CHILD SEXUAL ABUSE IN SUB-SAHARAN AFRICA

A REVIEW OF THE LITERATURE

East, Central and Southern African Health Community
January, 2011
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# TABLE OF CONTENTS

TABLE OF CONTENTS ........................................................................................................................................ iii
LIST OF TABLES ........................................................................................................................................... vii
LIST OF ACRONYMS ................................................................................................................................... viii
FOREWORD .................................................................................................................................................. Error! Bookmark not defined.
PREFACE ......................................................................................................................................................... xi
ACKNOWLEDGEMENTS ............................................................................................................................... xii
EXECUTIVE SUMMARY .............................................................................................................................. 13
1 INTRODUCTION ........................................................................................................................................ 19
  1.1 Background .......................................................................................................................................... 19
  1.2 Purpose and objectives ....................................................................................................................... 21
  1.3 Methodology ....................................................................................................................................... 22
  1.4 Limitations .......................................................................................................................................... 22
  1.5 Structure of the report ........................................................................................................................ 23
2 CONCEPTUAL FRAMEWORK .................................................................................................................. 26
  2.1 Definitions of “child” .......................................................................................................................... 26
  2.2 Global definitions of child sexual abuse ............................................................................................ 26
  2.3 Defining abuse ..................................................................................................................................... 28
  2.4 Defining structural sexual violence ..................................................................................................... 30
3 THE CONTEXT OF CHILD SEXUAL ABUSE IN SUB-SAHARAN AFRICA .............................................. 34
  3.1 Situations of Violence ........................................................................................................................ 34
  3.2 Child trafficking and child labour ..................................................................................................... 35
  3.3 Contexts of poverty ............................................................................................................................. 37
  3.4 Gender inequalities and gender based violence .................................................................................. 38
  3.5 HIV/AIDS ........................................................................................................................................... 39
4 THE MAGNITUDE OF THE PROBLEM ....................................................................................................... 44
  4.1 Non-contact abuse ............................................................................................................................ 44
    4.1.1 Sexual harassment ......................................................................................................................... 44
    4.1.2 Grooming ...................................................................................................................................... 45
  4.2 Contact abuse ..................................................................................................................................... 46
    4.2.1 Female genital mutilation or cutting ............................................................................................. 46
4.2.2 Virginity testing ................................................................. 47
4.2.3 Sexual touching ............................................................... 48
4.3 Penetrative sexual abuse ........................................................... 48
  4.3.1 Rape .............................................................................. 48
  4.3.2 Sexual exploitation, child prostitution and transactional sex ........... 52
  4.3.3 Incest / Intra–familial child sexual abuse .................................. 54
  4.3.4 Child marriage ............................................................... 54
4.4 Some conclusions regarding magnitude .......................................... 55

5 FACTORS ASSOCIATED WITH CHILD SEXUAL ABUSE IN SUB-SAHARAN AFRICA....60
  5.1 Age .................................................................................. 60
  5.2 Gender .............................................................................. 61
  5.3 Care arrangements .................................................................. 61
  5.4 Some variables related to the perpetrators ..................................... 62
  5.5 Environments of risk ............................................................ 63
    5.5.1 Home and family .......................................................... 63
    5.5.2 School and schooling environment ...................................... 64
    5.5.3 Health care systems, alternative care and prisons .................... 66
    5.5.4 Workplace ..................................................................... 66
  5.6 Some gaps regarding factors associated with child sexual abuse ........ 67

6 THE CONSEQUENCES OF CHILD SEXUAL ABUSE.............................................. 71
  6.1 HIV/AIDS and other STIs ....................................................... 71
  6.2 Reproductive health consequences ............................................ 72
  6.3 Psychosocial consequences ..................................................... 74

7 RESPONSES TO CHILD SEXUAL ABUSE ...................................................... 77
  7.1 The international and regional legal framework .............................. 77
    7.1.1 The UNCRC and African Charter ....................................... 78
    7.1.2 Other relevant international treaties ...................................... 80
    7.1.3 Regional treaties and agreements ....................................... 82
  7.2 National legal frameworks ...................................................... 83
    7.2.1 National laws ............................................................... 83
    7.2.2 National Plans of Action .................................................. 85
7.3 Programmatic responses .................................................................................. 85
7.3.1 Management of CSA by the health and criminal justice systems ............. 86
7.3.2 Responses to CSA in home and community ............................................... 87
7.3.3 Responses to child marriage .................................................................... 89
7.3.4 Response to FGM/C .............................................................................. 90
7.3.5 Responses in educational settings ........................................................... 91
7.3.6 Reducing the vulnerability of children living and/or working in the street ... 93
7.3.7 Children in alternate care ......................................................................... 94
7.3.8 Responses to sexual exploitation and trafficking ....................................... 95
7.3.9 Interventions with perpetrators ............................................................... 95
7.3.10 Gaps in responses .................................................................................. 97

8 CONCLUSION ................................................................................................. 102

9. RECOMMENDATIONS FOR AN APPROPRIATELY PREVENTATIVE AND RESPONSIVE ENVIRONMENT ................................................................. 103

9.1 Overarching recommendations ..................................................................... 103
9.1.1 For national governments ....................................................................... 103
9.1.2 Overarching recommendations for donors ............................................... 103
9.1.3 Overarching recommendations for civil society and advocacy groups ..... 104
9.1.4 Overarching recommendations for researchers ........................................ 104
9.2 A coordinated approach ............................................................................... 104
9.3 International and domestic legal framework ................................................ 105
9.4 Policies and programmes ........................................................................... 106
9.5 Services needed ......................................................................................... 107

SELECTED BIBLIOGRAPHY ........................................................................... 1

Conceptual framework and defining child sexual abuse .................................... 1
The context of CSA in SSA .............................................................................. 2
Gender-based violence .................................................................................... 2
HIV and AIDS ............................................................................................... 2
Forms of CSA ............................................................................................... 3
CSA generally ............................................................................................ 3
Contact CSA – FGM/C ................................................................................ 5
Contact CSA – virginity testing .................................................................... 5
## Penetrative abuse
- Rape ........................................................................................................... 6
- Sexual exploitation and trafficking ................................................................ 6
- Incest ............................................................................................................... 7
- Child marriage .............................................................................................. 8
- CSA in schools .............................................................................................. 8
- Transactional sexual relationships ................................................................. 9

## Associated factors ...................................................................................... 9
- Age .................................................................................................................. 9
- Gender ............................................................................................................ 10
- Care arrangements .......................................................................................... 10
- Risky environments – conflict areas .............................................................. 10
- Risky environments – child labour ............................................................... 11

## Consequences ............................................................................................... 12

## Responses ...................................................................................................... 13
- Law and policy ................................................................................................ 14
- Programmatic .................................................................................................. 15
- Franco-phone materials ................................................................................ 17

## ANNEXES ..................................................................................................... 1
- Annex 1 - List of key words used/in internet searches: ........................................ 2
- Annex 2 – Age at first marriage ...................................................................... 3
- Annex 3 - Percentage of 15-24 years old females who think that wife beating is completely justified ................................................................. 7
- Annex 5 – State of the ratifications of the Optional Protocols to the UN Convention on the Rights of Child in Sub-Saharan Africa ........................................ 8
- Annex 6 - Child-friendliness ranking/ of the countries in Sub-Saharan Africa .... 10
# LIST OF TABLES

Table 1  FGM/C prevalence from DHS surveys  
Table 2  FGM/C prevalence from MICS surveys  
Table 3  Rape prevalence from selected studies  
Table 4  Percentage of children answering “yes” to the question “have you ever been physically forced to have sex?” - GSHS  
Box 1  Provisions of the UNCRC relevant for child marriage
## LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACPF</td>
<td>African Child Policy Forum</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral therapy</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Disease Control and Prevention</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention to end all Forms of Violence against Women</td>
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<tr>
<td>CFA</td>
<td>Communauté Financière Africaine</td>
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<td>CHI</td>
<td>Child Helplines International</td>
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<tr>
<td>CSA</td>
<td>Child sexual abuse</td>
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<tr>
<td>CSEC</td>
<td>Commercial sexual exploitation of children</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of the Congo</td>
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<tr>
<td>ECD</td>
<td>Early childhood development</td>
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<tr>
<td>ECPAT</td>
<td>End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes</td>
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<tr>
<td>ECSA-HC</td>
<td>East, Central and Southern Africa Health Community</td>
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<tr>
<td>ESARO</td>
<td>East and Southern Africa Regional Office</td>
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<tr>
<td>FGM/C</td>
<td>Female genital mutilation/cutting</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<tr>
<td>GEM</td>
<td>Girls’ Education Movement</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>IOM</td>
<td>International Organisation for Migration</td>
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<tr>
<td>MGD</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey(s)</td>
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<tr>
<td>NPA</td>
<td>National Plan of Action</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<td>Acronym</td>
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<tr>
<td>PEP</td>
<td>Post-exposure prophylaxis</td>
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<tr>
<td>SALRC</td>
<td>South African Law Reform Commission</td>
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<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>SVRI</td>
<td>Sexual Violence Research Initiative</td>
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<tr>
<td>TECL</td>
<td>Towards eliminating the worst forms of Child Labour</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
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<td>UNCRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGEI</td>
<td>United Nations Girl’s Education Initiative</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
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<tr>
<td>UNVAC</td>
<td>United Nations Global Study on Violence against Children</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USAID/EA</td>
<td>United States Agency for International Development East Africa</td>
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<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<td>WHO-AFRO</td>
<td>World Health Organisation Regional Office for Africa</td>
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FOREWORD

This child sexual abuse (CSA) literature review is the first comprehensive and inclusive review for the sub-Saharan African region, conducted in both Anglophone and Francophone Africa. It addresses the forms, nature, and the magnitude of CSA as well as documents the efforts being made to respond to the problem in our region.

This literature review is the first step in a comprehensive strategy that the East, Central and Southern African Health Community (ECSA-HC) is implementing to address CSA in our sub-region. Our work builds on the African Charter on the Rights and Welfare of the Child (the African Charter), adopted by the Organisation of African Unity (now African Union) and responds to the call for action made by the World Health Organization Regional Committee for Africa in 2004, urging member states to break the silence around this pervasive silent emergency.

At the subregional level, ECSA Health Ministers have acknowledged the importance of addressing gender-based violence, including CSA with the adoption of three resolutions in the past five years urging member states to prioritize and accelerate action to end this pervasive human rights issue that has significant public health consequences. In addition to the literature review, ECSA-HC in collaboration with the World Health Organization Regional Office for Africa (WHO-AFRO) has developed generic guidelines for the clinical management of child sexual abuse and an advocacy strategy to address the issue.

It is our sincere hope that this review will contribute to the growing knowledge and understanding of child sexual abuse in sub-Saharan Africa, and provide practical ways of addressing the scourge so that Africa can truly become a continent fit for our children.

Dr. Josephine Kibaru-Mbae
Director General
ECSA-HC
January, 2011
PREFACE

Although the evidence base for child sexual abuse in sub-Saharan Africa has steadily been growing, the information tends to be fragmented, focused on certain types of CSA in a limited number of countries, and largely anecdotal. The East, Central, and Southern African Health Community commissioned the review to fill this knowledge gap. The main purpose of this review is to understand the magnitude and nature of CSA in SSA in order to raise awareness and inform sector policy and program responses for its prevention and management.

The literature review confirms that child sexual abuse is a significant problem in sub-Saharan Africa, affecting millions of children, posing a major threat to our development and efforts to reach the Millennium Development Goals. It establishes the need for more research on the issue to address the gaps, and makes several recommendations on how to prevent and respond to child sexual abuse. In particular, the findings confirm the dire need for a coordinated and holistic response based on a full and proper understanding of children’s rights.

ECSA-HC has led a broad coalition of partners including ECSA member states, development partners and civil society organizations in the completion of this document. The review is expected to be a useful reference for both decision makers and program managers working in the health, justice, education, security, social welfare, and gender sectors.

Dr. Odongo Odiyo
Manager, Family and Reproductive Health
ECSA-HC
January, 2011
ACKNOWLEDGEMENTS

The East, Central and Southern African Health Community (ECSA-HC) wishes to thank the United States Agency for International Development (USAID) Bureau for Africa for providing funding through the Africa’s Health in 2010 Project (Africa 2010) to enable this review to be undertaken.

The community wishes to sincerely thank Ms. Carol Bower and Professor Cheikh Ibrahima Niang, who successfully undertook this review. Ms. Bower led the review of the English literature on CSA and compiled the review from both Anglophone and Francophone African sources. Professor Niang led the review of the Francophone literature and provided critical review of drafts of this document.

We sincerely thank the Technical Working Group (TWG) composed of the following organizations: Africa 2010, ECSA-HC Secretariat, ECSA-HC Member states, Population Council, WHO-AFRO, SVRI, UNICEF-ESARO, UNICEF Tanzania and UNFPA. They formed a formidable support in designing the review process, provided valuable and critical input during the expert review workshop, and subsequent review of the final draft document. ANPPCAN Uganda, Amnesty International through TUN Kenya, and SWAGAA gave important contributions during the expert workshop on the document.

The core group consisting of ECSA-HC, Africa 2010, and the two consultants worked tirelessly throughout the process. Reena Borwankar Gender, Gender-based Violence Advisor of Africa 2010; Dr.Kibaru – Mbae, Director General ECSA – HC, Dr Odongo Odiyo and the entire ECSA-HC team provided guidance to the whole process from inception to the final product. To them we are most grateful.

We thank Ekong Emah and Antonia Wolff for editing this document and Jimmy Bishara for design and layout.

Ndack Diop and Coly Lamothe of the SAHARA Program at the Université Cheikh Anta Diop, Dakar, Senegal provided significant contribution on the review of the Francophone literature.

The Ministries of Health from ECSA Members States: Kenya, Lesotho, Malawi, Mauritius, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe gave very important support and contribution during the expert meeting, and helped in building the consensus on the document.
EXECUTIVE SUMMARY

Child sexual abuse (CSA) has emerged as a human rights, public health and development emergency with global dimensions. In sub-Saharan Africa (SSA), available information suggests that it is alarming. However, actual knowledge on the issue remains inadequate to inform development of policies and programmes. For this reason, the present review was commissioned by the East, Central and Southern African Health Community (ECSA-HC).

The objectives of the review were threefold:

- To understand the magnitude and nature of CSA experienced in SSA
- To raise awareness of CSA in SSA
- To inform sector policy and program responses for its prevention and management

The review sought to answer the following questions:

- How is CSA defined? In which contexts does it occur?
- How prevalent is CSA in SSA, and which factors and consequences are associated with it?
- What is being done to respond to CSA in SSA?
- What is needed for an appropriate prevention and response environment?

To answer these questions peer-reviewed articles, and the ‘grey literature’ published in English and French between 2000 and 2010 were analysed.

The review team utilised different methodologies: Conducted systematic searches of electronic databases such as PubMed, Medline, MBASE, DHS, Science Direct, Social Sciences Citation Index (SSCI), and MédecineTropicale using a list of keywords; Requested articles on CSA in SSA from various list servs; analyzed program reports and reports of national surveys generated by national and international NGOs, and international development agencies; and conducted searches online for web-based documents using the “Google” search engine.

This literature review has limitations, hence the need to interpret the results with caution. The identified limitations include varying definitions of CSA in use; a scarcity of rigorous statistical information on most forms of CSA; the concentration of research outputs in a limited number of countries, and lack of reports on monitoring and evaluation of good practices. Community perceptions of CSA, response to CSA from society, and information about abuse of boys are research gaps found in the existing literature. The dearth of information about the magnitude of CSA in SSA is due largely, to significant under-reporting. The abuse of boys was found to be even more under-reported than that of girls. The dearth of information about the magnitude of CSA in SSA is due largely to significant under-reporting, and the abuse of boys was found to be even more under-reported than that of girls.
This review adopted the definitions of childhood used by the United Nations Convention on the Rights of the Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (African Charter)\(^4\) that consider childhood as being below the age of 18. For CSA, it adopted the definition used by World Health Organization Regional Office for Africa (WHO-AFRO) that defines CSA as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society”.\(^5\)

In the literature, the term ‘child sexual abuse’\(^6\) was used interchangeably with ‘sexual violence against children’.\(^7\) CSA was classified according to the nature of the acts and the contexts in which they occurred, and categorised as non-contact abuse (inappropriate sexual solicitation and indecent exposure, for example), contact abuse (involving, for example, touching or fondling, and altering of the genital organs) and penetrative abuse (including oral, anal or vaginal intercourse).\(^8\)

Structural facilitators of CSA were found to include the authoritarian relationships which give greater weight to authority of men implicit in hierarchical social institutions such as the family, religious institutions, schools, and work-places\(^9\) (factors that are not in themselves sexual), and society’s management of sexuality, as can be seen in child marriage, FGM/C and trafficking.\(^10\)

High levels of gender-based violence (GBV) and poverty,\(^11\) and low levels of human development characterise the broad context in which CSA takes place in SSA, while the home,\(^12,13\) schools,\(^14\) and the immediate environment remain settings where CSA is frequently perpetrated.\(^15\) Situations of conflict and displacement were shown to exacerbate vulnerability,\(^16,17\) and children in conflict with the law were also found to be in increased danger.\(^18\)

Nevertheless, data from different regions of SSA suggest high prevalence of all the forms of CSA – non-contact, contact and penetrative abuse. Regarding the magnitude of non-contact CSA, levels of sexual harassment were found to be as high as 67%.\(^19\) High rates of contact abuse were found across the region, including rates for FGM/C of between a low of 5% in some countries to a high of 90% in others;\(^20\) rates of fondling (sexual touching) of between 25% in Ethiopia and 47% in Uganda were found.\(^21\) The review also found high rates of penetrative sexual abuse. Estimates found include that between 5%\(^22\) and 69%\(^23\) of all children had experienced penetrative abuse.

- Incest, while not necessarily reported as a form of CSA, is common, given the large numbers of children raped by close family members.\(^24\)
- Rates of child marriage are as high as 76% in some countries.\(^25\)
- Information on trafficking, based mostly on the numbers of children repatriated, indicates thousands of children are trafficked each year.\(^26\)
- The sexual exploitation of children is rife across the continent.\(^27\) In addition, children exploited as domestic workers also frequently face sexual exploitation.\(^28\)
- Transactional sex is prevalent but there is little reliable information as to prevalence.\(^29\)
HIV/AIDS has resulted in devastating consequences for families and communities in SSA. The region carries the heaviest HIV/AIDS burden in the world. Children orphaned by AIDS are on the increase. Women and girls in the region continue to be disproportionately affected by the epidemic accounting for at least 60% of all HIV infections; young women between the ages of 15 and 19 are particularly vulnerable. CSA was found to increase HIV-related vulnerability, while HIV in turn, was found to exacerbate vulnerability to CSA. Drivers of the AIDS epidemic in SSA include CSA, sexual abuse perpetrated against school children, child marriage, transactional sexual relationships and cultural beliefs that men are entitled to sex.

The immediate and long-term consequences of CSA in SSA are severe. They include physical injury (including traumatic fistula), gynaecological complications, sexually transmitted infections (including HIV), unwanted pregnancies and unsafe abortion. Mental health consequences included debilitating fears, anxieties, regressive behaviours, nightmares, withdrawal, depression, anger and hostility, self-injurious behaviours (including suicide), low self-esteem and inappropriate sexual behaviour.

The review determined that the development of appropriate prevention and response strategies to CSA should be informed by:

- The full range of international and regional conventions and agreements, including:
  - The Convention on the Rights of the Child (UNCRC) (ratified by all countries in SSA) and African Charter on the Rights and Welfare of the Child (ratified by 45 of the 53 countries in SSA);
  - The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW);
  - The two Optional Protocols to the UN Convention on the rights of children – children in armed conflict and the sale of children, child prostitution and child pornography;
  - the Palermo Protocol;
  - Various international commitments to ending GBV, including: the Beijing Declaration and Platform of Action; and the Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010–2014.
  - Regional and sub-regional policy frameworks, including the Maputo Declaration, the WHO/AFRO strategy and the sub-regional implementation framework for the prevention and response to GBV developed by ECSA-HC.

- At the policy and programme level, a three-tier intervention model comprising:
  - A strong primary prevention ethos at the base, linked to specific strategies that target all children to prevent maltreatment and abuse in the first place.
Specific strategies should be aimed at **intervention in the early stages** of becoming vulnerable (secondary prevention) so that families (and therefore children) receive the support they need to provide protective and nurturing environments in which to raise children.

Lastly, a layer of **statutory protection** (tertiary level) interventions is needed for children who have already become victims, to ameliorate the harm done to them and alleviate the consequences.

Programmatic response aimed at reducing vulnerability to CSA in SSA were found to include awareness-raising and behaviour change interventions, availability of child helplines, community-based approaches intended to prevent CSA and mitigate against stigma, and service-delivery projects. Specific approaches to addressing sexual harassment in schools, children living and working on the street, children in alternate care, children who have been trafficked and interventions directed to perpetrators were found to be promising.

The main recommendations for an environment conducive for effective prevention and management of CSA include:

- The ratification of international treaties.
- An appropriate statutory framework to prevent vulnerability, support those who are vulnerable, and address the consequences when children are harmed.
- Appropriate policies to provide operational legal protections, based on National Plans of Action that are integrated into national planning processes, and have realistic and time-bound targets for addressing CSA.
- Attitude and behaviour change, including work with boys and men.
- Training and capacity-building.
- Funding.
- Prevention services.
- Early intervention services.
- Protection services, including response teams, child-friendly reporting systems and adequate training for service providers.
- Health and reproductive health services, also delivered by trained personnel.
- Witness preparation and support services.
- Therapeutic and counselling services.
- Alternative care services.
- Rehabilitation and reintegration services.
5 WHO Regional Office for Africa. 2004.
25 Diagnostic and Health (DHS) surveys accessible at http://www.measuredhs.com/aboutsurveys/dhs/start.cfm
33 UNAIDS. 2009.
35 Meintjes H, Hall K, Marera D and Boulle A. 2009.
1. INTRODUCTION

1.1 Background

There is a growing global evidence base concerning child sexual abuse, with an estimated 150 million girls and 73 million boys under the age of 18 having experienced forced sexual intercourse or other forms of sexual abuse involving physical contact.\(^1\) Child sexual abuse occurs in places normally considered safe such as homes and schools, at the hands of perpetrators who are known and trusted by the child or who has authority over the child.\(^2\)

Commercial sexual exploitation of children (CSEC) is a common type of CSA, resulting from an increasingly globalised world and driven by a multi-billion-dollar-a-year industry.\(^3\) Commonly, CSEC is considered to include child prostitution and child pornography.\(^4\) Figures show that up to 3 million children are prostituted each year in the Southern Asia sex trade alone.\(^5\) In the USA, estimates indicate that 60,000 girls and 300,000 boys regularly engage in prostitution.\(^6\) In United Nations (UN) reports, it is estimated that 10 million Third-World children are involved in prostitution.\(^7\)

Child sexual abuse also includes traditional practices such as child marriage, prevalent in many countries in Africa, the Middle East and Asia.\(^8\) Cases of child brides, and pre-pubertal sexual relations with an adult husband, have been documented in many parts of the world. Other forms of CSA, such as virginity testing for example, have been reported in many parts of Asia and Southern Europe.\(^9\) Female genital mutilation/cutting (FGM/C) is also prevalent in many parts of Asia and Africa. UNICEF estimates that, in SSA, Egypt and Sudan, 3 million girls and women are subjected to FGM/C every year.\(^10\)

Child sexual abuse is a human rights and developmental issue with serious negative public health consequences including psychological, emotional, physical, and social effects. Long-term effects of CSA include depression,\(^11,12,13\) post-traumatic stress disorder,\(^14,15\) anxiety,\(^16\) eating disorders, poor self-esteem, dissociative and anxiety disorders, somatisation, neurosis, and chronic pain.\(^17\) Other consequences include sexually transmitted diseases,\(^18\) drug abuse, alcohol dependence, psychiatric disorder;\(^19\) and physical consequences including internal lacerations, bleeding, and damage to internal organs leading in some cases to death.\(^20\) and sexually transmitted diseases.\(^21\) These consequences impose a huge burden on health services, including mental health and social support services.

