



East, Central and Southern African Health  
Community (ECSA-HC)

# Child Sexual Abuse in Sub-Saharan Africa A Review of the Literature

East, Central and Southern African Health Community  
July 2011

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## LIST OF ACRONYMS

ACPF	African Child Policy Forum
AIDS	Acquired Immune Deficiency Syndrome
ANPPCAN	African Network for the Prevention and Protection Against Child Abuse and Neglect
ART	Anti-Retroviral Therapy
AU	African Union
CDC	Centres for Disease Control and Prevention
CEDAW	Convention to End all Forms of Violence Against Women
CFA	Communauté Financière Africaine
CHI	Child Helpline International
CSA	Child Sexual Abuse
CSEC	Commercial Sexual Exploitation of Children
DHS	Demographic and Health Surveys
DRC	Democratic Republic of the Congo
ECPAT	End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes
ECSA-HC	East, Central and Southern African Health Community
ESARO	East and Southern Africa Regional Office
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-Based Violence
GEM	Girls' Education Movement
GRAVE	Groupe d'Action Contre le Viol des Enfants
HIV	Human Immunodeficiency Virus
ICRW	International Centre for Research on Women
ILO	International Labour Organisation
IOM	International Organisation for Migration
KMG	Kembatti Mentti Gezzima

MDG	Millennium Development Goal
MICS	Multiple Indicators Cluster Survey
NPA	National Plan of Action
NGO	Non-Governmental Organisation
PEP	Post-Exposure Prophylaxis
PTSD	Post Traumatic Stress Disorder
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
SVRI	Sexual Violence Research Initiative
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNCRC	United Nations Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGEI	United Nations Girls' Education Initiative
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNVAC	United Nations Global Study on Violence Against Children
USAID	United States Agency for International Development
VAW	Violence Against Women
WHO	World Health Organisation
WHO-AFRO	World Health Organisation Regional Office for Africa

# FOREWORD

This child sexual abuse (CSA) literature review is the first comprehensive and inclusive review for the sub-Saharan African region, looking at both English and French literature in African countries. 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 Organisation Regional Committee for Africa in 2004, urging member states to break the silence around this pervasive silent emergency.

At the sub-regional 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 prioritise and accelerate action to end this pervasive human rights issue, which has significant public health consequences. In addition to the literature review, ECSA-HC in collaboration with the World Health Organisation 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

July 2011

## PREFACE

Although the evidence base for child sexual abuse in sub-Saharan Africa (SSA) 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 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 SSA, 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 organisations 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. ECSA-HC commissioned this review with funding from USAID to fill this knowledge gap.

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July 2011

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We sincerely thank the Technical Working Group (TWG) composed of representatives of ECSA-HC Secretariat, ECSA-HC member states and development partners including the Africa's Health in 2010 project, Population Council, Sexual Violence Research Initiative (SVRI), UNICEF-ESARO (United Nations Children's Fund-East and Southern Africa Regional Office), UNICEF Tanzania, United Nations Population Fund (UNFPA) Tanzania, United States Agency for International Development (USAID) Tanzania, and World Health Organisation Regional Office for Africa (WHO-AFRO). They provided formidable support in designing the review process and valuable and critical input during the expert review workshop and subsequent review of the final draft document. ANPPCAN Uganda, Amnesty International through *Tukomeshe Unajisi* Network Kenya and Swaziland Action Group Against Abuse made important contributions during the expert workshop.

The core group led by ECSA-HC and the two consultants worked tirelessly throughout the process. Ndack Diop and Coly Lamothe of the SAHARA Program at the Université Cheikh Anta Diop, Dakar, Senegal, provided significant contributions to the review of the Francophone literature.

The ministries of health from ECSA member states: Kenya, Lesotho, Malawi, Mauritius, Seychelles, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe provided important support and contributions during the expert meeting and helped to build consensus on the document. This literature review has been possible because of the generous support of the USAID Bureau for Africa, through the Africa's Health in 2010 Project.

Dr. Josephine Kibaru-Mbae

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July 2011

# EXECUTIVE SUMMARY

Child sexual abuse (CSA) has emerged as a human rights, public health and development emergency with global dimensions.<sup>1,2,3</sup> In sub-Saharan Africa, available information suggests that it is alarming. However, actual knowledge on the issue remains inadequate to inform the development of policies and programmes.<sup>4</sup> For this reason, ECSA-HC commissioned the present review.

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 programme 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 journal articles and the 'grey literature' published in English and French between 2000 and 2010 were analysed.

The review team used the following different methodologies: systematic searches of electronic databases such as PubMed, Medline, MBASE, Science Direct, Social Sciences Citation Index, and Médecine Tropicale using a list of key words; articles on CSA in SSA from various listservs; analysis of programme reports and reports of national surveys generated by national and international NGOs and international development agencies and online searches 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; lack of rigorous statistical information on most forms of CSA; the concentration of research outputs in a limited number of countries and scarcity of reports on monitoring and evaluation of good practices. Community perceptions of and responses to CSA and information about abuse of boys are research gaps found in the existing literature. 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)<sup>5</sup> and the African Charter<sup>6</sup> that consider childhood as below the age of 18. The reviewers adopted WHO-AFRO's definition of 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.'<sup>7,8</sup>

In the literature, the term 'sexual abuse' was often used interchangeably with 'sexual violence.' Terms such as 'sexual coercion' and 'sexual exploitation' were also commonly used in conjunction with CSA. 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).<sup>9</sup>

Structural facilitators of CSA were found to include the authoritarian relationships that favour male authority implicit in hierarchical social institutions such as the family, religious institutions, schools and work places<sup>10</sup> (factors that are not in themselves sexual), and society's management of sexuality, as can be seen in child marriage, FGM/C and trafficking.<sup>11</sup>

High levels of gender-based violence (GBV) and poverty<sup>12</sup> and low levels of human development characterise the broad context in which CSA takes place in SSA, while the home, school and immediate environment remain settings where CSA is frequently perpetrated.<sup>13,14,15,16</sup> Situations of conflict and displacement were shown to exacerbate vulnerability,<sup>17,18</sup> and children in trouble with the law were also found to be in increased danger.<sup>19</sup>

Nevertheless, data from different regions of SSA suggest high prevalence of all the forms of CSA—non-contact, contact and penetrative abuse. For example:

- As many as 67 percent of girls in a study in Botswana reported being subjected to sexual harassment at least once by teachers, including the following behaviours: unsolicited touching, patting and pinching, dirty jokes, sexual innuendoes, pressure for dates or whistles. Most (68 percent) of the sexual harassment took place at junior secondary schools, 18 percent at senior secondary schools; and 14 percent at primary schools.<sup>20</sup>
- Almost one quarter (24 percent) of the 4,412 schoolchildren surveyed in Malawi reported being forced to have sex against their will; 14 percent were touched on their genitals or breasts against their will; and 4 percent of children over 13 years were forced to engage in some form of oral sex.<sup>21</sup>
- Over 92 million females over age 10 are estimated to be living with the consequences of female genital mutilation/cutting (FGM/C) in Africa, with about 3 million new cases a year.<sup>22</sup> FGM/C rates range from 2 percent in Niger, 36 percent in Liberia, 62 percent in Ethiopia, and 89 percent in Guinea to as high as 90 percent in others and 97 percent in Somalia.<sup>23</sup>
- In a retrospective study of childhood experiences amongst 18- to 24-year-old girls, rape/forced sexual intercourse was the third most prevalent type of sexual abuse reported (following 'spoken to in a sexual manner' and indecent sexual touching) in Ethiopia (30 percent), Kenya (26 percent) and Uganda (43 percent).<sup>24</sup>
- Lifetime exposure to sexual abuse was reported by an average of 23 percent (9 percent to 33 percent) of 13- to 15-year-old schoolchildren from Namibia, Swaziland, Uganda, Zambia and Zimbabwe.<sup>25</sup>
- High levels of sexual coercion at sexual debut were reported by 12- to 19-year-old girls in four countries: In Malawi, 38 percent of those surveyed said they were

'not willing at all' at their first sexual experience followed by Ghana (30 percent), Uganda (23 percent) and Burkina Faso (15 percent).<sup>26</sup>

- One in three females (13 to 24 years) in Swaziland has experienced some form of sexual violence in her life. Among incidents that occurred prior to age 18, a third (33 percent) occurred in females' own home; 23 percent occurred in the house of a friend, relative or neighbour; 19 percent occurred in a public area/field; 10 percent occurred in a school building or on school grounds and 9.5 percent occurred on the way to or from school.<sup>27</sup>
- Child marriage is generally more prevalent in Central and West Africa—affecting 40 percent and 49 percent, respectively of girls under 19—compared to 27 percent in East Africa and 20 percent in North and Southern Africa.<sup>28</sup> The majority of women enter marriage before their 18th birthday in Guinea (71 percent), Chad (72 percent) and Niger (78 percent).<sup>29</sup>
- Information on trafficking, based mostly on the numbers of children repatriated, indicates thousands of children are trafficked each year.<sup>30</sup> The sexual exploitation of children is rife across the continent.<sup>31</sup> In Kenya, an estimated 10,000 to 15,000 12- to 18-year-old girls living in the coastal areas of Malindi, Mombasa, Kilifi and Diani 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.<sup>32</sup>

HIV/AIDS has resulted in devastating consequences for families and communities in SSA.<sup>33</sup> The region carries the heaviest HIV/AIDS burden in the world.<sup>34</sup> Children orphaned by AIDS are on the increase.<sup>35,36,37</sup> Women and girls in the region continue to be disproportionately affected by the epidemic, accounting for at least 60 percent of all HIV infections; young women between the ages of 15 and 19 are particularly vulnerable.<sup>38</sup> CSA was found to increase HIV-related vulnerability,<sup>39,40</sup> while HIV in turn, was found to exacerbate vulnerability to CSA.<sup>41,42</sup>

The immediate and long-term consequences of CSA in SSA are severe. They include physical injury (including traumatic fistula), gynaecological complications, sexually transmitted infections (STIs) including HIV, unwanted pregnancies and unsafe abortion.<sup>43,44,45,46,47</sup> Mental health consequences include debilitating fears, anxieties, regressive behaviours, nightmares, withdrawal, post traumatic stress disorder (PTSD), depression, anger and hostility, self-injurious behaviours (including suicide), low self-esteem and inappropriate sexual behaviour.<sup>48,49,50,51</sup>

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.

Moreover, the review found that Africa has no dearth of policies, treaties, laws and signed commitments against CSA. For example, 45 of 53 African Union (AU) member countries have signed, ratified and/or acceded to the African Charter;<sup>52</sup> and with the exception of Somalia, all African countries have ratified the UNCRC. Yet CSA persists and

continues to be shrouded in silence, especially when it occurs within families in SSA. The authors advocate for a holistic, multi-sectoral and coordinated approach to prevent and respond to CSA and protect children where they live and grow up. Stake-holders include government departments dealing with social services, women and children, justice, health, education, housing, police and the NGO and development communities.

The review makes the following recommendations to address CSA in SSA:

- **Increase awareness and dialogue** at all levels about CSA and its negative consequences. This includes establishing community mobilisation strategies to address harmful traditional practices; engaging boys and men; fostering attitude and behaviour change towards CSA survivors.
- **Enhance political will at the national level** to go beyond the ratification of international rights treaties to domestication by *enacting and enforcing 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.
- **Increase regional, national and local resources (financial, human, material)** to implement the laws, policies and programmes that are needed for an integrated prevention and response to CSA.
- **Provide comprehensive prevention, care and support services**  
A three tiered intervention model is recommended 1) Primary prevention: target all children to prevent maltreatment and abuse in the first place; 2) Early intervention for vulnerable children (e.g., children-headed households) so that families receive the support they need to provide protective and nurturing environments in which to raise children and 3) Provide statutory protection and a range of integrated services for those who experience CSA including child-friendly reporting systems; prompt medical treatment; court preparation and support; therapy and counselling; alternate care in shelters or safe homes and services for rehabilitation and reintegration.
- **Build capacity of different cadres** of those involved in the response (health, law enforcement, social workers, judiciary, families).
- **Enhance CSA data collection, documentation, information management and utilisation** for the promotion of evidence-based CSA-related legislation, policy formulation and programming in the region.

