven years old are reported to be victims of commercial sexual exploitation.

There is therefore a need to examine the extent to which sexual abuse or exploitation of children are causal factors for the high representation of children among the HIV/AIDS infected individuals below the age of 15, while also addressing the risks and challenges faced by children involved in commercial sex, as these have not been adequately addressed in HIV/AIDS interventions. These complex issues, in relation to the situation of children, have so far been largely overlooked, an omission that is impacting profoundly on their lives and overall, limiting the strategies to contain the pandemic in Africa, which need to be targeted and timely. From a child rights perspective, the high vulnerability of African children to violence, abuse and commercial sexual exploitation and its relation to HIV/AIDS infections in children

¹ UNAIDS Report on the Global AIDS Epidemic, May 2006

² Taking Stock: HIV in Children, World Health Organization, 2006.

must be critically examined and properly addressed. This calls for a better understanding of the interface between these phenomena.

Seeking to contribute to closing this knowledge gap and with the primary goal of establishing a regional framework of prevention, protection and care against HIV/AIDS for children at risk and those already involved in commercial sex, ECPAT International coordinated a six-month regional research study in six African countries in 2006. The information gathered through this research provided useful insights to the elements that must be considered when designing specialist interventions for this group of children at risk of exploitation and confirmed the urgent need to address their particular situation in national HIV/AIDS policies and in the work carried out by non-governmental organizations (NGOs) and international organisations dealing with HIV/AIDS or child rights issues.

The absence of interventions specifically designed for this group of children may explain why, despite widespread awareness raising efforts carried out in the continent in the last decades, child victims of sexual abuse or commercial sexual exploitation still display very poor knowledge of HIV/AIDS; are unaware of means of protection; and are unable to access related services. The testimony of a number of adult sex workers is particularly disquieting in this regard, as they noted that most children involved in prostitution barely know how to use condoms, a basic protection measure that they should be familiar with.

The research further indicated that children involved in prostitution rarely access HIV/AIDS prevention, care and support services. One of the key reasons is their fear of being exposed and discriminated against. This calls for an urgent reassessment of the way such services can be accessed and delivered, particularly by vulnerable children who already suffer considerable discrimination and marginalisation. There is a clear need to expand outreach and mobile interventions if CSEC victims are to be afforded proper protection and care against HIV and AIDS. Also necessary is the systematic training of staff at voluntary counselling and testing (VCT) centres, management centres and clinics on how to provide holistic, child-friendly assistance, and gradually attract and retain contact with vulnerable children and those already involved in commercial sexual exploitation. Such an approach would also need to deal with the various mistaken beliefs and risky behaviours and attitudes that such children present, as well as the development of techniques to dispel them.

At the same time, the children's desperation to survive and to make as much income as possible demands more resourceful responses and more targeted interventions and awareness raising with the perpetrators. It is therefore essential to tackle the demand side of commercial sexual exploitation of children, particularly in view of the myths that foster sex with children, on the basis that it protects oneself from AIDS, rejuvenates the body, cures diseases such as malaria, etc. Awareness raising campaigns must urgently engage the public in dispelling such myths,

targeting in particular the perpetrators who may seek sex with children for the above purposes.

Awareness raising campaigns must promote greater understanding of the ways in which traditional practices such as forced and early marriages increase children's vulnerability to commercial sexual exploitation and HIV/AIDS. Conversely, the gradual disappearance of certain traditional practices that promoted safe sex and disseminated sexual education among young girls has left a gap in terms of their knowledge on protection. A 'back to roots' and more culturally appropriate approach has been suggested by some researchers so that HIV/AIDS and CSEC interventions would integrate certain African rituals, customs and traditional educational models to educate children on safer sex and reintroduce values.

Several other findings presented in this regional overview demand careful consideration when devising such interventions: the appalling rate of sexual abuse experienced by many of the child respondents; the dangers existing in the school environment and how it facilitates sexual exploitation of children in many ways; and the very early sexual initiation of children, which demands preventative programmes targeting much younger age groups. The skills training, livelihood

alternatives and income generating initiatives being provided to children and families affected by HIV/AIDS do not fully cater to their real needs, making children easy prey to exploitative labour and commercial sex. In this regard, new models which are slowly emerging, such as focusing on the development of specific farming skills or fostering young people's employment in the tourism and services industries, demand broader replication.

Finally, the ECPAT research exposed serious gaps in combatting CSEC in all of the six African countries. Commercial sexual exploitation of children is a criminal act and children are not being afforded sufficient protection. An analysis of existing legislation and law enforcement mechanisms exposed severe gaps. The lack of appropriate rehabilitation and reintegration services remains inadequate and more innovative support and recovery programmes (staffed by trained caregivers) is required. ECPAT International hopes that the wide body of evidence presented in this regional overview will be used to support holistic child protection strategies at national, regional and global levels that are more responsive to the best interests of the child, thereby ensuring that children are "put at the centre of the response to the pandemic, adapting strategies to children's rights and needs".³

³ Committee on the Rights of the Child 2003. General Comment No. 3 (2003): HIV/AIDS and the Rights of the Child. 32nd session. 13-31 January

Research Methodology

Field Sites

The research was conducted in six countries in Africa: Ethiopia, Kenya, The Gambia, Togo, Uganda and Zambia. A minimum of three field sites, including the capital city, were selected in each country. The following characteristics were considered during the selection process: areas where prostitution is known to be high (red-light districts; parks; bus/train stations; particular roads/districts); geographic locations with high HIV prevalence rates; industrial/mining/ports/commercial towns and centres; 'tourist' destinations (where appropriate); and war affected areas/camps for internally displaced persons/military camps. A primary or secondary school was also identified at each selected site.

Target Groups

Information was gathered from three categories of respondents (their proportion varied slightly from one country to another):

- 1) Children involved in commercial sex, school children and orphaned or vulnerable children (OVC);
- 2) Individuals who participate directly or indirectly in the exploitation of children, such as procurers, security guards, bar and restaurant owners, hotel workers, taxi drivers and adult sex workers; and
- 3) Parents and individuals working on child protection or HIV/AIDS issues, such as teachers, law enforcers, health and social services staff, media organisations and NGOs working with children.

Sample Size

Around 700 children and 270 adults were interviewed.

Research Tools

The research teams included young people below the age of 20, some of them formerly involved in commercial sex, in an attempt to make the child respondents more comfortable, with interviewers of a similar age.

Open-ended, semi-structured questionnaires were developed to collect qualitative information, while quantitative data was gathered through closed-ended questionnaires. Focus group discussions also took place, and literature on CSEC and HIV/AIDS (particularly from Africa) was reviewed.

Ethical and Child Protection Considerations

ECPAT International's Guidelines for CSEC Research with Children and Young People were strictly followed. To ensure the maximum respect for the rights of the child respondents, the following areas were considered: rules of conduct for the researchers; children's right to participate or not in the research; children's right to privacy and confidentiality; protection from all forms of abuse and exploitation; and the right to information (pre- and post-research, user-friendly format). Each child respondent was informed about the purpose of the research in an understandable manner and consent of either the child, if of age and maturity, or that of the parents/guardian were sought before any contact was made. Participation was voluntary and the child respondents could choose not to participate in the research at any stage of the interview. To this end, each child respondent had to sign a consent form. The researchers were required to be honest, genuine and show empathy, while avoiding questions, attitudes or comments deemed judgmental, insensitive to the children's situation or cultural values, that place a child in danger or humiliate a child, or that reactivate a child's pain and grief to traumatic events. The researchers could not reveal a child's identity, be or pretend to be exploiters or child sex abusers, work with subterfuges or raise unrealistic expectations.

Study Limitations

The techniques of data collection were not without limitation. It was not easy to identify or locate children involved in commercial sexual exploitation, given the secrecy surrounding this criminal activity. Some children preferred not to answer certain questions, which they felt to be embarrassing or made them uncomfortable. In the absence of tangible evidence, it was sometimes difficult to ascertain whether the children were being completely honest, as their statements sometimes appeared contradictory.