CSA is a violation of human rights. It is a violation of international human rights laws irrespective of the perpetrator – peers, family members or strangers.\(^22\) Protection of children from CSA is increasingly recognised as integral to the protection of human rights in general,\(^23\) and is considered an element of international law.\(^24\) CSA should never remain unpunished.\(^25\) The United Nations Convention on the Rights of the Child (UNCRC) legally obliges states to protect children's rights. Articles 34 and 35 require states to protect children against all forms of sexual exploitation and sexual abuse, including coercion of a child to perform sexual activity, prostitution of children, and exploitation of children in pornography, abduction, sale, or trafficking of children.\(^26\) All countries in Africa (except Somalia) have acceded to the UNCRC.
CSA constitutes a serious threat to the well-being of children, and to that of their families, communities and to society, and a significant impediment to economic and social development.\textsuperscript{27} It has been implicated as one of the factors impeding the achievement of the Millennium Development Goals (MDGs).

\textbf{MDG 1 (to eradicate extreme poverty and hunger)}: CSA is linked to the deepening of poverty and thus represents an obstacle to the achievement of MDG1.\textsuperscript{28}

\textbf{MDG 2 (to achieve universal primary education)}: CSA in schools across Africa is linked to whether or not girls remain in school beyond the lower grades because CSA prevents, and is a serious obstacle to the achievement of MDG2.\textsuperscript{29}

\textbf{MDG 3 (to promote gender equality and empower women)}: The elimination of child marriage has been identified as a key element in promoting gender equality and the empowerment of women.\textsuperscript{30}

\textbf{MDG 4 (to reduce child mortality)}: Not only do children die as a direct consequence of CSA, but early pregnancy seriously undermines reproductive health outcomes, leading to difficult deliveries and higher risk of neonatal mortality.\textsuperscript{31}

\textbf{MDG 5 (to improve maternal health)}: Reducing the number of children giving birth to children by empowering young girls and reducing the rates of unwanted sex and unwanted pregnancies would have a significant effect on reducing maternal mortality and improving maternal health.\textsuperscript{32}

\textbf{MDG 6 (to combat HIV/AIDS, malaria and other diseases)}: Gender-based violence (GBV), of which CSA is considered a manifestation,\textsuperscript{33} is recognised as fuelling the HIV pandemic.\textsuperscript{34}

Prevalence studies on CSA conducted in the last two decades show considerable variability explained largely by differences in research methodology, data gathering techniques, and populations sampled. For example, international comparative reviews conducted by Finkelhor \textit{et al} in 1994\textsuperscript{35} and Pereda \textit{et al} in 2009\textsuperscript{36} documented that the prevalence of CSA across 28 countries ranged from 0 to 53\% in women and from 0 to 60\% in men. In North America, it is estimated that 15\% to 25\% of women and 5\% to 15\% of men were sexually abused when they were children.\textsuperscript{37} In industrialised countries, estimates indicate a prevalence rate of between 5 and 10\% of adult men reporting CSA.\textsuperscript{38}

Growing evidence suggests high prevalence rates of CSA in some countries in SSA. For example:

- South Africa is reputed to have the highest incidence of child and baby rape in the world.\textsuperscript{39} In a study on the effects of childhood adversity on adult mental health conducted in South Africa, 39.1\% of women and 16.7\% of men had experienced sexual abuse in childhood.\textsuperscript{40}

- Lifetime exposure to sexual violence was reported by an average of 23\% (9-33\%) 13-15 year old school children from Namibia, Swaziland, Uganda, Zambia, and Zimbabwe.\textsuperscript{41}
• High levels of sexual coercion at sexual debut were reported by 12-19 year old girls in four countries: In Malawi, 38 % of those surveyed said they were “not willing at all” at their first sexual experience followed by Ghana (30%), Uganda (23%) and Burkina Faso (15%).\textsuperscript{42}

• Over 92 million females over age 10 are estimated to be living with the consequences of FGM/C in Africa, with about three million new cases a year.\textsuperscript{43}

• Child marriage is generally more prevalent in Central and West Africa – affecting 40% and 49% respectively of girls under 19 – compared to 27 % in East Africa and 20 % in North and Southern Africa.\textsuperscript{44} Rates as high as 72% in Chad\textsuperscript{45} and 78.4% in Niger have been found.\textsuperscript{46}

In general, information on CSA in SSA is fragmented and inconsistent. Little systematic analysis has been possible to adequately inform prevention and response efforts. As Lalor (2004) noted, there are a relatively large number of published studies on CSA in South Africa,\textsuperscript{47} but little from the rest of the continent. Pitche, however, found, in a literature review spanning the period 1980 to 2003, that CSA occurs in all the regions of Africa, noting the relative wealth of information from Southern Africa and dearth of information from Central Africa (with the exception of Cameroon), and from West Africa (except Nigeria, Senegal and Togo).\textsuperscript{48} Moreover, the existing research only covered some types of CSA. For example, little information is available on the sexual abuse of boys, grooming of children, and rape of children by members of their families.

Apart from reliable information available from Demographic and Health Surveys (DHS) on FGM/C and child marriage, there is a dearth of rigorous statistical data and reporting on most types of CSA. Qualitative information increasingly suggests, however, that sexual abuse of boys is more widespread than previously thought.

Difficulty in establishing the magnitude of CSA is due to a number of factors including reporting rates that are far below the actual incidence.\textsuperscript{49,50} Other relevant factors are discussed in the section on limitations below.

These challenges prompted ECSA-HC to commission this literature review.

1.2 Purpose and objectives

The main purpose of this literature review is to understand the magnitude and nature of CSA in SSA, in order to raise awareness and inform sector policies and programme responses for its prevention and management.

The specific objectives of the review are to:

1 Understand the different forms, and spectrum of CSA, including their determinants, and consequences;

2 Determine the magnitude of CSA in SSA;

3 Identify existing policies and programmes that address CSA in SSA, and determine the gaps in these policies and programmes;

4 Make recommendations for a comprehensive inter-sector programmatic response against CSA
1.3 Methodology

The methodology for the review included the analysis of the available peer-reviewed articles on CSA in French and English from 2000 to 2010. The review also examined ‘grey’ literature from non-governmental organizations (NGOs), international development agencies, and national surveys and reports from this time period.

The review process included:

1. A core group comprising the manager of the Family and Reproductive Health Unit of ECSA-HC, the Gender, Gender-based Violence Advisor of Washington-based Africa’s Health in 2010 Project (Africa 2010), the lead consultant and the consultant for the French-speaking countries, and West and Central Africa. The core group met regularly to review progress and content of the literature review.


3. A request for reports and articles on CSA in SSA was sent out widely via the International Society for the Prevention of Child Abuse and Neglect (ISPCAN), SVRI and CRINMAIL list servs.

4. Systematic searches of electronic databases such as PubMed, Medline, MBASE, DHS, Science Direct, Social Sciences Citation Index (SSCI), and Médecine Tropicale were conducted using a list of keywords.

5. On-line searches for web-based documents using the “Google” search engine http://www.google.com

6. Review and analysis of available reports of international development agencies (UNICEF, WHO, UNFPA, USAID), international NGOs (Save the Children, ECPAT, Plan International, Human Rights Watch, Amnesty International and World Vision), and national NGOs such as GRAVE in Senegal, Kembatti Menttiin Ethiopia, CRADLE in Kenya, Girl Child Network in Zimbabwe, were accessed and analysed.

7. Review and analysis of national surveys and reports.

The list of the key words used in this process is presented in annexure 1.

1.4 Limitations

The research team identified a number of limitations that makes it necessary to interpret the findings presented here with caution. There was no standardized definition of CSA in the literature. Use of multiple definitions and terminologies to refer to the same phenomenon made review of the materials on CSA in SSA challenging. Moreover, methodological differences between studies, especially with regard to data collection, give rise to significant variability in prevalence estimates. The sources of data also show
significant differences across different studies and reports. Sources such as the DHS and the WHO multi-country study on women’s health and domestic violence against women, use large population-based samples of women 15-49 years of age and looked retrospectively at the issue. Others studies considered clinical samples, based on children attending medical facilities for treatment post-child sexual abuse. Still other studies are based on the collection of qualitative and largely anecdotal information. Thus, "in terms of academic discourse, or even within NGO [non-governmental organisations] and IGO [international governmental organisations] literature, the topic of child sexual exploitation in SSA consists of an almost total vacuum, in which dispersed and disconnected items of journalistic and project-oriented text are floating aimlessly”.  

There is a dearth of reports or published articles on good practices from international NGOs. We found only two peer-reviewed articles on the progress in the implementation of the UNCRC and the African Charter. The dearth of good practices reports notwithstanding, the richness of data available from multiple sources in the course of this review confirms that CSA is a significant problem in SSA. As to a contextual understanding of the phenomenon, there is a dearth of studies focusing on social and cultural factors, other than those of Levett\textsuperscript{52} and Clarfelt & Dwanda-Henda\textsuperscript{53}.

### 1.5 Structure of the report

The report is divided into nine chapters:

- Chapter 1 provides an introduction to the review, including its purpose, methodology and limitations.
- Chapter 2 covers definitions and terminologies.
- Chapter 3 examines the context of CSA in SSA in light of the HIV/AIDS pandemic, gender based violence and gender inequalities, and the overall socioeconomic, historical and political conditions in the region.
- Chapter 4 reviews the available data on the prevalence of CSA in SSA.
- Chapter 5 focuses on the identification of the factors associated with CSA.
- Chapter 6 summarizes the physical and psychosocial consequences of CSA.
- Chapter 7 documents the current state of the response, including responses by NGOs, at national, regional and global levels.
- Chapter 8 provides a general conclusion.
- Chapter 9 proposes recommendations for addressing CSA in SSA.

The selected bibliography contains all the materials cited in this review, and a number of other documents and materials which were consulted but not cited. Finally, the appendices contain tables which expand on some information provided in the review.

2 WHO Regional Office for Africa. 2004. Report of the Regional Director to the 54th Session of the Regional Committee for Africa, AFRC54/15 Rev. 1
7 Pinheiro P. 2006.
17 Arnow BA. 2004
25 Keesbury J & Aske, I. Undated. Towards a comprehensive response to sexual violence in sub-Saharan Africa: Lessons learned from implementation. Presentation available from ikeesbury@popcouncil.org
27 UNFPA. 2005.
2. CONCEPTUAL FRAMEWORK

The terms ‘child’ and ‘sexual abuse’ need to be explored to enhance understanding of the term child sexual abuse.

2.1 Definitions of “child”

The UNCRC and the African Charter define a child as a person below the age of 18 (UNCRC Article 1 and African Charter Article 2). However, the African Charter is stronger in this regard, since the UNCRC includes the weaker provision that a child is a person below the age of 18 “unless under the law applicable to the child, majority is attained earlier”. Whereas the implication for all those African countries that have ratified the Charter is that childhood should be defined as ending at 18 years of age in those countries. A full list of these countries appears in annexure 2.

There are many variations in the way a child is defined in SSA, and the notion of ‘childhood’ itself is culturally constructed. Similarly, the concept of ‘adolescence’ is ambiguous. While the World Health Organisation (WHO) definition of adolescence is 10- to 19 years, adolescence can start at age 10 and last until the age of 25 years. There is, however, some concurrence on the start of adolescence being marked by the onset of puberty, between the ages of 10 and 11. For the purposes of this review, the definition of childhood in the UNCRC and African Charter has been used, i.e., below the age of 18 years, which includes the majority of the period of adolescence.

While the 0-to-18 age category is useful for ensuring legal protection during childhood and adolescence, it does not deal with the different types of CSA across the period of childhood and adolescence, or of vulnerability to different types of CSA in relation to age. In addition, the severity and intensity of a given form of CSA may be related to narrower sub-categories within the broader age-range. A deeper understanding of vulnerability related to age might be helpful in determining research objectives and appropriate responses to CSA.

2.2 Definitions of child sexual abuse

WHO defines CSA as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or still that violates the laws or social taboos of society”. The WHO definition is comprehensive, but lacks subtlety with regard to the psychosocial and emotional after-effects of CSA. In addition, the notion of ‘informed consent’ within the context of CSA and coerced sex remains questionable. For example, the definition of rape under Namibia’s Combating of Rape Act (2000) requires the existence of certain “coercive circumstances”, instead of proof of lack of consent. A similar definition has been adopted in Lesotho’s Sexual Offences Act (2003). The Project Committee set up by the South African Law Reform Commission (SALRC) to develop new legislation on sexual
offences in that country, considered the term ‘coercive circumstances’ rather than ‘without consent’ – although this was subsequently rejected by the Parliamentary Portfolio Committee, and the notion of ‘without consent’ was retained in the new Act.\textsuperscript{6} In instances where a definition based on “coercive circumstances” is adopted, it is important to ensure that the circumstances listed are expansive, and do not revert to an emphasis on use of force or violence.\textsuperscript{7}

The UNVAC defines CSA as “any kind of sexual activity to which children are subjected, especially by someone who is responsible for them, or has power or control over them, and who they should be able to trust”\textsuperscript{8}. Given the relative vulnerability of children in their relations with most adults, the introduction by the UNVAC of the concept of “power and control” is also very useful.

However, the usual definitions of CSA appear to deal more with the acts committed than with the structural, social and interpersonal contexts in which CSA occurs. This includes a lack of clarity about which specific acts should be deemed sexual acts, and differing notions of which acts should be thus classified across different countries. A notable feature of the peer-reviewed literature on CSA has been its failure to consider the gendered nature of CSA, with a resultant failure to consider vulnerability in the light of the gendered nature of power relationships.\textsuperscript{9}

Also, important to note is that the terms ‘sexual abuse’ and ‘sexual violence’ are often used interchangeably by writers in SSA. Thus, rape, incest, FGM, and other forms of sexual interaction with children are usually named as such, but referred to also as forms of sexual abuse or as forms of sexual violence, often in the same document. For example, in its publication “Suffering to succeed” that documents violence against children in schools, Plan Togo provides information on “sexual violence and rape” against children.\textsuperscript{10} In linking poverty, parenting that does not adequately supervise and care for children, and poor interfamilial relationships, Townsend and Dawes describe children as vulnerable to sexual abuse in a context where they are also described as vulnerable to violence.\textsuperscript{11}

The terms ‘sexual exploitation’ and ‘sexual violence’ are also often used interchangeably. For example, ECPAT (End Child Prostitution And Trafficking for sexual purposes) uses ‘sexual exploitation’ and ‘sexual violence’ to refer collectively to rape, commercial sexual exploitation, sexual abuse, sexual exploitation, forced and early marriage, abduction and trafficking for sexual purposes. They note the “considerable difficulties in disentangling the different forms of sexual violence and abuse, typically because they do not occur in isolation.”\textsuperscript{12}

There are many such examples in almost all the documents that were reviewed. CSA is viewed as sexual violence against children, and can involve actual acts, as well as behaviour (harassment, grooming). While it might be argued that some forms of CSA are more physically violent than others, (the rape of a child, for example, might cause more physical damage than a more gradual grooming process), the consensus is that, in the wider understanding of the issue, any form of CSA is a form of violence against children.
2.3 Definitions of terminologies associated with CSA

Because authors often use terminologies in the area of CSA interchangeably, it is important to provide the definition of these commonly used terminologies. The WHO's definition of sexual violence in general is “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work”\(^\text{13}\). This definition notes that coercion includes a range of degrees of force, apart from actual physical force. Psychological intimidation, blackmail or other threats (for instance, the threat of physical harm) are included, as well as when the person was unable to give consent (while drugged or asleep for instance), or was mentally incapable of understanding the situation. Young children are, by definition, unable to understand the implications of the situation, and even older children do not have the experience and personal resources to do so.

The US Centre for Disease Control and Prevention (CDC) defines sexual violence as “any sexual act that is perpetrated against someone's will encompassing a range of offences, including a completed non-consensual sex act (i.e., rape), an attempted non-consensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment)”\(^\text{14}\).

Materials found through internet searches routinely defined CSA in terms of the nature and purpose of the abuse, in one of the following ways:

- **Sexual assault** includes sexual touching for the purpose of sexual gratification; for example, vaginal and anal rape and sexual penetration with an object\(^\text{15}\). Most U.S. states include in their definitions of sexual assault any penetrative contact of a minor's body, however slight, if the contact is performed for the purpose of sexual gratification\(^\text{16}\).

- **Sexual exploitation** includes victimising children for advancement, sexual gratification, or profit; for example, prostituting a child, and the production and dissemination of child pornography\(^\text{17}\).

- **Sexual grooming** is the conduct of a potential child sex offender who seeks to make a minor more accepting of their advances, for example in an online chat room\(^\text{18}\).

In the peer-reviewed literature, classification of CSA is more focused on the type of abuse. Thus, abuse is generally classified in one of the following three ways: \(^\text{19}\)

**Non-contact abuse**

This type of abuse encompasses a range of acts, including inappropriate sexual solicitation or indecent exposure. According to Richter and Higson-Smith\(^\text{20}\), these forms of abuse include forcing or manipulating children into watching pornography; having children watch adult sexual activity; and voyeuristically encouraging children to masturbate and photographing children under these circumstances. These authors further argue that, despite the fact that very little research has been undertaken on the consequences for children of non-contact abuse (with the exception of sexual harassment in educational settings), these activities deserve more attention because of their
potentially damaging consequences and because they are often a forerunner of other forms of CSA.\textsuperscript{21}

Non-contact abuse can also include verbal sexual harassment, such as sexual innuendo and derogatory remarks about girls’ bodies.\textsuperscript{22} Other forms of verbal sexual harassment include unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature.\textsuperscript{23} For example, in a study conducted in Malawi, “peeping” (covert observation) as a form of sexual harassment was reported by the girls involved, with boys most often being the perpetrators,\textsuperscript{24} usually in the toilets or by using mirrors placed on the floor to look up their skirts when girls stood up in class.\textsuperscript{25}

Grooming takes place when a child’s trust is secured in order to lure them into a situation where they will be abused.\textsuperscript{26} The South African Sexual Offences Act, in section 17, comprehensively prohibits grooming children for sexual abuse, linking this to sexual exploitation and the use of children in the production of pornography, or the exposure of children to pornography.\textsuperscript{27}

Non-contact forms of abuse are often a prelude to, or an accompaniment to, contact abuse and actual intercourse with a child. Grooming, for example, is a prelude to contact abuse (such as touching of the genitals) and to sexual abuse of young children involving penetration.

\textit{Contact abuse}

This form of CSA can involve sexual contact between a child and another person for the sexual gratification of that person, and can include unwanted touching of the sexual organs, breast and buttocks. Commonly called sexual harassment, it is often an expression of power relations using the body as a sexual object.\textsuperscript{28}

Virginity testing is an investigation of whether or not the hymen is intact,\textsuperscript{29} and involves the insertion of a finger into the vagina by a young girl’s mother, aunt, neighbour, or even prospective husband.\textsuperscript{30} It is practiced in some parts of countries in East and Southern Africa (Botswana, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe), and may take place in ceremonies approved by rural chiefs, as well as in churches and the home.\textsuperscript{31} The Girl Child Network has identified virginity testing in Zimbabwe as a significant problem, where girls as young as 5 years may be tested.\textsuperscript{32} Children identified as non-virgins are exposed to physical and emotional danger. Those sexually abused and identified as non-virgins face increased risks of abandonment, rejection and violence.\textsuperscript{33} The South African Human Rights Commission has declared that the practice compromises and potentially violates the girl child’s right to equality, dignity, privacy, freedom, security and bodily integrity.\textsuperscript{34}

Alteration of the sexual organs via FGM/C can also be considered contact abuse. FGM/C is classified in four ways.\textsuperscript{35} 36

1) \textit{Type 1 - Clitoridectomy}: partial or total ablation of the clitoris or (more rarely) of the prepuce.

2) \textit{Type 2 - Excision}: partial or total removal of the clitoris and of the labia minora, with or without excision of the labia majora.
3) **Type 3 - Infibulation**: Contraction of the vaginal orifice by the creation of a closing achieved by cutting and by repositioning the inner – and sometimes exterior – lips, with or without clitoris removal.

4) **Type 4 - Unclassified interventions** - such as pricking, piercing or incising the clitoris and/or the small and big lips, stretching, cauterizing, scraping, introducing corrosive substances, etc.\(^{37}\)

**Penetrative abuse**

Penetrative abuse includes oral, anal or vaginal intercourse. Rape (also known as defilement in SSA) has various definitions across countries, but generally includes the use of physical force or coercion to penetrate the vulva or anus, using a penis, other body parts or an object. Note that penetration of the anus is also often referred to as ‘sodomy’. Because children themselves have highlighted that they are often subjected to intense psychological or economic pressure to submit, rather than that adults have used physical force, some writers have used the term “forced sex”. Indeed, the literature increasingly reflects the concept of coercive sex and this is strongly related to vulnerability to contracting HIV.

The South African Criminal Law [Sexual Offences and Related Matters] Amendment Act (known as the Sexual Offences Act) defines rape as the unlawful and intentional commission of an act of sexual penetration with a complainant without their consent.\(^{38}\)

In Kenyan law, defilement is defined as an act that causes penetration with a child, while rape is defined as the intentional and unlawful penetration of the genitals of a person without their consent, or with consent obtained by threats or coercion. An intentional and unlawful act is defined as one obtained in any coercive circumstance, under false pretences, or by fraudulent means, or against a person who is incapable of appreciating the nature of an act which causes the offence.\(^{39}\)

Concepts developed in the social scientific analysis of violence in general can be useful here, and the concepts of structural violence, cultural violence and symbolic violence are particularly useful in understanding CSA.

### 2.4 Defining structural sexual violence

Sexual violence against children can be defined using analytical resources provided by the concept of structural violence and subsequent notions developed by the sociology of violence. **Structural violence** refers to a form of violence based on the systematic ways in which a given social structure or social institution harms people by preventing them from meeting their basic needs, a form of violence that has consequences for their health and well-being, or that violates their rights.\(^{40}\)

**Structural abuse** is “sexual emotional or physical abuse that is imposed on an individual or group by a social or cultural system or authority”. It is indirect and exploits the victim at an emotional, mental, psychological, economic and social level.\(^{41}\)
According to Bourdieu,\textsuperscript{42} \textbf{symbolic violence} refers to actions that have discriminatory or injurious meaning and implications. There are modes of cultural or social domination occurring within everyday social interactions.\textsuperscript{43} Cultural violence refers to aspects of culture that can be used to justify or legitimise violence and may be exemplified by religion, ideology, language, and science. So, as Galtung states,\textsuperscript{44} cultural violence makes direct (i.e. overt) and structural (i.e. covert) violence look “right” (or “not wrong”).

Based on these sociological concepts of violence, structural sexual violence can be defined in the following ways:

\textbf{Sexual abuse occurring within the hierarchical institutions which govern authority relations} (family, church, school, workplace), that are not in principle defined as having a sexual nature but that are instrumental in serving sexual purposes. Grooming may be classified in this category. In this framework, incest (intra-familial CSA) is usually defined as sexual intercourse between two people who are closely related.\textsuperscript{45} The Sudanese definition of incest, for example, is “illicit intercourse, sodomy or rape with an ascendant, a descendant or their spouse, or with his brother, sister or their children, or his paternal or maternal uncle or aunt”.\textsuperscript{46} Other countries in SSA define incest in much the same way.\textsuperscript{47}

\textbf{Sexual abuse generated and maintained by the cultural management of sexuality.} This is the case regarding early marriage, FGM/C and virginity testing.