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# 1. INTRODUCTION

## 1.1 Background

The global evidence base concerning child sexual abuse (CSA) is growing, 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.<sup>1</sup>

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 have authority over the child.<sup>2</sup> Commercial sexual exploitation of children (CSEC) is common, resulting from an increasingly globalised world and driven by a multi-billion-dollar-a-year industry.<sup>3</sup> CSEC includes child prostitution, child pornography and trafficking of children for sexual purposes.<sup>4</sup> Estimates from a study conducted in 2002 suggested that 5.7 million children were in forced or bonded labour, 1.8 million were involved in prostitution and pornography and 1.2 million were victims of trafficking.<sup>5</sup> Figures show that up to 3 million children are prostituted each year in the Southern Asia sex trade alone.<sup>6</sup>

CSA also includes traditional practices such as child marriage, prevalent in many countries in Africa, the Middle East and South Asia.<sup>7</sup> FGM/C is prevalent in many parts of Asia and Africa. It is estimated that, in SSA, Egypt and Sudan, 3 million girls and women are subjected to FGM/C every year.<sup>8</sup>

CSA 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, PTSD, anxiety eating disorders, poor self-esteem, dissociative and anxiety disorders, somatisation, neurosis and chronic pain.<sup>9,10,11,12,13,14,15</sup> Other consequences include sexually transmitted diseases, drug abuse, alcohol dependence, psychiatric disorder and physical consequences, including internal lacerations, bleeding and damage to internal organs leading in some cases to death.<sup>16,17,18</sup> 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.<sup>19</sup> Protection of children from sexual abuse is increasingly recognised as integral to the protection of human rights in general, and is considered an element of international law.<sup>20,21</sup> The 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, exploitation of children in pornography and the abduction, sale or trafficking of children.<sup>22</sup> 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.<sup>23</sup> It has been implicated as one of the factors impeding the achievement of the Millennium Development Goals (MDGs).

**MDG 1 (to eradicate extreme poverty and hunger):** Children who live in poverty are more vulnerable to violence, exploitation, abuse and discrimination including child marriage, trafficking, prostitution and cross-generational sex.<sup>24,25,26,27</sup>

**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 MDG 2.<sup>28,29,30,31</sup>

**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.<sup>32</sup> Delaying marriage can help ensure that girls delay pregnancy, complete their secondary education and improve prospects for the whole family, thus helping to break the cycle of intergenerational poverty.<sup>33</sup>

**MDG 4 (to reduce child mortality):** Child marriage and resulting early pregnancies and FGM/C seriously undermine reproductive health outcomes, leading to difficult deliveries and higher risk of neonatal mortality.<sup>34,35</sup>

**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.<sup>36</sup>

**MDG 6 (to combat HIV/AIDS, malaria and other diseases):** GBV, of which CSA is a manifestation, is increasingly being recognised as fuelling the HIV pandemic.<sup>37</sup>

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, the international comparative reviews conducted by Pereda et al in 2009 building on the work by Finkelhor et al in 1994, document that the prevalence of CSA across 28 mainly high- to middle-income countries ranged from 0 percent to 53 percent in women and from 0 percent to 60 percent in men.<sup>38,39</sup> In industrialised countries, estimates indicate a prevalence rate of between 5 percent and 10 percent for adult men reporting CSA.<sup>40</sup> Jewkes and Abraham, however, caution the use of international comparisons in developing countries because most of these countries lack the infrastructure for accurate crime reporting and do not have a substantial body of survey data.<sup>41</sup> The prevalence of childhood sexual abuse ranged from 1 percent to 21 percent in the WHO's multi-country study on women's health and domestic violence against women.<sup>42</sup>

Until recently, the information on CSA in SSA has been scarce, fragmented and inconsistent. Little systematic analysis has been possible to adequately inform prevention and response efforts. As Lalor (2004) noted, a relatively large number of peer-reviewed studies on CSA in South Africa exist, but little from the rest of the continent, and the focus has largely been on CSEC.<sup>43</sup> 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).<sup>44</sup>

Apart from reliable information available from Demographic and Health Surveys (DHS) on FGM/C and child marriage, the general perception is that not much is known about the various types of CSA experienced in SSA and the information is largely anecdotal. The secretive nature of CSA and resulting under-reporting also make it difficult to determine the extent of the problem. These challenges prompted ECSA-HC to commission the current 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 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 available peer-reviewed articles on CSA in French and English from 2000 to 2010. The review also examined grey literature from 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) as well as the project's lead consultant and 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.
- 2 A TWG to guide the review. This group included the core group, representatives of member states of ECSA-HC, the UNFPA, UNICEF-ESARO, USAID/Tanzania, WHO-AFRO, Population Council and SVRI.
- 3 A request for reports and articles on CSA in SSA via the International Society for the Prevention of Child Abuse and Neglect, SVRI and CRINMAIL listservs.
- 4 Systematic searches of electronic databases such as PubMed, Medline, MBASE, DHS, Science Direct, Social Sciences Citation Index and Médecine Tropicale using a list of key words.
- 5 Online searches for web-based documents using the Google search engine.

- 6 Review and analysis of available reports from international development agencies including UNICEF, WHO, UNFPA, USAID; international NGOs such as Save the Children, End Child Prostitution, Child Pornography and the Trafficking of Children for Sexual Purposes (ECPAT), Plan International, Human Rights Watch, Amnesty International and World Vision, and national NGOs such as African Child Policy Forum (ACPF), GRAVE (Groupe d'Action Contre le Viol des Enfants) in Senegal, Kembatti Mentti in Ethiopia, CRADLE in Kenya and Girl Child Network in Zimbabwe.
- 7 Review and analysis of national surveys and reports.

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

#### **1.4 Limitations**

The research team identified a number of limitations that makes it necessary to interpret the findings presented here with caution. No standardised definition of CSA exists 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 to 49 years of age and look retrospectively at the issue. Other studies considered clinical samples, based on children attending medical facilities for treatment of post sexual abuse. Still other studies are based on the collection of qualitative and largely anecdotal information. There is a general dearth of reports on good practices to address CSA from international NGOs. We found only two peer-reviewed articles on the progress of the implementation of the UNCRC and the African Charter. The lack 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, few studies focus on social and cultural factors, other than those of Levett<sup>45</sup> and Clarfelt and Dwanda-Henda.<sup>46</sup>

#### **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 socio-economic, 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 summarises the physical and psycho-social 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 offers recommendations for addressing CSA in SSA and discusses the implications of the findings of the literature review for its target audiences.

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

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## 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).<sup>1,2</sup> However, 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.'<sup>3</sup> 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, making it stronger in this regard. A full list of these countries appears in Annex 2.

Many variations exist 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 WHO's definition of adolescence is 10 to 19 years, adolescence can start at age 10 and last until the age of 25 years.<sup>4</sup> There is, however, some concurrence on the start of adolescence being marked by the onset of puberty, between the ages of 10 and 11.<sup>5</sup> 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 zero 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

The 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.'<sup>6,7</sup>

The WHO definition is comprehensive, but lacks subtlety with regard to the psycho-social 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 to develop new legislation on sexual offences in

that country, considered the term 'coercive circumstances' rather than 'without consent'—although the Parliamentary Portfolio Committee subsequently rejected this wording and the notion of 'without consent' was retained in the new act.<sup>8</sup> 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.<sup>9</sup>

The United Nations Global Study on Violence Against Children (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.'<sup>10</sup> Given the relative vulnerability of children in their relations with most adults, UNVAC's introduction 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.<sup>11</sup>

Also, important to note is that the terms 'sexual abuse' and 'sexual violence' are often used interchangeably in the literature on CSA 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.<sup>12</sup> 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.<sup>13</sup> The term 'sexual coercion' is often used in conjunction with 'sexual violence.' For example, Wagman et al describe sexual violence as including 'various typologies of abuse including sexual coercion' and consider sexual coercion as being 'inclusive of sexual violence such as rape.'<sup>14</sup>

The terms 'sexual exploitation' and 'sexual violence' are also often used interchangeably. For example, ECPAT describes 'sexual exploitation' and 'sexual violence' as 'umbrella terms encompassing a variety of harmful and sexually abusive behaviours to include all forms of sexual abuse, sexual assault, pornography, prostitution, trafficking for sexual purposes, sex tourism, early and forced marriage and enslavement.'<sup>15</sup> It notes the 'considerable difficulties in disentangling the different forms of sexual violence and abuse, typically because they do not occur in isolation.' Many such examples are given in almost all the documents 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 expressions. 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.'<sup>16</sup> 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 instances 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 U.S. Centres 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).'17

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** takes many forms including attacks such as rape or attempted rape, as well as any unwanted sexual contact or threats.<sup>18</sup> 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.<sup>19</sup>
- **Sexual exploitation** includes victimising children for advancement, sexual gratification or profit; for example, prostituting a child and the production and dissemination of child pornography.<sup>20</sup>
- **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.<sup>21</sup>
- **Sexual coercion** is the act of forcing (or attempting to force) an individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstance to engage in sexual behaviour against his or her will. It can include a wide range of behaviours from violent forcible rape to more contested areas such as cultural expectations that require young women to marry and sexually service men not of their choosing.<sup>22</sup>

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:<sup>23,24</sup>

### ***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,<sup>25</sup> 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. The 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.

Non-contact abuse can also include verbal sexual harassment, such as sexual innuendo and derogatory remarks about girls' bodies, exposing genitalia, unwelcome sexual advances, requests for sexual favours and other verbal or physical conduct of a sexual nature.<sup>26,27,28</sup> 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, usually in the toilets or by using mirrors placed on the floor to look up their skirts when girls stood up in class.<sup>29</sup>

Grooming takes place when a child's trust is secured in order to lure them into a situation where they will be abused.<sup>30</sup> 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.<sup>31</sup>

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.

### ***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, this is often an expression of power relations using the body as a sexual object.<sup>32</sup>

Virginity testing is an investigation of whether or not the hymen is intact, and involves the insertion of a finger into the vagina by a young girl's mother, aunt, neighbour or even prospective husband.<sup>33,34</sup> 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.<sup>35</sup> The Girl Child Network has identified virginity testing in Zimbabwe as a significant problem, where girls as young as five years may be tested.<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup>

Alteration of the sexual organs via FGM/C can also be considered contact abuse. FGM/C is classified in four ways:<sup>39,40</sup>

- 1) Type 1 - Clitoridectomy: partial or total ablation of the clitoris or (more rarely) of the prepuce.
- 2) 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.<sup>41</sup>

### ***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.<sup>42</sup>

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 his/her 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.<sup>43</sup>

Concepts developed in the social scientific analysis of violence such as the concepts of structural violence, cultural violence and symbolic violence can be particularly useful in understanding CSA and are discussed further in 2.4 below.

## **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.<sup>44</sup> This type of abuse is indirect and exploits the victim at an emotional, mental, psychological, economic and social level.

According to Bourdieu,<sup>45</sup> **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.<sup>46</sup> **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,<sup>47</sup> 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:

**Sexual abuse occurring within the hierarchical institutions that govern authority relations** (family, church, school, workplace), which 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.<sup>48</sup> 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.'<sup>49</sup> Other countries in SSA define incest in much the same way.<sup>50</sup>

**Sexual abuse generated and maintained by the cultural management of sexuality.** This is the case regarding child marriage, FGM/C and virginity testing.

**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.'<sup>51</sup>

**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.<sup>52</sup> 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.

**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.<sup>53</sup>

**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.<sup>54</sup>

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.

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### **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 backdrop of violence, be it within their own families, in the communities in 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 authors, including those involved in compiling 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.<sup>1</sup>

All levels of violence can lead to displacement and migration, probably less commonly when the violence is within a 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 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 associated with 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.<sup>2,3</sup>

Human Rights Watch reports that 'tens of thousands of women and girls' have suffered horrific acts of sexual violence in the Democratic Republic of the Congo (DRC).<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

In January 2010, the Africa Warwick Conference highlighted the situation of sexual violence in camps and conflict zones in Northern Uganda.<sup>7</sup> 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 child marriage.<sup>8</sup> 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 were reportedly abducted, raped and abused on an enormous scale.<sup>9</sup>

An issue paper prepared for the Sixth African Development Forum 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.'<sup>10</sup> This vulnerability arises from the disruption and dismantling of the formal and informal protection mechanisms of families, communities and the state and poor site planning and camp management decisions that subject women and children to risks that contribute to violence against women (VAW), especially sexual violence. Girls in particular are often the primary targets of abduction, often resulting in their being forced to participate directly in hostilities as fighters, or in 'support' roles as spies, messengers, servants and sexual and domestic slaves.<sup>11</sup>

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.<sup>12</sup>

The violence and violation of human rights perpetrated by colonial regimes, apartheid and post-colonial 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 19<sup>th</sup> century.<sup>13</sup> 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.<sup>14,15</sup>

### **3.2 Child trafficking and child labour**

Sexual exploitation is the most commonly identified form of human trafficking globally (79 percent), followed by forced labour (18 percent).<sup>16</sup> UNICEF conducted a comprehensive study that confirmed the prevalence of trafficking of women and children in Africa across all sub-regions as well as the complexity of its forms.<sup>17</sup> The study highlights the challenge Africa faces both as a region of origin for trafficked women and children and also as a region of destination, in the sense that most trafficking appears to occur within the continent itself.