Furthermore, while the links between HIV/AIDS and the entry of boys into commercial sexual exploitation were also explored, not much evidence of this interface was found. This was possibly because in the countries investigated, the prostitution of boys is a more recent phenomenon, a taboo topic, virtually nonexistent or very well hidden.

HIV/AIDS Protection Mechanisms Available for Vulnerable Children, Children Exploited in CSE and/or Affected by HIV/AIDS in Africa

In seeking to estimate the extent to which children at risk or involved in CSE are able to access HIV/AIDS prevention, and care and support services, Section 1 of this report focuses on the HIV/AIDS protection

mechanisms and interventions available for this group of children in the six countries where the research took place. This should provide a small sample of the general situation in the African context.⁴

THE GAMBIA

There are very few organizations providing support services for children involved in CSEC, vulnerable to it or at increased risk of contracting HIV/AIDS. There are no safe havens tailored for this particular group of children, and very few organisations provide them with alternative means of livelihood, psychosocial care, counselling and general recovery and reintegration assistance.

General efforts to increase awareness and knowledge of HIV/AIDS in The Gambia have largely

succeeded. The Government's HIV/AIDS Rapid Response Project (HARRP) has been particularly effective, while many national and community-based organizations (CBOs) have been strengthened to intensify the awareness campaign at community level. Furthermore, nearly all major towns and large villages in the country have youth groups and organisations involved in preventative projects, which is also very strategic given that young people are among the most affected segments of the population. Sixteen (22 per cent)

of the CSEC victims interviewed during the study claimed that they did not know anything about HIV/AIDS, which suggests that such awareness efforts must be strengthened in terms of targeting specific vulnerable groups. Interestingly, 86 per cent of the CSEC victims interviewed said that they knew where to go for an HIV screening test, but only 16 per cent had actually taken the test. Most of the respondents declined to reveal their HIV status; among those who did, 84 per cent were not infected.

⁴ As one of the objectives of the research was to map out resources, specific contact details of organisations providing support services to at-risk children and CSEC victims are available by contacting the research organisations directly

Good practice:

The Gambia's HIV/AIDS Strategic Framework 2003-2008 includes a National School-Based and Community Peer Education and Life Skills Programme which aims to increase the awareness level of youth between the ages of 15 and 24 to 100 per cent by 2008, and to reach 95 per cent of young people with relevant and useful information on VCTs as an effective entry point for prevention and care.

The NGOs involved in the fight against HIV/AIDS in The Gambia include Action Aid International, Catholic Development Organisation (CaDO), Catholic Relief Service (CRS), Medical Research Council, and Hands on Care Project. The Santayalla Support Society and the Nyaniya Kiling Society are the two main support societies for people living with HIV/AIDS (PLWHA). The following organisations have programmes with a focus on child protection issues and/or HIV/AIDS: Child Protection Alliance, the Guidance and Counselling Unit of the Department of State for Education, and Nova Scotia Gambia Association.

In 2001, with funding from the World Bank, the Government began implementation of the US\$15 million HIV/AIDS Rapid Response Project, which was phased out at the end of 2005. Two national structures, the National AIDS Council and the National AIDS Secretariat, were established under the Project. Both institutions are under the Office of the President, who is the Chairperson of the National AIDS Council.

Among the CSEC victims interviewed in the country, 54 per cent were living in urban areas (Kanifing Municipality and Brikama) and 46 per cent in rural areas (Farafenni and Basse). These areas were found to be appropriate to carry out HIV/AIDS interventions from a child rights perspective.

Besides fear of discrimination, some of the children mentioned the following reasons for their reluctance to take the screening test and access support services:

- "Because I heard that if you go to the hospital for an HIV test, before they tell you the result they frighten you." (female, 15-17 years, Brikama)
- "It does not exist. People are paid to act as though they are infected." (female, 15-17 years, Kanifing)
- "Because I know if my time is up I will die." (male, 15-17 years, Basse)
- "I know I don't have it." (male, 10-14 years, Farafenni)
- "I don't have time for that." (female, 15-17 years, Sierra Leonean, Brikama)
- "I do want to but I am afraid." (female, 15-17 years, Basse)
- "Never!" (male, 15-17 years, Brikama)

Very few organisations in Zambia are working with child victims of CSEC, a group considered particularly difficult to work with as available livelihood alternatives cannot compete with the income they derive from commercial sex. The Tasintha Programme and the Young Women's Christian Association work with child victims of CSEC; other organisations may work with this group of children on an ad hoc basis. There is an urgent need for the establishment

The National HIV/AIDS Act, enacted by Parliament in 2000, led to the creation of the National HIV/AIDS/STI/TB Council. However, this coordination body does not have sufficient regulatory powers, therefore real coordination in terms of efforts and resources is difficult. The Council oversees various committees and technical working groups such as the Orphaned and Vulnerable Children Technical Working Group, to which Children in Need (CHIN), the ECPAT group in the country, also belongs.

Zambia's National HIV/AIDS Policy has as one of its objectives the

protection of the rights of children and young people and provision of their access to HIV/AIDS prevention and care services. The policy does not, however, have a broad and comprehensive objective on commercial sex, or on child victims of CSEC, thus strategies to target such groups do not exist. This perhaps would not be the case if Zambia had a national plan of action against CSEC. In the Fifth National Development Plan (FNDP) currently being developed, HIV and AIDS have a separate chapter to which all other sectors are to align their related programmes and policies.

Good practice:

The German Technical Cooperation (GTZ) has been piloting a Social Cash Transfer Scheme where households headed by grandparents are provided with a small fund of about K30,000 (US\$ 6) per month. This is a modest amount by any standard, but its impact on households is said to be quite significant. In many cases it has been able to maintain the family unit, as grandchildren are not sent to live with other relatives or pushed into domestic work, where they are often abused, work long hours and are rarely paid or are paid very little for their work. The cash transfer scheme was recently included in the Social Protection chapter of the Fifth National Development Plan, and will be funded by the Ministry of Community Development and Social Services.

of a mechanism for children who want to escape commercial sexual exploitation, such as a child helpline or a one-stop centre. Also worrying is the lack of state safety homes and centres able to receive children withdrawn from dangerous circumstances. Such children are often referred to NGOs, which tend to be financially constrained. There is therefore a need for the government to establish safety homes, as well as increase support for organisations that assist children and effectively monitor how they are meeting the minimum standards of care.

Uganda's Ministry of Health has established VCTs countrywide, but it appears that such services target the population as a whole and disregard the specific needs of children who are exploited in prostitution. While the CSEC victims interviewed showed considerably high awareness of the VCT centres (possibly due to their availability near the childrens' residence or work areas), very few of them had actually taken the screening test.

Similarly, while the cost of

antiretroviral drugs (ARVs) has been significantly reduced and are distributed for free in most government-supported health units, their access by children involved in commercial sex remains very limited.

The research on whether existing HIV/AIDS services are child-friendly with regard to the existence and scope of outreach interventions targeting children at risk or those involved in commercial sexual exploitation, is inconclusive. The

children interviewed mentioned fear of discrimination and stigmatization as the main factors in their hesitation to access such services. Some children involved in prostitution who said they were HIV positive stated that they did not see the point of practicing safe sex or seeking treatment. The research also suggested that although condom use has increased steadily in the past years, some men do not use them when exploiting children.

Holistic programmes to prevent the spread of HIV/AIDS are being implemented by government departments, international and local NGOs such as the African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN) Uganda Chapter, The AIDS Support Organisation (TASO) Uganda, Health Alert Uganda, and civil society organisations such as Christian Women Child Ministries, Network for People Living with AIDS, Laro Peace Women Association and Noah's Ark. A number of newspapers and radio stations have also played a significant role in the fight against HIV/AIDS (and CSEC) in the country: the New Vision, Daily Monitor, Bukedde and Straight.

The National Overarching Policy on AIDS (NOPA) provides the basis for the National Strategic Framework on HIV/AIDS. Other relevant policies include the National Orphans and other Vulnerable Childrens' Policy, the National Condom Use Policy and Strategy, the National Policy on HIV/AIDS and the World of Work, the Voluntary Counselling and Testing Policy and the National Antiretroviral Policy for Uganda. Nevertheless, knowledge of these policies among the population seems to be very limited. More importantly, there are no preventative or support initiatives to specifically handle the situation of CSEC victims in the country.