\textbf{Child prostitution and/or sexual exploitation} is defined by the Save the Children Alliance as “the imposition of sexual acts, or acts with sexual overtones, by one or more persons on a child”.\textsuperscript{48}

\textbf{Transactional sex} is defined as the exchange of gifts or money for sex, usually involving girls or younger women and men who are several years older.\textsuperscript{49} Transactional sex is sometimes seen as a short-term solution for the girls to pay for their school fees, food and other needs or to ‘pay’ for school grades.

\textbf{Prostitution} generally refers to the sale of sexual services, and involves multiple partners on a daily basis. When the sexual services being sold are those of a child, that child is most often the victim of commercial sexual exploitation. Prostitution is not gender-specific, although most prostitutes are female.\textsuperscript{50}

\textbf{Trafficking for sexual exploitation} refers to the cross-border or internal recruitment, transportation, transfer and harbouring or receipt of children for sexual exploitation. Not all children who are trafficked are sexually exploited, but trafficking provides a systemic basis for sexual exploitation.\textsuperscript{51}

This range of structural sexual abuse can take any of the different specific forms of CSA described above, i.e., non-contact, contact and penetrative abuse.

\footnotesize{\textsuperscript{1} See http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en#2
\textsuperscript{2} UNCRC, Article 1.}

WHO. 2010.

WHO Regional Office for Africa. 2004. Report of the Regional Director to the 54th Session of the Regional Committee for Africa, AFR/RC54/15 Rev. 1


44 Galtung J. 1969.


46 Jones N & Espey J. 2008. Increasing visibility and promoting policy action to tackle sexual exploitation in and around schools in Africa. Plan International


3. THE CONTEXT OF CHILD SEXUAL ABUSE IN SUB-SAHARAN AFRICA

The context of CSA in SSA is characterised by the social, economic and political crises that have affected this part of the world for several decades.

3.1 Situations of Violence

Many children in SSA live against a back-drop of violence, be it within their own families, in the communities within which they live, or in areas of armed conflict. The link between living in a home where domestic violence is perpetrated and vulnerability to CSA has been established by a number of writers. This was also highlighted in the UNVAC. For example, Childline South Africa reported that many female victims of domestic violence are unable to protect their children from sexual assault by their own violent male partners.¹

All levels of violence can lead to displacement and migration, although less commonly when the violence is within family (although it could be argued that children who choose to live and work on the street have been displaced by violence in their homes). Living in contexts of violence increases children’s vulnerability to the full range of abuse and neglect, including sexual abuse; being displaced as a consequence of the violence further exacerbates vulnerability.

Over the past decade, the West, and Central Africa regions have been subject to conflict-related dislocation and extreme violence. Côte d’Ivoire, the Democratic Republic of the Congo, Liberia, Sierra Leone, Rwanda and Uganda are still embroiled in, or emerging from, extensive upheaval and destruction due to long-term war. Many thousands of children in these countries have been victims of abduction, torture and forced recruitment into the armed forces, with very large numbers also experiencing rape and sexual violence.²

Human Rights Watch found that tens of thousands of women and girls have suffered horrific acts of sexual violence in the Democratic Republic of the Congo (DRC).³ The Special Representative of the UN Secretary General on Children and Armed Conflict found that children in West and Central Africa are especially vulnerable to violence, recruitment, sexual exploitation, disease, malnutrition and death.⁴ In Burundi, the UN Secretary General noted that cases of rape and sexual violence, abduction and detention of children, and child recruitment by warring forces increased during the period before the release of all children associated with armed groups and their reunification with their families in April 2009.⁵

In January 2010, the Africa Warwick Conference highlighted the situation of sexual violence in camps and conflict zones in Northern Uganda.⁶ The abduction of children as young as 11 was reported, as well as high numbers of boys forced to take girls as wives and girls forced into early marriage.⁷ Gang-rape and sexual abuse of girls was found to be rife; however, boys were also forced to have sex for food; and boys and girls are abducted, raped and abused on an enormous scale.⁸
An issue paper prepared for the Sixth African Development Forum (ADF VI) highlighted the particular vulnerability of girls and women in conflict and post-conflict situations: "Women’s bodies have become part of the battleground for those who use terror as a tactic of war, whereby women and girls are raped, abducted, humiliated and made to undergo forced pregnancy, sexual abuse, trafficking and slavery". This vulnerability arises from the disruption and dismantling of the formal and informal protection mechanisms of families, communities and the State; poor site planning and camp management decisions that subject women and children to risks that contribute to VAW, especially sexual violence; girls in particular are often the primary targets of abduction, often resulting in being forced to participate directly in hostilities as fighters, or in ‘support’ roles as spies, messengers, servants, and sexual and domestic slaves.

These situations of violence have been found to have prolonged historical inequality. After having suffered from the slave trade, colonial domination or apartheid, many African communities and societies endured authoritarian political regimes for decades, and some still do.

The violence and violation of human rights perpetrated by colonial regimes, apartheid and postcolonial states destroyed the social mechanisms, referral systems, and regulatory institutions that may once have acted to prevent violence and CSA in SSA. For example, in apartheid South Africa, sexual violence against boys within the mining industry has been noted since the 19th Century. The destruction of the social systems that may once have underpinned the harmonious development of women and children, and the use of violence and power by the colonisers have left a legacy that has subverted societies across the continent, contributing to the breakdown of their points of reference and moral values.

### 3.2 Child trafficking and child labour

Even when sexual exploitation may not have been the primary motivation for trafficking, children who have been trafficked for domestic or agricultural labour are also vulnerable to sexual abuse. These children, isolated from family or support structures, dependent on the trafficker and harshly treated, can be and are abused in multiple ways.

Further, the commercial exploitation of children is known to also involve exploiting the labour of children, particularly in the domestic and agricultural sectors. Research undertaken on behalf of the Towards the Elimination of Child Labour (TECL) project in South Africa established that domestic work and agriculture account for a large proportion of work done by children, with girls being more likely to be in domestic work and boys more likely to be in agricultural work; furthermore, many children are simultaneously engaged in domestic work and in agricultural work. In a 2008 study covering 24 countries in West and Central Africa, sexual exploitation of children was on the rise and linked to labour, child prostitution, sex tourism and the production of pornography.

Many young girls in Africa are trafficked for domestic labour, placing them in situations where they are vulnerable to CSA. A study of female domestic workers in Nigeria found that 85% of the girls questioned were coerced into sexual intercourse with a male within the household where they were working, with some as young as 10 years of age. In
Togo, children as young as 3 years were reported to be exploited as domestic and agricultural workers.\textsuperscript{20}

According to the African Child Policy Forum (ACPF), 90\% of domestic workers in SSA are girls.\textsuperscript{21} Child domestic workers are often denied an education, and face high levels of physical, sexual and psychological abuse. In Guinea, children as young as 8 years are employed in situations where they are vulnerable to - and regularly experience - verbal, physical and sexual abuse.\textsuperscript{22}

The National Survey on Child Trafficking in Guinea published in 2003, provided evidence of the trafficking of Guinean children, but also of children from neighbouring countries such as Mali, Sierra Leone and Ghana. It was noted that many children are trafficked across borders:\textsuperscript{23}

- under the pretext that they are going to study at a Koranic school;
- to work as domestics in the homes of relatives, with increased vulnerability to CSA; and
- to work in the mines, where there is an increased risk of sexual exploitation.

In the DRC, a UNICEF study found girls aged 12 to 15 working in bars, hotels and brothels.\textsuperscript{24} In 2004, it was estimated that there were 820,000 orphaned children in Rwanda, with more than 100,000 of these heading households. These children are often driven into prostitution to ensure the survival of their families.\textsuperscript{25} More than two-thirds of domestic workers questioned by the ILO for a small study in Ethiopia had experienced physical violence during the course of their work.\textsuperscript{26}

Statistics from the United States State Department indicate that more than 200 Beninese children were repatriated from Nigeria, from September to October 2003.\textsuperscript{27} In Burkina Faso, 640 children (among whom 620 from Burkina Faso) were intercepted in 2003.\textsuperscript{28} In Guinea, 600 children were withdrawn from the cocoa and coffee fields, and 6 boys heading to Mali were intercepted in November 2003.\textsuperscript{29} In Mali, 112 children from Burkina Faso were intercepted in December 2003, and more than 6,000 Malian children were repatriated from Côte d’Ivoire between 2000 and 2003.\textsuperscript{30} In 2004, 258 Chadian children were repatriated, and 2,458 Togolese children were repatriated between 2002 and 2004.\textsuperscript{31}

According to a survey on child labour in 2001, 18.2 million Ethiopian children aged between 5 and 17 years were working; 81.2\% of them (12.6 million) were below the age of 15. Almost the same number of girls and boys were working (50.6\% were boys and 49.4\% girls).\textsuperscript{32}

While the scale of the problem is difficult to ascertain, one can assume that children working on the streets are vulnerable to sexual abuse from many individuals, including from passers-by and from those who offer them shelter, in some cases. They also risk being recruited by pimps and traffickers for sexual and economic exploitation or having to resort to ‘survival sex’ (sex in exchange of food or shelter). A 2007 study in Zambia mentioned figures of around 35,000 children living and working in the streets.\textsuperscript{33}
3.3 Contexts of poverty

The highest proportion of the population (51%) living below the international poverty threshold of US$ 1.25 per day is found in SSA. Economic policies, in particular the structural adjustment policies implemented in the 1980s, have also increased the level of poverty and adversely affected the social service sector.

The link between living in extreme poverty and being the victim of CSA has been established by a number of authors in the literature coming from SSA. In their study of the level of knowledge in Malawi of the UN Convention on the Rights of Children, the Malawi chapter of the African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN) noted that poverty is named as the most significant cause of child rights violations in that country. The International Labour Organisation (ILO) 2001 study on juvenile prostitution in Tanzania indicated, for the 250 girls interviewed, that the most common reason given for leaving home was poverty (30%); only 3% of respondents specifically mentioned sexual abuse in the home as their primary reason for leaving.

Prevailing poverty renders children vulnerable to trafficking, which is confirmed by analyses of and reports on trafficking of human beings in Africa that typically recognise poverty as the most visible cause for trafficking.

The 2008 UNICEF report on Zambia drew attention to the fact that, although there are few hard data, descriptive evidence suggests that parents make decisions about their children working, based on economic considerations – more than half of those surveyed stated that their household’s living standard would drop, that its survival would be threatened, and/or that it would not survive, if their children stopped working. In Burkina Faso, for example, girls from poor families were found to be trafficked within the country to work as domestic servants and prostitutes. Similar evidence exists for a number of countries in SSA. In Togo, becoming a prostitute has been linked to young girls running away from home to avoid poverty, violence and abuse within their families.

However, sometimes, parents who send their children away hope to ensure a better life for them. Traffickers readily exploit this desire, and this is one of the primary reasons why trafficking is so prevalent in Africa. Widespread poverty and the lack of educational and employment opportunities for young people strongly encourage them to seek opportunities elsewhere.

Prevailing poverty is associated, in much of the information from SSA, with usually exploitative, often hazardous and frequently violent child labour, including domestic work, prostitution, and the production of pornography. International agreements recognise the following as the ‘worst forms’ of child labour:

- hazardous work,
- so-called ‘unconditional’ worst forms of child labour, such as slavery, trafficking, debt bondage and other forms of forced labour,
- forced recruitment of children for use in armed conflict, and
- the use of children in prostitution and pornography, and other illicit activities.
High levels of poverty and the number of children orphaned by AIDS have contributed to the high prevalence of child labour in Kenya, with 41.3% of the children between 10 and 14 years of age estimated as being exploited for cheap labour.\textsuperscript{44} Sex tourists often access children who are domestic workers at tourist accommodation.\textsuperscript{45}

Poverty is associated with children’s vulnerability to early marriage, prostitution and transactional sexual relationships.\textsuperscript{46} However, in the case of transactional relationships involving adolescents, the link to poverty is not direct. The motivations for adolescent girls to engage in sexual relationships with older men are varied and overlapping; gifts and other financial benefits were found to be the major reasons, with extreme household poverty as a motivator of sexual activity less often described.\textsuperscript{47} The motivations for financial rewards tend to be complex, ranging from economic survival to desire for status and possessions. Leclerc-Madlala, researching the situation in South Africa, has found that many young women in South Africa, especially among unmarried young women, conceptualise their sexuality as a “resource that can be drawn on for material or economic advantage.”\textsuperscript{48}

### 3.4 Gender inequalities and gender based violence

The gender-related development index, which ranks 155 countries, indicates that, out of the 20 countries that have the lowest ranks, 19 are in SSA. That region also has the lowest rates of girls accessing education and the lowest number of girls accessing education, relative to the number of boys who do so.\textsuperscript{49} The net secondary school enrolment of girls in the period 2004 to 2007 was 24% in SSA.\textsuperscript{50} In many countries in the region, fewer than 50% of girls go to school, and in some, the rate is as low as 25%.\textsuperscript{51} Remaining in school was linked to a delay in sexual debut in Kenya, for example, and to lower risk of HIV infection in Zimbabwe.\textsuperscript{52}

Women and children across Africa are vulnerable to and experience gender-based violence on a large scale.\textsuperscript{53} Domestic law and policy as well as regional and international treaties attest to the equal rights of women; but on the ground, for enormous numbers of women, not much has changed to reduce that vulnerability.

In Benin, for example, the law provides for the rights of women, and the country has adopted a national policy to eliminate gender inequality in education and training. Yet, the enrolment of girls in school is relatively low and they tend to stop attending school early, because of pregnancy and early marriage.\textsuperscript{54} The situation is similar in most countries in SSA, i.e., although law theoretically protects women’s rights, this has little effect on the practical lives of most women.

In many countries in SSA, the principle of marital power considers women relatively as legal minors.\textsuperscript{55} While some countries have developed good law and policy, it remains true that the social construction of masculinity and femininity in SSA generally prescribes low status for women and high status for men, although this is by no means peculiar to Africa. Women’s status is largely determined by their relationships to men - father, husband, son or brother.

A WHO report\textsuperscript{56} highlights that boys are more likely than girls to be the victims of physical violence, drawing the link between experiencing physical violence in childhood
and violent behaviour in adulthood. In addition, the socialisation of boys has been shown to include a too-early push towards autonomy and a repression of desires for emotional connection, and social pressure to achieve rigidly defined male roles that support the myths that “masculine sexual appetite is insatiable, that boys’ need for sex is biologically uncontrollable, and that sex is something to be done, not talked about.”

Factors influencing CSA in Zimbabwe were found to be male dominance in society, men’s professed inability to control their sexual desire, and a belief in magical properties of sex with children. The Institute of Migration (IOM) has shown that the prevalence of attitudes which ‘sexualise’ and ‘commoditise’ young girls leave them at greater risk of being trafficked.

Chege and Sifuna suggest that traditional attitudes about gender roles, inequitable power relations and overall unequal gender relations tilt the balance of heterosexual relations in Kenya – the socialisation of girls impels them towards submissiveness, dependency and passiveness, while that of boys prioritises aggression and initiative. These gender norms and power disparities negatively affect sexual attitudes and behaviour.

A multi-country study in South Africa conducted in Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe confirmed that cultural norms often encourage men to have more than one sexual partner and require that women submit to men’s authority. It is also the case that the pervasiveness of CSA leads to a situation where it is effectively normalised, and seen as what can be expected. For example, many of the girls surveyed in a study in Kenya considered much of the abuse they suffered - physical, sexual and psychological - to be appropriate or “normal”.

The stereotype of masculinity is of being strong and in control, knowing what you want and going after it, at whatever cost; it is inextricably linked to an active sex life, frequently to having multiple sexual partners, and to a sense of entitlement about sex. Conversely, femininity is linked to being weak and subservient, to being unable to mean no when you say no; it is inextricably linked to the fact of being in a relationship at any price - including a lack of space to negotiate sex. The social worth of women is ‘proven’ through the ability to have (and keep) a male partner, in addition to the possible economic benefits of this relationship. In Botswana, the desire by women to maintain a male-centred status quo was one factor identified as compromising the position of children and exacerbating their vulnerability to sexual abuse. However, there is some evidence from anthropological studies, that local cultures and historical heritage abound with concepts and practices that challenge male authority.

### 3.5 Vulnerability to HIV

There is growing recognition that the risk of, and vulnerability to, HIV among women and girls are largely shaped by pervasive gender-inequalities – sexual violence in particular. The HIV pandemic has wreaked havoc upon the families and communities of SSA– the most heavily affected area globally - and had a significant negative impact on children’s vulnerability. Available evidence suggests that:
• Over two thirds (67%) of people living with HIV globally are found in SSA, and nearly three quarters (72%) of AIDS-related deaths in 2008 were in this region.

• Between 20.8 million and 24.1 million people in the region are living with HIV.

• More than 14 million children have lost one or both of their parents to AIDS.

• Women and girls continue to be disproportionately affected by HIV in the region, accounting for 60% of all HIV infections, and young women aged 15 to 19 years are particularly vulnerable.

• The heaviest burden is carried by the nine countries in Southern Africa - each has an adult HIV prevalence greater than 10%.

• Swaziland has the most severe level of infection in the world, with an adult prevalence of 26%.

• South Africa (15% to 20%) is home to the most people (5.7 million) living with HIV.

• Prevalence rates in Tanzania (more than of 5%), Zambia and Zimbabwe (both 15% to 20%) are declining, while those in Lesotho (23.2%) and East Africa generally appear to have stabilised.

• West and Central Africa in general have the lowest prevalence rates, although rates in Côte d’Ivoire (3.9%) and Ghana (1.9%) are relatively high.

Globally, women constitute 50% of the HIV epidemic. In SSA, 60% of the people living with HIV are female.71 SSA has a young population – about a quarter are aged 10 to 19 years. There are now more young people in Africa entering adulthood than at any other time in history.72

Virgin cleansing in relation to HIV has been cited by several writers of CSA in SSA, including in South Africa73 and Zimbabwe.74 This is buoyed by an old myth: the belief that sex with children is a cure for a variety of diseases. This myth has been traced to places as varied as 17th-century South America and Victorian England.75 It has been argued that there is little empirical evidence to support virgin cleansing as an element of an increase in CSA cases, and that a likelier cause and more prevalent problem is that the fear of HIV causes men to seek ever-younger partners in the belief that they will be less likely to be infected with HIV.76

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UNICEF. 2007. Analyse de la situation des enfants victimes de la traite en République du Congo. UNICEF

UNICEF. 2005. La traite des personnes, en particulier des femmes et des enfants en Afrique de l’Ouest et du Centre. UNICEF

UNICEF. 2005.

UNICEF. 2005.

UNICEF. 2005.

UNICEF. 2005.

UNICEF. 2005.

UNICEF. 2005.

UNICEF. 2005.


51 UNDP. 2000.
54 Bernard A. 2009.
57 Barker G. 2000.
60 Bernard A. 2009.
68 FNUAP.2008. L’analyse de la Violence basée sur le genre au Sénégal. FNUAP.


4. THE MAGNITUDE OF THE PROBLEM

It is often said that the magnitude of CSA in SSA is unknown. This is largely related to the fact that it is seriously under-reported, as noted by a number of authors. WHO, for example, refers to CSA as “a silent health emergency [that] goes unnoticed, is grossly under-reported and poorly managed [and] surrounded by a culture of silence and stigma”. Although not specific to CSA, a recent report from Kenya notes that accurate statistics on all forms of sexual abuse are not known due to low reporting rates, as a consequence of stigma and a lack of systematic management protocols and guidelines, which (among other negative consequences) impedes the ability to prosecute. In addition, the terms ‘prevalence’ and ‘incidence’ are often used in the literature without clarification. According to Pereda et al, prevalence is “the proportion of a population who have suffered sexual abuse during childhood (generally before the age of 18) and it is based on retrospective accounts”, while incidence is an estimate of the number of new CSA cases occurring during a specified period of time.

However, data from the peer reviewed and ‘grey’ literature reviewed for this document confirm that CSA is a significant problem in SSA. Childhood experiences of unwanted sexual touching are reported at rates from 5.2% to 26.3% (the divergence is most likely due to differing operationalization of child sexual abuse; in this instance, “touched sexually by force” compared to “unwanted genital fondling,” respectively). Rates for childhood experiences of abusive sexual intercourse are less divergent; 7.5% for “rape and attempted rape”; 5.8% for “sexual intercourse”; 3.86% for “sexual intercourse by force”, and 4.5% for “oral/anal/vaginal intercourse by force”.

This section discusses the magnitude of CSA in SSA, delineated into non-contact abuse, contact abuse, and penetrative sexual abuse

4.1 Non-contact abuse

4.1.1 Sexual harassment
The literature considered for this review routinely considers both sexual harassment and coerced sexual activity in the same breath especially in educational settings. This is largely because, it seems, sexual harassment is the precursor to girls becoming sexually involved with their teachers. However, sexual coercion is not exclusively linked to teachers. Moore et al found that sexual harassment and sexual coercion are linked not only to each other but also to “violent sexual behaviour which reflects underlying structural factors that contribute to the oppression and exploitation of women”. A further complication in establishing magnitude is that “sexual harassment” is used to describe both non-contact and contact forms of CSA.

One consequence of this is that there are limited statistics available about the magnitude of sexual harassment as a ‘stand-alone’ form of CSA. The United States Agency for International Development (USAID) has noted that the impact of gender-based violence on education and health has not been systematically examined.
However, there is much information suggesting that it is a significant problem. A study in Botswana concluded that there is “a culture of sexual harassment in schools” with up to 67% of girls reporting sexual harassment by teachers, with 18% of these reports from children in primary school. Human Rights Watch found very high rates of sexual harassment of girls at school in South Africa, perpetrated by both male teachers and male pupils at their schools. The ACPF found that, in Cameroon, 16 per cent of secondary school students had been sexually abused.

The Dossier of Claims, which considered sexual violence in 31 African countries, found sexual harassment to be a problem in all of them, but gave no indication of magnitude. The Desk Review undertaken by the UNICEF East and Southern African Regional Office (ESARO) in preparation for the Regional Consultation for the UNVAC determined that sexual harassment in schools was a problem in several countries in the region, notably South Africa, Kenya, Tanzania, Zimbabwe, and Malawi; again, no indication of magnitude was given in this work.

In addition, some evidence of the magnitude of the problem of sexual harassment in schools can be found in studies in Ethiopia, Kenya and Malawi.

In 2008, for example, a study in Ethiopia covering 127 primary and secondary schools found that verbal abuse of girls by members of the school community aimed at undermining their self-esteem was the most common type of abuse experienced, with up to 29% of girls from some regions (for example, Amhara) reporting it.

Kariuki’s 2004 study on sexual harassment in 3 secondary schools in Kenya involved 1,279 participants. Of these, 60% of girls and 55% of boys (57.5% of all respondent) disclosed that they had experienced sexual harassment. For girls, the areas of the body that were mostly targeted were the breasts, genitals and buttocks, while for boys, these were the penis, chest and buttocks. This study is illustrative of the definitional complexities related to sexual harassment, as its definition of sexual harassment includes unwanted touching, so arguably forms a sub-set of contact abuse.

A study conducted in Malawi in 2005 found that almost one quarter (23.8%) of the 4,412 school children surveyed reported having been forced to have sex against their will; more than one tenth (14%) report having been touched on their genitals or breasts against their will, and 3.9% of children over 13 years report being forced to engage in some form of oral sex.

Sexual harassment was also found to be a precursor to other forms of sexual abuse. For example, Ruto found, in a follow-up to the Kariukis study above, that 575 of the 1,230 children involved had received “love proposals” from adults. Leach et al found that 27 percent of the female respondents had been propositioned by their school teacher in a study conducted in Ghana.