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.<sup>18</sup> 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.<sup>19</sup>

According to ACPF, 90 percent of domestic workers in SSA are girls.<sup>20</sup> Child domestic workers are often denied an education, and face high levels of physical, sexual and psychological abuse. A study of female domestic workers in Nigeria found that 85 percent of the 200 girls (some as young as 10 years of age) questioned were coerced into sexual

intercourse with a male within the household where they were working.<sup>21</sup> In a study conducted in urban Ethiopia, half (48 percent) of the 1,837 out-of-school females 10 to 19 years of age were domestic workers. Compared with other young women, the domestic workers were significantly more likely to have had sex before age 15 and to have been coerced into have sex.<sup>22</sup>

The National Survey on Child Trafficking in Guinea, published in 2003, provided evidence of the trafficking of Guinean children as young as eight years, and of children from neighbouring countries such as Mali, Sierra Leone and Ghana.<sup>23</sup> It noted that many children are trafficked across borders:

- 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
- To work in the mines where they face an increased risk of sexual exploitation

In the DRC, a UNICEF study found girls aged 12 to 15 working in bars, hotels and brothels.<sup>24</sup> A Human Rights Watch report in Togo documented the experiences of children trafficked when they were anywhere from three to 17 years of age.<sup>25</sup>

In 2004 it was estimated that 820,000 children were orphaned 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.<sup>26</sup>

Statistics from the U.S. State Department indicate that more than 200 Beninese children were repatriated from Nigeria from September to October 2003.<sup>27</sup> In Burkina Faso, 640 children were intercepted in 2003, all but 20 were local.<sup>28</sup> In Guinea, 600 children were withdrawn from the cocoa and coffee fields, and six boys heading to Mali were intercepted in November 2003.<sup>29</sup> 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.<sup>30</sup> In 2004, 258 Chadian children were repatriated, and 2,458 Togolese children were repatriated between 2002 and 2004.<sup>31</sup>

According to a survey on child labour in 2001, 18.2 million Ethiopian children aged between five and 17 years were working; 81.2 percent of them (12.6 million) were below the age of 15. Almost the same number of girls and boys were working (50.6 percent were boys and 49.4 percent were girls).<sup>32</sup>

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 passersby and from those who offer them shelter, in some cases. They are also at risk of being recruited for sexual and economic exploitation or having to resort to 'survival sex' (sex in exchange of food or shelter).<sup>33</sup> A 2007 study in Zambia estimated figures of around 35,000 children living and working in the streets.<sup>34</sup>

### 3.3 Contexts of poverty

The highest proportion of the population (51 percent) living below the international poverty threshold of US\$1.25 per day is found in SSA.<sup>35</sup> 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.<sup>36</sup>

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 its 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.<sup>37</sup> 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 percent); only 3 percent of respondents specifically mentioned sexual abuse in the home as their primary reason for leaving.<sup>38</sup>

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 hard data are lacking, 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 their survival would be threatened and/or that they would not survive if their children stopped working.<sup>39</sup> 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.<sup>40</sup> In Togo, becoming a prostitute has been linked to young girls running away from home to avoid poverty, violence and abuse within their families.<sup>41</sup>

However, sometimes, parents who send their children away hope to ensure a better life for them.<sup>42</sup> 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.<sup>43</sup>

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:<sup>44</sup>

- 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
- 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 percent of the children between 10 and 14 years of age estimated as being exploited for cheap labour.<sup>45</sup> Sex tourists often access children who are domestic workers at tourist accommodations.<sup>46</sup>

However, in the case of transactional sex 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.<sup>47</sup> 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.'<sup>48</sup>

### **3.4 Gender inequalities and gender-based violence**

The UNDP gender-related development index, which ranks 155 countries, indicates that out of the 20 countries that have the lowest ranks, 19 are in SSA.<sup>49</sup> Primary school completion rates in most African countries still remain far below levels required to achieve the MDG of universal primary school completion by 2015, and inequalities by gender and household wealth within countries, including the poorest countries persist.<sup>50</sup> In many countries in the region, fewer than 50 percent of girls go to school, and in some, the rate is as low as 25 percent.<sup>51</sup> Furthermore, only 17 percent of girls are enrolled in secondary school in SSA,<sup>52</sup> and the gender gap in secondary enrolment in SSA has actually grown wider since 2000.<sup>53</sup>

Women and girls across Africa are vulnerable to and experience GBV on a large scale.<sup>54,55</sup> High levels of acceptance also surround the practice in the region. For example, the percentages of 15- to 24-year-old females who reported that wife beating is justified under certain conditions was 51 percent in Rwanda, 61 percent in Liberia, 72 percent in Uganda and as high as 83 percent in DRC.<sup>56</sup> 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.'<sup>57</sup>

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 child marriage.<sup>58</sup> The situation is similar in most countries in SSA, i.e., although laws theoretically protect 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 to be legal minors.<sup>59</sup> 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 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.<sup>60</sup> In addition, the socialisation of boys has been shown to include a too early push towards autonomy; 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.'<sup>61</sup>

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.<sup>62</sup> The International Organisation for Migration (IOM) has shown that the prevalence of attitudes that 'sexualise' and 'commoditise' young girls leave them at greater risk of being trafficked.<sup>63</sup>

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.<sup>64</sup> These gender norms and power disparities negatively affect sexual attitudes and behaviour.<sup>65</sup>

A multi-country study in Southern 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.<sup>66</sup>

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.<sup>67,68</sup> 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.<sup>69</sup> The social worth of women is 'proven' through their 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.<sup>70</sup> However, some evidence from anthropological studies indicate that local cultures and historical heritage abound with concepts and practices that challenge male authority.<sup>71</sup>

### **3.5 The HIV/AIDS epidemic**

The HIV pandemic has wreaked havoc upon the families and communities of SSA—the most heavily affected area globally—and has had a significant negative impact on children's vulnerability. This is particularly important given that SSA has a young population—about a quarter are aged 10 to 19 years, and more young people in Africa are now entering adulthood than at any other time in history.<sup>72</sup>

Available evidence for SSA suggests that:<sup>73</sup>

- More than two-thirds (67 percent) of people living with HIV globally are found in SSA, and nearly three-quarters (72 percent) 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 percent 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 percent.
- Swaziland has the most severe level of infection in the world, with an adult prevalence of 26 percent.
- South Africa is home to the most people (5.7 million) living with HIV (15 percent to 20 percent of the population).
- Prevalence rates in Tanzania (more than 5 percent), Zambia and Zimbabwe (both 15 percent to 20 percent) are declining, while those in Lesotho (23.2 percent) 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 percent) and Ghana (1.9 percent) are relatively high.

There is growing recognition that the risk of, and vulnerability to, HIV among women and girls is largely shaped by pervasive gender inequalities—sexual violence in particular.<sup>74</sup> Virgin cleansing in relation to HIV has been cited by several authors of CSA research in SSA.<sup>75,76</sup> This belief is buoyed by an old myth: that sex with children is a cure for a variety of diseases. The myth has been traced to places as varied as 17<sup>th</sup> century South America and Victorian England.<sup>77</sup> It has been argued that little empirical evidence exists showing virgin cleansing is connected to 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.<sup>78</sup>

The UNVAC highlighted two studies where a strong correlation was found between the epidemic and the entry of orphaned children into occupations that are associated with violence such as domestic work, quarrying and prostitution in Ethiopia, Tanzania and Uganda.<sup>79,80</sup> Orphans who have lost one or both parents to HIV/AIDS are taken in by extended family members and frequently subjected to sexual violence from uncles, stepfathers and cousins.<sup>81,82</sup>

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## 4. THE MAGNITUDE OF THE PROBLEM

It is often said that the magnitude of CSA in SSA is unknown. The difficulties in establishing the extent of the problem are largely related to the measurement issues (varying definitions, operationalisation and study methods) around CSA discussed in Chapters 1 and 2 of this document. It is also related to the fact that CSA is seriously under-reported, as noted by a number of authors. The 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.'<sup>1</sup> A study report on the characteristics of rape survivors in 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.<sup>2</sup>

Estimates of CSA vary by country, and according to study methodology, and which behaviours or experiences are included in the prevalence estimate. 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.<sup>3</sup>

The vast and diverse collection of articles and reports across several disciplines and countries in SSA, which this literature review considered, clearly demonstrates that contrary to widespread belief, the literature on CSA in SSA is in fact quite rich and steadily growing. Despite the limitations and continuing challenges of being able to compare studies within and across countries, the findings from the peer reviewed and grey literature examined for this document confirm that CSA is a significant problem in SSA. This section highlights and attempts to tease out the available data on the magnitude of the different types of CSA: non-contact abuse, contact abuse and penetrative sexual abuse. It also discusses the limitations of the available data on these different types of CSA.

### 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.<sup>4</sup> 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.'<sup>5</sup>

A further complication in establishing magnitude is that 'sexual harassment' is often used to describe both non-contact and contact forms of CSA. One consequence is that limited

data are available about the magnitude of contact and non-contact sexual harassment as a 'stand-alone' form of CSA. However, much information is available to suggest that it is a significant problem.

For example, a study on sexual harassment in three secondary schools in Kenya involved 1,279 participants. Of these, 60 percent of girls and 55 percent of boys (58 percent of all respondents) 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.<sup>6</sup> 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 subset of contact abuse.

Similarly, a study in Botswana concluded that there is 'a culture of sexual harassment in schools' with up to 67 percent of girls reporting sexual harassment by teachers.<sup>7</sup> Sexual harassment in this study included being subjected to any of the following behaviours at least once by teachers: unsolicited touching, patting, pinching, dirty jokes, sexual innuendoes, pressure for dates or whistles. Most (68 percent) of the sexual harassment took place at the junior secondary schools, 18 percent at the senior secondary schools and 14 percent at primary schools.<sup>8</sup>

An ACPF study conducted in Ethiopia, Kenya and Uganda separate the non-contact forms of abuse in the following way: spoken to in a sexual manner (vulgar language and speaking to a girl in a sexual way about her body); someone exposing their genitalia; forced to look at sexual scenes and made to pose indecently.<sup>9</sup> The most prevalent form of sexual abuse reported was being spoken to in a sexual manner (ranging from 52 percent to 88 percent) while the least prevalent was being made to pose indecently (under 5 percent).<sup>10</sup>

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 percent of girls from some regions (for example, Amhara) reporting it.<sup>11</sup>

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.<sup>12</sup> The UNICEF-ESARO Desk Review undertaken 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.<sup>13</sup>

Sexual harassment was also found to be a precursor to other forms of sexual abuse. For example, Ruto found that 51 percent of girls and 39 percent of boys among the 1,230 children interviewed had received 'love proposals' from adults.<sup>14</sup> Leach et al found that 27 percent of the female respondents had been propositioned by their school teacher in a study conducted in Ghana.<sup>15</sup>

#### **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 the Internet.<sup>16</sup>

### **4.2 Contact abuse**

#### **4.2.1 Sexual touching**

Sexual touching (also called fondling) emerged from the materials reviewed here as a significant problem in SSA. One of the 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, describe the prevalence rate of any form of (physical) contact sexual abuse amongst secondary school students in South Africa (Northern Province) as being 56 percent for males and 53.2 percent for females, and include sexual kissing and touching as well as oral, anal or vaginal intercourse in their definition.<sup>17</sup> When separated, high levels of sexual touching (61 percent) and sexual kissing (87 percent) were found.<sup>18</sup>

An unpublished review of the literature on CSA in Africa and the Middle East reports rates of fondling from several studies: 25 percent in Ethiopia; 13 percent of males and 28 percent of females in Tanzania and 27 percent for males and 47 percent for females in Uganda.<sup>19</sup> The authors conclude that on average girls were more likely to have been victims of fondling than boys in studies conducted in East Africa. However in Southern Africa, the prevalence of fondling reported for girls and boys didn't differ as much: Zambia (10 percent vs. 7 percent) and South Africa (31 percent and 36 percent, respectively).<sup>20</sup>

In a nationally representative sample of 4,500 children nine to 18 years old in Malawi, sexual touching (defined as unwanted touching of the genitals or breasts) was reported by 9 percent of children under 14 years compared to 26 percent of children 14 years and older.<sup>21</sup> In a qualitative study among adolescent women 15 to 17 years old in the Rakai District of Uganda, 46 percent reported unwanted touching.<sup>22</sup>

#### **4.2.1 Female genital mutilation or cutting**

FGM/C in African countries has been comparatively well-researched, and a great deal of information is available on the subject. Reported prevalence rates are as low as under 5 percent in some countries to over 90 percent in others. While FGM/C is not practiced only in Africa, it is practiced in at least 28 countries in Africa.<sup>23</sup> 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.<sup>24</sup>

The prevalence rates from DHS and Multiple Indicators Cluster Survey (MICS) for SSA countries are shown in Tables 1 and 2 below.