There has been a rapid expansion of NGO and CBO support for orphans and vulnerable children in Kenya providing a wide range of services: residential care, health care, skills building, counselling, income generating activities, HIV/AIDS education, community and family sensitisation, and family support. These services also focus

on preventing these children from engaging in exploitative work. A number of outreach programmes are available for children who are not in school; and ARVs and medical check-ups are usually provided free of charge.

The research indicated, however, that CSEC victims rarely access

such services, especially as these children are usually unable to attend during the day. Most HIV/AIDS interventions only reach CSEC victims indirectly, rather than purposefully, as part of a broader strategy. Awareness of the services provided by the VCTs was high among children in Suba, in contrast to Mombasa and Nairobi.

The National AIDS Control Council (NACC) takes on the role of the national coordinating authority. Within NACC, a Harmonisation Task Force serves to further coordinate donor, civil society and government entities, as well as to identify gaps and areas of duplication.

The Kenya National HIV/AIDS Strategic Plan was developed in a highly participatory manner and its progress is reviewed each year in the annual Joint AIDS Programme Review. Over the past years, Kenya has seen a significant increase in donor funding, which, combined with government funds, greatly expanded community responses as well

as wider access to treatment. However, little attention has been given to marginalized groups until recently. As such, the Plan seeks to promote behaviour change among priority groups such as youths and adolescents in and out of school, women and girls.

Other positive features of the Plan include enhancing community care for HIV/AIDS patients, to avoid children being kept out of school to take care of sick relatives; enhancing parenting of teenage children through inculcating moral values; fostering the education of girls; introducing family life education in schools; and developing an AIDS curriculum in learning institutions.

While various care centres and clinics for people living with HIV/AIDS offer child-friendly services, it is unclear to what extent CSEC victims benefit from them, as they rarely disclose information on their activities and are not questioned either. The research suggested that only child victims rescued from CSE (which does not often happen in Togo) actually access these services. Furthermore, the limited availability of funds for these institutions is of serious concern. It was reported that the services provided at some reception centres

for children in difficult situations (e.g. CSEC victims, children exploited in domestic work and abused children) can be rather “poor and discriminatory”, and that the children assisted may be verbally abused and ill-treated.

HIV screening rates in general remain weak in Togo, and only 33 per cent of the children interviewed (no differentiation was made with regards to CSEC victims) affirmed that they had taken the test. The CSEC victims who mobilized themselves for the HIV test did so

because they felt more exposed to the virus or because NGO workers visited their homes and the locations where they were sexually exploited, as part of sensitization efforts. Vulnerable children and students mentioned fear, lack of financial means and ignorance of screening centres to justify their refusal to take the test. The overall low incidence of condom use has been worsened by a halt in the production of female condoms in the country.

HIV/AIDS interventions in Togo are carried out by the Ministry of Health and the Conseil National de Lutte contre le SIDA (CNLS), as well as a number of NGOs and associations which receive funding mainly from the government’s Programme National de Lutte contre le SIDA (PNLS), Population Services International (PSI), the Global Fund, Ras + Togo, Santé Internationale, UK Friends of Togo, Fondation Maagdenhuis, Amis du Père Louis, UNICEF, UNDP, UNAIDS, GTZ, foreign embassies, the World Bank and the European Union.

The researchers visited some clinics which offer free services: Promotion Développement Humaine (PDH),

Aides Médicales et Charité (AMC), Espoir Vie Togo (EVT) Sokodé, Club des Amis et Frères de Tchaoudjo (CAFT), Appui au Développement et à la Santé Communautaire (A.DE.S.CO), and Circle de Réflexion pour l’Emergence des jeunes (CREje).

CSEC victims assisted by child rights NGOs such as WAO-Afrique, Centre Oasis, Centre la Providence, Association pour la Jeunesse d’Afrique (AJA), A.DE.S.CO and Association Ojougbo usually undergo medical examinations to check for sexually transmitted infections (STIs).

Outreach work is carried out by a number of NGOs in locations where sexual exploitation of children takes place:

In Lomé: PSI, Centre Providence, Centre de la Confiance

In Sokodé: Although there is no evidence of permanent child prostitution sites, some NGOs have been quite effective in locating victimised children: Association Togolaise pour le Bien Etre Familiale (ATBEF), Association de Développement Intégral de promotion de la Femme et de la jeune Fille (ADDIF), Bon Secours, GTZ, PSI, CAFT and A.DE.S.CO.

Voluntary and anonymous screening centres are either state-controlled or run by NGOs and associations such as the Consultation and Documentation Centre, Association pour la Promotion de la Femme (ASPROFEM), PDH and AMC. The availability of screening centres is lacking in the cities of Atakpamé and Sokodé. The HIV screening test is however provided in hospitals. It is important to note that, due to financial constraints, NGOs and structures providing test facilities do not work directly with people living with HIV/AIDS. This is quite problematic as some people diagnosed as being HIV positive may not have the courage to face the situation or seek support at management centres. Others are under the impression that by going to another centre their HIV status will be further exposed.

The key national policies on HIV/AIDS feature a number of interesting measures, such as the provision of HIV/AIDS education in schools, universities and apprenticeship gathering centres, and the introduction of peer educators. Also envisaged is the popularisation of Law No. 2005 012, which deals with the prevention and protection of people living with HIV/AIDS and affected individuals. Another achievement is the creation of three hotlines for free information on the issue.

Good practice (Togo):

Most of the care centres for people living with HIV/AIDS that the researchers visited in Togo offer assistance to HIV positive parents and their children. The Director of Promotion et Développement Humain (PDH), for instance, reported that “our centre receives people living with HIV/AIDS and automatically registers their children. The fact that the children are also being taken care of reduces their likelihood of resorting to prostitution to meet the needs of their young brothers/sisters or sick parents. The level of management however varies from one structure to another, and not all the children can have their needs fully met, given our limited means”. The assistance provided includes funding for income generating activities and life skills education.

16

Especially designed to appeal to children and youth, the website www.100pourcentjeune.tg is highly interactive and offers them the chance to address the issues of HIV/AIDS, health and sexuality, evaluate their risk of becoming infected by using a “Sidamètre”, and obtain information on VCTs and management centres for people living with HIV/AIDS. Children and youth are also able to exchange their views on various issues related to the pandemic. The website also offers opportunities for parents to discuss issues of sexuality with their children. In order to attract more young people, the website features the latest news on pop culture. The site is managed by PSI and a youth committee.

ETHIOPIA

A wide range of support services need to be provided for children affected by HIV/AIDS in Ethiopia, especially in relation to the fulfillment of their basic needs.

School children and the CSEC victims interviewed were aware of where they could take the HIV screening test. While the vast majority of CSEC victims said they were concerned about their HIV status and knew where to find VCTs, very few had actually accessed these services.

Organisations working with vulnerable children in Addis Ababa, Nazareth and Bahir Dar include Ethiopian Gemini Trust, Jerusalem Children and Community Development Organisation, the Organisation for the Prevention, Rehabilitation and Integration of Female Street Children (OPRIFS), Family Guidance Association of Ethiopia, Forum on Street Children-Ethiopia, Pro-Gynist, Pro-Pride, Pro-Poor Admass Children Rehabilitation, Children of the Queen of Mercy and local health centres. Forum on Street Children-Ethiopia is the only organisation in the country working specifically on CSEC issues.

Some of the organisations also work in the area of HIV/AIDS, particularly those in Bahir Dar, where

support is provided to adults and children living with HIV/AIDS. Organisations assisting people living with HIV/AIDS include the Family Guidance Association of Ethiopia (FGAE), OSSA, DKT and Mekdim Ethiopia. Organisations supporting children living with HIV/AIDS include Dawn of Hope/Tesfa Goh, SRID, Goal Ethiopia, Mekedem Ethiopia and Hiwot Ethiopia.