4.1.2 Grooming

No information on magnitude was found on grooming. However, it is likely that this is not reported at all, as it is probably the case that attempts at grooming children are not even recognised as such, and invariably lead either to contact or penetrative abuse, or
both. Grooming of girls and adolescents by European tourists is reported to occur through internet.\textsuperscript{26}

4.2 \hspace{1em} Contact abuse

4.2.1 \hspace{1em} Female genital mutilation or cutting

FGM/C in African countries has been comparatively well-researched, and there is a great deal of information about it. Reported prevalence rates are as low as less than 5\% in some countries to over 90\% in others. While FGM/C is not practiced only in Africa, at least 28 of the countries that do practice it are African.\textsuperscript{27} It is estimated that, in Africa, over 92 million female persons over the age of 10 are living with the consequences of FGM/C, with about 3 million new cases a year.\textsuperscript{28}

The prevalence rates from DHS and MICS surveys for SSA countries are shown in Tables 1 and 2 below.\textsuperscript{29}

Table 1 – FGM/C prevalence from DHS surveys

<table>
<thead>
<tr>
<th>Country/Year</th>
<th>% 15-19</th>
<th>% Urban</th>
<th>% Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin 2006</td>
<td>7.9</td>
<td>9.3</td>
<td>15.4</td>
</tr>
<tr>
<td>Cameroon 2004</td>
<td>0.4</td>
<td>0.9</td>
<td>2.1</td>
</tr>
<tr>
<td>Chad 2004</td>
<td>44.4</td>
<td>47.0</td>
<td>44.4</td>
</tr>
<tr>
<td>Eritrea 2008</td>
<td>78.3</td>
<td>86.4</td>
<td>90.5</td>
</tr>
<tr>
<td>Ethiopia 2005</td>
<td>62.1</td>
<td>68.5</td>
<td>75.5</td>
</tr>
<tr>
<td>Guinea 2005</td>
<td>89.3</td>
<td>93.9</td>
<td>96.4</td>
</tr>
<tr>
<td>Kenya 2008</td>
<td>14.6</td>
<td>16.5</td>
<td>30.6</td>
</tr>
<tr>
<td>Liberia 2007</td>
<td>35.9</td>
<td>39.5</td>
<td>72.0</td>
</tr>
<tr>
<td>Mali 2006</td>
<td>84.7</td>
<td>80.9</td>
<td>87.4</td>
</tr>
<tr>
<td>Niger 2006</td>
<td>1.9</td>
<td>2.1</td>
<td>2.3</td>
</tr>
<tr>
<td>Nigeria 2007</td>
<td>21.7</td>
<td>36.8</td>
<td>25.6</td>
</tr>
<tr>
<td>Senegal 2005</td>
<td>24.8</td>
<td>21.7</td>
<td>34.4</td>
</tr>
<tr>
<td>Tanzania 2004/05</td>
<td>9.1</td>
<td>7.2</td>
<td>17.6</td>
</tr>
<tr>
<td>Uganda 2006</td>
<td>0.5</td>
<td>0.2</td>
<td>0.7</td>
</tr>
</tbody>
</table>

In Niger, FGM/C is practiced in the west of the country by certain ethnic groups, with clitoridectomy being the most common form. UNICEF has noted a reduction in the rate of FGM/C from 5\% in 1998 to 2.2\% in 2006.\textsuperscript{30} It is more widespread in Guinea where the most harmful version of FGM/C, i.e. infibulations, is practiced.\textsuperscript{31}
Health and Demographic Surveys in some countries (Senegal, Guinea) have also noted a decline in the rate, although this is slight in some countries; for rural Guinea, for example, rates declined from 99% in 1999 to 96.4% in 2005.

Table 2 – FGM/C prevalence from MICS surveys

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>% 15-19</th>
<th>% Urban</th>
<th>% Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>2006</td>
<td>59.7</td>
<td>76.0</td>
<td>71.2</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>2008</td>
<td>18.7</td>
<td>20.9</td>
<td>29.3</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>2006</td>
<td>28.0</td>
<td>33.9</td>
<td>38.9</td>
</tr>
<tr>
<td>Djibouti</td>
<td>2006</td>
<td>-</td>
<td>93.1</td>
<td>95.5</td>
</tr>
<tr>
<td>Gambia</td>
<td>2005/06/07</td>
<td>79.9</td>
<td>72.2</td>
<td>82.8</td>
</tr>
<tr>
<td>Ghana</td>
<td>2006</td>
<td>1.4</td>
<td>1.7</td>
<td>5.7</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>2006</td>
<td>43.4</td>
<td>39.0</td>
<td>48.2</td>
</tr>
<tr>
<td>Mauritania</td>
<td>2007</td>
<td>68.0</td>
<td>59.7</td>
<td>84.1</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>2006</td>
<td>81.1</td>
<td>86.4</td>
<td>97</td>
</tr>
<tr>
<td>Somalia</td>
<td>2006</td>
<td>96.7</td>
<td>97.1</td>
<td>98.4</td>
</tr>
<tr>
<td>Togo</td>
<td>2006</td>
<td>1.3</td>
<td>4.1</td>
<td>7.3</td>
</tr>
</tbody>
</table>

In Djibouti, the 2002 DHS reported a rate of 98% of FGM/C for women aged 15 to 45 years with nearly 70% of this being infibulation. However, recent research indicates a decline in the rates of FGM/C in Djibouti, and a delay in the age at which it is performed.

4.2.2 Virginity testing

In general, statistics and information on the prevalence of virginity testing are not available. Qualitative reports from South Africa, Zimbabwe and Swaziland suggest this practice often happens on a large scale. For example, one media report claimed that “thousands of young Zulu maidens made their way up to Nongoma in KwaZulu-Natal” for the annual Reed Dance, so called because girls and young women each carry an unbroken reed to signify their status as virgins – which culminates with a genital test to ensure that the hymen is still intact. The Girl Child Network in Zimbabwe identified 7,000 girls who had been subjected to virginity testing between 2001 and 200. South Africa is the only country that has outlawed the practice, and as yet there are no records of virginity testing having been reported to the police or to service-delivery points.

The understanding of virginity testing is complicated by the cultural concepts which underlie it, with the claim being made that it is voluntary. The ‘proven’ virginity of an unmarried girl is construed as a ‘victory’ over males and virginity testing commonly occurs in a ritualistic and festive context, apparently focused on educating those tested.
4.2.3 Sexual touching
Sexual touching (also called fondling) emerged from the materials reviewed here as a significant problem in SSA. In a presentation made at the 18th ISPCAN International Congress on Child Abuse and Neglect held in 2010, rates of fondling of 25% were cited in Ethiopia; in Tanzania, 13% of males and 28% of females reported unwanted touching, while in Uganda the rates were 27% for males and 47% for females.38

One of challenges experienced in conducting this review, as already noted, has been the conflation of various different forms of sexual abuse within the materials reviewed. Madu and Peltzer, for instance, describes the prevalence rate of any form of (physical) contact sexual abuse as being 60% for males and 53.2% for females, and include sexual kissing and touching as well as oral, anal, or vaginal intercourse in their definition.

4.3 Penetrative sexual abuse
Although adults are often reluctant to acknowledge it, the evidence confirms that many children are sexually active. A Save the Children Sweden publication on children’s rights and sexuality in the context of the HIV/AIDS pandemic cites several studies providing evidence that African children are sexually active, and that some of this activity may be consensual, for example:39

- Bankole, Woog and Wulf found in 2004 that 46% of girls and 37% of boys between the age of 15 and 19 years in sub-Saharan Africa have had sex.
- Analysis of Demographic and Health Survey data from 14 countries in the region showed that at least 15% of girls reported having sex before their fifteenth birthday.
- Pattman and Chege found in 2003 that children as young as 6 or 7 years have had some sexual experience.

However, in at least some of these cases, the sexual activity is likely to have been coerced, and could include rape, and Maharaj and Munthree have noted that coercion may play an important role in compelling young women to engage in sexual intercourse at an early age.40

4.3.1 Rape
There are a number of published studies from South Africa on penetrative abuse, but accurate figures are rarer in other parts of the continent. In addition, many studies do not focus on rape per se but on “sexual abuse”, “sexual violence” or “sexual coercion”. A relatively large number of studies focus on “forced first sex”. For example, Polonko et al note that the latter term could tap into both CSA and dating violence.41 Maharaj and Munthree reported both a decline in age at first intercourse and an increase in reporting of coercive first sex in a study in KwaZulu-Natal, South Africa.42 A population-based study conducted in Kenya found that, among sexually experienced respondents aged 10 to 24 years, the first sexual experience of 21% of females and 11% of males was
coerced, with intimate partners being the perpetrators in most cases.\textsuperscript{43} The coercion involved either deception or partner insistence in the face of the reluctance of the victim. These findings suggest that respondents may understand forced sex differently from rape, with the latter being seen as perpetrated by strangers.\textsuperscript{44}

There are many other methodological obstacles to the comparative assessment of child rape prevalence: methods of data collection vary, as do sampling methods and sample sizes. Study populations also differ across countries. Countries affected by conflict such as the DRC show high levels of all forms of sexual abuse, while prevalence in countries that have not been affected by conflict is relatively lower (e.g. in Cameroon and Burkina Faso).\textsuperscript{45}

A number of the peer-reviewed studies considered for this review include data on several countries. Pitche, for example, found in a review of literature conducted in 2005 in SSA that frequency of genital penetration varied between 70\% and 97\% of all cases of CSA.\textsuperscript{46}

**Table 3 – Rape prevalence from selected studies**

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Type</th>
<th>N</th>
<th>%</th>
<th>Definition</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>2004</td>
<td>National survey</td>
<td>5,950</td>
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</tr>
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<td>61</td>
<td>62</td>
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<td>6.1</td>
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<td>Madu</td>
</tr>
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</table>

\textsuperscript{43} \textsuperscript{44} \textsuperscript{45} \textsuperscript{46}
<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Type</th>
<th>N</th>
<th>%</th>
<th>Definition</th>
<th>Source</th>
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<td>Moore et al</td>
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</tbody>
</table>

Sources: Compilation of McCrann et al, Moore et al, Stavropoulos, Madu, Menick(a), Menick(b), World Vision, Ndoko et al, Senegalese Ministry of Education.

**In Southern and East Africa**

Levels of between 9% and 31% of coerced sexual activity perpetrated on both girls and boys were found in 5 countries (see Table 4 below) in SSA by the *Global School-Based Student Health Survey* (GSHS).

**Table 4 - Percentage of children answering “yes” to the question “have you ever been physically forced to have sex”** - GSHS

<table>
<thead>
<tr>
<th>Country</th>
<th>% of girls</th>
<th>% of boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Namibia</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Swaziland</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>Uganda</td>
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<td>13</td>
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<tr>
<td>Zambia</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>14</td>
<td>11</td>
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</tbody>
</table>

The African Child Policy Forum 2006 Conference on Violence Against Girls in Africa found that 31% of girls questioned in a survey in Uganda had experienced rape.

In reviewing the literature on CSA in SSA, Lalor estimated a rate of penetrative abuse of 5% in 5 southern African countries: Botswana, Mozambique, South Africa, Zambia and Zimbabwe. Various other researchers have reported different prevalence levels for rape in SSA. An ANPPCAN Malawi study found 13% of secondary school students described their first sexual experience as unwanted.

Ruto has suggested a rising incidence of reported crimes targeting women and girls in Kenya in recent years. Police records in Kenya documented 2,908 reported cases of rape.
in 2004 compared with 1,987 cases in 2001 (i.e. a 46.4% increase). Data from Nairobi Women’s Hospital indicated that 55% of these cases involved girls from birth to 15 years. In another study involving 228 children aged between 14 and 18 years, 20% of the 112 girls had been raped. This study also indicated that child rape or defilement cases in Kenya range from 10% to 27% of all cases. In Tanzania, cases of street children been sexually abused have been documented by the Mkombozi Centre for Street Children. In Zambia, approximately 1,400 cases of CSA were reported in 2004, according to police statistics.

For more than a decade now, with escalating conflict in Zimbabwe, vulnerability to rape and CSA has been reported to be increasing; as was noted by the Agence France-Presse, there was a higher risk of being raped by members of the militia and police. One study in Zimbabwe found that CSA cases account for between 40% and 60% of all reported rape cases, with many more believed to remain unreported. The Family Support Trust, a Zimbabwean NGO providing free treatment to children who have been sexually abused, has recorded about 29,000 cases in the last four years, and about 70,000 during the last decade in Harare alone.

Police statistics in Madagascar indicate that half of the offences committed against children are sexual offences. Research undertaken in the city of Mahajanga found 69% of the victims were children. In the Comoros, 182 rapes and 91 cases of what is called “child seduction” were reported to the authorities between 1998 and 2002. In the 12 months ending in March 2005, the South African police reported more than 22,000 cases of child rape, in a context where it is estimated that at most, only 1 in 9 cases of rape is reported.

In West and Central Africa

A retrospective study which considered the period between 1998 and 2003 in Congo Brazzaville found that 46.1% of rape cases reported to the police involved children. The 2007 Human Rights Watch report on sexual violence in Côte d’Ivoire noted high levels of rape and sexual abuse of girls, including kidnapping and enslavement.

In the conflict-ridden DRC, where rape is perpetrated at least in part as a result of the conflict, a recent study found that of the approximately 1,684 rape survivors who reported to one facility between January 2005 and December 2007, 233 were less than 20 years old. One study reported as many as 40 cases of rape a day in the period 2002 to 2005, with half the victims being girls under the age of 18. UNICEF reported that it recorded 900 cases of sexual violence in Burundi in 2007, with half of these being children under the age of 18; a further 549 cases were recorded in the first 6 months of 2008, with one third being children.

UNICEF in Burkina Faso undertook an investigation with local partners into 127 cases of CSA in 2001. Overwhelmingly (110 of the 127), the cases were related to sexual abuse, but there were 27 cases of CSEC. A year later, in 2002, 168 CSA cases were surveyed, among which 150 were cases of penetrative abuse. Similarly, in Djibouti, 50% of sexual violence cases reported involved victims aged 11 to 19 years. A report on the rape of children in Togo found that 4.9% of girls reported being victims of sexual abuse, in a more general survey on abuse and experiences of violence.
Groupe d’Action Contre le Viol des Enfants (GRAVE) investigated 400 cases of CSA that were committed between September 2006 and September 2007 in Senegal.\textsuperscript{81} Their findings indicated that, in one region alone, Kolda, more than 100 teen pregnancies were as the result of CSA perpetrated by teachers. In Senegal, it was found that 3\% of the children interviewed disclosed being the victims of sexual violence, and 8\% of girls and 3\% of boys had witnessed sexual violence being perpetrated.\textsuperscript{82}

WHO estimated that in Guinea 10\% of displaced women and girls were victims of gender-based violence. At the camps in one region, half of the 20 children who had experienced various forms of violence had experienced rape.\textsuperscript{83}

\subsection*{4.3.2 Sexual exploitation, child prostitution and transactional sex}

By its very nature, trafficking is a clandestine activity and there is a dearth of information on prevalence.\textsuperscript{84} Nevertheless, the IOM has estimated that each year approximately 1,000 girls aged between 14 and 24 are taken from Mozambique to work as prostitutes in South Africa.\textsuperscript{85}

ECPAT International has found that in West Africa, Senegal Cameroon, Benin and Côte d’Ivoire are affected by sex tourism, with Senegal being one of the more popular destinations.\textsuperscript{86} A 2002 survey in 3 areas in Senegal (Dakar, Petite Côte, and Ziguinchor) covering a three-month period, found 613 children who had been victims of sexual exploitation. While the data are patchy and comparisons are difficult, indications from three years of work in Ziguinchor are that CSEC is increasing in Senegal.\textsuperscript{87} Recent evidence from Senegal indicates that young girls are being recruited for pornographic films and bestiality (i.e. sexual activity with animals).\textsuperscript{88} Similarly, in Cameroon, boy and girl children aged 14 to 18 can be found posing and working in strip clubs, where they are filmed.\textsuperscript{89}

In Côte d’Ivoire, the number of girl victims of trafficking and prostitution networks has doubled since the end of the crisis; more than 58\% of the girls interviewed were younger than 16 years, and 52\% of them were living with a sexually transmitted disease.\textsuperscript{90}

The Human Rights Watch Report on child trafficking in Togo has brought to light that forced prostitution of young girls is centred in an area of Lome known as \textit{marché du petit vagin} (literally, \textit{market of the small vagina}).\textsuperscript{91}

Madagascar, too, has significant numbers of children being sexually exploited, but data are scarce. However, estimates of the numbers of children involved in commercial sexual exploitation in Toamasina in 2002 were up to 13\% of the total population, and in Ilakaka in 2005, it was estimated that nearly 70\% were aged 12 to 18.\textsuperscript{92} Research in Dar es Salaam (Tanzania) revealed that 40\% of children from poor families are being sexually exploited.\textsuperscript{93} CSA is rampant among street children; it is estimated that 30 to 40\% of boys are abused by older boys and market vendors, and 90\% of girls are abused and generally end up in prostitution.\textsuperscript{94}

Sexual exploitation of children in the tourist-oriented west coast of Kenya is well documented.\textsuperscript{95} It suggests also that children are trafficked to these areas from rural areas around the country. One internet site, for example, claims that: “you don’t have to spend a lot of time at the Kenyan coast to know that child prostitution and sex tourism
are rampant there”. It further claims that “in Mombasa and Malindi, it is common to see aging white men well into their 70s and 80s with girls young enough to be their granddaughters”.96 This report highlights the links between poverty and exploitation, noting that “nothing gets a family out of poverty faster than a daughter who has a white boyfriend”97 and that parents and relatives encourage these relationships. Similar findings have been made in Gambia.98

A study undertaken by UNICEF on the Kenyan Coast found that up to 30% of 12-to-18-year-old girls living in the coastal areas of Malindi, Mombasa, Kilifi and Diani were involved in casual sex work.99 It is estimated that 10,000 to 15,000 of girls living in these areas are being sexually exploited in tourism at irregular intervals or seasonally; another 2,000 to 3,000 girls and boys are sexually exploited year-round by sex tourists, in these same areas; 30,000 girls aged between 12 and 14 years are lured into hotels and private villas to be sexually exploited. During the low tourism season, reports indicate that local demand sustains the sexual exploitation of children; children involved in prostitution also pay locals who help them gain access to tourists, such as beach boys, bar staff, waiters and others, with sex.100

According to some reports,101 Lesotho is a source and transit country for women and children subjected to trafficking for forced labour and forced prostitution, and for men in forced labour.102 It is reported that long-distance truck drivers offer to transport women and girls looking for legitimate employment in South Africa. En route, some of these women and girls are raped by the truck drivers then later prostituted by the driver or an associate. Reports indicate that children who have lost at least one parent to HIV/AIDS are more vulnerable to manipulation by traffickers; older children trying to feed their siblings are most likely to be lured by a trafficker’s fraudulent job offer.103

The UN Committee on the Rights of the Child reported an increase in child prostitution in Maputo, Beira, Nacala and other rural areas in Mozambique. Reports in that country affirm that the majority of victims are girls, some as young as 10 to 14, mostly with little or no education. Many of these girls are employed as domestic workers or in subsistence agriculture and are exploited in prostitution at night for additional money. In some cases, girls who work as hawkers and domestic servants suffer sexual abuse and harassment in the course of their work.104

Transactional sex is variably also referred to as ‘cross-generational sex’ and the ‘sugar-daddy syndrome’. The transactional nature of cross-generational sex has important implications for interventions.105 Although most cross-generational sex is transactional, cross-generational sex is differentiated from commercial sex or prostitution. A review of more than 45 studies of cross-generational sex in SSA found a transactional component to sexual relations for adolescent girls who were engaged in neither trafficking nor prostitution.106

One of the difficulties in establishing the prevalence of transactional sex is that it is not necessarily reported to authorities or researchers as a form of abuse in its own right. However, in an effort to deal with this challenge, many studies have looked at issues such as the relative age difference between a girl or young woman and her male sexual partner. A review of over 45 studies of cross-generational sex in SSA found that substantial proportions of girls’ partners were six or more years older.107 This study cited another study that found relative age differences of more than 10 years in between 12%
and 25% of cases, and another that found relative age differences of over 25 years in between 27% and 40% of cases.\textsuperscript{108}

A 2004 UNICEF study undertaken in Malawi found that many girls entered into sexual relationships with teachers for money, became pregnant, and subsequently left school.\textsuperscript{109} In Malawi, "kupimbira" a practice that allows a poor family to receive a loan or livestock in exchange for a daughter, was found in some areas.\textsuperscript{110}

\textbf{4.3.3 Incest / Intra–familial child sexual abuse}

The incidence of incest is very difficult to ascertain, and there is little in the literature that focuses specifically on this form of CSA. However, information from both qualitative and quantitative research confirming the high rates of CSA perpetrated by people closely related to the victim provides support for the contention that rates of incest in SSA are high. In addition, incest is frequently identified as part of larger studies on CSA in SSA as a significant problem.\textsuperscript{111}

As long ago as 1996, the Eastern and Southern African Regional Consultation held in preparation for the First World Congress against commercial sexual exploitation of children drew attention to the high rates of incest perpetrated against children in the region.\textsuperscript{112} Research in Togo has indicated high rates of incest, and has highlighted that such situations are seldom brought to the attention of authorities because "communities consider such problems to bring shame to the family".\textsuperscript{113} A Zambian study has noted that more boys than girls had experienced intercourse or oral sex with a family member.\textsuperscript{114}

A study in Cameroon surveyed 37,719 women and girls in a total of 30 towns, and identified that 18% of cases of rape were perpetrated by a family member, extrapolating from this that approximately 78,000 girls and women had been victims of incest in that country.\textsuperscript{115}

\textbf{4.3.4 Child marriage}

Child marriage (i.e., marriage before the age of 18 years) is prevalent in a number of countries in SSA, with rates reported to be high in Kenya, the DRC, Guinea, Liberia, Mali, Mozambique, Niger, Nigeria, Senegal, Sierra Leone, and Tanzania.\textsuperscript{116} Due to the fact that it invariably involves sexual relations with the husband, child marriage has been classified as a form of penetrative abuse.

The prevalence of child marriage in SSA and globally is very well documented, primarily because the DHS and MICS surveys collect data on this indicator (see annexure 3). DHS and MICS surveys in SSA indicate the following prevalence of early marriage:

- Early marriage is generally more prevalent in Central and West Africa – affecting more than 40% of girls under 18, compared to around 20% in East, North and Southern Africa.\textsuperscript{117}

- In countries like the Central African Republic, Chad, Guinea, Mali, and Niger more than 60% of women entered into marriage or into a union before their eighteenth birthday.\textsuperscript{118}
In Uganda, although the legal age for marriage is 21, more than half of girls are married before they reach the age of 18.\textsuperscript{119}

In some regions of Nigeria, including Kebbi State in the north, girls generally marry soon after their 11\textsuperscript{th} birthdays.\textsuperscript{120}

Girls from poor backgrounds with low levels of education are most at risk.\textsuperscript{121}

Although early marriage is still practiced, the rate seems to be declining in some countries, namely Senegal, Uganda and Ethiopia.\textsuperscript{122}

4.4 Some conclusions regarding magnitude

In conclusion, the information available on CSA suggests that it is a serious problem in SSA. Despite the fact that there is a considerable amount of information available on the issue, rigorous research is not comprehensive and data collection methods differ widely; thus making comparisons across countries and across studies difficult, as is a deeper understanding of the nuances within CSA.

The issue of the under-reporting of CSA exacerbates this problem, and is well-documented across the region.\textsuperscript{123,124}

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1 WHO Regional Office for Africa. 2004. Child Sexual Abuse – A Silent Health Emergency. Report of the Regional Director to the 54\textsuperscript{th} Session of the Regional Committee for Africa. AFR/RC54/15 Rev. 1
9 Madu S N, & Peltzer K. 2001
10 Madu S N, & Peltzer K. 2001


Polonko et al. 2010.