**Table 1: Prevalence of FGM/C from Demographic and Health Surveys**

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

Source: Population Reference Bureau, 2010.<sup>25</sup>

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 percent in 1998 to 2.2 percent in 2006.<sup>26</sup> The practice is more widespread in Guinea where the most harmful version of FGM/C, i.e., infibulations, is practiced.<sup>27</sup> Demographic and Health surveys in some countries (Senegal, Guinea) have also noted a decline in the rate, although this is slight; for rural Guinea, for example, rates declined from 99 percent in 1999 to 96.4 percent in 2005.<sup>28</sup>

**Table 2: Prevalence of FGM/C from Multiple Indicators Cluster Survey**

Country	Year	% 15-19	% Urban	% Rural
<b>Burkina Faso</b>	2006	59.7	76.0	<b>71.2</b>
<b>Central African Republic</b>	2008	18.7	20.9	<b>29.3</b>
<b>Côte d'Ivoire</b>	2006	28.0	33.9	<b>38.9</b>
<b>Djibouti</b>	2006	-	93.1	<b>95.5</b>
<b>Gambia</b>	2005/06/07	79.9	72.2	<b>82.8</b>
<b>Ghana</b>	2006	1.4	1.7	<b>5.7</b>

<b>Guinea-Bissau</b>	2006	43.4	39.0	<b>48.2</b>
<b>Mauritania</b>	2007	68.0	59.7	<b>84.1</b>
<b>Sierra Leone</b>	2006	81.1	86.4	<b>97</b>
<b>Somalia</b>	2006	96.7	97.1	<b>98.4</b>
<b>Togo</b>	<b>2006</b>	<b>1.3</b>	<b>4.1</b>	<b>7.3</b>

Source: Population Reference Bureau, 2010<sup>29</sup>

In Djibouti, the 2002 DHS reported that 98 percent of women aged 15 to 45 years experienced FGM/C with nearly 70 percent 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.<sup>30</sup>

#### 4.2.2 Virginit testing

In general, data and information on the prevalence of virginit 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.<sup>31</sup> The Girl Child Network in Zimbabwe identified 7,000 girls who had been subjected to virginit testing between 2001 and 2004.<sup>32</sup> South Africa is the only country that has outlawed the practice, and as yet no records exist of virginit testing having been reported to the police or to service-delivery points.

The understanding of virginit testing is complicated by the cultural concepts that underlie it, with the claim being made that it is voluntary. The ‘proven’ virginit of an unmarried girl is construed as a ‘victory’ over males, and virginit testing commonly occurs in a ritualistic and festive context, apparently focused on educating those tested.<sup>33</sup>

#### 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:<sup>34</sup>

- Bankole, Woog and Wulf found in 2004 that 46 percent of girls and 37 percent of boys between the age of 15 and 19 years in SSA have had sex.
- Analysis of DHS data from 14 countries in the region showed that at least 15 percent of girls reported having sex before their 15th birthday.

- Pattman and Chege found in 2003 that children as young as six or seven 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. Maharaj and Munthre have noted that coercion may play an important role in compelling young women to engage in sexual intercourse at an early age.<sup>35</sup>

#### 4.3.1 Rape

Many studies in SSA do not focus on rape per se but on ‘forced sexual intercourse’ or ‘sexual coercion.’ A relatively large number of studies also focus on ‘forced first sex.’ Polonko et al note that the latter term could tap into both CSA and dating violence.<sup>36</sup> As described earlier, rape is often combined with other forms of non-contact and contact abuse as ‘sexual violence’ and ‘sexual abuse.’ For example, a Save the Children report describes a study in Uganda that showed ‘75.8 percent of the children experienced sexual violence, including exposure to pornography, being touched, unwanted attention, being exposed to adults being sexual, being forced to touch adults in sexual ways or being forced to have sex.’<sup>37</sup>

As demonstrated by Table 3, many other methodological obstacles stand in the way of performing comparative assessments of child rape prevalence: methods of data collection vary, as do definitions, 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).

Wagman et al suggest that despite its broad definition (see Chapter 2), much of the research on sexual coercion has focused on intercourse/penetrative abuse with insufficient attention to the continuum of coercion from non-contact to non-penetrative contact abuse.<sup>38</sup> In their qualitative study on adolescents 15 to 17 years old in Rakai District, Uganda, these same authors report that sexual coercion was perceived to be a normal part of intimate relationships.

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 on CSA and associated STIs/HIV conducted in 2005 in SSA that frequency of genital penetration varied between 70 percent and 97 percent of all cases of CSA.<sup>39</sup>

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

Country	Year	Type	N	%	Definition	Source
<b>Burkina Faso</b>	2004	National survey	5,950	15	Sexual coercion at sexual debut	Moore et al
<b>Burundi</b>	2006	Structured questionnaire	61	62	Forced sexual activity	World Vision
<b>Cameroon</b>	2008	Survey	37,719	5.2	Rape	Ndonko et al

<b>Cameroon</b>	2009	Case files	405	4.7	Rape	Menick <sup>a</sup>
<b>Cameroon</b>	2002	Questionnaire	269	38.7	Rape	Menick <sup>b</sup>
<b>DRC</b>	2006	Structured questionnaire	61	87	Forced sexual activity	World Vision
<b>Ethiopia</b>	2006	Retrospective survey	485	29.7	Rape	Stavropoulos
<b>Ghana</b>	2004	National survey	4,252	30	Sexual coercion at sexual debut	Moore et al
<b>Kenya</b>	2006	Retrospective survey	500	26.3	Rape	Stavropoulos
<b>Malawi</b>	2004	National survey	4,012	38	Sexual coercion at sexual debut	Moore et al
<b>Rwanda</b>	2006	Structured questionnaire	60	50	Forced sexual activity	World Vision
<b>Senegal</b>	2008	Questionnaire	N/A	46	Rape	Government
<b>South Africa</b>	1998	Self-rating interview schedule	414	6.1	Forcible sexual abuse	Madu
<b>Tanzania</b>	2006	Self-administered questionnaire	487	27.7	Unwanted sexual activities	McCran et al
<b>Tanzania</b>	2006	Structured questionnaire	61	69	Forced sexual activity	World Vision
<b>Uganda</b>	2006	Retrospective survey	499	42.6	Rape	Stavropoulos
<b>Uganda</b>	2006	Structured questionnaire	61	62	Forced sexual activity	World Vision
<b>Uganda</b>	2004	National survey	5,065	23	Sexual coercion at sexual debut	Moore et al

Sources: Compilation of McCran et al,<sup>40</sup> Moore et al,<sup>41</sup> Stavropoulos,<sup>42</sup> Madu,<sup>43</sup> Menick(a)<sup>44</sup>, Menick(b)<sup>45</sup>, World Vision,<sup>46</sup> Ndoko et al<sup>47</sup>, Senegalese Ministry of Education<sup>48</sup>

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.<sup>49</sup> A population-based study conducted in Kenya found that, among sexually experienced respondents aged 10 to 24 years, the first sexual experience of 21 percent of females and 11 percent of males was coerced, with intimate partners being the perpetrators in most cases.<sup>50</sup> 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.<sup>51</sup>

A number of published studies are available from South Africa on penetrative abuse. In a review of CSA studies from South Africa, Lalor points out that there is less divergence in rates of childhood experiences of abusive sexual intercourse compared to studies reporting on unwanted sexual touching: ranging from 7.5 percent for ‘rape and attempted rape,’ 5.8 percent for ‘sexual intercourse’ and 3.86 for ‘sexual intercourse by force, compared to 5 percent to 26 percent for unwanted sexual touching.’<sup>52</sup> However, the Three Province Study and the 1998 DHS found rates of 1.2 percent and 1.6 percent, respectively of rape and forced sex before the age of 15.<sup>53</sup>

### **In Southern and East Africa**

The Global School-Based Student Health Survey measured the level of coerced sexual activity perpetrated on both boys and girls in five SSA countries and found that between 9 percent and 31 percent of those surveyed reported such activity (see Table 4 below).<sup>54</sup>

**Table 4: Percentage of children answering ‘yes’ to the question ‘Have you ever been physically forced to have sex?’**

Country	% of girls	% of boys
<b>Namibia</b>	19	19
<b>Swaziland</b>	10	9
<b>Uganda</b>	25	13
<b>Zambia</b>	31	30
<b>Zimbabwe</b>	14	11

Source: Global School-Based Student Health Survey<sup>55</sup>

The African Child Policy Forum 2006 Conference on Violence Against Girls in Africa found that 31 percent of girls questioned in a survey in Uganda had experienced rape.<sup>56</sup>

In reviewing the literature on CSA in SSA, Lalor estimated a rate of penetrative abuse of 5 percent in five Southern African countries: Botswana, Mozambique, South Africa, Zambia and Zimbabwe.<sup>57</sup> Various other researchers have reported different prevalence levels for rape in SSA. An ANPPCAN Malawi study found 13 percent of secondary school students described their first sexual experience as unwanted.<sup>58</sup>

Ruto has suggested a rising incidence of reported crimes targeting women and girls in Kenya in recent years.<sup>59</sup> 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 percent increase). Data from Nairobi Women’s Hospital indicated that 55 percent of these cases involved girls from birth to 15 years. In another study involving 228 children aged between 14 and 18 years, 20 percent of the 112 girls had been raped.<sup>60</sup> This study also indicated that child rape or defilement cases in Kenya range from 10 percent to 27 percent of all cases.<sup>61</sup> In Tanzania, cases of street children being sexually abused have been documented by the Mkombozi Centre for Street Children.<sup>62</sup>

With escalating conflict in Zimbabwe, vulnerability to rape and CSA has been reported to be increasing.<sup>63,64</sup> One study in Zimbabwe found that CSA cases account for between 40 percent and 60 percent of all reported rape cases,<sup>65</sup> with many more believed to remain unreported. In 2009 the Family Support Trust, a Zimbabwean NGO providing free treatment to children who have been sexually abused, reported seeing about 29,000 cases in the last four years, and about 70,000 during the last decade in one clinic in Harare alone.<sup>66</sup>

Police statistics in Madagascar indicate that half of the offences committed against children are sexual offences.<sup>67</sup> Research undertaken in the city of Mahajanga found 69 percent 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.<sup>68</sup> According to a new article, 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 one in nine cases of rape is reported.<sup>69</sup>

### **In West and Central Africa**

A retrospective study that considered the period between 1998 and 2003 in Congo Brazzaville found that 46.1 percent of rape cases reported to the police involved children.<sup>70</sup> 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.<sup>71</sup>

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.<sup>72</sup> 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.<sup>73</sup> 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 six months of 2008, with one-third being children.<sup>74</sup>

UNICEF in Burkina Faso undertook an investigation with local partners into 127 cases of CSA in 2001. Overwhelmingly, 110 cases out of 127 were related to sexual abuse, but the remaining cases were related to CSEC.<sup>75</sup> A year later, in 2002, 168 CSA cases were surveyed; 150 of those were cases of penetrative abuse.<sup>76</sup> Similarly, in Djibouti, 50 percent of sexual violence cases reported involved victims aged 11 to 19 years.<sup>77</sup> A report on the rape of children in Togo found that 4.9 percent of girls reported being victims of sexual abuse in a more general survey on abuse and experiences of violence.<sup>78</sup>

GRAVE investigated 400 cases of CSA that were committed between September 2006 and September 2007 in Senegal.<sup>79</sup> Its findings indicated that in the Kolda region alone more than 100 teen pregnancies were the result of CSA perpetrated by teachers. In Senegal, it was found that 3 percent of the children interviewed disclosed being the victims of sexual violence, and 8 percent of girls and 3 percent of boys had witnessed sexual violence being perpetrated.<sup>80</sup>

The WHO estimated that in Guinea 10 percent 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.<sup>81</sup>

#### 4.3.2 Sexual exploitation, child prostitution and transactional sex

By its very nature, trafficking is a clandestine activity and information on prevalence is severely lacking.<sup>82</sup> 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.<sup>83</sup>

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.<sup>84</sup> A 2002 survey in three areas of 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.<sup>85</sup> Recent evidence from Senegal indicates that young girls are being recruited for pornographic films and bestiality (i.e., sexual activity with animals).<sup>86</sup> Similarly, in Cameroon, boy and girl children aged 14 to 18 can be found posing and working in strip clubs where they are filmed.<sup>87</sup>

In Côte d'Ivoire, the number of girl victims of trafficking and prostitution networks has doubled since about 2005; more than 58 percent of the girls interviewed were younger than 16 years, and 52 percent of them were living with a sexually transmitted disease.<sup>88</sup>

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 Lomé known as *marché du petit vagin* (literally, *market of the small vagina*).<sup>89</sup>

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 percent of the total population, and in Ilakaka in 2005, it was estimated that nearly 70 percent were aged 12 to 18.<sup>90</sup> Research in Dar es Salaam (Tanzania) revealed that 40 percent of children from poor families are being sexually exploited.<sup>91</sup> CSA is rampant among street children; it is estimated that 30 percent to 40 percent of boys are abused by older boys and market vendors, and 90 percent of girls are abused and generally end up in prostitution.<sup>92</sup>

Sexual exploitation of children in the tourist-oriented west coast of Kenya is well documented.<sup>93,94</sup> Children are trafficked to these areas from rural areas around the country and '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.'<sup>95</sup> A news article 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'<sup>96</sup> and that parents and relatives encourage these relationships. A UNICEF study found that up to 30 percent of 12- to 18-year-old girls living in the coastal areas of Malindi, Mombasa, Kilifi and Diani were involved in casual sex work.<sup>97</sup> It is estimated that 10,000 to 15,000 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 and 30,000 girls aged between 12 and 14 years are lured into hotels and private villas to be sexually exploited.<sup>98</sup> During the low tourism season, reports indicate that local demand sustains the sexual exploitation of children, and children

involved in prostitution are forced to pay locals who help them gain access to tourists, such as beach boys, bar staff, waiters and others, with sex.<sup>99</sup>