Ethiopia's national policy on HIV/AIDS features number of provisions related to institutional, home and community-based health care and psychosocial support for people living with HIV/AIDS, including orphans and surviving dependents. In addition, the Strategic Framework for the National Response to HIV/AIDS in Ethiopia, developed in 2001 by the National AIDS Council, stipulates that special attention be given to women, children and youth, as well as to high-risk groups such as commercial sex workers and their clients, mobile groups (e.g. street children, youth groups, refugees, truck drivers and internally displaced persons) and uniformed professionals (e.g. active service men, demobilised soldiers and the police force).

Linkages between CSEC and HIV/AIDS in Africa

In an attempt to explore the extent to which the AIDS pandemic has become both a cause and consequence of CSEC in Africa, the research investigated the following aspects of the interface between both phenomena:

1) *What is the impact on the lives of children who care for parents and family members with HIV/AIDS, or who have become orphaned by it? Are they more likely to be pulled into commercial sexual exploitation?*

18

“There are many children involved in prostitution in Gulu (Uganda) today because of poverty caused by the war and HIV/AIDS; that’s why the HIV prevalence rates in Gulu are on the rise, especially among the children.”
(The District Probations and Welfare Officer, Gulu, Uganda)

Children affected by HIV/AIDS who are orphaned experience poverty, become the family breadwinners and are forced into exploitative labour, including commercial sexual exploitation.

When HIV/AIDS attacks a family’s breadwinner, the reduction in the family income, increased health care expenditures, the burden of managing the household, educating and providing for younger siblings and grandparents, oblige many children to seek employment which is often exploitative in

nature. Across all countries investigated during the research, most of the CSEC victims interviewed stated ‘survival’ as the main reason for their involvement in prostitution. In The Gambia, 39 per cent of the CSEC victims interviewed declared that they had become involved in CSE after the death of their parents. In Zambia, 23 per cent reported having sick parents whom they needed to support; a number of children also reported supporting their grandparents. Many children who had lost their parents indicated that they had to care for them while they were sick.

About 20 per cent of the CSEC victims interviewed in Zambia had initially tried other means of livelihood, the most common was washing clothes: one child reported earning as little as K2,000 (US\$0.50 cents) after a long day of washing clothes, and hence opted for prostitution, which appeared to be more rewarding. Several children ended up working as domestic servants, barmaids and street vendors. Being exposed at such an early age, without parental supervision or adequate protection mechanisms, they are highly vulnerable to abuse, including sexual exploitation by employers and other adults whom they meet in

these working situations. They are also easy targets for those seeking to recruit children for commercial sexual exploitation.

The ECPAT research was unable to absolutely determine whether being orphaned due to AIDS leads to commercial sexual exploitation, as AIDS was not always mentioned by the CSEC victims interviewed as the reason for their parents' death. Many of them declared ignorance about the real cause of their parents' death, or attributed it to malaria or other illnesses, which may well have been a consequence of AIDS. An exception is in

Uganda, where most of the interviewed children who had lost their parents did mention HIV/AIDS as the cause of death (especially in Gulu). Fear of discrimination may explain this: AIDS is considered a 'shameful disease' in Africa, most related deaths do not seem to take place in hospitals, and talking about it is uncommon within families. Considering the large numbers of children orphaned by the pandemic, it would be safe to assume that a reasonable percentage of children in CSE have lost their parents due to AIDS, as indicated in previous studies.

A study conducted by the International Labour Organization (ILO) in Zambia estimated that 71 per cent of the children engaged in commercial sexual exploitation have lost one or both parents to HIV/AIDS. Evidence gathered through the ECPAT research suggests that orphanhood due to AIDS is likely to lead children into commercial sex within two to three years of his/her parents' death.

Children affected by HIV/AIDS drop out of school and miss out on school-based HIV/AIDS prevention programmes so that they can work; lack of education also compromises their survival options.

Orphans and other children affected by AIDS are usually forced to drop out of school to look after sick parents or relatives or to support the family. Many of the children interviewed had abandoned school either during their parents' illness or within a year of their death, as they lacked the means to continue their education. Some also leave school as a result of family breakdown. Leaving the school system with the ability to read and write, but not with a skill that can be used to earn a living, very much reduces their survival options. The problem is exacerbated by the fact that schools rarely provide for life skills or vocational training.

Across all countries investigated, it was clear that a great deal of effort has been put into ensuring the provision of HIV/AIDS education in schools. Invariably, the interviewed children who were in school demonstrated a much better knowledge on the issue, as well as a higher rate of condom use: this seems to be a major preventative strategy adopted in Africa. School dropouts thus become more difficult to reach, particularly as it does not seem that much outreach work on this issue is being conducted in the continent.

HIV/AIDS education provided in schools still needs to be improved, as a significant number of school children demonstrated deficient knowledge about the epidemic and its modes of transmission.

Children affected by HIV/AIDS suffer discrimination, the consequences of which increase their vulnerability to commercial sexual exploitation.

Stigma and discrimination related to HIV/AIDS is still far-reaching across Africa. The stigmatization that many children whose parents die of AIDS are faced with often causes them to become involved in commercial sex as the only alternative source of livelihood. Zambia's Orphans and Vulnerable Children Situation Analysis of 2004 indicated that such children are stigmatised long before their parents' deaths, since carers, relatives and friends pass judgment and condemnatory remarks about their parents' illness. Such attitudes partially explain why these children may not be fully accepted into the families of surviving relatives and why finding other forms of work or survival within familiar environments becomes difficult. Hidden away from friends, relatives and neighbours, children are then trapped into commercial sex.

Focus group discussions with orphans and vulnerable children and children affected by HIV/AIDS carried out in Togo indicated that the consequences of discrimination include withdrawal from school, shamefulness and feelings of rejection by classmates and neighbours, depression, suicide, resorting to crime, and seeking 'bad company' - which compromises their self-esteem and survival options and thus increases their vulnerability to commercial sexual exploitation.

Children affected by HIV/AIDS lack proper parental supervision and experience a breakdown in their family structure, which are well-known pathways to commercial sexual exploitation.

The absence of a solid family structure was a common feature among the CSEC victims interviewed by ECPAT researchers. Most of them had lost one or both parents and only a small percentage had both parents alive. Among those whose parents were both alive, very rarely were the parents living together. Of the estimated number of orphaned children in Africa, a very small percentage have access to institutional care or other forms of assistance, such as reunification with family members, foster care or adoption. The breakdown in extended family systems and the absence of safety nets makes children easy prey for exploitation, including sexual exploitation. The lack of a solid and supportive family environment has long proved to be a major factor in the vulnerability of children to CSE.

In the case of children obliged to seek employment to cater for the family needs, spending long periods of time at work further deprives them of proper parental care and increases their risk of falling into commercial sexual exploitation.

2) How do children already involved in CSEC view the risks from HIV/AIDS? To what extent do children involved in CSEC have the chance to protect themselves from HIV/AIDS?

While consistent use of condoms was found to be low among all groups of sexually active children,

it was significantly lower for children involved in commercial sex. A high proportion of the CSEC victims interviewed rarely negotiate condom use, mostly for fear of losing customers or because they are coerced into unprotected sex. They also miscalculate the risks of contracting HIV, or are oblivious to its consequences, and rarely seek medical care if they are injured or fall sick from a sexually transmitted infection. It is important to note that the use of condoms among students is generally much higher in comparison with those who are not in school, which indicates that access to education plays a key role in HIV/AIDS prevention.

Factors increasing the vulnerability of CSEC victims to HIV/AIDS include:

CSEC victims are powerless to negotiate safe sex.

This has emerged from the research as a key reason for their higher vulnerability to HIV/AIDS. Taking advantage of the fact that a child entrapped in prostitution is weaker and less assertive than an adult sex worker, the perpetrators usually pressure the child into not using condoms. They invariably offer more money in return (which is difficult to refuse given the children's desperate circumstances) and also provide inaccurate information regarding the importance of safe sex (either knowingly or deluded by myths regarding the safety, and even "desirability", of having sex with children). Unlike adult sex workers, who normally have the power to decide on condom use, the children interviewed reported that they

feel intimidated by the perpetrators who demand unprotected sex.