Maharaj P and Munthree. 2007.


77 UNICEF. 2008.  
79 Higonnet E.  
82 République de Madagascar. 2008.  
90 Pinheiro P. 2006.  
96 Ogweno OJ. 2005.  
UNICEF. 2005. La traite des personnes, en particulier des femmes et des enfants en Afrique de l’Ouest et du Centre Unicef.
Bureau International du Travail (BIT). 2006. Étude de base sur les PFTE dans le nord et sud de Madagascar. BIT.
Stöpler L. 2009.
United States Department of State. 2010.


Democratic and Health (DHS) surveys accessible at: http://www.measuredhs.com/aboutsurveys/dhs/start.cfm.

O’Flaherty M. 2005. Trafficking in human beings, especially women and children, in Africa. UNICEF.


See for example Lalor K. 2004.
5. FACTORS ASSOCIATED WITH CHILD SEXUAL ABUSE IN SUB-SAHARAN AFRICA

According to Lalor,¹ the focus on child sexual exploitation and prostitution in the developing world has resulted in the neglect of the more pervasive sexual abuse of children perpetrated in their own homes, neighbourhoods and communities, frequently by peers, teachers, parents, legal guardians and other relatives. Factors that are examined here are those of age, gender, social conditions and settings for the child and the perpetrator.

5.1 Age

Children of all ages appear to be at risk of CSA, and the youngest children are not exempt. Pitche, for example, in reviewing the literature pertaining to CSA in SSA, noted that the average age of victims of CSA was 8 years.²

A retrospective study covering the period 1998 - 2003 carried out in Congo Brazzaville indicated that 46.1% of cases of sexual abuse involved children aged 11 to 15 years, and that 37.3% of the aggressors in these cases were aged 21 to 25 years.³ The youngest victim was only 4 years old, and the person who raped her was himself a child aged 14.⁴ The 2007 Human Rights Watch report in Côte d’Ivoire noted the rape and sexual abuse of girls as young as 6 years.⁵

In the DRC, a study on 1,684 rape survivors (January 2005 - December 2007), revealed 25 children under the age of 15 and 198 aged 16 to 20 years⁶ who had been raped. Among the 40 cases of rape a day reported in the period 2002 to 2005, half the victims were girls under the age of 18 and a quarter were under the age of 13 years.⁷

Police statistics in Madagascar show that 20% of sexual offences cases in 2006 involved children aged 0 to 6 years. In research undertaken in the city of Mahajanga, the mean age of child victims of CSA was 10.⁸

A UNICEF study in Burkina Faso indicated that more than half the child survivors of CSA were younger than 14, with almost 10% being younger than 10.⁹ Reports from Djibouti indicate 50% of sexual violence cases reported involved victims aged 11 to 19 years.¹⁰ Research in Chad indicates that cases of sexual abuse and sexual exploitation rarely come to the attention of the authorities.¹¹ Nevertheless, the available information indicated that 4 in 10 cases involved children aged 13 to 15 years, and more than 25% involved children aged 10 to 12. The sample included a child under the age of 9.¹² Most of the cases involved girls, but a small percentage of boys had been victims.

In a sample of 147 children from Côte d’Ivoire, 56% of the cases of sexual violence against children were reported by children aged 13 to 18; children aged 5 to 12 reported 41% of the cases, and children under the age of 5 reported a further 3%.¹³

The global school-based student health survey showed that 9.8% of girls aged 13 to 15 years and 21.1% of girls aged 16 years and older reported having been physically forced
into sexual intercourse. In several primary and secondary schools, 19.2% of students had been sexually abused, with those aged 10 to 15 years being the most affected.\textsuperscript{14}

In a recent national study on violence against girls and young women in Swaziland, 1 in 3 girls reported that their first sexual experience was forced.\textsuperscript{15} Among girls aged 13 to 17 years, 2.3% reported that they had been raped, 5.7% reported that they had been coerced into agreeing to have sex, and 16.8% reported that someone had attempted to rape them.\textsuperscript{16} The rape of 3 sisters, aged two weeks, two years and three years was reported by the Girl Child Network in Shamva in Zimbabwe.\textsuperscript{17}

Other types of CSA such as child prostitution, sexual exploitation and early marriage and FMG/C affect also very young children, as shown in tables in the annexures. Girls in some ethnic groups in Burkina Faso are excised very young – 50% of girls are excised before their fourth birthdays; while in other groups, girls are usually excised at the age of 8 or 9 years.\textsuperscript{18}

\section*{5.2 Gender}

In all the countries in SSA, CSA is perpetrated against both girls and boys, although, in general, girls are more at risk.\textsuperscript{19} Recent research undertaken by the South African Medical Research Council suggests that 3.5% of young men have been sexually abused in childhood – i.e. 1 in 30 South African men – and they argue that this, at least in part, fuels the high rates of rape and sexual abuse in that country.\textsuperscript{20}

In a baseline study on safe schools in Malawi, more boys than girls reported being subject to sexual comments, witnessing genital exposure, being forced to view sexual acts or pornographic materials, being forced to remove their clothing and experiencing insertion of objects into their genitals and anus.\textsuperscript{21}

Recent work in rural South Africa by Jewkes et al found that, in their sample of 1,637 men living in rural villages, 16.7% had experienced sexual CSA abuse.\textsuperscript{22}

\section*{5.3 Care arrangements}

Skinner et al\textsuperscript{23} highlight that living arrangements are a core component of vulnerability, referring in particular to the large numbers of children no longer living with their biological parents (and in particular their biological mothers). Care arrangements have been specifically impacted by the HIV pandemic.

Becoming orphaned can have serious negative implications for children’s development and protection. This is especially true in situations of conflict and displacement. For example, a study on refugee children in Guinea, Sierra Leone, and Liberia found that the children most vulnerable to sexual exploitation were those living without the care of their parents, children in child-headed households, orphaned children, children in foster care, children living with extended family members, and children living with just one parent.\textsuperscript{24}

Despite concerns that orphaned children face greater risks of CSA, little substantive work has been done in this area.\textsuperscript{25} However, research undertaken in SSA in the last few years has shown clearly that:
• Orphans were nearly one and a half times more likely to have had sex than non-orphans and were more likely to have had sex by age 13; \(^2^6\)

• Youth who lived with both parents were less likely to have had sex than youth who lived with one or neither parent; \(^2^7\) and

• Orphan status significantly affects sexual risk, with children orphaned before the age of 12 being more likely to test positive for HIV, or herpes simplex virus type-2 or, in the case of girls, to be pregnant. \(^2^8\)

One study concluded that “there is something about being an orphan [...] which puts youth at risk of becoming sexually active”, \(^2^9\) while another was even more specific, claiming that “having an HIV-infected parent and loss of the mother constitute the greatest and most consistent sources of vulnerability to adverse reproductive health outcomes”. \(^3^0\)

Orphaned children are often forced into early marriage, and this is sometimes related to the practice of sororate - the mandatory custom for a sister to marry the husband of her deceased sister irrespective of her age.

5.4 Some variables related to the perpetrators

Kariuki\(^3^1\) indicates that, in studies done in Kenya, the main perpetrators of sexual harassment were other children (60%) followed by strangers (16%), neighbours (6%) then teachers (5%). The Indian Ocean Region Child Rights Observatory (ODEROI) has noted that, in the Seychelles, 30% of CSA was perpetrated by the victim’s father. \(^3^2\)

The UNVAC reported that a large proportion of women who report CSA indicate that a family member was the perpetrator. \(^3^3\) For example, experiences among high school students in South Africa suggest that 1 in 5 victims of CSA are abused by a parent or guardian, and that adolescents raised by a step-parent or in a group home were significantly more likely to experience child abuse. \(^3^4\)

Children left at home by working parents are often also at risk of CSA, though this is then not always perpetrated by members of their immediate family, but by “opportunistic predators”. \(^3^5\) In general, the perpetrators of non-penetrative contact and penetrative CSA are more likely to be known to their victims, and be members of the victim’s family, neighbourhood, or community. \(^3^6\) According to Meursing et al., \(^3^7\) a study in Zimbabwe indicated that men known to the child are the most common offenders. Another study found that, in Ghana, 14% of schoolgirls said they had been raped by boys they knew well. \(^3^8\)

Research evidence indicates victims of violent offences, including of sexual offences, are more likely than non-victims to become perpetrators of violent offences, including sexual offences, themselves. \(^3^9\) In addition, both violent offending and violent victimisation share many of the same risk factors – previous violent victimisation, drug and alcohol use and depression. \(^4^0\) According to the report of a workshop held in South Africa by the United Nations Development Programme (UNDP) Child Justice Project, international research indicates that 50% of adult sexual offenders begin their offending behaviour during childhood. \(^4^1\)
A study of cross-generational sex in SSA found overall that substantial proportions of girls’ partners were six or more years older. This study cites findings of relative age differences of more than 10 years in between 12% and 25% of cases, and another study that found relative age differences of over 25 years in between 27% and 40% of cases.

5.5 Environments of risk

According to Kariuki’s study in Kenya, the home was found to be an environment of high risk for CSA (27%), followed by the school (24%), the journey from home from school (15%) and other people’s home (12%). The incidence of CSA perpetrated in public places (bush, market, disco, town, ceremonies) was found to be 15%.

5.5.1 Home and family

Children are at significant risk of sexual abuse within their own home, and this applies across several types of abuse.

Even if the actual commission of FGM/C takes place in other settings, in those countries where it is practiced, it is in the home that it is often most strongly defended. Women living in these countries “would never think of living without being excised. These are the women who ask to be excised and infibulated, and they are the ones who force their daughters to be excised because it is the norm.” It is the case, however, that most of the FGM/C is performed traditionally – i.e., performed by a traditional practitioner including local specialists known for performing circumcisions, traditional birth attendants, and older women. Between 73.6% (in Nigeria) and 99% (in Benin) of circumcisions are traditionally performed in SSA. Vulvectomy (the cutting of the vulva) is also usually carried out on children in their homes by traditional practitioners.

Child marriage can also be considered to a form of CSA perpetrated in the home - the Zimbabwean Girl Child Network observed several cases of sexual abuse where girls under 13 years were married (with these marriages sanctioned by local church elders), which came to light some years later when the victims were at risk of death due to complications associated with pregnancy. Children have also been known to flee their homes to avoid child marriage, and reports of children being abducted for child marriage are common.

In their qualitative study titled Violence against children in Ethiopia: In their words, the African Child Policy Forum notes several instances of CSA perpetrated by close relatives within the victims’ home. In a recent national study on violence against girls and young women in Swaziland, 33.3% of girls aged 13 to 17 years reported that their first sexual experience was forced, and stated that it took place in their own homes, with the most common perpetrators being men or boys from the respondent’s neighbourhood.

Ugandan children reported high levels of sexual abuse, with one third stating that this took place in their homes. A UNICEF study in Zambia also highlighted the fact that CSA occurs in a context of silence which is protective of social relationship and the hierarchy within the family and community.
However, the immediate community also poses risk of CSA. A recent study of sexual abuse among young female street-hawkers in Nigeria found that, with an average age of 13 years, nearly 70% of 186 girls hawking on the streets (130 of the respondents), had been sexually abused, that 28.1% of them had been raped and that the perpetrators were overwhelmingly adult males.  

While the scale of the problem is difficult to ascertain, it is clear that the majority of children living and working on the streets are boys. Girls and boys living on the street are vulnerable to sexual abuse from many individuals, including from passers-by and from those who offer them shelter. They also risk being recruited by pimps and traffickers for sexual and economic exploitation or having to resort to ‘survival sex’ (sex in exchange for food or shelter). A 2007 study in Zambia cites figures for children living and working on the streets in Zambia as around 35,000 children.

5.5.2 School and schooling environment
CSA in school settings is described by many writers and researchers in the region as a serious problem, which mostly impacts on girls, but not exclusively. Research indicates that school environments are high-risk locations for CSA, although homes and market places were found to be riskier.

CSA in school settings involves sexual “favours” in exchange for good grades as well as transactional sex where the victim is coerced into sexual activity in return for educational benefits such as school fees and materials. Plan Togo, for example, has identified the concept of ‘notes sexuellement transmissibles’ (sexually transmitted marks) being in common usage in secondary schools.

Recent research undertaken by PLAN, Save the Children, Action Aid and UNICEF reveals that school violence, including sexual violence, has spread in SSA. School violence is multifaceted and embedded in violence and gender discrimination at family and community level. It is a complex societal issue, in which the power relationships, and the domination and discrimination practices of the community and wider society are reflected.

UNICEF in West and Central Africa noted that sexual abuse in school setting occurs in all the countries in the region. Teachers were found to be ‘seducing’ school girls in 21 of the 22 countries studied; verbal harassment of school girls by school boys was identified as a problem in 20 of the countries; and sexual favours in exchange for marks was prevalent in 20 of the countries. It was also noted that Ministries of Education were aware of the problem and considered it to be one of the main reasons why girls drop out of school.

Several authors identify girls at secondary-school level as at greater risk than younger school girls. For example, in 2004, WHO reported high levels of sexual violence and harassment in secondary schools, with both boys and girls experiencing some form of sexual abuse. However, children in primary school are also vulnerable to abuse by teachers, as was found by Shumba in Zimbabwe in 2001.

A Human Rights Watch study on sexual abuse in South Africa found that girls can be raped in school toilets, empty classrooms, dormitories and hostels. However, other research undertaken in South Africa by, for example, the Medical Research Council,
confirms high levels of sexual abuse of girls in South African schools, but reports that, while male teachers use various methods and opportunities to gain sexual access to the girls learners in their schools, this does not necessarily occur in school toilets.\textsuperscript{70}

Research in Ghana found that 53.3\% of the instances of sexual abuse took place in the school environment – 6.7\% in the school building or grounds, and 46.6\% on the way to and from school.\textsuperscript{71} In Swaziland, 10\% of those interviewed experienced sexual violence in a school building or the school grounds, and in 9.5\% of cases, the abuse was perpetrated while the victim was on her way to or from school.\textsuperscript{72}

High levels of sexual violence in Kenyan schools has also been noted, including the incident at St. Kizito, where 70 girls were raped while 19 others lost their lives when their male peers descended on them during what was supposed to be a school strike.\textsuperscript{73}

The research on CSA in school settings is focussed primarily on girls, and there is less documented evidence of boys as victims; there is some evidence, however, that boys are also at risk. A study in Ghana, for instance, identified that a small percentage of boys had also experienced sexual harassment.\textsuperscript{74} Similarly, a study in Malawi found that, although girls were at greater risk for peeping, unwanted touching and coerced sex, boys were more at risk of some forms of non-contact and contact sexual abuse, including being forced to watch sexual activity and look at pornography, as well as of having objects inserted into their anus.\textsuperscript{75} The Global School-Based Student Health Survey found that 21.4\% of boys had been sexually abused in the five SSA i that participated.\textsuperscript{76}

It must be noted that addressing GBV in school settings must include boys, who are victims as well as perpetrators of violence.\textsuperscript{77}

School authorities seldom recognise or acknowledge the levels of CSA being perpetrated in school environments. For instance, a study in Ghana found that only 20\% of teachers acknowledged that CSA was a problem in the area, whereas 81\% of parents in the same area identified it as a problem.\textsuperscript{78} Similarly, in Benin, one study found that 33\% of pupils disclosed sexual violence in their schools, while only 15\% of teachers did so.\textsuperscript{79} This is, however, not a consistent finding. In Niger, for example, 48\% of the young people interviewed said they saw their teachers express love feelings towards one of their female class mates, while 88\% of the teachers stated that sexual incidents occurred in their school in which pupils and teachers were involved.\textsuperscript{80} Nevertheless, it is often the case that school administrators, the larger community, and the ministries of education in many countries do not take female student’s complaints seriously, and incidents are seldom even reported for fear of reprisal, especially from teachers, and also because the victims believe that nothing will be done.\textsuperscript{81}

In a UNICEF study in Zambia in 2001, more cases of sexual abuse were found to occur among children not attending school than among those who attend school.\textsuperscript{82} According to the study, the majority of those who had been sexually abused (60\%) reported that they spend much of their time selling on the street or playing around town areas, and more than one quarter reported that most of their time was spent around the home.\textsuperscript{83}
5.5.3 Health care systems, alternative care and prisons
In the case of FGM/C, it is often performed by health-care providers. The increase in the numbers of people seeking FGM/C from health-care providers (doctors, nurses, and midwives) is attributed to that fact that FGM/C has historically been addressed as a health issue, and to a growing awareness of its negative health consequences. A recent analysis of existing data shows that more than 18% of all girls and women who have been subjected to FGM/C in the countries from which data are available have had the procedure performed on them by a health-care provider. The highest rate of medically performed FGM/C in SSA is found in Guinea (10%).

Health-care providers who perform FGM/C are noted as violating girls’ and women’s right to life, right to physical integrity, and right to health, as well as the fundamental ethical principle of ‘do no harm’. The WHO has developed guidelines on ending this practice.

Various studies have recorded a wide range of abuses against children and an increased vulnerability to violence in alternate care institutions, including systematic rape and other forms of sexual abuse, exploitation, trafficking, physical assault, and psychological harm including isolation, the denial of affection and humiliating discipline. This is due mainly to the closed and often isolated nature of such care, compounded by the fact that many children in residential care are unaware of their rights, and in any event are powerless to defend themselves. Children with disabilities are at an increased risk of such abuse.

Anecdotal and qualitative evidence suggest that the sexual abuse of young people in prisons is a significant problem, and affects large numbers of boys. However, there is almost no statistical information available on the extent of the problem. Research in one prison in South Africa in 2007, for instance, could not obtain statistics of reported assaults, but interviews within the general prison population tended to indicate that the prevalence rate was around 50%.

5.5.4 Workplace
The material reviewed here showed clearly that children are vulnerable to both CSA and child labour, and that children engaged in labour are at higher risk of CSA. For example, a study of female domestic workers in Nigeria found that 85% of the girls questioned were sexually abused. In Uganda, one study found a rate of 12.6% child domestic labour charges in the 17,349 cases of child abuse reported to the Ugandan police in 2007.

In Mauritania, the AFCF documented 202 cases of girl domestic workers who were victims of sexual abuse.

In the DRC, a UNICEF study found girls aged 12 to 15 working in bars, hotels and brothels. They work 7 days a week for three weeks every month, with 1 week off while

1 Alternate care is defined as “a formal or informal arrangement whereby a child is looked after outside the parental home, either by decision of a judicial or administrative authority or duly accredited body, or at the initiative of the child, his/her parent(s) or primary caregivers, or spontaneously by a care provider in the absence of parents” – see The Better care Network at http://bettercaretoolkit.org/BCN/Toolkit/Glossary/index.asp.
they are menstruating – a lucrative industry that generates well over 2 million CFA per month.  

Research conducted in 2009 in six areas of Dar es Salaam indicated that commercial areas in Tanzania, including mining and fishing areas, were known locations for child prostitution. Anecdotal information confirmed that a large number of children travel to these areas on payday to solicit sex.

5.6 Some gaps regarding factors associated with child sexual abuse

This review of the literature has highlighted some of the individual factors linked to the age and sex of the victims of CSA. The interpersonal and social relations with the perpetrators have been described, as well as the situations and contexts in which CSA occurs. However, some potentially useful variables, such as place of residence, whether in a rural or urban setting, level of education, child birth order, parents’ income, family ties, degree of social cohesion and the role of traditional systems of sexual control are largely not reflected in the literature.

In demographic and health surveys, the age categories used are not always relevant to an understanding of determinants, associated factors and responses to CSA, and the inclusion of CSA indicators in population surveys would allow for optimal use of the data thus generated.


Grynko, P. 2006


Pinheiro, P. 2006


Kariuki C. 2005

Pitche P. 2005

Inter-Parliamentary Union. 2009. *How to put an end to the practice of female genital mutilation (FGM)*? Accessible at http://www.ipu.org/PDF/publications/fgm08-e.pdf


References:

85 UNFPA, UNICEF. 2010.
87 UNFPA, UNICEF. 2010.
88 UNFPA, UNICEF. 2010.
6 THE CONSEQUENCES OF CHILD SEXUAL ABUSE

CSA has immediate and long-term consequences. These include physical injury, sexually transmitted infections (including HIV), emotional trauma and even death. In the older child, it may result in unwanted pregnancy and unsafe abortion with its attendant complications. Other social outcomes include poor school performance, rejection by family and society, family disharmony, poor parenting and abusive behaviour in later life.¹

The consequences of CSA, according to the African Child Policy Forum, include:²

- Denial of fundamental rights
- Undermining development goals
- Health complications
- Social and behavioural problems
- Psychological consequences (increased depression, anxiety, suicide)
- Perpetuating the cycle of violence
- Socio-economic costs

In a recent study in South Africa, Jewkes et al found negative health and psychological consequences for both women and men who had experienced CSA. For women, CSA was found to result in higher rates of HIV infection and alcohol abuse in adulthood; for men, CSA was found to result in higher rates of alcohol abuse and depression.³

6.1 HIV/AIDS and other STIs

As highlighted in Chapter 3, the HIV epidemic has had a significant negative impact on children’s vulnerability in SSA and it continues to do so.⁴

Meursing et al reported that half of the sexual abuse of children is detected through STDs and some have HIV.⁵ In his literature review, Pitche⁶ noted that:

- The frequency of STI transmission was variable – between 10 and 67% of children suffering from STIs had been sexually abused; while between 15 and 30% of sexual abuse cases were linked to STIs.
- HIV frequency varied from 3 to 37%.

The rape and sexual coercion of young girls is often associated with more severe genital injury than is the case with adult women.⁷ In addition, when pregnancy does result, many young girls seek illegal terminations of pregnancy, despite the fact that abortion is prohibited in most countries in SSA. These can result in serious gynaecological problems and even in death.⁸
Children who are raped are at higher risk of HIV infection than are adults for reasons related to their anatomy and physiology.9 A significant factor is that the pre-pubertal vaginal lining is only a single cell thick; the vaginal mucosa only thickens with the introduction of oestrogen at puberty. The risk is compounded by the fact that the risk of tearing and damage to the vagina of a child – thus facilitating the transmission of HIV - is high; indeed, microscopic tears are common even in consensual intercourse between adults. These risks are compounded by the involvement of anal rape.10

Cross-sectional studies have shown that intimate partner violence and gender inequity in relationships are associated with increased prevalence of HIV in women.11 In addition, research indicates that the risk of HIV transmission is higher with higher levels of violence and inequity, and that these variables impact more significantly on HIV transmission in combination than either does in isolation.12 However, few HIV prevention programmes address these issues; organisations driving HIV prevention agendas for women, particularly UNAIDS and WHO, need to ensure that policies, programmes, and interventions to build gender equity and prevent partner violence are developed and widely implemented.13

As we have seen in this review, SSA is a region with high levels of GBV, CSA and HIV. The situation is compounded by low reporting of CSA, and the limited access to treatment, including antiretroviral therapy (ART) for HIV/AIDS. Although regional treatment coverage has improved from 2% in 2003 to 44% in 2008, fewer than half of those who need ART received it.14 Trafficking and sexual exploitation also enormously exacerbate the risks of HIV transmission.

CSA increases HIV-related vulnerability on several levels, and in two directions, i.e., CSA can both result in HIV infection and play a role in exacerbating vulnerability to HIV. Risk factors for STIs, including HIV, include the age of first intercourse, unsafe sexual practices and treatment services.15 The links between CSA and HIV and AIDS pertain to both boy and girl children. There is increasing evidence that high numbers of boy children are also victims of sexual abuse. The vulnerability of boys is compounded (in children beyond babyhood) by the greater risks of HIV transmission linked to anal rape – which is not to say that girl children are not also raped anally.