According to U.S. State Department reports, 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.<sup>100</sup> Long-distance truck drivers reportedly offer to transport women and girls looking for legitimate employment in South Africa. They are often raped en route and later prostituted by the driver or an associate.<sup>101</sup> 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.<sup>102</sup>

The UN Committee on the Rights of the Child reported an increase since the 1990s in child prostitution in Maputo, Beira, Nacala and other rural areas in Mozambique.<sup>103</sup> 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.<sup>104</sup>

Transactional sex is also referred to as 'cross-generational sex' or the 'sugar-daddy syndrome.' The transactional nature of cross-generational sex has important implications for interventions.<sup>105</sup> 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.<sup>106</sup>

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 cross-generational sex in SSA found that substantial proportions of girls' partners were six or more years older.<sup>107</sup> Data from the DHS in six sub-Saharan African countries show that among sexually active young women ages 15 to 17 years, the percent who have recently had sex with men at least 10 years older ranges from less than 1 percent in Malawi to more than 21 percent in Nigeria.<sup>108</sup>

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.<sup>109</sup> 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.<sup>110</sup>

#### **4.3.3 Incest/intra-familial child sexual abuse**

The prevalence of incest is very difficult to ascertain, and little in the literature 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.<sup>111</sup>

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.<sup>112</sup>

In Namibia, 21 percent of women reported experiencing CSA. Of these, 47 percent indicated that a family member was the perpetrator.<sup>113</sup> Among high school students in the Northern Province of South Africa, one in five victims of CSA reported being abused by a parent or guardian.<sup>114</sup> Research in Togo indicated high rates of incest and highlighted that such situations are seldom brought to the attention of authorities because 'communities consider such problems to bring shame to the family.'<sup>115</sup> A Zambian study noted that more boys than girls had experienced intercourse or oral sex with a family member.<sup>116</sup>

#### **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. 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 well documented, primarily because the DHS and MICS collect data on this indicator (see Annex 3). These sources indicate the following prevalence of child marriage in SSA:

- Child marriage is generally more prevalent in Central and West Africa—affecting more than 40 percent of girls under 18, compared to around 20 percent in East, North and Southern Africa.<sup>117</sup>
- In countries like the Central African Republic, Chad, Guinea, Mali and Niger more than 60 percent of women entered into marriage or into a union before their 18<sup>th</sup> birthday.<sup>118</sup>
- In Uganda, although the legal age for marriage is 21, more than half of girls are married before they reach the age of 18.<sup>119</sup>
- In some regions of Nigeria, including Kebbi State in the north, girls generally marry soon after their 11 birthdays.<sup>120</sup>
- Girls from poor backgrounds with low levels of education are most at risk.<sup>121</sup>
- Although child marriage is still practiced, the rate seems to be declining in some countries, namely Kenya, Senegal, Uganda and Zimbabwe; with little change in rates in countries such as Cameroon, Cote d'Ivoire, Lesotho, Liberia and Mali.<sup>122</sup>

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## 5. FACTORS ASSOCIATED WITH CHILD SEXUAL ABUSE IN SUB-SAHARAN AFRICA

According to Lalor, 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.<sup>1</sup> Factors that are examined here are those of age, gender, social conditions and settings for the child and the perpetrator.

### 5.1 Age

The UNVAC report suggested that sexual violence predominantly affects those who have reached puberty or adolescence.<sup>2</sup> However, authors such as Nhundu and Shumba suggest that prepubertal children are often most at risk for sexual abuse compared to other age groups.<sup>3</sup> Pitche, for example, in reviewing the literature pertaining to CSA in SSA, noted that the average age of victims of CSA was eight years.<sup>4</sup> The ethical and practical considerations of interviewing very young children limit a thorough understanding of sexual abuse among this population.<sup>5</sup> The varying age classifications in addition to other methodological differences across studies make it challenging to conduct meaningful comparisons. However, the evidence considered in this review clearly suggests that children of all ages appear to be at risk of CSA, and even the youngest children are not exempt.

Of the 1,194 new clients presenting for treatment at a CSA clinic in Harare between 2004 and 2005, 90 percent were female and ranged in age from seven weeks to 16 years: 93 percent and 59 percent of the boys and girls, respectively, were classified clinically as prepubertal.<sup>6</sup>

The global school-based student health survey from five sub-Saharan African countries confirmed the prevalence of sexual abuse across all age sub-groups studied: The percentage of girls who reported ever being physically forced into sexual intercourse was 22 percent for 13 years and under and 14 year olds, and ranged from 27 percent for the 15 year olds and 29 percent for those 16 years and older. For boys, the percentages reported were highest among the 13 and under sub-group (24 percent), lowest for the 14 year olds (17 percent), 22 percent for 15 year olds and 21 percent for those 16 years and older.<sup>7</sup>

In a national study on violence against girls and young women (13 to 24 years) in Swaziland, one in three girls reported experiencing some form of sexual violence prior to age 18.<sup>8</sup> Among girls aged 13 to 17 years, the prevalence of forced intercourse was 2 percent, coerced intercourse was 6 percent and of attempted unwanted intercourse was 17 percent.<sup>9</sup>

A retrospective study covering the period 1998 to 2003 carried out in Congo Brazzaville indicated that 46.1 percent of cases of sexual abuse involved children aged 11 to 15 years, and that 37.3 percent of the aggressors in these cases were aged 21 to 25

years.<sup>10</sup> The youngest victim was only four years old, and the person who raped her was himself a child aged 14.<sup>11</sup> The 2007 Human Rights Watch report in Côte d'Ivoire noted the rape and sexual abuse of girls as young as six years.<sup>12</sup> The rape of three sisters, aged two weeks, two years and three years was reported by the Girl Child Network in Shamva in Zimbabwe.<sup>13</sup> A Save the Children report highlights data from Childline in South Africa noting that in 2001, 50 percent of the reported CSA cases were under the age of seven.<sup>14</sup>

In the DRC, a study on 1,684 rape survivors (January 2005 to December 2007) revealed 25 children under the age of 15 and 198 aged 16 to 20 years who had been raped.<sup>15</sup> 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.<sup>16</sup>

Police statistics in Madagascar show that 20 percent of sexual offences cases in 2006 involved children aged zero to six years. In research undertaken in the city of Mahajanga, the mean age of child victims of CSA was 10.<sup>17</sup>

A UNICEF study in Burkina Faso indicated that more than half the child survivors of CSA were younger than 14, with almost 10 percent being younger than 10.<sup>18</sup> Reports from Djibouti indicate 50 percent of sexual violence cases reported involved victims aged 11 to 19 years.<sup>19</sup> Research in Chad indicates that cases of sexual abuse and sexual exploitation rarely come to the attention of the authorities.<sup>20</sup> Nevertheless, the available information indicated that four in 10 cases involved children aged 13 to 15 years, and more than 25 percent involved children aged 10 to 12. The sample included a child under the age of nine.<sup>21</sup> 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 percent of the cases of sexual violence against children were reported by children aged 13 to 18; children aged five to 12 reported 41 percent of the cases and children under the age of five reported a further 3 percent.<sup>22</sup>

As discussed previously in Section 4.3.2, a significant proportion of young African women are engaged in cross-generational sex with older men. While the reasons for entering into these relationships vary along a continuum of volition or willingness—from voluntarily on one end of the continuum to being coerced into sex on the other end, and 'economically rational sex' in between—all cross-generational sex is inherently risky for young women because of the imbalance in power and their lack of control in making decisions.<sup>23,24</sup>

The literature on early marriage highlights that the younger a bride is when she marries, the greater the age difference is between her and her spouse. This is demonstrated through the mean age difference between wife and spouse when the girl marries before age 15 years compared to when she marries before age 20: Ethiopia (10.1 vs. 8.6); Mali (12.7 vs. 9.9); Nigeria (12 vs. 8.5) and Zambia (7.8 vs. 5.7).<sup>25</sup>

Other types of CSA such as child prostitution, sexual exploitation and child marriage and FMG/C also affect very young children, as shown in tables in the annexes. Girls in some ethnic groups in Burkina Faso are excised very young—50 percent of girls are excised before their fourth birthdays; while in other groups, girls are usually excised at the age of eight or nine years.<sup>26</sup>

## 5.2 Gender

The review showed that CSA is perpetrated against both girls and boys in SSA, although, in general, girls are more at risk.<sup>27,28</sup> For example, the global school-based health survey data from Namibia, Swaziland, Uganda, Zambia and Zimbabwe showed that the odds of having been exposed to sexual violence were greater among girls than boys after age adjustment, although differences between genders were not large.<sup>29</sup> A compilation of studies featured in the World Report on Violence and Health showed that forced sexual initiation was higher among adolescent girls compared to boys, respectively, in Cameroon (37 percent vs. 30 percent), Ghana (21 percent vs. 5 percent), Mozambique (19 percent vs. 7 percent); South Africa (28 percent vs. 6 percent) and Tanzania (29 percent vs. 7 percent).<sup>30</sup>

It is, however, important to also acknowledge that a lot of the research around CSA in SSA to date has focused on girls. The existing evidence on boys, nonetheless, confirms that boys are also at risk for sexual abuse in the region. Recent research undertaken by the South African Medical Research Council suggests that 3.5 percent of young men have been sexually abused in childhood—i.e., one in 30 South African men—and it argues that this, at least in part, fuels the high rates of rape and sexual abuse in that country.<sup>31</sup> Also, a study in rural South Africa by Jewkes et al found that in their sample of 1,637 men living in rural villages, 16.7 percent had experienced CSA.<sup>32</sup>

Some of the research suggests that in several countries boys might be more at risk for certain types of sexual abuse. 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.<sup>33</sup>

More recent analyses (unpublished) conducted by Polonko et al suggest that while the patterns of CSA for East, West and Central Africa are similar to those of North America and Europe where girls have higher victimization rates than boys, there does appear to be something different about South and Southeast Africa that diverges from this pattern. The authors found comparable rates of CSA for boys and girls for fondling and penetrative abuse in Zambia and South Africa.<sup>34</sup>

## 5.3 Care arrangements

Skinner et al 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).<sup>35</sup> 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.<sup>36</sup>

Despite concerns that orphaned children face greater risks of CSA, little substantive work has been done in this area.<sup>37</sup> However, research undertaken in SSA in the last few years shows 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<sup>38</sup>
- Youth who lived with both parents were less likely to have had sex than youth who lived with one or neither parent<sup>39</sup>
- 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.<sup>40</sup>

One study concluded that ‘there is something about being an orphan [...] which puts youth at risk of becoming sexually active.’<sup>41</sup> Another study 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.’<sup>42</sup> However, in a study conducted in Cameroon, although girls were more likely to be sexually abused than boys, this was not affected by whether they were orphans or not: in fact, the orphaned girls reported the lowest rates of corporal punishment and of sexual abuse.<sup>43</sup>

Orphaned children are often forced into child 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.<sup>44</sup>

#### **5.4 Some variables related to the perpetrators**

In general, the perpetrators of non-penetrative contact and penetrative abuse are more likely to be known to their victims and be members of the victim’s family, neighbourhood or community.<sup>45,46</sup> In a Kenyan study among schoolchildren across 70 schools, the main perpetrators of sexual harassment were other children (60 percent) followed by strangers (16 percent), neighbours (6 percent) then teachers (5 percent).<sup>47</sup>

The UNVAC documented that a large proportion of women who report sexual abuse indicate that a family member was the perpetrator.<sup>48</sup> For example, experiences among high school students in South Africa suggest that one in five 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.<sup>49</sup> This study showed that children left at home by working parents are often also at risk of CSA, though this abuse is not always perpetrated by members of their immediate family, but by ‘opportunistic predators.’<sup>50</sup>

According to Meursing et al, a study in Zimbabwe indicated that men known to the child are the most common offenders.<sup>51</sup> Another study found that in Ghana 14 percent of school girls said they had been raped by boys they knew well.<sup>52</sup> The Indian Ocean Region Child Rights Observatory has noted that in the Seychelles 30 percent of CSA was perpetrated by the victim’s father.<sup>53</sup>

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.<sup>54</sup> In addition, both violent offending and violent victimisation share many of the same risk factors—previous violent victimisation, drug and alcohol use and depression.<sup>55</sup>

## 5.5 Environments of risk

As already highlighted in this review, many African children are at risk of experiencing sexual abuse in their immediate environments—their own homes and communities, including schools and workplaces. These environments of risk are further discussed below.