In addition, children in commercial sex experience high levels of violence and are often raped, sometimes by clients under the effect of drugs or alcohol. Their helplessness is aggravated by the fact that they rarely report such abuses, either for fear of being locked up if prostitution is illegal, or because of previous negative experiences at the hands of law enforcers.

"It is easier to manipulate a child, as opposed to an adult prostitute, into not using condoms." (mentioned by several exploiters in Togo)

CSEC victims, desperate to survive, do not see HIV/AIDS prevention as a priority.

In Zambia, children reported making as little as K10,000 for protected sex (US\$2.50), compared to over ten times as much for unprotected sex - between K100,000 to K150,000 (US\$22.50 to US\$33). Children gave several reasons for not prioritising safe sex: "a hungry man is an angry man", "I would like to eat today and die tomorrow from AIDS", "hunger kills as well as AIDS", etc. Avoiding pregnancy

"These children normally have no hope for the future due to post-war traumas, so they only look forward to getting what can sustain them for that time and do not mind whether they end up falling sick or not." (a parent in Gulu, Uganda)

seems to take priority for sexually exploited children, who often take contraceptive pills for this purpose.

22 Adult sex workers interviewed in Zambia provided useful insights as to why younger girls are at great risk of contracting HIV. They were of the opinion that many children in prostitution do not actually know how to use condoms, and pointed out that some of the frequent questions younger girls in prostitution ask the women revolve around the use of condoms. This suggests a serious gap in HIV/AIDS preventative interventions, as this key vulnerable group does not seem to be properly sensitised. The sex workers also highlighted the fact that younger girls do not know how to handle clients, and usually opt for making more money, even if this means having unprotected sex.

CSEC victims have insufficient knowledge about HIV/AIDS.

Across all countries researched, the children interviewed displayed a rather vague knowledge of HIV/AIDS, which appears to greatly influence their poor rates of condom use. They seem to judge the “safety” of having sex with someone based on whether they appear to be sick or not, and may easily sleep with anyone without a condom as long as the person does not exhibit symptoms they have heard about, such as a grey complexion, rashes, etc. These children did not demonstrate much awareness of transmission modes or of protection means.

CSEC victims believe that regular customers offer less risk and more easily accept unprotected sex with them.

The regularity of the exploiter seems to create a false sense of confidence and the child victim more easily succumbs to having unprotected sex.

CSEC victims have limited access to condoms.

In Uganda and Ethiopia, respondents mentioned that access to condoms is very limited for children.

CSEC victims are prone to substance abuse, which makes them less careful about protected sex.

Children exploited in CSE often take drugs and alcohol, which exacerbates risky behaviours such as failing to insist on protected sex.

CSEC victims rarely seek medical help.

A range of factors, including their marginal position in society, being in conflict with the law, impossibility to afford medication, lack of adult care

“ ... I stopped using condoms when I noticed the regularity of my customer. He convinced me that I was the only girl with whom he had sexual intercourse. I realised also that he was in good health,” (15 year-old girl, Togo)

“The girls don’t use condoms because they are scarce in the camp ... they are also so expensive for an ordinary person, each going at 500 Ugandan shillings.” (from a parent’s focus group discussion in Gulu)

and supervision, low self-esteem, being prone to risky behaviour, stigma and discrimination, prevent children in CSE from seeking medical attention.

CSEC victims are more likely to get injured through penetrative sex and thus contract and spread HIV.

Children who find themselves forced to have sexual intercourse at such young ages are at great risk of contracting HIV as their bodies are not fully developed and are more likely to suffer injuries from penetrative sex, making it easier for the virus to enter their blood system.

Children affected by conflict and trafficked for sexual purposes are forced to have unprotected sex with many partners.

In northern Uganda, a war affected area, the high incidence of trafficking in children for sexual purposes was mentioned by respondents as one of the factors that increase children's risk of contracting HIV. As a result of the war presently affecting the country, children are abducted and taken to Sudan to work as sex slaves for the rebel commanders, where they are forced to have unprotected sex and are abused in other ways.

CSEC victims are easy prey for exploiters who are HIV positive and seek to spread the virus.

This disturbing explanation was mentioned by respondents in Togo.

3) What are the interrelated factors that place children at higher risk of HIV infection and/or involvement in CSEC?

A number of push factors have been found to make children vulnerable to both commercial sexual exploitation and HIV contraction:

Widespread myths establish dangerous links between children and HIV/AIDS.

Several myths across Africa explicitly link HIV/AIDS and children, helping to perpetrate sexual abuse and commercial sexual exploitation of children, as well as making children and adults extremely vulnerable to contracting HIV:

- "Children do not have HIV/AIDS, they are just sweet."
- "Children cannot transmit HIV because they lack the sexual fluid that may contain the virus."
- "Children can survive HIV as they are resistant."
- "Sex with a virgin cures HIV/AIDS." (although this myth has less impact on children in commercial sex as they have lost their virginity, respondents strongly believed it is responsible for the high incidences of child sexual abuse in some African countries).

Other myths, while not explicitly claiming a link between children and HIV/AIDS, are equally harmful as they encourage sex with children and the early (and unsafe) sexual initiation of children:

- “Having sex with young boys and girls make the older get younger.”
- “Sexual intercourse with small girls cures malaria.”
- “Sex with a child can make you rich.”
- “Once a young man is circumcised, he has to sleep with a woman before getting healed.” (This superstition leads young men to seek younger, sometimes prostituted girls to have sex with before getting healed or sometimes they are sexually exploited by older women).
- “Girls who have painful menstruation cycles haven’t had sex so they need to have sex in order to reduce the pain.” (from a primary school teacher in Gulu, Uganda).
- “The more alcoholic drinks one takes when they have HIV/AIDS, the more the virus will be killed in that person’s body.” (This myth may increase the consumption of alcohol among certain communities and create a carefree attitude regarding safe sex practices, including those conducted with sexually exploited children).
- “Having sex after midnight does not transmit HIV/AIDS since the virus will be asleep.” (Children may thus be subjected to or more easily succumb to riskier sexual practices after midnight)

Other dangerous myths raised by respondents during the research include:

- “Condoms contain HIV/AIDS.”
- “The first urine one passes in the morning can cure AIDS.”
- “Prayer cures AIDS.”

- “ARVs cure AIDS.”
- “Some medicines can prevent AIDS.”
- “AIDS is invented by sorcerers.”
- “AIDS is a divine punishment.”
- “No ejaculation, no AIDS.”
- “AIDS is a western invention to control Africans.”

The high incidence of sexual abuse of children in Africa is a gateway to CSEC and AIDS.

Several studies conducted around the world clearly demonstrate that sexual abuse is a major factor in making children more vulnerable to commercial sexual exploitation. Very often, CSEC victims were sexually abused from an early age, and sexual abuse of children usually involves unprotected sex.

In The Gambia, 25 per cent of the CSEC victims interviewed affirmed that their first sexual experience involved violence or coercion. In Ethiopia, respondents were asked whether their first sexual experience was by force or free will: 19 out of 28 CSEC victims stated that they were raped or forced. In Uganda, a high proportion of the interviewed children said their first sexual experience was forced (the research did not disaggregate the data among children involved in CSE, those vulnerable to it and school children).

In Togo, many of the children interviewed (no disaggregation of data was made among CSEC victims, vulnerable children and students) maintained that they had their first sexual experience either by force or under false promises, generally with someone from their immediate

surroundings (close relatives, managers and in some cases teachers). Even though a higher number of children (81 per cent) said that they had their first sexual experience “voluntarily” (which may have been under false promises), one must question to what extent their consent minimized the potential negative impact of their early sexual initiation, considering their immaturity and the fact that many had their first experience when they were well below the legal age of consent. Some of the interviewed children ran away after their first traumatic experience and went to live with friends, only to find that the financial hardships that awaited them would force them to resort to prostitution (especially as they lacked any vocational training).

In Zambia, over 80 per cent of the children interviewed, including those in commercial sex, reported having had consensual sex with either a boyfriend or a girlfriend the first time. The issue of sexual abuse of children was not particularly highlighted as in other countries, although the researchers pointed out that it was difficult for respondents to make the distinction between sexual abuse and commercial sexual exploitation of children (particularly where in-kind gifts were promised by the perpetrators).