Structural factors associated with HIV risk and prevention are increasingly being seen as important in understanding and addressing the HIV pandemic.16 These include physical, social, cultural, organisational, community, economic, legal or policy aspects of the environment that impede or facilitate efforts to avoid HIV infection, create vulnerable populations and sustain high-risk behaviour.17

A number of factors related to vulnerability to HIV transmission are at play with regard to CSA in SSA, and are reflected in vulnerability to transmission in all settings where CSA.

6.2 Reproductive health consequences

According to the WHO, adolescent pregnancy can result in pregnancy-induced hypertension, anaemia, infections (including malaria and HIV), premature labour and delivery, low birth-weight, peri-natal and infant mortality, maternal mortality, and obstructed and prolonged labour (common in immature girls who bear children), which
often results in vesico-vaginal fistulae (also known as obstetric fistula), and loss of full control of urinary or rectal functions. One study in Niger found that 88% of women suffering from fistulae were married between the ages of 10 and 15. A study in South Africa found that, of the 3,299 subjects from a nationally representative household survey of youths aged 15–24 years in South Africa, girls aged 18 and over who had been threatened or coerced were less likely to use condoms than girls who were not, and more likely to have been pregnant before the age of 18.

These consequences have poor health and well-being outcomes for pregnant adolescents, and are often exacerbated by the risks associated with unsafe and illegal abortion. These risks are further compounded by the fact that pregnant adolescents often delay seeking a termination until the pregnancy is considerably advanced. More than a quarter of unsafe abortions in Africa are performed on girls aged 15 to 19 years.

The risk of physical injury to the genitals and reproductive organs is also higher in young children, due to the small size, inelasticity, and lack of lubrication of the vagina and cervix; this is exacerbated if there is exposure to frequent, unprotected, or forced sexual intercourse.

The physical consequences of FGM/C include severe bleeding and problems urinating, and later, potential childbirth complications and new-born deaths. The WHO multi-country study on FGM/C (involving Senegal, Burkina Faso, Sudan, Ghana, Nigeria and Kenya) found that women who had been subjected to FGM have higher risks of caesarean section, post-partum haemorrhage, extended maternal hospital stay, infant resuscitation, still birth or neonatal death (1 to 2 perinatal deaths per 100 deliveries) and low birth weight.

The consequences of abuse in situations of conflict and displacement include high rates of death, pregnancy, vaginal fistulas, sexually transmitted infections (including HIV), infertility, stigmatisation, exclusion, psychological suffering, and depression.

Girls who are married young are also more vulnerable to sexually transmitted infections (STIs), including HIV/AIDS. For example, in Kisumu, Kenya, HIV infection rates were found to be nearly 33% among married girls aged 15 to 19 years, compared with 22% among unmarried, sexually active girls of the same age. This is compounded as the average age gap between young brides and the men they marry reaches eight to ten years or more - the older the husband is, the more likely it is that he would have had multiple sexual partners and may be HIV-positive. Also in Kenya, Erulkar found in a 2004 study that non-consensual sex was associated with negative reproductive health behaviour and outcomes for young women, including higher numbers of sexual partners and higher rates of reproductive tract infection.

However, recent research in Lesotho has indicated that the migration of young people for extended periods for the purpose of employment has resulted in later marriage and an extended period of premarital sexual activity, during which young people may engage in a greater number of sexual partnerships, with more frequent partner change, and thus greater risk of HIV transmission.

The power imbalances that are implicit within transactional sexual relationships, especially between younger women and relatively older men, may make it difficult to
refuse sex, or negotiate condom or contraceptive use. These young women tend to be disadvantaged in terms of gender, age and economic status.\textsuperscript{32}

### 6.3 Psychosocial consequences

Mental health consequences of CSA include debilitating fears, anxieties, regressive behaviours, nightmares, withdrawal,\textsuperscript{33} depression, anger and hostility, self-injurious behaviours, low self-esteem\textsuperscript{34} and inappropriate sexual behaviour,\textsuperscript{35} and severe psychiatric disorder.\textsuperscript{36} These consequences often leave children unable to benefit from educational opportunities or having to leave school due to pregnancy and early motherhood.\textsuperscript{37} They are prone to ending up in violent and sexually abusive relationships through their lives - often, they engage in high risk-taking behaviour, including drug and substance abuse and prostitution.\textsuperscript{38} Boys who have been victimised were found to share the same range of negative psychological consequences as girls.\textsuperscript{39}

The short-term emotional consequences of CSA can include fear, lack of concentration, flashbacks, phobias, and anger.\textsuperscript{40}\textsuperscript{41} Longer-term consequences include psychological problems such as anxiety or depression, psychosomatic symptoms such as unexplainable illnesses, suicide, delinquency, and further victimisation.\textsuperscript{42} Rape survivors have been found to have high rates of persistent post-traumatic stress disorder.\textsuperscript{43} Insomnia, eating disorders, dissociation, inattention, memory impairment, self-medication, self-mutilation, sexual dysfunction, and hyper-sexuality have also been found to result from CSA.\textsuperscript{44} Studies in West Africa found alarmingly high rates of acute suicide risks amongst girls who were victims of sexual abuse and exploitation.\textsuperscript{45} In some cultural contexts, CSA survivors may also face social stigma and possible rejection by their families or community, because of the high cultural value attached to sexual purity.\textsuperscript{46} These can result in lost educational, skills training and employment opportunities, and reduced chances of marriage, social acceptance and integration.\textsuperscript{47}

Children who are raped in conflict situations are unlikely to have access to support mechanisms that will enable them to cope with the physical and psychological effects of rape.\textsuperscript{48}

CSA has also been shown to result in changes in the view that girls have of their bodies. One widely reported consequence appears to be that girls trivialise commercial sexual encounters and view their bodies as bargaining tools to obtain material possessions, good grades or basic necessities such as food and lodging while they are in school.\textsuperscript{49}

In addition, recent (and unpublished as at September 2010) research in South Africa indicates that the rape of a child has serious negative emotional and psychosomatic consequences for the child’s caregiver, which impact on the caregiver’s capacity to provide appropriate support to the child, further exacerbating the negative emotional consequences of sexual abuse for the child.\textsuperscript{50} Feelings of shock and anger, the tendency to internalise their own feelings of pain and an inability to articulate their feelings, and emotional distress (often linked to their own exposure to violence) impede the caretaker’s ability to support the child’s recovery post-rape.\textsuperscript{51}

Meursing \textit{et al} concluded that victims are traumatised by the abuse itself as well as by subsequent problems in family, health and in court.\textsuperscript{52} Chege and Sifuna indicate that the
The effect of sexual abuse on the personal development of the victims is adverse while the consequences for male perpetrators are, in general, light. 

Botswana, Liberia, and South Africa are identified as some of the countries in SSA where the sexual abuse of girls in schools is an impediment to them being able to complete their education. In Benin, Chad, the DRC, Ethiopia, Gambia, Guinea-Conakry, Kenya, Liberia, Mauritania, Mozambique, Niger, Nigeria, the Democratic Republic of Congo, Tanzania, and Togo high rates of early marriage are responsible for low rates of girls entering or completing secondary school. In addition, high levels of teenage pregnancy and prohibitions on girls remaining in school once they become pregnant are a problem in Cape Verde and Togo, among other countries.

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7. RESPONSES TO CHILD SEXUAL ABUSE

At the highest level, rights are protected by international and regional treaties, and this is also true of the rights of children. The rights of African children are enshrined in the United Nations Convention on the Rights and Welfare of the Child (the UNCRC) and the African Charter on the Rights and Welfare of the Child (the African Charter). Responses to CSA should be governed by the full range of international and regional rights treaties.

At the policy and programme level, a three-tier intervention model based on a continuum-of-care approach is needed to protect children from all forms of abuse and neglect in general, comprising: ¹

- At the base of the tier should be a strong primary prevention ethos, linked to specific strategies that target all children to prevent maltreatment and abuse in the first place. Adequate access to the necessities for survival and development - nutrition and primary health care to ensure survival and physical development; opportunities for emotional, social and cognitive development (including access to at least basic education); and being raised in nurturing and loving families - are the basic rights of all children, no matter what the circumstances into which they are born.

- Second, specific strategies should be aimed at intervention in the early stages of becoming vulnerable (secondary prevention) so that families (and therefore children) receive the support they need to provide protective and nurturing environments in which to raise children. These strategies should focus efforts and resources on families where there are children known to be at greater risk of maltreatment, in order to prevent the development of full-scale or on-going abuse. Early intervention services should have the following primary goals:
  - To prevent the removal of children from their families;
  - To prevent the recurrence of problems and reduce the negative consequences of risk factors;
  - To divert children away from either the child- and youth-care system or the criminal justice system.

- Last, a third layer – one of statutory protection (tertiary level) interventions - is needed for children who have already become victims, to ameliorate the harm done to them and alleviate the consequences.

7.1 The international and regional legal framework

Both the Universal Declaration of Human Rights and the African Charter on Human and People's Rights accord the same rights to all human beings without any distinction (i.e., including children) and this is referred to in the Preambles of both the UNCRC and the African Charter, in which it is also stated that children require special care and assistance. These additional rights held by children are the subject matter of the UNCRC and the African Charter.
7.1.1 The UNCRC and African Charter
Obligations are placed on state parties to protect children from all forms of violence, cruelty, exploitation and abuse under both the UNCRC and the African Charter.

All the countries in Africa, with the exception of Somalia, have ratified the UNCRC. Indeed, only 2 of the 193 UN member-states have not ratified it, with the other being the United States of America. The UNCRC has the distinction of being the most-ratified and fastest-ratified human rights document in history.

Africa is the only region in the world with its own child rights treaty, yet not all African countries have ratified it. When a country has signed a treaty or convention, there are no obligations on it yet. Once a country has ratified a treaty or convention, however, it must domesticate it (i.e., enshrine it in domestic law) and report regularly to the relevant UN or AU Committee. Sometimes, countries just accede to a treaty – which means they have signed and ratified it.

As at September 2010, 45 of the 53 AU-member countries in Africa have signed, ratified and/or acceded to the African Charter. However, the Central African Republic, the DRC, Djibouti, Sao Tome & Principe, Somalia, and Swaziland have signed but not ratified it.\(^2\)

While very similar in many respects, the African Charter contains some provisions more strongly stated than those in the UNCRC. These include:\(^3\)

- The best interests of the child are the primary consideration (where the UN Convention states that the best interests of the child must be a primary consideration).
- The inherent right to life of a child must be protected by law.
- Affirmative action and measures for education must be taken in respect of female, disadvantaged and gifted children.
- Protection and promotion of the rights of girls to continue education while pregnant. Pregnancy is no longer a legitimate ground for discrimination.
- Affirmative action must be taken to provide mobility and access to public institutions for children with disability.
- Basic health-service programmes must be integrated into national development plans.
- States must provide technical and financial support for the mobilisation of local community resources in the development of primary health care for children.
- States must assist parents and guardians in the case of need, to provide material assistance and support programmes with extra regard to health, education, clothing and housing.
- The rights of internally displaced children are protected.
- States must adopt machinery to monitor the well-being of an adopted child.
- States must accord the highest priority to children living under discriminatory regimes and when possible provide material assistance to these children. States must take direct action to eliminate all forms of discrimination.
• The recruitment of children into the military is prohibited.
• The use of children in begging and other exploitative practices is prohibited.
• States must provide for the best interests of children of imprisoned mothers.

The UNCRC is stronger than the African Charter in the following respects:
• It disallows domestic discipline
• It has more clarity and stronger safeguards with respect to children in conflict with the law
• It provides directly for social security for the child.
• It provides for an obligation to rehabilitate and integrate into society a child victim.

In Article 2, however, the African Charter allows for the UNCRC to supersede it if provisions “contained in the law of a State Party or in any other international Convention or agreement in force in that State are more conducive to the realisation of the rights and welfare of the child”.

Both the UNCRC and the African Charter contain articles with particular application to the current Review.

**In the UNCRC:**

*Article 19* states that “States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child”. Article 19 also gives States the duty of ensuring that these protective measures should include “effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement”.

*Article 34* strengthens these provisions, and states that State Parties “(must) undertake to protect the child from all forms of sexual exploitation and sexual abuse and take all the necessary national, bilateral and multilateral measures to prevent:

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

Finally, *Article 35* addresses the abduction, sale and trafficking of children, giving States the responsibility of taking “all appropriate national, bilateral and multilateral measures
to prevent the abduction of, the sale of or traffic in children for any purpose or in any form”.

Box 1 – Implications of early marriage in selected articles of the UNCRC

<table>
<thead>
<tr>
<th>Provisions of the UNCRC relevant to early marriage:</th>
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<tbody>
<tr>
<td><strong>Article 1</strong>: A child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.</td>
</tr>
<tr>
<td><strong>Article 2</strong>: Freedom from discrimination on any grounds, including sex, religion, ethnic or social origin, birth or other status...</td>
</tr>
<tr>
<td><strong>Article 3</strong>: In all actions concerning children ... the best interests of the child shall be a primary consideration.</td>
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<tr>
<td><strong>Article 6</strong>: Maximum support for survival and development...</td>
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<tr>
<td><strong>Article 12</strong>: The right to express his or her views freely in all matters affecting the child, in accordance with age and maturity...</td>
</tr>
<tr>
<td><strong>Article 19</strong>: The right to protection from all forms of physical or mental violence, injury or abuse, maltreatment or exploitation, including sexual abuse, while in the care of parents, guardian, or any other person...</td>
</tr>
<tr>
<td><strong>Article 24</strong>: The right to health, and to access to health services; and to be protected from harmful traditional practices...</td>
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<tr>
<td><strong>Articles 28 and 29</strong>: The right to education on the basis of equal opportunity...</td>
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<tr>
<td><strong>Article 34</strong>: The right to protection from all forms of sexual exploitation and sexual abuse...</td>
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<tr>
<td><strong>Article 35</strong>: The right to protection from abduction, sale or trafficking...</td>
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<tr>
<td><strong>Article 36</strong>: The right to protection from all forms of exploitation prejudicial to any aspect of the child’s welfare...</td>
</tr>
</tbody>
</table>

In the African Charter:

**Article 14** provides for similar services and programmes regarding children’s right to health as does Article 24 in the UNCRC; however, the African Charter is more expansive with regard to expectant and nursing mothers and the roles of the community and civil society organisations.

**Article 16** contains similar protections to Article 19 of the UN CRC, requiring States Parties to take specific legislative, administrative, social and educational measures to protect children from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse. Special measures for monitoring and support units, reporting, referral and follow-up are also required.

**Article 29** prohibits the sale, trafficking and abduction of children, similarly to Article 35 of the UN Convention on the rights of children. Interestingly, the African Charter in this Article also prohibits the use of children for begging.

7.1.2 Other relevant international treaties

In addition, other international treaties also provide for the protection of children from various forms of sexual abuse.
The **Beijing Declaration and Platform of Action** grew out of the Fourth World Conference on Women Beijing Declaration, held in September 1995. Subsequently, Beijing+10 and Beijing+15 were held in 2005 and 2010 respectively. These international processes include recommendations and commitments to eradicate the conditions that allow GBV to flourish.

The **Convention on the Elimination of All Forms of Discrimination against Women** (CEDAW) has been signed and ratified by all African countries, and is fully applicable to girls under 18 years of age. Article 16.2 of CEDAW provides that the betrothal and marriage of a child shall have no legal effect and that all necessary action, including legislative action, shall be taken by States to specify a minimum age for marriage, and to make the registration of marriages in an official registry compulsory.

There are two **Optional Protocols to the UN Convention on the rights of children** – one dealing with children in armed conflict and the other on the sale of children, child prostitution and child pornography. Only 22 SSA countries have ratified the Optional Protocol on the involvement of children in armed conflict, and 31 have ratified the Optional Protocol on the sale of children, child prostitution and child pornography.

The first **World Congress against Sexual Exploitation** was held in Stockholm, Sweden, in August 1996, and the second took place in Yokohama, Japan, in December 2001. The **Yokohama Global Commitment** reaffirmed the urgency of acting against the sexual exploitation of children and facilitated the development of several regional commitments to this end also.

The **ILO Convention on the Worst Forms of Child Labour (No. 182)** has been ratified by all African states, except Eritrea, Guinea-Bissau and Sierra Leone. Article 1 binds state parties to act urgently to end the worst forms of child labour. Article 2 defines the Worst Forms of Child Labour as:

- all forms of slavery or practices similar to slavery, such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict;
- the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances;
- the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties;
- work that, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.

Given the scale of the HIV pandemic and the close links between HIV, GBV and CSA, the **Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV 2010–2014** is particularly relevant. The Agenda supports the implementation of the UNAIDS Action Framework, which was developed in response to the need to address the persistent gender inequalities and human rights violations that put women and girls at a greater risk of, and make them more vulnerable to, HIV and threaten the gains that
have been made in preventing HIV transmission and in increasing access to antiretroviral therapy. The framework focuses on 3 areas:

- Strengthening strategic guidance and support to national partners to ‘know their epidemic and response’ in order to effectively meet the needs of women and girls;
- Assisting countries to ensure that national HIV and development strategies, operational plans, monitoring and evaluation frameworks, and associated budgets address the needs and rights of women and girls in the context of HIV;
- Advocacy, capacity strengthening and fund raising to deliver a comprehensive set of measures to address the needs and rights of women and girls in the context of HIV.

The Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (known more commonly as the Palermo Protocol) entered into force in 2003. It is the first global legally binding instrument with an agreed definition on trafficking in persons, and is intended to facilitate the development and coordination of national approaches to dealing with trafficking, including the protection and support of victim.

While somewhat outside of the 2000 – 2010 period that was the focus of this review, the 1994 International Conference on Population Development urged governments to prohibit FGM wherever it exists and to give vigorous support to efforts among nongovernmental and community organisations and religious institutions to eliminate such practices.

7.1.3 Regional treaties and agreements

The Maputo Declaration bound the governments of the African, Caribbean and Pacific Group of States to policies that focus on addressing the needs of the most vulnerable sections of their communities, to attaining universal primary education by 2015, and to ensuring that legal and institutional structures provide adequate guarantees to protect and enhance the political, economic and social status of women. The declaration also condemned child abuse and child trafficking.

In 2004, WHO/AFRO identified CSA as a public health concern, calling it “a silent health emergency” and developed a strategy that includes the following priority interventions:

- Advocacy
- Law enforcement
- Development of standardised protocol, clinical care and management
- Multidisciplinary and coordinated responses
- Rehabilitation of CSA survivors
- Community-based surveillance, support and reporting

In 2006, USAID/East Africa (USAID/EA) and UNICEF Regional Office for East and Southern Africa (UNICEF/ESARO) developed a strategic framework for the prevention of and response to GBV that describes the strategic priorities for prevention and response including:

- Promoting and protecting human rights
- Promoting participatory processes that engage all stakeholders
- Working with men
• Targeting youth
• Research on promising programming approaches
• Monitoring GBV in the region
• Investing in GBV programmes and policies

Based on the strategic priorities called for in these two frameworks, and to operationalise them, ECSA-HC, with the support from the Africa’s Health in 2010 project, developed a *sub-regional implementation framework for the prevention and response to GBV*.\(^{12}\)

### 7.2 National legal frameworks

The African Child Policy Forum’s survey of the child-friendliness of African countries drew attention to the important role played in child protection by provisions made in national laws to protect children against abuse and exploitation and whether or not countries had developed national action plans.\(^{13}\) The other criteria against which the determination of child friendliness was made were: whether or not international and regional treaties had been acceded to; whether or not a juvenile justice system was in place; and whether or not a policy of free education was in place (annex 6).

#### 7.2.1 National laws

In terms of the child protection ranking in the survey noted above, Kenya emerged as the country most protective of children, followed by Madagascar, Burundi, Namibia, Rwanda, Mali, Burkina Faso, and Nigeria. Guinea-Bissau, Swaziland and Gambia emerged as the countries least protective of children.\(^{14}\) Countries with high rankings were characterised by, among other things, their development of provisions within domestic law that criminalise child trafficking and sexual exploitation. The survey noted that one third of the African countries surveyed do not have legal provisions for protection against child trafficking, and one quarter have no legislation prohibiting harmful traditional practices.\(^{15}\)

A 2008 study conducted in West and Central Africa in preparation for the Third World Congress against the Sexual Exploitation of Children found that:\(^{16}\)

• Democratic Republic of Congo has promulgated laws for the protection of children, including criminalising the sexual exploitation and trafficking of children under the age of 18 years;

• In Benin, Togo, Cameroon and Côte d’Ivoire, laws prohibiting the trafficking of children have been or are being adopted;

• Benin, Togo and Congo have adopted or are in the process of adopting a Code on children;

• The Penal Code is being revised in Chad and Benin;

• Laws against the sexual harassment of school children in schools in Togo have been promulgated.
In Senegal, the Penal Code provides for prison sentences of 5 years for indecent assault and 10 years for rape if the victim is less than 13 years old.

Other evidence that legal protection of children from abuse and neglect in SSA is growing is provided by the following:

- South Africa passed the Children’s Act after a decade of development, in 2007. This comprehensive piece of legislation protects children against abuse and neglect, has a strong emphasis on prevention and early intervention, and criminalises trafficking.

- Lesotho has just tabled its Children’s Protection and Welfare (CPW) Bill. As with the South African Children’s Act, the Lesotho CPW Bill makes provisions for all children in the country.

- Both the South African and Lesotho statutes acknowledge the havoc being wreaked on African families by the HIV pandemic, and both mandate their departments concerned with social welfare with the protection of children.

According to UNICEF, 13 countries now have laws against FGM/C, including Benin, Burkina Faso, Côte d’Ivoire, Djibouti, Ghana, Guinea, Central African Republic, Senegal, Togo, Tanzania, Uganda and Nigeria. Legal prohibition has had some positive results. For example, in Burkina Faso, FGM/C has been prohibited by law since February 1997. Several FGM/C practitioners have been sentenced to prison terms. In Côte d’Ivoire, FGM/C was prohibited in 1998, with heavy fines, imprisonment and suspension from being allowed to practice as a doctor if the operation results in detrimental health outcomes or death.

Similarly, in Djibouti, Guinea, Central African Republic, Senegal and Togo, FGM/C is prohibited by law, with fines and imprisonment for those found guilty of breaking it. However, the law seems not to have been implemented in the Central African Republic. In Togo, it is also legislated that anyone knowing of and not reporting FGM/C has committed a crime.

Other countries in the region, notably Benin, have no legal prohibition, despite high rates of FGM/C. In others, such as Mali, a law prohibiting FGM/C was under discussion in 2006.

Child marriage still takes place in many countries, despite statutory prohibition on children under the age of 18 years being married. This is largely because many countries still practice traditional, religious and cultural law alongside statutory provisions. So, for instance in Niger, statutory law sets the age of marriage at 18 for boys and 15 for girls, but traditional law allows marriage at an earlier age.

UNICEF has reported that the government’s response in Malawi to the number of girls who enter into sexual relationships with teachers for money, become pregnant, and subsequently leave school has been to expand the legal protection of students subjected to exploitation and inappropriate relationships at school. In one such case, a teacher was sentenced to prison term.
7.2.2 National Plans of Action

The outcomes document of the UN General Assembly Special Session (UNGASS) on Children held in New York in May 2002, A World Fit for Children, and its associated Plan of Action called for the development of national plans of action (NPAs) and, where appropriate, regional plans by the end of 2003. These were to be based on specific, time-bound and measurable goals, take the best interests of the child into account, be consistent with national laws and uphold the human rights and fundamental freedoms set forth in the UNCRC.

Most countries in SSA (with the exception of Angola, Benin, and Djibouti) have prepared NPAs for the protection of children and established coordinating bodies to follow up and monitor these NPAs. However, these bodies are often poorly resourced and lack the capacity to effectively discharge their responsibilities.