### 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.’<sup>56</sup> 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.<sup>57</sup> Between 73.6 percent (in Nigeria) and 99 percent (in Benin) of circumcisions are traditionally performed in SSA.<sup>58</sup> Vulvectomy (the cutting of the vulva) is also usually carried out on children in their homes by traditional practitioners.<sup>59</sup>

Child marriage can also be considered 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 (and 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.<sup>60</sup> Children have also been known to flee their homes to avoid child marriage, and reports of children being abducted for early marriage are common in Burundi, DRC, Ethiopia, Ghana, Kenya, Sierra Leone and South Africa, especially in Eastern Cape Province.<sup>61,62,63,64,65,66,67</sup>

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’ homes.<sup>68</sup>

In a national study on violence against girls and young women in Swaziland, 33 percent of girls 18 to 24 experienced some form of sexual violence prior to 18 years. Among incidents that occurred prior to age 18, a third (33 percent) occurred in females’ own home; 23 percent occurred in the house of a friend, relative or neighbour; 19 percent occurred in a public area/field; 10 percent occurred in a school building or on school grounds and 9.5 percent occurred on the way to or from school.<sup>69</sup> Similar results were found in a study conducted amongst Kenyan schoolchildren where the home (one’s own or that of other people) was found to be a location of high risk for experiencing unwanted sex (52 percent), followed by the bush (21 percent), school (8 percent) and disco (6 percent).<sup>70</sup> For sexual harassment, too, the most unsafe venue was cited as the home

(27 percent), followed by the school (24 percent), the journey back home from school (15 percent) and other people's home (12 percent).<sup>71</sup> Sexual harassment experienced in public places (bush, market, disco, town, ceremonies) was found to be 15 percent.<sup>72</sup>

Ugandan children reported high levels of sexual abuse, with one-third stating that the abuse took place in their homes.<sup>73</sup> A UNICEF study in Zambia also highlighted the fact that CSA occurs in a context of silence, which is protective of social relationships and the hierarchy within the family and community.<sup>74</sup>

However, the immediate community also poses risk of CSA. A study of sexual abuse among young female street-hawkers in Nigeria found that, with an average age of 13 years, nearly 70 percent of 186 girls hawking on the streets (130 of the respondents) had been sexually abused, that 28.1 percent of them had been raped and that the perpetrators were overwhelmingly adult males.<sup>75</sup>

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.<sup>76</sup> Girls and boys living on the street are vulnerable to sexual abuse from many individuals, including from passersby 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).<sup>77</sup> A 2007 study in Zambia cites figures for children living and working on the streets as around 35,000 children.<sup>78</sup>

### **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 girls, but not exclusively. As already discussed in this document, school environments are high-risk locations for CSA. In some studies, homes and market places were found to be riskier.<sup>79,80</sup>

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.<sup>81</sup> Plan Togo, for example, has identified the concept of '*notes sexuellement transmissibles*' (sexually transmitted marks) being in common usage in secondary schools.<sup>82</sup>

School violence is multifaceted and embedded in violence and gender discrimination at the 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 settings 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.<sup>83</sup> 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.<sup>84</sup>

Several authors identify girls at the secondary-school level at greater risk than younger school girls. For example, in 2004 the WHO reported high levels of sexual violence and harassment in secondary schools, with both boys and girls experiencing some form of

sexual abuse.<sup>85</sup> However, children in primary school are also vulnerable to abuse by teachers, as was found by Shumba in Zimbabwe in 2001.<sup>86,87</sup>

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.<sup>88</sup> 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 girl learners in their schools, this does not necessarily occur in school toilets.<sup>89</sup>

Research in Ghana found that 53.3 percent of the instances of sexual abuse took place in the school environment—6.7 percent in the school building or grounds and 46.6 percent on the way to and from school.<sup>90</sup> In Swaziland, 10 percent of those interviewed experienced sexual violence in a school building or on the school grounds, and in 9.5 percent of cases the abuse was perpetrated while the victim was on her way to or from school.<sup>91</sup>

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.<sup>92</sup>

The research on CSA in school settings is focussed primarily on girls, and less documented evidence is available on boys as victims; some evidence, however, shows that boys are also at risk. A study in Ghana, for instance, identified that a small percentage of boys had also experienced sexual harassment.<sup>93</sup> 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.<sup>94</sup> Addressing GBV in school settings must include boys who are victims as well as perpetrators of violence.<sup>95</sup>

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 percent of teachers acknowledged that CSA was a problem in the area, whereas 81 percent of parents in the same area identified it as a problem.<sup>96</sup> Similarly, in Benin, one study found that 33 percent of pupils disclosed sexual violence in their schools, while only 15 percent of teachers did so.<sup>97</sup> This is, however, not a consistent finding. In Niger, for example, 48 percent of the young people interviewed said they saw their teachers express love feelings towards one of their female classmates, while 88 percent of the teachers stated that sexual incidents occurred in their school in which pupils and teachers were involved.<sup>98</sup> Nevertheless, it is often the case that school administrators, the larger community and the ministries of education in many countries do not take female students' 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.<sup>99</sup>

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.<sup>100</sup> According to the study, the majority of those who had been sexually abused (60 percent) 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.<sup>101</sup>

### 5.5.3 Health care systems, alternative care and prisons

FGM/C is often performed by health-care providers in the hope that it will reduce the risk of various complications. The increase in the numbers of people seeking FGM/C from health-care providers (doctors, nurses and midwives) is attributed to the fact that FGM/C has historically been addressed as a health issue, and to a growing awareness of its negative health consequences.<sup>102</sup>

A recent analysis of existing data shows that more than 18 percent 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 by a health-care provider.<sup>103</sup> The highest rate of medically performed FGM/C in SSA is found in Guinea (10 percent).<sup>104</sup>

Health-care providers who perform FGM/C are noted to be 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.'<sup>105</sup> The WHO has developed guidelines on ending this practice.<sup>106</sup>

Various studies have recorded a wide range of abuses against children and an increased vulnerability to violence in alternate care institutions,<sup>i</sup> 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.<sup>107</sup> 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.<sup>108</sup>

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, almost no statistical information is available on the extent of the problem. Research of one prison in South Africa in 2007, for instance, could not obtain data of reported assaults, but interviews within the general prison population tended to indicate that the prevalence rate was around 50 percent.<sup>109</sup>

### 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 percent of the girls questioned were sexually abused.<sup>110</sup> In Uganda, one study found that child domestic

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<sup>i</sup> 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>.

labour charges accounted for 13 percent of the 17,349 cases of child abuse reported to the Ugandan police in 2007.<sup>111</sup>

In Mauritania, the *Association des Femmes Chefs de Famille* documented 202 cases of girl domestic workers who were victims of sexual abuse.<sup>112</sup>

In the Republic of Congo, a UNICEF study found girls aged 12 to 15 working in bars, hotels and brothels. They work seven days a week for three weeks every month, with one week off while they are menstruating—a lucrative industry that generates well over 2 million CFA Francs per month.<sup>113</sup>

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.<sup>114</sup>

## 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.

The age categories used across studies, including the DHS are not always relevant to an understanding of determinants, associated factors and responses to CSA.

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## 6. THE CONSEQUENCES OF CHILD SEXUAL ABUSE

The consequences of CSA, according to the African Child Policy Forum, include:<sup>1</sup>

- Denial of fundamental rights
- Development goals undermined
- Health complications
- Social and behavioural problems
- Psychological consequences (increased depression, anxiety, suicide)
- Cycle of violence perpetuated
- Socio-economic costs

The review briefly discussed the global evidence of the immediate and long-term consequences of CSA in Chapter 1. This chapter goes into more detail on the health and psycho-social consequences of CSA found within the literature specifically for SSA. For example, in a 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 associated with higher rates of HIV infection and alcohol abuse in adulthood; for men, CSA was associated with higher rates of alcohol abuse and depression.<sup>2</sup>

### 6.1 Vulnerability to HIV/AIDS and other STIs

As highlighted in Chapter 3, the HIV epidemic has had a significantly negative impact on children's vulnerability in SSA and it continues to do so.<sup>3</sup> A number of factors related to vulnerability to HIV transmission are at play with regard to CSA in SSA, and are reflected in all settings where CSA occurs.

The link between violence against women and HIV is complex, involving multiple pathways in which violence is seen both as a driver of the epidemic as well as at times a consequence of being HIV-positive.<sup>4</sup> Similarly for CSA, penetrative sexual abuse can result in direct HIV infection—children who are raped are at higher risk of HIV infection than are adults for reasons related to their anatomy and physiology.<sup>5</sup> A significant factor is that the prepubertal 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 possibility that the vagina will be torn or damaged is high, thus facilitating the transmission of HIV.<sup>6</sup> The rape and sexual coercion of young girls is often associated with more severe genital injury than is the case with adult women.<sup>7</sup>

The links between CSA and HIV and AIDS pertain to both boy and girl children. The vulnerability of boys is compounded (in children beyond babyhood) by the greater risks of HIV transmission linked to anal rape since anal tissues can be easily damaged, allowing the virus an easier entry into the body,<sup>8</sup> which is not to say that girl children are not also raped anally.

Meursing et al reported that half of the sexual abuse of children in their study in Zimbabwe was detected during care seeking for sexually transmitted diseases and HIV.<sup>9</sup> In his literature review, Pitche<sup>10</sup> noted that:

- Some studies found between 10 percent and 67 percent of children suffering from STIs had been sexually abused; while between 15 percent and 30 percent of sexual abuse cases were linked to STIs.
- HIV infection was detected in 3 percent to 37 percent of sexually abused children.

Risk factors for STIs, including HIV, comprise the age of first intercourse, unsafe sexual practices and treatment services.<sup>11</sup> Experiencing sexual abuse and being susceptible to HIV share a number of risk behaviours including increased likelihood of engaging in unprotected sex, having multiple partners, participating in sex work and substance abuse.<sup>12</sup> People who experience forced sex in intimate relationships often find it difficult to negotiate condom use. These risk taking behaviours often reported as a consequence of CSA could then lead to HIV infection later in life.

A study conducted in rural South Africa showed that young women 15 to 26 who experienced intimate partner violence and high gender inequity in relationships had increased incidence of HIV infection.<sup>13</sup> The study indicates that the risk of HIV transmission is higher with higher levels of violence and inequity, and that these variables have a more significant impact on HIV transmission in combination than either does in isolation.<sup>14</sup> However, few HIV prevention programmes address these issues.<sup>15</sup>

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.<sup>16</sup>

In another study on youth in rural South Africa, 39.1 percent of women and 16.7 percent of men reported childhood sexual abuse.<sup>17</sup> In this study, CSA in women was associated with incident HIV infections and alcohol abuse in adulthood.<sup>18</sup>

Girls who are married young are also more vulnerable to STIs, including HIV/AIDS.<sup>19</sup> For example, in Kisumu, Kenya, and Ndola, Zambia, studies using bio-markers found higher HIV infection rates among married girls ages 15 to 19 compared to sexually active unmarried girls of the same age (33 percent compared to 22 percent in Kenya, and 27 percent compared to 16 percent in Zambia).<sup>20,21</sup> This is compounded as the average age gap between young brides and the men they marry reaches eight to 10 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.<sup>22</sup>

Structural factors associated with HIV risk and prevention are increasingly being seen as important in understanding and addressing the HIV pandemic.<sup>23</sup> 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.<sup>24</sup>

## 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.<sup>25</sup> One study in Niger found that 88 percent of women suffering from fistulae were married between the ages of 10 and 15.<sup>26</sup> A study in South Africa found that, of the 3,299 subjects from a nationally representative household survey of youths aged 15 to 24 years, 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.<sup>27</sup>

In a national study conducted in Swaziland, sexual violence against girls was associated with a significantly increased probability that lifetime experience of unwanted pregnancy and pregnancy complications or miscarriages would be reported.<sup>28</sup>

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. More than a quarter of unsafe abortions in Africa are performed on girls aged 15 to 19 years.<sup>29</sup> 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.<sup>30</sup>

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.<sup>31</sup>

The physical consequences of FGM/C include severe bleeding and problems urinating, and later, potential childbirth complications and newborn deaths.<sup>32</sup> 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, need for infant resuscitation, still birth or neonatal death (one to two peri-natal deaths per 100 deliveries) and low birth weight babies.<sup>33</sup>

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.<sup>34</sup>

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 time young people may engage in a greater number of sexual partnerships, with more frequent partner change, and thus run a greater risk of contracting HIV.<sup>35</sup>

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.<sup>36</sup>

### 6.3 Psycho-social consequences

Mental health consequences of CSA include debilitating fears, anxieties, regressive behaviours, withdrawal, depression, anger and hostility, self-injurious behaviours, low self-esteem, inappropriate sexual behaviour and PTSD.<sup>37,38,39</sup> Children suffering from these consequences are often unable to benefit from educational opportunities or are forced to leave school due to pregnancy and early motherhood.<sup>40</sup> They are prone to ending up in violent and sexually abusive relationships throughout their lives—often they engage in high risk-taking behaviour, including drug and substance abuse and prostitution.<sup>41</sup> Boys who have been victimised were found to share the same range of negative psychological consequences as girls.<sup>42</sup>