Not enough attention is given to the fact that schools seem to be key venues where CSEC and sexual abuse of children take place.

In Africa, sexual harassment of girls by teachers, other staff and male students is growing to

such an extent that it is now reported as a common cause for females’ low interest in education and subsequent school abandonment. The schoolchildren interviewed affirmed that sexual demands may be accompanied by threats of physical punishment, promises of better grades or a financial reward. In The Gambia, the Policy Guidelines and Regulations on Sexual Misconduct and Harassment in Gambian Educational Institutions (November 2004) was instituted to protect and support students and personnel within the educational system. It recognised sexual harassment as ‘a serious societal problem’ that affects educational institutions at all levels. In Kenya and Ethiopia, child prostitution was found to be common in schools. An exception was Zambia, where incidences of sex in exchange for favours at school were reported as minor.

Intimidated by their teachers’ authoritative position (culturally, elder people are afforded great respect and usually obeyed by the younger without much questioning), children are prone to accept offers of money or better grades in return for sex. In other instances, they are forced to have sex if they decline. Sexual abusers/exploiters include not only teachers but also boys from the same school and individuals from the neighbourhood.

“When a student does not pass his or her exams, the teacher will tell her to come to his house and later they will have sex and the person will be upgraded.” (female student, 15-17 years, Garba Jahumpa Upper Basic School, Banjul, The Gambia)

Traditional practices

Responses given by school children and teachers in Ethiopia to the question, 'Can you think of any traditional or cultural beliefs or practices that would encourage people to have sex with children?'

Response	No. of Respondents	Percentage
Yes	12	48.0
No	8	32.0
I don't know	5	20.0
Total	25	100.0

Some traditional practices involving young girls often entail sexually exploitative relationships that render the girls extremely vulnerable to commercial sexual exploitation and to contracting the HIV virus.

The issue of forced or early marriage, which still takes place in many African societies, was mentioned by respondents as a key cultural/traditional practice that is a form of CSEC. Underage girls offered for marriage, usually in return for a dowry, often end up divorced or abandoned by husbands, partners and parents, the ensuing lack of financial support causing many of them to engage in prostitution. Some girls run away following a forced marriage (or to avoid it), becoming easy targets for commercial sexual

exploiters, and HIV infection, by extension. Paradoxically, however, some children can end up in prostitution simply because they are not married (as was identified in the Gambia research). In a society where being unmarried at the socially and culturally expected 'age of marriage' is frowned upon, a girl in such a situation is compelled to contribute, in whatever way, to her upkeep as well as that of her family. Hence, she may feel pressured to engage in whatever kind of job is available, very often in prostitution, to contribute to the family's maintenance and survival.

The following traditional practices were specifically mentioned by respondents from Togo as placing children in risky situations with regard to CSEC and/or HIV/AIDS:

- Female circumcision: the ritualistic removal of a girl's clitoris
- Sororate: where the younger sister of the deceased spouse is expected to marry the widowed husband
- Levirate: where a man must marry the widow of his deceased brother if she has no male descendants
- Convent voodoo: where a girl is forced to

"I was forced into marriage when I was 14 years old ... We had three children. Later he divorced me and there was no one to help me and my children. So I decided to engage myself in this work (commercial sex) so that I can feed my children."
(female, 16-17 years, Brikama, The Gambia)

remain enclosed in a special 'convent' in order to be initiated in voodoo practices or to serve the voodoo. Many girls suffer sexual abuse and run away. They are then ostracized by their families and become vulnerable to CSE.

- Kidnapping: (more frequent in villages) the wooer makes an agreement with the girl's family to take her away.
- Scarification: scars or marks made on people's faces to identify the tribe or ethnic group they belong to
- Gris-gris: the use of charms, amulets, fetishes, or juju, to obtain something

Gender disparity

All the abovementioned practices reflect deeply negative social constructions of women. Gender disparity was mentioned by the respondents as one of the key reasons for a girl's high vulnerability to commercial sexual exploitation and HIV/AIDS. In several African societies, women are denied involvement in family and community decisionmaking processes, even in matters that directly affect their lives. They have very little say on issues related to their reproductive health, including the decision to regulate childbirth and negotiate condom use.

Across the region, women are disproportionately affected by HIV. On average, there are 13 women living with HIV for every 10 infected men, and the gap continues to widen. In Sub-Saharan Africa, recent population based studies suggest that there

are on average, 36 young women living with HIV for every 10 young men. In most countries, women are being infected at earlier ages than men, the differences in infection being most pronounced among children and young people (aged 15 to 24 years).

Attitudes and perceptions

The following attitudes and perceptions highlighted by the research respondents also demand special attention if African children, girls in particular, are to be effectively protected against HIV/AIDS and CSE:

- Children involved in prostitution are 'safer' as they have had fewer sexual encounters than the older prostitutes and are hence less likely to be infected with HIV.
- "Paying children for sexual services helps them financially." (Mentioned by several exploiters in Togo in particular, as one of the reasons for their seeking children for sex).

"After my success at the Primary school leaving certificate (CEPD), my father, who was a fervent Muslim, decided to marry me to a koranic teacher because I was 15 years old at that time and he found that my age was too advanced to continue studies. I refused and I begged my mother to intervene to prevent this marriage so that I could continue my studies. But what could my mother do in front of the all powerful of the house, my father? That is why I ran away one day and I met a girl in another town who agreed to provide shelter for me for a while. She initiated me to night outings in order to have money and satisfy my fundamental needs. We use gris gris to get men who have good financial incomes and thanks to that I am living and learning a profession". (from a 17 year-old girl in Togo)

- “Educating a girl is useless.” (Many girls stop attending school at an early age, where some basic knowledge about HIV/AIDS is usually provided, thereby missing out on education, an essential tool to enable them to understand and demand their basic rights).
- “Deflowering a girl is a reason for pride.”
- “A sweet/banana cannot be eaten with the wrapper/peel.” (i.e., sex is not enjoyable with a condom).
- Many individuals have more confidence in traditional practices and customs and prefer to confide in and seek help from a religious priest rather than expose themselves openly in HIV/AIDS management care centres.
- AIDS is regarded as a ‘disgraceful disease’, a ‘curse’, and people usually avoid talking about it, thus hindering the dissemination of information on prevention measures, etc.
- The ‘ABC approach’ to HIV/AIDS causes many individuals to feel embarrassed about procuring condoms: it preaches abstinence as a priority, being faithful and using condoms
- the underlying assumption being that those who utilise condoms are either prostitutes or ‘immoral people’.
- Sex is taboo and rarely discussed between parents and children. Furthermore, having sexual intercourse before marriage is considered a sin by several religious groups. As such, children and adolescents receive very little sexual education and are left to their own ‘experimentation’, very often being deceived into dangerous sexual practices.

The first sexual experience of children

The first sexual experience of children Responses given by a group of CSEC victims interviewed in Ethiopia to the question, ‘How old were you when you had sex for the first time?’

Age	No. of children
7	1
8	1
9	1
12	4
13	6
14	7
16	4
Total	24

The average age at which children begin to engage in consensual sex appears to be much lower than commonly believed. In The Gambia, for instance, 60 per cent of the interviewed CSEC victims affirmed that they had their first sexual experience between 12 and 14 years old, while 29 per cent were between 15 and 17 years old. In Togo, 29 per cent of the interviewed children (no disaggregation of data was made between CSEC victims and other groups of children) had their first sexual experience when they were around 14 years old, while 24 per cent were aged around 15.

These children’s immaturity to deal with all the implications of having a sexually active life puts

them at high risk of unwanted pregnancies, unsafe abortions and contracting sexually transmitted infections and HIV. Such problems are exacerbated by the fact that parents rarely discuss issues concerning sexuality with their children. The situation is slightly better for children who are in school: the research in all the countries indicated that being in school delays the age at which children become sexually active.

Peer pressure, the perception that being sexually active would somehow make them more valued and accepted within their societies, and the desire to have more money, were mentioned by child respondents as motives for their early sexual initiation. A 13 year-old respondent from Nairobi, Kenya attributed it to “trying to identify with the

“... they hear and see a lot of sex in the video shows, and hear very interesting stories about sex from their peers, who pressure them to indulge in sexual intercourse.”
14 year-old female respondent, Mombasa, Kenya)

society so that we too can be recognised by the society”.