M’jid reported that, in 2004, 13 of the 24 countries in West and Central Africa had developed NPAs, and identified focal points in departments responsible for social issues, social welfare, children, women, family, justice or health, depending on the actual ministries in each country. Cameroon, Congo, Guinea, Chad and Togo had not done so; however, NPAs have subsequently been developed also in these countries.

In some cases, there are inter-countries responses; for example the Indian Ocean Region Child Rights Observatory (ODEROI), based at the University of Mauritius, works in an area where a total of around 10 million children live – the Comoros, Madagascar, the Seychelles, La Réunion and Mauritius.

But in many cases, legal provisions and national plans of actions do not translate into significant sustainable actions with meaningful impacts. A lack of adequate resources is often given as the reason that systems don’t work as well as they should, or for limited access to services. Nevertheless, the African Child Policy Forum found that national commitment to the protection of children is not necessarily related to national income. Despite relatively low GDPs, Kenya, Malawi, Rwanda and Burkina Faso are noted as among the most child-friendly countries, having made the greatest effort to put in place an adequate legal foundation for protecting children and meeting their basic needs, whereas relatively wealthier countries such as Equatorial Guinea and Angola are investing relatively fewer resources in child well-being.

There is some improvement in national budgetary allocations toward meeting children’s basic needs, and the African Child Policy Forum’s Report on Child Well-Being noted that, between 2001 and 2005, Malawi, Burkina Faso, Togo, Burundi, Rwanda and DRC significantly increased their budgetary commitments to health sector expenditure. However, the Comoros, Liberia, Chad, São Tomé and Príncipe, Sudan, Benin, Gambia and Zimbabwe showed a sharp decline in budgetary allocations to health and education, and Zimbabwe and Benin have showed marked increases in military expenditure.

7.3 Programmatic responses

There is general agreement that governments and policy-makers should put into place integrated programmes to combat violence against children. These should include ratification of international rights treaties, domestication of these by enacting legislation
on all forms of violence, and harmonisation of laws and procedures to establish a proper system of positive legislation that promotes and protects children’s rights. However, it is also the case that, beyond law and policy, actual activities to prevent and respond to CSA should be implemented. Where such activities exist, the majority of them are delivered at local level by civil society organisations rather than by government. In South Africa, for example, close to 90% of prevention activities and a very high proportion of response-related activities are delivered by civil society organisations, and this is true across the continent.

Information concerning actual programmatic interventions and projects to address CSA in SSA is difficult to come by. What is clear is that there are many thousands of non-governmental organisations delivering services to children on the continent. The Child Rights Information Network (CRIN), for example, lists numerous members in countries in SSA. While many of these are not concerned only with CSA, the fact that they are members of CRIN implies that at least part of their work is concerned with protecting the rights of children. Interestingly, the UN Directory of African NGOs does not include the category of “children” in its “NGOs by category” link, although it does have links for both “women” and “youth”.

This lack of information on specific projects is compounded by the fact that there is even less information available on projects that have been evaluated and that could thus potentially be rolled out in other communities and geographic locations. This notwithstanding, there is some very good work being done to prevent and respond to CSA in SSA, and some of this could be gleaned from the materials reviewed here.

Projects and activities to address CSA are, of course, not only the domain of civil society organisations – governments themselves, as well as international organisations are also involved in delivery of such programmes to a significant degree. Indeed, some of the most successful interventions are those involving a range of stakeholders. Many writers in this area of endeavour, as well as numerous international undertakings and agreements, stress the importance of holistic and integrated response systems and activities.

WHO has acknowledged the important contribution made to preventing sexual and physical violence against women by the collective initiatives of men, and states that men’s groups against GBV of all types can be found in Australia, Africa, Latin America and the Caribbean and Asia, and in many parts of North America and Europe. There is little information available on initiatives by men’s groups addressing CSA specifically, mainly because research and information on programmes working with adolescent boys has not been documented, and programme experiences are new and have not yet been evaluated or recorded. An exception is the One Man Can campaign currently being implemented in eight of South Africa’s nine provinces, and in Burundi, Kenya, Malawi, Mozambique, Namibia and Uganda. However, initiatives by men to address GBV more generally are likely to have positive spin-offs for children also.

7.3.1 Management of CSA by the health and criminal justice systems

It has been argued that the prevailing legal and social climate not only perpetuates incidents of abuse, but also constrains survivors from accessing medical care and legal services.
Children tend to disclose CSA as “part of a process rather than a single event”; in addition, children are relatively more likely to present to police or health facilities than adults. This has implications for the medical management and collection of evidence in cases of CSA, including that invasive examination is not necessary and that it may be too late to gather meaningful forensic evidence.

Although the medical management of CSA cases has much in common with that of adults, the following should be borne in mind when examining children:

- When there are serious physical injuries, children can be examined under anaesthesia;
- Examinations should always be non-invasive unless the use of speculums and other implements is medically indicated;
- Children should never be left alone with a suspected offender, even if that person is the parent or guardian of the child.
- The medical history should be obtained from the care-giver if at all possible (rather than from the child).
- Post-exposure prophylaxis (PEP) regimens for children should be determined on a case-by-case basis by the child’s weight. Compliance with PEP regimens is dependent on the cooperation and understanding of the child’s care-giver.

The approach to the evaluation and counselling of CSA victims should be informed by the need for sensitivity in order to minimise the long-term physical and psychological consequences of CSA. The carers or parents of abused children often need counselling and support themselves, and have been found to suffer from a range of debilitating consequences themselves when a child in their care is abused. This may impede their capacity to provide the appropriate support to the abused child.

7.3.2 Responses to CSA in home and community

The Kenyan “Be a champion for children campaign” highlighted by the UNVAC is a good example of attempts to deal with CSA taking place in the community, including homes. Launched in 2006, this is a partnership between UNICEF and Kenyan NGOs, and calls upon families, schools, faith-based organisations, the private sector, the mass media and all other elements of Kenyan society to collaborate (with financial and other support) in efforts to ensure that every home, school and community in the nation is committed to stopping violence against children. The campaign raised funds to support a number of activities including a core package of child protection services for the most vulnerable communities:

- Hotlines where both children and adult victims of violence can call for help.
- Safe houses for those who need to escape violence in their homes.
- Training for counsellors to help victims and also to help families and other perpetrators of violence break their patterns of violent behaviour.
- Training for teachers, health workers and police in how to reduce violence and intervene when it occurs.
- School-based programmes and youth programmes to reduce violence.
- Publicity and awareness-raising.
In South Africa, Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN), a local NGO, has developed a resource for situations in which children who have suffered CSA are unlikely to access formal counselling. The Healers Package is a therapeutic toolkit to support community-level practitioners and parents or care-givers in therapeutic work with sexually abused children, and consists of:51

- Therapeutic activity books for children aged 4-7, children aged 8-12, and adolescents
- A practitioner's manual
- A manual for the parents or caregiver/s of the child
- Activity materials such as play dough, toys, a journal, crayons, etc.

The international movement of child helplines is also a good practice in addressing issues related to prevention of and response to CSA. Child Helpline International (CHI) is a global helpline network that was established in 2001; as of 2008, it comprised around 160 members, with the greatest increase in members being among developing countries. The UNVAC identified the setting up of these helplines as critical in providing support to children who have been sexually abused.52 Child helplines usually have short and easy-to-remember numbers, and provide children with a confidential space to talk about what they are experiencing and how they can seek help.

According to the website of CHI,53 14 countries in SSA have established helplines – Botswana, Côte d’Ivoire, Guinea, Kenya, Lesotho, Malawi, Namibia, Nigeria, Senegal, South Africa, Swaziland, Togo, Uganda and Zimbabwe. In addition, child helplines are being established in Ethiopia, Mozambique and Zambia.

Although the basket of services offered by child helplines in different countries differs from country to country, all child helplines that are members of CHI “provide children with unique opportunities to express their thoughts, feelings, and needs and to seek help in their own terms, without fear or inhibition. Trusted by children, Child Helplines help to keep children safe and to receive respect, nurturance and support. They do this through their own direct responses and by using the knowledge given to them by children to advocate on their behalf”.54

South Africa has introduced Thuthuzela Care Centres (‘thuthuzela’ means ‘comfort’ in isiXhosa) to provide a ‘one-stop’ integrated response to the high rates of sexual violence against women and children; this model is increasingly held up as an example of good practice.55 It has an integrated approach to the care of rape victims, including respect, comfort and restoration of dignity, as well as ensuring that justice is accessed. The services offered include examination by specially trained doctors and nurses, counselling by local NGO partners, and the opportunity to bath or shower; a statement is only taken when the victim feels ready to give it, and transportation home afterwards as well as follow-up services, including further counselling and HIV testing, are also provided.56 The centres work closely with nearby specialised Sexual Offences Courts staffed by specially trained prosecutors, social workers, investigating officers, magistrates, health professionals and police. Although set up to serve all victims of sexual assault, the centres provide ‘child-friendly’ spaces and links to formal child witness preparation programmes (commonly delivered by local NGOs57) for children who are to appear in court.
However, there is growing evidence that ‘one-stop shops’ are not the only, or even the ideal, model for delivering comprehensive services. In terms of a comprehensive response, one of the lessons learned has been that integrated health services with links to the police, help desks at health clinics with support persons on site, and strengthening police responses have been very effective in responding to CSA.  

_Groupe d’Action Contre le Viol des Enfants_ (GRAVE) in Senegal provides especially legal services specifically for victims of CSA. Other activities in West Africa were found to include:  

- In Côte d’Ivoire, a child helpline affiliated to CHI is in existence, and social services are delivered in the schools;  
- In Congo Brazzaville, a network of trauma counselling service is provided by Movement pour la Vie, Réseau de Trauma-counselling, and hospitals in some areas provide free medical assistance and counselling;  
- In the DRC, NGOs in Saint Joseph, Kitumayni, Bomoto and Nganda work together to facilitate the identification of victims of CSA, and their access to assistance, medical treatment and counselling. There is a toll-free helpline, but it seems not to be affiliated to the international child helpline movement.

### 7.3.3 Responses to child marriage

According to the Population Council, children can be protected from early marriage by programmes that delay the age of marriage by assuring girls’ attendance at school, providing economic opportunities, and providing information and services for adolescents using peer education, youth clubs, street theatre and skills-building workshops. This protection can be extended by supporting those girls who are married early. For example, a programme in western Kenya is raising awareness of the HIV risks associated with early marriage, establishing clubs for married girls, and promoting voluntary counselling and testing among couples who are newly married or contemplating marriage.

The International Centre for Research on Women (ICRW) analysed potential risk and protective factors for child marriage for the 20 countries with the highest child marriage prevalence (“hotspot” countries), using Demographic and Health Surveys (DHS) data. This research found that:

- Girls’ education was the most important factor associated with age at marriage, with secondary education emerging as the factor most strongly associated with reduced prevalence of child marriage; however, primary education was the most important for younger girls, many of whom marry at an early age.  
- The age difference between husbands and wives was also strongly associated with child marriage. Education and awareness-raising on the negative outcomes often associated with age gap, such as domestic violence, could help minimise this phenomenon.  
- Some regions within countries have much higher rates of child marriage and require focused attention from intervention efforts.  
- Economic status of the households in which girls live is also an important influence on age at marriage. Prevention efforts could address this by increasing girls’ ability to generate income, by helping families offset the costs of postponing marriage, and by changing local norms on bride price and dowry.
Different factors are associated with the marriage of younger girls at the “tipping point” age - the age at which child marriage prevalence in a country starts to increase markedly. Thus programmes seeking to prevent marriage when it first becomes a serious problem should target and tailor efforts to young girls approaching the “tipping point” age.

7.3.4 Response to FGM/C
Some success in countering FGM/C has been found, for example, in Ethiopia, where, although it is still a widespread practice, a decline in prevalence rates from 80% (2000 DHS) to 74% in 2005 was noted, and comparing prevalence rates across age groups using the 2005 figures confirms this trend, with 62% of women aged 15-19 having been cut compared to 81% of women aged 45-49.

Importantly, a significant change in attitude has been noted in the same period, from 60% of the population approving of FGM/C in 2000 to only 31% doing so in 2005. However, the cultural norms that largely drive approval of FGM/C and the ‘medicalization’ of the practice (which allows people to feel that it is more acceptable if performed by a trained practitioner) remain serious stumbling blocks to its total eradication.

As awareness of the potential health consequences of FGM/C has increased, an increasing trend toward the medicalization of the practice has been noted. The highest rates of use of medical personnel performing FGM/C in SSA can be found in Kenya (34%), and Sudan (36%); with 9% of FGM in Guinea and 13% in Nigeria being carried out by medical personnel.

While medicalization may improve the conditions under which FGM/C is performed (e.g., better hygiene, under anaesthesia, in combination with anti-tetanus vaccinations), it violates principles of professional health ethics and does not address the potential long-term medical, psychological, and psychosexual complications and the violation of women’s rights. WHO has developed guidelines on dealing with this aspect of FGM/C.

Despite the fact that FGM/C is not mandated by any religion, many people believe that their religion requires it. This is true of both the Christian and Muslim communities, although more common among Muslim women - for example, 30% of Muslim women and 15% of Christian women in Guinea reported that FGM is required by religion.

In response, Frontiers, a Kenyan organisation, has developed a religious oriented approach to encouraging the abandonment of FGM/C, which brings together religious scholars and medical professionals to educate the community. This allows the myths and misconceptions around the practice, its purpose and thus perceived benefits to be addressed with both religious and medical arguments.

In the Kembatta/Tembaro Zone, the NGO Kembatti Mentti Gezzima (KMG) has been working to reduce FGM/C since 1999 by providing innovative, integrated health, vocational, and environmental programmes in the region. A key element of these programmes has been a mechanism called Community Conversation – KMG has ensured that the sensitised elders, women and youth, uncircumcised girls, local and religious leaders, and edir (mutual-assistance groups) have acted collectively.
KMG introduced the concept of Community Conversation in 2002 as a strategy to:

- Provide space and opportunity for active interaction, dialogue, reflection and sharing without fear and discrimination;
- Facilitate the process of transformation, using participatory tools and skills;
- Assist community members to understand the impact of sustaining harmful traditional practices, such as FGM/C, and to take action to eradicate them.

The Ethiopian NGO Rohi Wedu has been active in the Afar Region since 2004. Their introduction of a methodology similar to the one utilised by KMG, a Community Dialogue, at local level in the Gewane/Afar area enabled villagers and local leadership to ‘own’ the process, which was supported primarily by clan and religious leaders, and two supervisors from Rohi Wedu, who regularly monitor the intervention, using a clan-based approach.

The facilitators were responsible for:

- Conducting Community Dialogues at village and community level;
- Facilitating individual counselling for parents with infant daughters;
- Registering children at birth;
- Following-up FGM/C incidents and reporting them to clan and sub-district leaders for action, and
- Attending monthly review meetings and reporting on the implementation of activities agreed to during Community Dialogue.

The Senegalese organisation TOSTAN, cited above, has also had some success in combating FGM/C using its community-based approach. The involvement of communities in abandoning the practice of early marriage also led to them abandoning FGM/C. Community-based approaches to changing attitudes and behaviour with regards to FGM have also been successful in Burkina Faso.

7.3.5 Responses in educational settings

Arc-en-Ciel (Rainbow) Clubs organised by girls in Togo with the support of Plan International are having some success at combating sexual harassment in school. They provide a setting where girls and young women can share their stories and learn to defend their own interests, and actively discourage transactional sexual relationships and sexual relationships with teachers.

The World Association for Schools as an Instrument for Peace has a flourishing branch in Cameroon that has developed a programme that provides guidelines for different stakeholders within the school system in preventing and addressing all forms of violence, including CSA, with 3 themes:

- For children, the guidelines are called Know how to Protect Yourself;
- The guidelines for parents are called Know so that you can Protect; and
- For educators they are known as Know so that you can Prevent.

The Zambia Civic Education Association (ZCEA) implements a Child Participation Programme that supports Child Rights Clubs in primary and secondary schools – there are at least 300 of these clubs operating now throughout Zambia, and ZCEA reports very
positive results, not only in addressing sexual harassment but also in empowering children.80

In Nigeria, the NGO Women Against Rape, Sexual Harassment and Exploitation (WARSHE), which was formed in response to the gang rape of a female student on a university campus, has extended its activities to secondary schools. They have been successful in raising awareness and providing support to victims.81

The United Nations Girls’ Education Initiative (UNGEI) was launched in 2000, and is emerging as an effective strategy for the prevention of violence against girls. As an element of this initiative, the Girls Education Movement (GEM) has been established in Botswana, Lesotho, Kenya, Uganda, South Africa, Tanzania, Zambia and Zimbabwe.82 GEM is conceptualised as a pan-African education initiative through which girls would become leaders in the transformation of Africa and agents in the decision-making processes concerning their educational chances. In Uganda, GEM has been working with local authorities and traditional leaders to address the issue of early marriage; in Botswana, GEM has undertaken a baseline study on safety in schools; in South Africa, a Girls’ Parliament has been sponsored by GEM, in conjunction with the National Department of Education, providing girls with the opportunity to contribute to policy-making around issues of sexual violence in schools.83

Also in South Africa, the National Department of Education issued guidelines in 2000 for combating sexual violence in schools.84 This resulted in the development, at provincial level, of a protocol for handling sexual abuse in the school setting. In the Western Cape Province, for example, the publication Abuse no more was developed.85 The Department of Education in the Western Cape is very confident that this has had a significant impact on the problem.86

The DTS Consortium’s literature review of school-related GBV identified a number of promising initiatives:87

- In Nigeria, for example, the Girls’ Power Initiative (GPI) educates girls to resist stereotypes and promotes healthy sexuality by providing information on reproductive health and sexuality.
- CAMA in Ghana has deployed trained members to work in schools and communities to raise awareness about legal rights and CSA, breaking the silence surrounding abuse and enlisting the efforts and support of all community members in confronting the problem.
- Also in Ghana, the Strengthening HIV/AIDS Partnerships in Education (SHAPE) project has designed interventions that focus on educating teacher trainees about HIV/AIDS and encouraging teachers to view themselves as the protectors, rather than the abusers, of children. The materials are designed to sensitise teachers to the negative effect that school-based sexual abuse has on girls.
- The Tanzanian Female Guardian Programme is a primary-school-based initiative involving parents and communities, which includes guardians or melzi - teachers chosen by their colleagues and trained to give advice in cases of sexual violence or harassment and other matters related to sexual and reproductive health. It aims to reduce sexual harassment, forced sexual relationships, and rape, and to reduce schoolgirl pregnancy while also preventing the blaming and expulsion of young girls who become pregnant.
The Mathare Youth Sports Association (MYSAs) in Kenya provides sports opportunities alongside HIV-awareness training and a gender-equality project.

In Zimbabwe, CAMA has worked with communities and with young women to develop a policy on abuse in Zimbabwe, and advocates for a multi-sectoral approach to the issue.

Doorways is a life-skills curriculum developed by the Safe Schools Programme (SSP) aimed at reducing gender-based violence in schools. It was developed by DevTech Systems and is funded by the U.S. Agency for International Development, and Office of Women in Development. The curriculum is being implemented in Ghana and Malawi. The SSP works with individuals, groups, and institutions at local and national levels, and engages students, school staff, parents, community leaders, and policy makers in understanding and institutionalising children's rights to safe schools. Activities include:

- Life-skills training for students;
- Counselling and referral services for students;
- School-related GBV prevention training for teachers;
- Development of community action plans to counter school-related GBV;
- Development of a Teachers' Code of Conduct for school-related GBV; and
- A national advocacy initiative to promote school-related GBV legislation, policy, and enforcement.

7.3.6 Reducing the vulnerability of children living and/or working in the street

Street Child Africa (SCA) supports 10 African organisations in 7 African countries (Ghana, Mozambique, Nigeria, Senegal, Uganda, Zambia and Zimbabwe) that work with children living in street situations. Street Child Africa recognises that children living and working on the street are entrepreneurial, tenacious and intelligent, and like other children, are entitled to education, healthcare and protection. However, the extent to which these children are stigmatised leads to their access to these rights being denied, and makes them vulnerable to a wide range of abuse, including CSA. To reduce the vulnerability of children on the street, a range of different services is required.

Organisations at local level supported by SCA include:

- Avenir de l'Enfant (ADE), Senegal. ADE's street workers carry out visits to the streets by day and night, talking to children and offering them support, including information about physical and sexual abuse, rejection, stigmatisation, theft, drugs, diarrhoeic illnesses, sexually transmitted infections and HIV/AIDS, and hygiene. Family tracing and reunification are also offered, and temporary shelter is available at the ADE centre in Rufisque or more permanent accommodation, with access to educational opportunities at the "family-style" centre.

- The Street Children Project in Ghana was established in 2005. The focus of their outreach work is mainly on young girls living and working on the street, and information and support with regard to hygiene and STIs are regularly offered in lessons given to small groups on the streets. The organisation operates a centre where the girls can access services, including two crèches for the children of street mothers.

- The Masese Community School in Uganda is a traditional African community school that has been proactive in building links with its neighbouring slums and in encouraging parents to send their children to school. Its support of children living and working on the street is aimed at supporting the development of the beneficiaries’ independence and self-sufficiency through sponsoring their
education and other income-generating and rights-based workshops and activities.\textsuperscript{93}

*Mkombozi*, an NGO working in the Kilimanjaro and Arusha regions of Tanzania, has researched the situation of street children in that region and concluded that children are on the street because of multiple forms of vulnerability, including the death of a parent, domestic violence, physical abuse and sexual abuse.\textsuperscript{94} Services offered include:

- Training in IT skills
- Education
- Fostering and reunification
- Mentoring
- Psychosocial support
- Shelter, food and healthcare

### 7.3.7 Children in alternate care

Protecting children against violence and abuse is becoming an increasing feature of NGO and state social workers’ workloads in many countries, especially where justice against the perpetrator is hard to achieve. In South Africa, for example, residential care places of safety and even children's homes are being used to protect abused children; the same is true also in Zambia, Swaziland and Malawi to a lesser extent.\textsuperscript{95}

To address the challenges of very large numbers of children needing alternative care for one reason or another, Save the Children USA has developed a toolkit based on work done in Ethiopia. This innovative approach is rights-based and draws heavily on the UN Guidelines for the Alternative Care of Children.\textsuperscript{96} The toolkit addresses the following issues:\textsuperscript{97}

- Design for scale and harness partner strengths at local level. A network of concerned individuals, care givers and institutions able to provide support and care should be set in place.
- Adopt a multi-level, tiered approach by building the institutional and technical capacity of existing grassroots, community-based organizations and local NGOs. This builds sustainable, long-term safety nets and services to OVC and their families.
- Build on existing community coping mechanisms and groups.
- Empower and mobilise communities themselves to organise, assess, plan and act collaboratively to increase and improve care and support to orphans and vulnerable children.
- Build capacity at multiple levels to ensure standardisation of training and effective roll-out of comprehensive, family-focused coordinated care services to vulnerable children and households.
- Actively involve children and care-givers in decisions related to access to education, food and medical care, psychosocial counselling, legal advice and protection, life skills training, micro-credit for income-generating activities, and safer homes.
### 7.3.8 Responses to sexual exploitation and trafficking

There has been some success in addressing trafficking. For example, in 2000, the governments of Côte d’Ivoire and Mali signed a Cooperation Agreement on Combating Trans-border Trafficking of Children, under the aegis of UNICEF and in the presence of NGOs combating trafficking. This was a ground-breaking initiative, and the first in West and Central Africa to establish formal procedures for cooperation against child trafficking between two States. The establishment of Village Committees in Benin, an initiative between the government of Benin and UNICEF, has also achieved marked success in combating trafficking of children.