In a study in rural South Africa, CSA was associated with alcohol abuse and depression amongst men.<sup>43</sup> The short-term emotional consequences of CSA can include fear, lack of concentration, flashbacks, phobias and anger.<sup>44,45</sup> Findings from the Global School-based Student Health Survey conducted in Namibia, Swaziland, Uganda, Zambia and Zimbabwe showed that the odds of reporting persistent loneliness, persistent sleep problems due to worry and having had suicidal ideations were all higher among children exposed to sexual violence compared to unexposed children.<sup>46</sup>

In the national study conducted in Swaziland where high levels of sexual violence were found among 13- to 17-year-old girls (28 percent), respondents reported high levels of experiencing depression (51 percent), suicide ideation (10 percent) and difficulty sleeping (24 percent).<sup>47</sup> In this study, sexual violence was associated with a significantly increased probability that lifetime experience would be reported of ever feeling depressed, having thoughts of suicide, attempting suicide, sleeping difficulties and consuming alcohol.<sup>48</sup>

Child rape survivors have been found to have high rates of persistent psychological distress even four to six months post-rape.<sup>49</sup> Insomnia, eating disorders, dissociation, inattention, memory impairment, self-medication, self-mutilation, sexual dysfunction and hyper-sexuality have also been found to result from CSA.<sup>50</sup>

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.<sup>51</sup> These can result in lost educational, skills training and employment opportunities, and reduced chances of marriage, social acceptance and integration.<sup>52</sup>

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.<sup>53</sup>

CSA has also been shown to change girls' perceptions 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.<sup>54</sup>

In addition, recent (and unpublished as of 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.<sup>55</sup> Feelings of shock and anger, the tendency to internalise his/her own feelings of pain and an inability to articulate his/her feelings and emotional distress (often linked to his/her own exposure to violence) impede the caretaker's ability to support the child's recovery post-rape.<sup>56</sup>

Meursing et al concluded that victims are traumatised by the abuse itself as well as by subsequent family, health and court-related problems.<sup>57</sup> Chege and Sifuna indicate that the effect of sexual abuse on the personal development of the victims is adverse while the consequences for male perpetrators are, in general, light.<sup>58</sup>

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 completing their education.<sup>59</sup> In Benin, Chad, the DRC, Ethiopia, Gambia, Guinea-Conakry, Kenya, Liberia, Mauritania, Mozambique, Niger, Nigeria, the DRC, Tanzania and Togo high rates of early marriage contribute to low rates of girls entering or completing secondary school.<sup>60</sup> 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.<sup>61</sup>

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<sup>15</sup> Ibid.

<sup>16</sup> Erulkar A. 2004. The Experience of Sexual Coercion Among Young People in Kenya. *International Family Planning Perspectives*, 30(4):182–189.

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## 7. RESPONSES TO CHILD SEXUAL ABUSE

The review found a wide range of responses to CSA ranging from commitments to international and regional treaties, the existence of national laws and policies and diverse programs being implemented in SSA. This chapter provides an insight into and discusses the limitations of these responses.

### 7.1 The international and regional legal framework

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 and the African Charter on the Rights and Welfare of the Child.

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 two of the 193 UN member-states have not ratified it, with the other being the United States. The UNCRC has the distinction of being the most-ratified and fastest-ratified human rights document in history.

Also 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, it is not under obligation to enforce it. 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 African Union (AU) committee. Sometimes, countries just accede to a treaty, which means they have signed and ratified it.

As of September 2010, 45 of the 53 AU-member countries have signed, ratified and/or acceded to the African Charter. However, the Central African Republic, the DRC, Djibouti, São Tomé and Príncipe, Somalia and Swaziland have signed but not ratified it.<sup>1</sup>

While very similar in many respects, the African Charter contains some provisions more strongly stated than those in the UNCRC. These include:<sup>2</sup>

- 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.
- The rights of girls must be protected and promoted to enable them to continue their 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 child victims into society.

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 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**

#### **Provisions of the UNCRC relevant to early marriage:**

**Article 1:** A child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.

**Article 2:** Freedom from discrimination on any grounds, including sex, religion, ethnic or social origin, birth or other status...

**Article 3:** In all actions concerning children ... the best interests of the child shall be a primary consideration.

**Article 6:** Maximum support for survival and development...

**Article 12:** The right to express his or her views freely in all matters affecting the child, in accordance with age and maturity...

**Article 19:** 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...

**Article 24:** The right to health, and to access to health services; and to be protected from harmful traditional practices...

**Articles 28 and 29:** The right to education on the basis of equal opportunity...

**Article 34:** The right to protection from all forms of sexual exploitation and sexual abuse...

**Article 35:** The right to protection from abduction, sale or trafficking...

**Article 36:** The right to protection from all forms of exploitation prejudicial to any aspect of the child's welfare...

### ***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 UNCRC, 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, similar to Article 35 of the UNCRC. 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 platforms 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<sup>3</sup> 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.<sup>4</sup>

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 UNAIDS ***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.<sup>5</sup> The framework focuses on three 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/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 victims.<sup>6</sup>

While somewhat outside of the 2000 to 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.<sup>7</sup>

### **7.1.3 Regional treaties and agreements**

The ***Maputo Declaration***<sup>8</sup> 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, attaining universal primary education by 2015 and

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:<sup>9</sup>

- 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 **the United States Agency for International Development/East Africa and UNICEF Regional Office for East and Southern Africa** developed a strategic framework for the prevention of and response to GBV that describes the strategic priorities for prevention and response including:<sup>10</sup>

- Promoting and protecting human rights
- Promoting participatory processes that engage all stake-holders
- Working with men
- Targeting youth
- Researching 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 developed a **Sub-regional Implementation Framework for the Prevention and Response to GBV**.<sup>11</sup>

## **7.2 National legal frameworks**

The ACPF 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.<sup>12</sup> 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.<sup>13</sup> 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.<sup>14</sup>

A 2008 study conducted in West and Central Africa in preparation for the Third World Congress against the Sexual Exploitation of Children found that:<sup>15</sup>

- The 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 schoolchildren in schools in Togo have been promulgated.
- In Senegal, the Penal Code provides for prison sentences of five 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 in 2007 after a decade of development.<sup>16</sup> 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 Bill. As with the South African Children's Act, the Lesotho bill makes provisions for all children in the country.<sup>17</sup>

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.

At least 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.<sup>18</sup> 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.<sup>19</sup> In Côte d'Ivoire, FGM/C was prohibited in 1998; penalties include heavy fines, imprisonment and suspension of medical license if the operation results in detrimental health outcomes or death.<sup>20</sup>

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.<sup>21</sup> The Central African Republic, however, does not appear to have implemented the law.<sup>22</sup> In Togo, it is also legislated that anyone knowing of and not reporting FGM/C has committed a crime.<sup>23</sup>

Other countries in the region, notably Benin, have no legal prohibition, despite high rates of FGM/C.<sup>24</sup> In others, such as Mali, a law prohibiting FGM/C was under discussion in 2006.<sup>25</sup>

Child marriage still takes place in many countries, despite statutory prohibitions on children under the age of 18 years engaging in the practice. 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.<sup>26</sup>

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 a prison term.<sup>27</sup>

### **7.2.2 National Plans of Action**

The outcomes document of the UN General Assembly Special Session 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.<sup>28</sup> These plans 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 UNCRD.

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.<sup>29</sup>

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.<sup>30</sup> Cameroon, Congo, Guinea, Chad and Togo had not done so; however, NPAs have subsequently been developed in these countries also.<sup>31</sup>

In some cases, inter-country responses have been developed; for example the Indian Ocean Region Child Rights Observatory, 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.<sup>32</sup>

But in many cases, legal provisions and national plans of action 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, as is limited access to services. Nevertheless, ACPF 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 fewer resources in child well-being.<sup>33</sup>

Some improvement is being reported 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 the 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.<sup>34</sup>

The United Nations Secretary-General's Campaign UNiTE to End Violence Against Women 2008-2015 calls on all countries to have adequately resourced NPAs adopted and underway by 2015.<sup>35</sup> Searches conducted using the UN Secretary-General's database on VAW, launched in 2009, show that several African countries have developed NPAs to end violence against women and girls, some of which specifically include actions to address FGM/C, early marriage and sexual harassment. Examples are Algeria, Burkina Faso, DRC, Djibouti, Liberia, Seychelles, Sudan and Uganda.<sup>36</sup>

### **7.3 Programmatic responses**

It is generally agreed 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.<sup>37</sup> 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 are delivered at the local level by civil society organisations rather than by government. In South Africa, for example, close to 90 percent of prevention activities and a very high proportion of response-related activities are delivered by civil society organisations,<sup>38</sup> 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 many thousands of NGOs deliver services to children on the continent. The Child Rights Information Network, for example, lists numerous members in countries in SSA.<sup>39</sup> While many of these are not concerned only with CSA, the fact that they are members of the network 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.'<sup>40</sup>

This lack of easily accessible information on specific projects is compounded by the fact that even less information is available on projects that have been evaluated and that could thus potentially be rolled out in other communities and geographic locations. This notwithstanding, some very good work is 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.<sup>41,42</sup>

The 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.<sup>43</sup> Little information is available on men's groups' initiatives to address CSA specifically, mainly because research and information on programmes working with adolescent boys have not been well documented, and programme experiences are new and have not yet been evaluated or recorded.<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup>

Children tend to disclose CSA as part of a process rather than a single event.<sup>47</sup> In addition, children are relatively more likely to present to police or health facilities than adults, which has implications for the medical management and collection of evidence in cases of CSA.<sup>48</sup> Although some progress has been made in the past decade around post-rape health care in SSA especially in Kenya, Malawi and South Africa, health services continue to struggle to meet both the physical and psycho-social needs of survivors, especially children, due to the lack of policy, poorly developed services and untrained health workers.<sup>49,50,51</sup> Many sub-Saharan African countries do not have comprehensive post-rape care services, and significant gaps exist in coordination and communications among sexual and reproductive health and HIV services, legal and judicial systems and sexual violence legislation.<sup>52,53,54</sup>

Ensuring that child survivors are protected from re-victimisation, especially those abused by close family members or by adults in positions of authority is critical.<sup>55</sup> 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:<sup>56</sup>

- When suffering from 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 caregiver 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 caregiver.

The ***evaluation and counselling*** approach to CSA victims should be informed by the need for sensitivity to minimise the long-term physical and psychological consequences of CSA. Parents or caregivers of abused children often need counselling and support themselves, and have been found to suffer from a range of debilitating consequences when a child in their care is abused.<sup>57</sup> This may impede their capacity to provide the appropriate support to the abused child.

### **7.3.2 Responses to CSA in the 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.<sup>58</sup> Launched in 2006, it 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 caregivers in therapeutic work with sexually abused children, and consists of:<sup>59</sup>

- Therapeutic activity books for children aged 4 to 7, 8 to 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 to develop child helplines is also a good practice in addressing issues related to the prevention of and response to CSA. Child Helpline

International (CHI) is a global helpline network established in 2001; as of 2008, it comprised around 160 members, with the greatest growth in membership coming from developing countries. The UNVAC identified these helplines as critical in providing support to children who have been sexually abused.<sup>60</sup> 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 CHI website, 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.<sup>61</sup> In addition, child helplines are being established in Ethiopia, Mozambique and Zambia.

Although the basket of services offered by child helplines 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.’<sup>62</sup>

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.<sup>63</sup> The centres embrace an integrated approach to the care of rape victims, including respect, comfort and restoration of dignity, and ensure that justice is accessed. The services offered include examination by specially trained doctors and nurses, counselling by local NGO partners and the opportunity to bathe 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.<sup>64</sup> 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 NGOs<sup>65</sup>) for children who are to appear in court.

However, growing evidence indicates 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 is that integrated health services with links to the police, help desks at health clinics with support persons onsite and strengthened police responses have been very effective in responding to CSA.<sup>66</sup>

GRAVE in Senegal provides legal services specifically for victims of CSA.<sup>67</sup> Other activities in West Africa were found to include:<sup>68</sup>

- In Côte d’Ivoire, a child helpline affiliated with CHI is operational, and social services are delivered in the schools
- In Congo Brazzaville, a network of trauma counselling services 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. The country has a toll-free helpline, but it seems to not be affiliated with CHI.

Programmes that address gender equality by engaging men and the community are also useful. An example of community engagement is the Stepping Stones programme for HIV prevention, which aims to improve sexual health by 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.<sup>69</sup>

The Men as Partners programme is targeted towards men and is currently being implemented in six provinces in South Africa. Its objectives are to:<sup>70</sup>

- Improve men's awareness and support of their partners reproductive health choices
- Increase awareness and responsibility for the 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 practices that encourage gender equality.<sup>71</sup>

### **7.3.3 Responses to child marriage**

According to the Population Council, children can be protected from early marriage through programmes that delay the age of marriage by ensuring 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.<sup>72</sup> This protection can be extended by supporting those girls who are married early. For example, programmes in western Kenya and in the Amhara region of Ethiopia are raising awareness of the HIV risks associated with early marriage, establishing savings clubs for married and unmarried girls, providing critical support to married girls who are socially isolated and promoting voluntary counselling and testing among couples who are newly married or contemplating marriage.<sup>73,74</sup>

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 DHS data.<sup>75</sup> 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 an 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.