Migrating children, often affected by HIV/AIDS, are more exposed to commercial sexual exploitation.

Responses given by CSEC victims in Ethiopia to the question, ‘Why did

you move from your place of origin?’

Migrating children, often affected by HIV/AIDS, are more exposed to commercial sexual exploitation.

Responses given by CSEC victims in Ethiopia to the question, ‘Why did you move from your place of origin?’

Response	Frequency	Percentage
Parents are not alive	11	52.4
Parents divorced	2	9.5
Parents don't have enough money to support me	5	23.8
Parents forced me to marry an old man	2	9.5
Father's death	1	4.8
Total	21	100

The ECPAT research sought to investigate the place of origin of children in prostitution, in order to ascertain the extent to which migration played a role in their vulnerability to CSE. Most of the CSEC victims interviewed were not living in their places of origin, often due to their parents’ death or financial difficulties, which may suggest that they had been affected by HIV/AIDS.

Children who move to urban areas, to work as domestic servants and other menial jobs, become especially vulnerable to sexual exploitation and

ultimately to HIV, particularly as they often drop out of school and miss out on sexual health education. Respondents in Ethiopia highlighted that, in order to recruit young girls for commercial sexual exploitation, brokers and older sex workers monitor bus terminals where migrants from the rural areas disembark in the city for the first time.

The girls are taken to a bar or restaurant and are provided with shelter, food and clothing. After a few days of hospitality they are invariably pressured or physically coerced into commercial sex work. In Togo, respondents noted that many exploiters are travelling to the villages in search of girls, supposedly to 'help poor families in difficult situations'. With the excuse that the children will live and work in the city to bring back money for the family, or to be able to receive some kind of professional training, profitable arrangements are then made between parents and these "hunters of children".

Despite the fact that children involved in commercial sexual exploitation are highly exposed to HIV and key potential agents for its dissemination, the existing HIV/AIDS prevention, care and support interventions are neither holistic nor do they stimulate or facilitate access by this group of children. Little emphasis is placed on testing children, and there appear to be no real instances of child-friendly services, which may also explain why the CSEC victims interviewed demonstrate so much reluctance to take the HIV screening test and to access support services. While many such children are aware of voluntary counselling and testing services, they do not necessarily understand why they need to be tested, or what kind of support they could benefit from. They also fear stigmatisation by their friends, families and fellow community members if known to be associated with the disease, a reality for many already affected by HIV/AIDS.

Similarly, national HIV/AIDS policies and programmes to combat the pandemic fail to take into account the special needs and circumstances of children exploited in commercial sex. This demonstrates a worryingly shortsighted approach, considering that this group of children is very much exposed to the virus and in

demand by exploiters, who believe that they are 'safe' and thus choose them to have unprotected sex with, a situation that is likely to cause progressive cycles of HIV transmission and sexual exploitation.

There are already an estimated three million children below the age of 15 who are infected by HIV/AIDS in Sub-Saharan Africa. Two modes of infection among these children can be identified: mother-to-child transmission and children infected through contaminated bodily fluids and other high risk contact/behaviours, most probably through sexual contact. With so many of these children below the age at which sexual activities can be expected, it is likely that sexual abuse and/or exploitation is a significant cause. This concern is backed up by research in the region highlighting the rise in numbers of children who are below 15-years-old and are being sexually exploited in Sub-Saharan Africa and with younger children as victims. In Togo, for example, children as young as seven years old are reported to be victims of commercial sexual exploitation.

The linkages between commercial sexual exploitation of children and the AIDS phenomenon in Africa cannot be ignored if African children are to receive

the protection that they are entitled to against both tragedies, and if the pandemic is to be controlled in the long term. As identified in this research, the commercial sexual exploitation of children may contribute to the advancement of AIDS in Africa in multiple ways, which indicates that HIV/AIDS interventions must pay more attention to child victims of sexual abuse and exploitation as well as to the abusers and exploiters, if they are to be more effective and strategic.

Likewise, children affected by HIV/AIDS face many of the typical situations that make children vulnerable to sexual exploitation and the pandemic appears to be a significant factor pushing African children into commercial sexual exploitation. From a protection perspective, the widespread unsafe sex practices involving CSEC victims must be addressed at the same time as efforts to rescue them from CSE situations, in order to better protect them from HIV/AIDS and continued exploitation.

It is critical that antiretroviral drug treatment becomes more widely available in Africa to prevent mother-to-child transmission and to treat and prolong the life of people living with HIV. Until this happens, the HIV/AIDS related death toll will continue to rise at an alarming rate, leaving increasing numbers of children orphaned and at risk of commercial sexual exploitation. Government and NGO schemes (such as 'social cash transfer' schemes) to supplement family income to affected families is proving to be one of the

most effective ways to support caregivers needs and to help children remain in families and stay in school.

Emerging from this research, a number of factors were found to place African children at risk of both HIV contraction and commercial sexual exploitation. These include the high incidence of sexual abuse of children in the countries researched and the high incidence of sexual exploitation of children within schools - situations evidenced by a large number of respondents across all countries investigated. This aspect of child rights violations in the continent must receive urgent attention from relevant authorities and institutions as it seriously hinders the advancement of African society at so many levels.

In African countries, HIV/AIDS disproportionately affects girls and women. In the most severely affected regions of the continent, five times more girls than boys between the ages of 15 and 19 are infected. Social inequality and girls' roles as expected caretakers (for example, of other children in the family, sick parents or elderly relatives) puts them at greater risk of dropping out of school and makes them more vulnerable to sexual abuse and exploitation, early marriage and HIV infection. Preventing and dealing with gender-based discrimination and violence needs to be a clear goal of all care and protection programmes.

In view of these research findings, it is clear that government institutions, NGOs and reproductive

health service providers must mainstream, in their programmes, the special needs of children affected or infected by HIV/AIDS or involved in CSE. Similarly, child rights organisations and those working on HIV/AIDS issues must combine efforts to design joint programmes that could more effectively achieve their particular goals and missions. There is also a need for greater coordination and collaboration among organisations and donors working on both issues. Finally, the linkages between HIV/AIDS and CSEC should be taken into account in relevant national policies. Given the growing indication of boys' involvement in CSEC, it is imperative that such policies also address gender issues, including issues of sexual diversity.

The ultimate goal of the research initiative was to establish an appropriate framework of prevention, protection and care against HIV/AIDS for children at risk or already involved in commercial sexual exploitation. As such, much of the information provided in this summary report focused on detailing tangible situations, together with a number of personal and cultural attitudes, that need to be carefully considered in the design of holistic interventions (covering all aspects of prevention, treatment and care) that effectively control the spread of the AIDS pandemic in Africa and diminish the vulnerability of children to both HIV/AIDS and commercial sexual exploitation. This report concludes that specific assistance must be provided for these children and their families. Based on the information gathered

through the research, CSEC and HIV/AIDS prevention and mitigation programmes appropriate for the Africa context should involve the following:

HIV/AIDS Awareness and Prevention Services

- More awareness raising that aims to clarify the interface between HIV/AIDS and violence, abuse and commercial sexual exploitation of children, is needed. Participatory routes such as educative radio programmes, drama and video shows, sketches, songs and interesting literature that children enjoy, should be used more intensively, with special attention given to audiences with low levels of literacy. Parents, teachers, children in school and out of school, apprentices and the general public must be targeted. Schools, anti-AIDS clubs, clubs in the local 'kebele' (neighbourhood administrative unit), market centres, beaches and health and family planning centres constitute key areas for such campaigns. Messages should be disseminated in all relevant dialects.
- Education is a child's future and the best investment for protection against HIV and CSEC. School attendance is therefore a key element in HIV/AIDS prevention in Africa and in creating a more risk-free environment for children. Constitutional and legislative provisions that make basic education free and compulsory for all children must be enforced and measures must be taken to ensure their retention, targeting girls in particular. Government and community-based

schemes must be developed to help vulnerable and affected children to stay in school, by covering other costs, such as for uniforms or books..