The Southern Africa Regional Network against Trafficking and Abuse of Children (SANTAC) is based in Maputo, Mozambique. Its mission is to “build synergies amongst Southern Africa institutions and individuals to fight against all manifestations of child abuse, in particular child sexual and commercial exploitation, child labour and trafficking of children for any purpose, through lobby and advocacy, protection, law reform, rehabilitation and care services for victims”. Currently, its membership includes local organisations in Angola, the DRC, Malawi, Mozambique, Namibia, South Africa, Zambia and Zimbabwe. International members include Terre des Hommes and Save the Children.

Apart from the projects run by individual members in their home countries, SANTAC supports and facilitates research, networking and consultations with governments in the region as part of the SADC structures.

The Mouvement Africain des Enfants et des Jeunes Travailleurs/ The African Movement of Working Children and Youth is active in 126 towns in 21 countries to support child victims of trafficking and exploitation. The Movement undertakes advocacy, awareness-raising and prevention campaigns, and has a good record of using the media and school groups, with a strong focus on child participation, and has established many forums comprised of children.

### 7.3.9 Interventions with perpetrators

The rehabilitation of young sex offenders is an issue of critical importance, and yet there is very little information available on programmes and projects to address sexual offending by boys.

There are a number of provisions that must be in place for the appropriate management of young sex offenders. These include:

- Assessment at an early stage of any criminal proceedings;
- A range of treatment options must be available that take into account the risk of re-offending, the specific needs of a particular offender in terms of criminogenic factors present, and the ability of the offender to respond to a particular type of intervention.

The International Association for the Treatment of Sexual Offenders has stated that the following principles should apply for the care of juveniles who have committed sexual offences:
Juveniles are best understood within the context of their families and social environments - including the relative advantage or disadvantage of the neighbourhoods in which they reside.

Assessment and treatment of juveniles should be based on a developmental perspective, should be sensitive to developmental change, and should be an ongoing process.

Assessment and treatment should include a focus on the youth’s strengths.

The development of sexual interest and orientation is dynamic. The sexual interests of youth can change over the course of adolescence and this is the period when sexual orientation emerges.

Youth who have committed sexual offences are a diverse population. They should not be treated with a “one size fits all” approach.

Treatment should be broad-based and comprehensive.

Labels can be more iatrogenic in children and adolescents than in adults and the juvenile and his/her family/primary care-giving system should be treated with respect and dignity.

Sexual offender registries and community notification should not be applied to juveniles.

Effective interventions result from research guided by specialized clinical experience, and not from popular beliefs or unusual cases in the media.

Conferencing is a widely-used form of restorative justice that has been adopted specifically for sexual assault, and involves victims, offenders, and their family and friends meeting after intensive preparation. Anecdotal evidence indicates that offenders gain insight into their own behaviour and the harm they have caused, and are able to make positive changes as a result.

A diversion programme for young sex offenders, the South African Young Sex Offenders Programme (SAYStOP), was developed in 2000, and has been implemented at the Stepping Stones Project in Eastern Cape Province. It is also used by the provincial Department of Social Development in Western Cape, South Africa. A 2002 evaluation of SAYStOP suggested that it had developed an intervention useful for holding children who have committed sexual offences accountable and providing them with an opportunity to reflect on their abusive behaviour. The sessions appeared to be fairly successful in accomplishing their individual aims and objectives. In particular, the children assessed seemed to have developed insight into their victim’s feelings and realised the importance of responsible decision-making. Group work seemed to be a necessary and beneficial aspect.

As very few adult offenders are ever apprehended, the majority of adults who commit sexual offences against children never engage with rehabilitation programmes. Thus, prevention programmes that halt the perpetration of sexual offences against children in the first place are critical. School-based life skills education programmes that include information about child rights and human rights, as well as impulse management and education on responsible sexual behaviour to all learners at every level of the educational process are important, as is information and skills-training on responsible parenting.
Programmes such as that offered by the *Stepping Stones* programme are also useful. The Stepping Stones programme for HIV prevention aims to improve sexual health through building stronger, more gender-equitable relationships with better communication between partners. It uses participatory learning approaches to build knowledge of sexual health, awareness of risks and the consequences of risk-taking and communication skills, and provides opportunities for facilitated self-reflection on sexual behaviour. Developed for use in Uganda, the *Stepping Stones* programme has now been used in over 40 countries, adapted for at least 17 settings, and translated into at least 13 languages.\textsuperscript{111}

The *Men as Partners* (MAP) programme is targeted towards men and is currently being implemented in six provinces in South Africa. Its objectives are to:\textsuperscript{112}

- Improve men’s awareness and support of their partners reproductive health choices
- Increase awareness and responsibility for prevention of sexually transmitted disease and HIV/AIDS
- Increase understanding of gender equity and healthy relationships
- Increase awareness of and strive to prevent domestic and sexual violence
- Improve men’s access to reproductive health information and services.

The *Access to Justice and Equality for Women and Children in the Kilimanjaro Region* Project conducts a Human Rights and Gender Education programme to promote respect and make people aware of legal rights, human rights and gender issues and influence practice that encourages gender equality.\textsuperscript{113}

*Multi-Agency Risk Interventions* have also shown some promise. According to Dosio and Boer, there are a variety of these programmes and related effectiveness studies in the literature, including the Multi-systemic Therapy (MST) model, which has been shown to be effective in reducing recidivism and other indicators of antisocial behaviour amongst various subgroups of serious offenders, including sexual offenders.\textsuperscript{114} Key elements of this model include:

- Encouragement of attendance and the importance of programme completion;
- A comprehensive structured treatment team and a research basis for evaluating change and programme effectiveness;
- The involvement of a range of agencies including the Departments responsible for court services, health, education, social services, and police.

Basic sex-offender treatment generally involves group work and individual therapy, and is based on cognitive and behavioural modification principles. It is geared towards offenders accepting responsibility for their actions, and the exploration and implementation of mechanisms to prevent further offending.\textsuperscript{115}

### 7.3.10 Gaps in responses
While much is often made about statutory protection, there is commonly less emphasis on and interest in the implementation of law and policy, their impact and the cultural and social mechanisms which may impede enforcement. In addition, there is almost no information on traditional pre-colonial systems regarding sanctions against CSA. It is possible that deepening this knowledge would enhance child protection in local cultural contexts.\textsuperscript{116}

While many programmes and strategies have been developed to prevent and respond to CSA, these are limited also with regard to monitoring and evaluation of impact.

2 Confirmed by Sonia Vohito, representative of the Global Initiative to end Corporal Punishment to the CSO Forum of the African Committee of Experts on the Rights and Welfare of the Child, Addis Ababa. Personal communication 23 April 2010, contact: vohito@africanchildforum.org
3 This section is based on a workshop run by Amanda Lloyd of the University of Surrey and is used with permission.
10 WHO Regional Office for Africa. 2004. Child Sexual Abuse – A Silent Health Emergency. Report of the Regional Director to the 54\textsuperscript{th} Session of the Regional Committee for Africa.AFR/RC54/15 Rev. 1
16 M’jid N. 2008.
20 TOSTAN/UNICEF. 2008. La Décennie qui a fait reculer l’excision”. Dakar: TOSTAN/UNICEF.


See http://www.crm.org/.


WHO Regional Office for Africa. 2004.


Rumbold V. 2008.

Rumbold V. 2008.


Mathews S. 2009.

Pinheiro P. 2006.


Pinheiro P. 2006.

See www.childhelplineinternational.org.

CHI. Undated. *Child Helpline International is the global member network of child helplines working to protect the rights of children*. Accessible at http://www.childhelplineinternational.org/.

Pinheiro P. 2006.


See for example Child Witness Project at http://www.rapcan.org.za/programmes/activitydetail.asp?act_ID=11. Note that RAPCAN has developed a toolkit on this project so that it can be implemented in other places.


69 Muteshi J, and Sass J.  2005
71 Muteshi J, and Sass J.  2005
73 Dagne H.  2009.
74 Dagne H.  2009.
75 Dagne H.  2009.
76 TOSTAN/UNICEF.  2008.
81 Pinheiro P.  2006.
82 Pinheiro P.  2006.
83 Pinheiro P.  2006.
89 Sphere.  2006.
8. CONCLUSION

This literature review on CSA in SSA considered a wide range of information on CSA in SSA from both the peer reviewed and ‘grey’ literature. This rich collection of information and data adds considerably to the knowledge in the field.

The review indicates that, while WHO and UNVAC’s definitions of CSA are valid within the SSA context, they are not very operational in the sense that they do not consider the complexity of the phenomenon; further, they do not allow provide the latitude for exploring the interaction between types of abuse and existing social structures.

This literature review highlighted the socio-economic and political contexts in which CSA takes place in SSA - economic crisis, a poor human rights development record, poverty, gender inequalities, gender-based violence and political violence. CSA occurs across SSA though prevalence data are, in general, insufficient and non-exhaustive. The high rate of under-reporting was found to be a significant contributor to this situation. The available statistics on rape, incest, sexual harassment, FGM/C, child prostitution, child marriage and sexual exploitation indicate that the problem is significant. Children are at risk in a range of settings (home and family, workplace, school, the street), and there are serious public health, development and human rights consequences to CSA. This is in addition to a range of individual physical and mental health sequelae.

Research on the factors associated with CSA is limited, particularly with regard to variables such as place of residence, level of education and income, among others. The voices of children, their families and communities are also largely absent in the literature on CSA in SSA.

The review also indicates that prevention and response activities in the region are limited.
9. RECOMMENDATIONS FOR AN APPROPRIATELY PREVENTATIVE AND RESPONSIVE ENVIRONMENT

9.1 Overarching recommendations

9.1.1 For national governments

Given that CSA is prevalent in all countries of SSA, governments in the region need to acknowledge that it is a public health problem with serious short-, medium- and long-term consequences, that need to be addressed, via public policy and appropriate budget allocation.

National growth and development strategies such as the poverty-reduction strategies and NPAs are subject to periodic review and revision. Governments should ensure that comprehensive data are collected on the incidence of CSA, and that national policy documents reflect monitored and evaluated strategies for preventing CSA and responding to it.

CSA remains a multisectoral problem requiring a multisectoral response, and multisectoral coordination especially between the health (including reproductive and mental), education, legal, justice, and social development sectors.

All governments in SSA regard and treat HIV/AIDS as a priority, but fail to integrate HIV/AIDS, GBV and CSA services. The links between HIV/AIDS, GBV and CSA are underemphasized in country responses. Clear policy frameworks that address the prevention, treatment, and care and support spectrum in an integrated manner are required.

All governments in SSA should develop data collection systems that facilitate the collection of meaningful data on the breadth and depth of CSA in order to:

- Establish the evidence-base for the magnitude of the problem in their countries through empirical research; and
- Facilitate using up-to-date information in developing policies, strategies, and programmes.

All governments in SSA should progressively work towards the provision of the full range of services outlined in section 9.4 below. In addition CSA needs to be addressed through continued monitoring and evaluation of strategies, policies and programmes.

9.1.2 Overarching recommendations for donors

Donors should ensure that funding follows the call for a holistic and coordinated approach, across the prevention, treatment, and care and support spectrum.

Donors should coordinate their efforts with regional and national policy frameworks, and with national plans of action.
9.1.3 Overarching recommendations for civil society and advocacy groups

Civil society organizations including women’s associations, men’s groups against violence, youth groups, human rights structures in the countries, and NGOs should intensify efforts to combat GBV in general, and hold their governments accountable for the development and implementation of appropriate laws and policies to combat and respond to CSA. These groups have a particular role in increasing awareness about GBV in general and CSA in particular using the media and public fora to talk about the multisectoral nature of GBV/CSA, and as a major development and public health concern.

Particular attention should be paid to the State’s allocation of resources to these activities, and to monitoring the implementation of policy and programmes.

9.1.4 Overarching recommendations for researchers

Information about CSA should be augmented with rigorous and scientific studies within and across countries in the region. Particular attention should be paid to investigating the factors that facilitate the perpetration of CSA, such as place of residence, income, etc. Research which explores the gendered nature of CSA should be prioritised. Greater attention should be paid to the voices of communities and of children themselves.

Interventions and programmes which show promise and the potential for scale-up should be evaluated.

9.2. A coordinated approach

9.2.1. An appropriate system of prevention and response to CSA requires a holistic and coordinated approach characterised by programmes and activities that seek to protect families in which children live. Government departments dealing with social services, women and children, law, justice, health, education, finance, housing, employment, police, and labour among others, and the NGO sector should all be part of this coordinated approach. Departments of finance and national planning should endeavour to budget appropriately for CSA in order to ensure provision of services to children and other vulnerable groups.

The CSA literature in SSA points to the need for a coordinated and broad response reinforcing similar recommendations in the USAID/EA and UNICEF/ESARO strategic framework for prevention of GBV. These frameworks stress stakeholder involvement, and the need to develop response initiatives through participatory processes.

9.2.2. Vulnerability to one form of CSA invariably exacerbates vulnerability in other areas. Because children who are vulnerable to sexual abuse or who have already been sexually abused are also vulnerable to further sexual abuse and a range of other abuses, there is a need to broadly protect children from any abuse and neglect.

9.2.3. Initiatives in response to CSA need to prioritize prevention and early intervention, instead of focusing only on post-abuse programming. The model proposed by WHO to combat violence against women, for instance, specifies a three-tiered intervention:

- **Primary prevention**: approaches that prevent violence before it occurs,
- **Secondary prevention**: more immediate responses to violence including pre-hospitalisation care, emergency services and treatment of sexually transmitted infections,
- **Tertiary prevention**: long-term care in the event of violence – rehabilitation, reintegration, and mitigation of the effects of trauma.
9.2.4. The guiding principles of the WHO-AFRO CSA strategy\(^3\) should inform every action taken to protect children:

- Equity and human rights such as the right of the child to be protected from abuse and neglect, and to confidentiality;
- Commitment of Member States to ratified international conventions: the UNCRC, CEDAW, and the African Charter;
- Empowerment of households, communities and families through information on prevention and management of CSA;
- Multidisciplinary and participatory approaches to ensure comprehensive care and support for victims of CSA; and
- Formation of partnerships to ensure coordination and collaboration at all levels, including the community level, to maximise resources.

9.2.6. Adequate resources should be allocated to interventions aimed at prevention, care and management.

**9.3 International and domestic legal framework**

9.3.1. Where they have not done so, States should be urged to (a) ratify the African Charter and the two Optional Protocols to the UNCRC and (b), rescind reservations they have lodged to these treaties. Ratification of these international treaties indicates the will of a member state to protect the rights of children, and should be linked to strengthened cooperation with the relevant treaty body (the Committee of the Rights of the Child, for example). Such ratification should provide a framework for the development of law and policy to protect the victims of CSA and those vulnerable to being abused, as mandated by articles within the treaties themselves.

9.3.2. Laws that entrench the rights of children and criminalise all forms of CSA are needed. Where laws do not exist to prohibit CSA, they should urgently be developed and enacted. Where laws regarding the matter exist, their implementation should be prioritised. Legal prohibition of sexual violence against children should include:\(^4\)

- A clear definition of the legislative goal;
- Consultation with relevant stake-holders (including complainants, NGOs, service-providers, relevant government departments, national human rights institutions, personnel and officials in the criminal justice system, healthcare professionals, social and counselling service deliverers, and religious and community leaders);
- An evidence-based approach; and
- Coordinated and sensitive implementation.

9.3.3. The development of law should be guided by the following principles:

- Be rights-based;
- Address CSA as a form of gender-based discrimination, and a violation of children’s human rights;
• Make clear that CSA is unacceptable and that eliminating it is a public responsibility;
• Ensure that complainants/survivors of violence be not ‘re-victimised’ through the legal process;
• Promote children’s agency and empower individual children who are complainants/survivors of violence;
• Promote children’s safety in public spaces;
• Take into account the differential impact of measures on children according to their race, class, ethnicity, religion, disability, culture, indigenous or migrant status, legal status, age or sexual orientation.
• Mechanisms to monitor the implementation of legal reforms to assess how well they are working in practice should be developed; and
• Legislation should be constantly reviewed and reformed in the light of new information and understanding.

9.3.4. Law should be linked to an effective criminal justice system that is sensitive and responsive to the needs of children (in order to reduce further trauma), and that ensures that cases of CSA are efficiently prosecuted, with no impunity for perpetrators.

9.4 Policies and programmes

9.4.1 Policy is required to detail how law is to be implemented. A systematic framework to protect children should be integrated into national planning processes, including budgeting. National Plans of Action to deal with CSA should have realistic and time-bound targets for addressing it.

9.4.2 Policies should be regularly evaluated, to ensure that they indeed are able to protect children, and that gaps are identified and adjustments made to the programmes.

9.4.3 To combat CSA in schools, policy should be developed which include:  
• investing in the professionalism of teachers to prevent violence in the schools and create schools that are child-friendly;
• prominently displaying on school property the laws and rules that are intended to protect children, especially those that condemn and prohibit sexual relations between teachers and pupils;
• development of Codes of Conduct in each school;
• development of a professional Code of Conduct for teachers, that should be enforced by the Ministry of Education in each country, and that should clarify the important role teachers have in the protection of children’s rights;
• ensuring that there are enough teachers, especially in rural areas;
• increasing the number of female teachers; and
• improving conditions of employment so as to encourage the retention of trained and professional teachers.
9.4.4 To address CSA in the home and community, a criminal justice system that facilitates rather than restricts reporting is critical. Personnel should receive specialised training in dealing with child victims of sexual abuse. A victim-friendly approach that keeps complainants informed of the status of cases would also be helpful.

9.4.5. At every level, CSA should be addressed by protecting children’s rights to survival and development, and by policies relating to social security, nutritional support, housing, job-creation, basic education and primary health care, among others.

9.4.6. Addressing GBV, gender norms and inequalities should be part of a broader response to CSA. Also important in changing attitudes and behaviour, and hence gender norms and the prevailing constructions of masculinity and femininity, is work done directly with men and boys.

9.4.7. The media should be recognised as an important element in the efforts to change attitudes and behaviour.

9.4.8. Human rights education should be promoted and be directed to policy implementers and traditional and community leaders.

9.4.9 Training and capacity-building at all levels are vital ingredients for government and civil society organisations providing health, security, and social welfare services to women, children and men.

9.5 Services needed

9.5.1. Prevention services should target all children with the intent of keeping them within their families, include:

- Pre-natal care, including adequate nutrition,
- Home visits during the first few weeks of a child’s life,
- On-going capacity-building for parents and care-givers to provide a nurturing and loving environment in which to raise children, such as information on child development, parenting support, and training on, among other matters, child rights and non-violent discipline,
- Support to children’s nutritional status in the form of social security for households and school-feeding schemes,
- Fee-exemptions or free primary school education to keep children in school,
- Early childhood development programmes for pre-school children,
- Primary health care and immunisation against preventable diseases.

9.5.2. Targeted early intervention services for vulnerable children should be implemented.

- Children living on the street require access to: education, health services and nutrition, and training for income-generation, for example.
Child-headed households require access to: social security, school fee exemptions, parenting support, and ECD facilities, for example.

Children in conflict with the law require access to: diversion from the criminal justice system, rehabilitation and reintegration, and income-generation.

9.5.3. Children who have been sexually abused require an increased range of formal services including:

- Response teams comprising health care personnel, the judiciary, law enforcement, psychosocial support, civil society and health facility managers,
- Early identification and linkages appropriate support services including:
  - child-friendly reporting systems,
  - medical treatment,
  - court preparation and support,
  - therapy and counselling,
  - alternate care, and
  - rehabilitation and reintegration.

1 See for example, WHO Regional Office for Africa. 2004. Child Sexual Abuse – A Silent Health Emergency. Report of the Regional Director to the 54th Session of the Regional Committee for Africa. AFR/RC54/15 Rev. 1


3 WHO Regional Office for Africa. 2004.


SELECTED BIBLIOGRAPHY

Conceptual framework and defining child sexual abuse


The context of CSA in SSA

Gender-based violence


HIV and AIDS


Forms of CSA

CSA generally


**Contact CSA – FGM/C**


Inter-Parliamentary Union. 2009. *How to put an end to the practice of female genital mutilation (FGM)*? Accessible at http://www.ipu.org/PDF/publications/fgm08-e.pdf


**Contact CSA – virginity testing**


**Penetrative abuse - rape**


**Penetrative abuse – sexual exploitation and trafficking**


Penetrative abuse - incest


**Penetrative abuse – child marriage**


**CSA in schools**


**Transactional sexual relationships**


**Associated factors**

**Age**

Gender


Care arrangements


Risky environments – conflict areas


**Risky environments – child labour**


Consequences


Behrendt A, and Mor Mbaye S. 2008. The Psychosocial Impact of Parental Loss and Orphanhood on Children in an Area of high HIV Prevalence: a Cross Section Study in the North West Section of Cameroon. PLAN, USAID, FHI, AWARE.


**Responses**


Willow C. 2010. *Children's right to be heard and effective child protection. A guide for Governments and children rights advocates on involving children and young people in ending all forms of violence*. Save the Children Sweden. Accessible at
Law and policy


Keesbury J & Askew, I. Undated. Towards a comprehensive response to sexual violence in sub-Saharan Africa: Lessons learned from implementation. Presentation available from jkeesbury@popcouncil.org


**Programmatic**


CHI. Undated. Child Helpline International is the global member network of child helplines working to protect the rights of children. Accessible at http://www.childhelplineinternational.org/.


Guidelines for the Alternative Care of Children are accessible at http://www.crin.org/docs/Guidelines-English.pdf


Council, accessible at http://www.popcouncil.org/pdfs/frontiers/reports/Kenya_Somali_FGC.pdf


Franco-phone materials


Bureau International du Travail (BIT). 2006. Étude de base sur les PFTE dans le nord et sud de Madagascar. BIT.

Carrefour de Développement Association pour le développement humain et socia. 2005. Études prospectives de la Prostitution de mineures à Lomé. Lomé, Carrefour de Développement


FNUAP/UNIFEM. 2010 (Forthcoming). *Analyse Situationnelle des violences basées sur le genre au Sénégal, Dakar*.


TOSTAN/UNICEF. 2008. *La Décennie qui a fait reculer l’excision*”. Dakar: TOSTAN/UNICEF.


UNICEF WCARCO. 2006. *Abus, exploitation et violence sexuels des enfants à l'école en Afrique de l'Ouest et du Centre.* Dakar: UNICEF.


UNICEF. 2005. *La traite des personnes, en particulier des femmes et des enfants en Afrique de l'Ouest et du Centre.* UNICEF.


Annex 1 - List of key words used/in database and internet searches:

Adolescence
Adolescents
Child abuse
Child sexual abuse
Sexual abuse of children in schools
Sexual abuse of children in the (criminal) justice system
Sexual abuse of children in conflict zones
Sexual abuse of children following natural disasters
Coercive sex
Commercial sexual exploitation
Cross generational sex
Demographic surveys early intervention
Early marriage
Female circumcision
Female genital cutting
Female genital mutilation
Household surveys non-consensual sex
Non-consensual sex
Rape
Services for children
Sexual harassment
Sexual violence
Sex work
Sugar daddies
Trafficking
Transactional sex
Violence against children
Virgin cleansing
Vulnerability
### Annex 2– State of the Ratifications of the African Charter in Sub-Saharan Africa

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### Annex 3 – Age at first marriage

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<th>% of women aged 20 - 49 married before 18 yrs (DHS)</th>
<th>% of women aged 20 – 24 married before 18 yrs (MICS)</th>
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*Data from before 2000 was used in the absence of more recent information.
Annex 4 - Percentage of 15-24 years old females who think that wife beating is completely justified

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*based on DHS survey information.
### Annex 5 – State of the ratifications of the Optional Protocols to the UN Convention on the Rights of Child in Sub-Saharan Africa

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*East, Central and Southern Africa Health Community. Swaziland is also a member but has not ratified the African Charter*
### Annex 6 - Child-friendliness ranking of the countries in Sub-Saharan Africa

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*Members of ECSA-HC