- Establishing strong parent/family and school partnerships and increasing community mobilization to support school programmes can help to reduce the abusive and exploitative risks currently facing children in some African schools, help create safer environments and promote quality learning.
- It is essential that the provision of sex/health education in primary and secondary schools is broadened and enhanced to include discussions on topics such as HIV/AIDS prevention, commercial sexual exploitation of children, sexual abuse and child rights. There is also a need to teach children about assertiveness, promote their ability to challenge or question sexual advances, establish reporting mechanisms in case of abuse and encourage condom use, voluntary counselling and testing among children. Guidance and counseling programmes within schools must also be strengthened and teachers equipped with skills to enable them to identify problems and refer students for appropriate assistance.
- Sex/health education must target out-of-school adolescents. Orphanages, drop-in centres, shelters, youth centres and community centres have all been cited as locations where these should be provided when necessary. Civil society organisations and/or peer supporters should be mobilised in order to reach this target group.
- Specific targeted education programmes for vulnerable children on the streets
- Hotlines or helplines providing HIV/AIDS information (on prevention, screening test centres, care taking and management of people living with HIV/AIDS, etc) should be more widely available and well publicised.
- Religious leaders are key opinion formers but generally remain silent on issues related to CSEC and HIV/AIDS. Awareness raising campaigns must seek their support in order to be more effective.
- Condoms must be distributed freely and widely, in bars, nightclubs, hotels, lodges and guesthouses and other key places where children exploited in commercial sex meet perpetrators.
- Families must be supported to be able to adequately meet the needs of their children: this involves not only the provision of income generating opportunities, but also education on life skills, which should be a key component of interventions to protect children from HIV/AIDS and CSE. Open discussions on sexual issues between parents and their children should also be encouraged/stimulated.
- Laws that penalise parents, guardians or carers who neglect, abuse or abandon their children need to be strengthened and enforced.
- Where appropriate, positive African cultural mechanisms can be used for a 'back to roots' perspective. For example, in Zambia, the Ministry of Community Development and Social Services initiated a programme with 'ifimbusa' and

‘alangizi’ (women who teach girls and women during rites of passage and marriage ceremonies) which educates girls on safer sex and reintroduces values that will serve to better protect them.

HIV/AIDS Care and Support Services

- In order to encourage children to take the HIV screening test and access HIV/AIDS care and support services, awareness raising and preventative programmes targeting the general public must also focus on dispelling attitudes of stigmatisation and discrimination towards individuals affected by HIV/AIDS. Whenever such programmes target CSEC victims and vulnerable children in particular, it is essential to assure them that the services provided are strictly confidential and that the children will not be exposed in any way. This message should be clear in the communication materials used and in any interactions with the staff conducting such interventions. The facilities should thus offer these guarantees.
- Similarly, HIV/AIDS interventions targeting CSEC victims must carefully consider the various reasons, exposed throughout this report, for children’s reluctance to undergo the HIV screening test and access support services, to effect behaviour change.
- Organisations conducting HIV/AIDS interventions must work to provide training on child-friendly practices to staff at HIV/AIDS care centres, reproductive health clinics and VCT centres. Such

services must also be more accessible to CSEC victims and vulnerable children, by: 1) making it easy for children to make appointments; 2) locating them at strategic and discreet locations, e.g. areas where children involved in CSE frequent or live; 3) dispensing with parental consent whenever a child requests counselling; and 4) strengthening and publicising existing helplines for children victimised through commercial sexual exploitation.

- Outreach programmes and mobile services targeting children vulnerable to commercial sexual exploitation and hence to HIV/AIDS, such as street children, child domestic workers, child labourers, child hawkers, vulnerable children in reception centres and migrating children, must be intensified and enhanced. For instance, mobile antiretroviral therapy provided to children exploited in prostitution and to children living on the street, home-based care, etc.
- An example of a best practice that should be replicated are the care centres in Togo, which also register and offer support to children of HIV positive parents, who the centres assist.
- The development and dissemination of a directory of services available to children affected by HIV/AIDS and commercial sexual exploitation is highly recommended.
- To foster coordination on CSEC and HIV/AIDS issues, it is recommended that national mappings of all organisations, institutions, and departments working with children are prepared according to

thematic groups or clusters. A clear institutional framework for the care and protection of children in each country needs to be developed and should feature clear channels of communication to facilitate linkages.

- There is a need for a more coordinated approach between agencies including the development of protocols between medical and support organizations.

Targeting CSEC Victims and Vulnerable/At-Risk Children

- Peer educators must be recruited and trained to work on interventions to reach vulnerable children and those at risk of or already involved in commercial sexual exploitation.
- When awareness raising is targeted at CSEC victims in particular, key actors, such as adult sex workers, should be involved to better convey the need for safe sex.
- Child Protection Committees must be established within communities to enhance reporting and monitoring of child protection issues, so that community members gradually engage themselves more actively to support vulnerable children.
- There is a need to establish specialized rehabilitation centres for children victimised through commercial sexual exploitation, with staff trained to respond to their specific needs. It is necessary that appropriate care is available to CSEC victims which meets both their physical and emotional needs and which is part of a

programme of rehabilitation.

- Livelihood and vocational centres must be made more widely available in rural and urban areas, for both in-school and out-of-school children and particularly for those at higher risk of sexual abuse and exploitation and HIV/AIDS. This could involve training in agricultural business with a focus on horticulture development, poultry, dairy farming, sewing and knitting, which would greatly enhance the girls' ability to develop and manage their business, produce marketable goods, secure income and/or leave exploitative situations.
- Some of the income generating activities for children yield very few benefits, so children are forced back to prostitution to make ends meet. The same applies to certain skills training programmes, e.g. in tailoring and carpentry, in which young people are often not interested (especially as affordable clothing and traditional wear from other countries leave a small market for these trades). Such programmes should therefore be designed to attract, retain and empower young people or place them within sectors with scope for development (e.g. in the tourism or service sectors).
- Existing helplines, legal aid, medical and psychosocial care for children affected by HIV/AIDS and/or CSE must be expanded and strengthened.
- Services should be provided that support families in difficulties and the promotion of family reintegration of children that have been sexually exploited.

Targeting the Demand Side – the Exploiters

- Awareness raising materials and interventions should aim to dispel the various myths, attitudes and social perceptions that increase the vulnerability of children to CSEC and HIV/AIDS. Such materials and interventions should also specify the role that some harmful traditional practices play in this regard, in order to discourage them. This also applies to interventions targeting the demand aspect of commercial sexual exploitation of children, the perpetrators in particular, who are highly motivated by such myths.
- While there is no typical profile of an exploiter, respondents identified them as fellow community members, school staff, teachers, security personnel, civil servants, businessmen, drivers, and NGO workers. Messages emphasising the link between HIV/AIDS and sexual exploitation of children, as well as the penalties for sex with minors, could work as a strong deterrent to those prone to seeking sex with children.
- Those who facilitate CSEC within a sex tourism context should also be targeted, including hotel owners, hotel staff or security guards who take children to the rooms, “bumsters” (beach boys) and taxi drivers who act as intermediaries.
- Hotlines should be established for the public to report cases of sexual exploitation of children. Cooperation must be maintained with legal aid institutions for proper follow up of such reports and with support for the children.
- The public and media discourse should focus more on how to deal with children’s vulnerability rather than just on issues concerning HIV/AIDS. The negative portrayal of children living on the streets or involved in commercial sex, which often project them as delinquents, must be avoided.
- National laws need to be reviewed and strengthened to criminalise all sexual acts with children, regardless of the use of violence or force, and regardless of the age of the child. Governments should take urgent action to ensure effective application and enforcement of the relevant legislation.
- As child marriage has been identified as one of the harmful practices exposing children to both commercial sexual exploitation and HIV/AIDS, this practice should be banned at all levels of society. Law enforcers must be targeted in such interventions as well, to ensure that the relevant Family Law provisions are well known and enforced by the authorities.
- Traditional leaders should be involved in awareness raising, monitoring and reporting on child protection issues. The traditional leader structure is respected and viewed as a sustainable aspect of African culture.

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