#### **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 percent (2000 DHS) to 74 percent in 2005 was noted.<sup>76</sup> Comparing prevalence rates across age groups using the 2005 figures confirms this trend, with 62 percent of women aged 15 to 19 having been cut compared to 81 percent of women aged 45 to 49.<sup>77</sup>

Importantly, a significant change in attitude has been noted in the same period, from 60 percent of the population approving of FGM/C in 2000 to only 31 percent doing so in 2005.<sup>78</sup> However, the cultural norms that largely drive approval of FGM/C and the 'medicalisation' 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, a growing trend toward the medicalisation of the practice has been noted.<sup>79</sup> The highest rates of use of medical personnel performing FGM/C in SSA can be found in Kenya (34 percent) and Sudan (36 percent); with 9 percent of FGM in Guinea and 13 percent in Nigeria being carried out by medical personnel.<sup>80</sup>

While medicalisation 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 psycho-sexual complications and the violation of

women's rights.<sup>81</sup> The WHO has therefore developed guidelines on dealing with this aspect of FGM/C.<sup>82</sup>

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 it is a more common belief among Muslim women. For example, 30 percent of Muslim women and 15 percent of Christian women in Guinea reported that FGM is required by religion.<sup>83</sup>

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.<sup>84</sup>

In Ethiopia's 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.<sup>85</sup>

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<sup>86</sup>

The Ethiopian NGO *Rohi Wedu* has been active in the Afar Region since 2004. Their introduction of a methodology similar to the one used by KMG, a local-level Community Dialogue, enabled villagers and local leadership to 'own' the process, and was supported primarily by clan and religious leaders and two supervisors from Rohi Wedu, who regularly monitor the intervention, using a clan-based approach.<sup>87</sup>

The facilitators were responsible for:

- Conducting Community Dialogues at the 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
- Attending monthly review meetings and reporting on the implementation of activities agreed to during Community Dialogue

The Senegalese organisation *TOSTAN* 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 the abandonment of FGM/C.<sup>88</sup> Community-based approaches to changing attitudes and behaviour with regards to FGM have also been successful in Burkina Faso.<sup>89</sup>

### 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.<sup>90</sup>

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 for preventing and addressing all forms of violence, including CSA, with three themes:<sup>91</sup>

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

The Zambia Civic Education Association 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 the association reports very positive results, not only in addressing sexual harassment but also in empowering children.<sup>92</sup>

In Nigeria, the NGO Women Against Rape, Sexual Harassment and Exploitation, which was formed in response to the gang rape of a female student on a university campus, has extended its activities to secondary schools. It has been successful in raising awareness and providing support to victims.<sup>93</sup>

The United Nations Girls' Education Initiative 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.<sup>94</sup> 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, GEM is sponsoring a Girls' Parliament 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.<sup>95</sup>

Also in South Africa, the National Department of Education issued guidelines in 2000 for combating sexual violence in schools.<sup>96</sup> This resulted in the development, at the

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.<sup>97,98</sup>

The DTS Consortium's literature review of school-related GBV identified a number of promising initiatives:<sup>99</sup>

- In Nigeria, for example, the Girls' Power Initiative 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 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 the rate of school girl pregnancy while also preventing the blaming and expulsion of young girls who become pregnant.
- The Mathare Youth Sports Association 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 aimed at reducing gender-based violence in schools. It was developed by DevTech Systems and is funded by USAID's Office of Women in Development.<sup>100</sup> The curriculum is being implemented in Ghana and Malawi. The programme 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.<sup>101</sup> 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
- 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 supports 10 African organisations in seven 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, health care 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.<sup>102</sup> To reduce the vulnerability of children on the street, a range of different services is required.

Organisations at the local level supported by Street Child Africa include:

- *Avenir de l'Enfant*, Senegal. This organisation'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, STIs and HIV/AIDS and hygiene. Family tracing and reunification are also offered, and temporary shelter is available at a centre in Rufisque or more permanent accommodation, with access to educational opportunities at the 'family-style' centre.<sup>103</sup>
- The Street Children Project in Ghana was established in 2005. The focus of its 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.<sup>104</sup>
- 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 developing independence and self-sufficiency through sponsorship of education and other income-generating and rights-based workshops and activities.<sup>105</sup>

*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.<sup>106</sup> Services offered include:

- Training in IT skills
- Education
- Fostering and reunification
- Mentoring
- Psycho-social support
- Shelter, food and health care

### **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.<sup>107</sup>

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.<sup>108</sup> The toolkit makes the following recommendations:<sup>109</sup>

- Design for scale and harness partner strengths at the local level. A network of concerned individuals, caregivers 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 orphans and vulnerable children 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 caregivers in decisions related to access to education, food and medical care, psycho-social 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**

The review found examples of 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 involved in 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.<sup>110</sup> 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.<sup>111</sup>

The Southern Africa Regional Network Against Trafficking and Abuse of Children 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.<sup>112</sup> 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.<sup>113</sup>

Apart from the projects run by individual members in their home countries, the network supports and facilitates research, networking and consultations with governments in the region.

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.<sup>114</sup> The movement undertakes advocacy, awareness-raising and prevention campaigns; has a good record of using the media and school groups, with a strong focus on child participation and establishes 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 very little information is available on programmes and projects to address sexual offending by boys.

A number of provisions must be in place for the appropriate management of young sex offenders. These include:<sup>115</sup>

- Assessment at an early stage of any criminal proceedings
- A range of treatment options 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 to the care of juveniles who have committed sexual offences:<sup>116</sup>

- 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 on-going 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 caregiving 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 specialised 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<sup>117</sup> 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.<sup>118</sup>

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.<sup>119</sup> It is also used by the provincial Department of Social Development in Western Cape, South Africa.<sup>120</sup> 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.<sup>121</sup>

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 provide 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.<sup>122</sup>

*Multi-agency risk interventions* have also shown some promise. According to Dosio and Boer, a variety of these programmes and related effectiveness studies are available in the literature, including the Multi-Systemic Therapy 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.<sup>123</sup> 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 the 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.<sup>124</sup>

### 7.3.10 Gaps in responses

While much is often made about statutory protection, there is generally less emphasis on and interest in the implementation of law and policy, its impact and the cultural and social mechanisms that may impede enforcement. In addition, almost no information is available on traditional pre-colonial systems regarding sanctions against CSA. It is possible that deepening this knowledge would enhance child protection in local cultural contexts.<sup>125</sup>

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

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- <sup>1</sup> 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](mailto:vohito@africanchildforum.org)
- <sup>2</sup> This section is based on a workshop by Amanda Lloyd of the University of Surrey and is used with permission.
- <sup>3</sup> See [http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-8&chapter=4&lang=en#2](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&lang=en#2)
- <sup>4</sup> The Yokohama Global Commitment. 2001. [www.csecworldcongress.org/PDF/en/Yokohama/Outcome\\_documents/YOKOHAMA%20GLOBAL%20COMMITMENT%202001\\_EN.pdf](http://www.csecworldcongress.org/PDF/en/Yokohama/Outcome_documents/YOKOHAMA%20GLOBAL%20COMMITMENT%202001_EN.pdf)
- <sup>5</sup> UNAIDS. 2010. *Agenda for Accelerated Country Action for Women, Girls, Gender Equality & HIV Operational Plan for the UNAIDS Action Framework: Addressing Women, Girls, Gender Equality & HIV*. Geneva: UNAIDS. [http://data.unaids.org/pub/Agenda/2010/20100226\\_jc1794\\_agenda\\_for\\_accelerated\\_country\\_action\\_en.pdf](http://data.unaids.org/pub/Agenda/2010/20100226_jc1794_agenda_for_accelerated_country_action_en.pdf)
- <sup>6</sup> UNODC. Undated. *United Nations Convention against Transnational Organized Crime and its Protocols*. <http://www.unodc.org/unodc/en/treaties/CTOC/index.html?ref=menuaside>
- <sup>7</sup> ICPD. 1995. *Summary of the Programme of Action*. United Nations Department of Public Information, <http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm#intro>
- <sup>8</sup> Maputo Declaration. 2004. [http://www.acpsec.org/summits/maputo/maputo\\_declaration\\_en.html](http://www.acpsec.org/summits/maputo/maputo_declaration_en.html)
- <sup>9</sup> WHO Regional Office for Africa. 2004. *Child Sexual Abuse – A Silent Health Emergency. Report of the Regional Director to the 54<sup>th</sup> Session of the Regional Committee for Africa*. AFR/RC54/15 Rev. 1
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- <sup>11</sup> ECSA-HC. 2009. *ECSA Sub-Regional Implementation Framework for Gender-Based Violence Prevention and Control*. [http://africahealth2010.aed.org/PDF/GBV\\_Implementation.pdf](http://africahealth2010.aed.org/PDF/GBV_Implementation.pdf)
- <sup>12</sup> African Child Policy Forum. 2008. *The African Report on Child Wellbeing: How Child-friendly are African Governments?* Addis Ababa: African Child Policy Forum.
- <sup>13</sup> Ibid.
- <sup>14</sup> Ibid.
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## 8. CONCLUSION

This literature review 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 the 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 provide the latitude for exploring the interaction between types of sexual 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. It confirms that CSA occurs across SSA though reliable data are, in general, still insufficient and non-exhaustive. The available data indicate that the problem is significant and that serious public health, development and human rights consequences are associated with CSA. This is in addition to a range of individual physical and mental health sequelae. The home and community are places where a child should feel safe. Unfortunately, evidence suggests that for many children in Africa, their homes, families, neighbourhoods and communities can be risky environments for experiencing sexual abuse.

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 COMPREHENSIVE PREVENTION OF AND RESPONSE TO CSA IN SSA

Based on the evidence from existing research and practice, the review identified the following as being critical elements of a comprehensive prevention and response to CSA in SSA. The chapter concludes with the implications of the findings of this review for its intended target audiences as they seek to create an environment fit for children.

### 9.1. A coordinated approach

9.1.1. 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. This includes government departments dealing with social services, women and children, law, justice, health, education, finance, housing, employment, police and labour, among others; development partners 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 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 made in existing regional and sub-regional strategic frameworks for the prevention of GBV and CSA.<sup>1,2,3</sup> These frameworks stress stakeholder involvement and the need to develop response initiatives through participatory processes.

9.1.2. 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, children need to be broadly protected from any abuse and neglect.

9.1.3. Responses to CSA should be governed by the full range of international and regional rights treaties discussed further in Section 9.2. Services need to prioritise prevention and early intervention, instead of focusing only on post-abuse programming. A three-tiered intervention model discussed further in Section 9.4 below is recommended.

9.1.4. The guiding principles of the WHO-AFRO CSA strategy<sup>4</sup> 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
- Multi-disciplinary and participatory approaches to ensure comprehensive care and support for victims of CSA

- Formation of partnerships to ensure coordination and collaboration at all levels, including the community level, to maximise resources

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

## 9.2 International and domestic legal framework

9.2.1. 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.

9.2.2. 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:<sup>5</sup>

- 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, health care professionals, social and counselling service deliverers and religious and community leaders)
- An evidence-based approach
- Coordinated and sensitive implementation

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

- Ensure laws are 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 are 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

- Develop mechanisms to monitor the implementation of legal reforms to assess how well they are working in practice
- Constantly review and reform legislation in the light of new information and understanding

9.2.4. 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 cases of CSA are efficiently prosecuted, with no impunity for perpetrators.

### **9.3 Policies and programmes**

9.3.1 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.

9.3.2 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.

9.3.3 To combat CSA in schools, policies should be developed that include:<sup>6</sup>

- Investment in the professionalism of teachers to prevent violence in the schools and create schools that are child-friendly
- Prominent displays on school property of 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 clarifies the important role teachers have in the protection of children's rights
- Provision of enough teachers, especially in rural areas
- An increased number of female teachers
- Improved conditions of employment to encourage the retention of trained and professional teachers

9.3.4 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.

9.3.5. 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.

9.3.6. Addressing GBV, gender norms and inequalities should be part of a broader response to CSA. Work done directly with men and boys is also important in changing

attitudes and behaviour and hence gender norms and the prevailing constructions of masculinity and femininity.

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

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

9.3.9 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.

#### 9.4 Services needed

A three-tiered intervention model based on a continuum-of-care approach is needed to protect children from all forms of abuse and neglect in general.<sup>7</sup>

- At the base of the tier a strong **primary prevention** ethos, linked to specific strategies that target all children to prevent maltreatment and abuse in the first place, is needed.<sup>8</sup> 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 the presence and guidance of nurturing and loving families—is the basic right 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 children are known to be at greater risk of maltreatment to prevent the development of full-scale or ongoing 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 succumbed to sexual abuse to ameliorate the harm done to them and alleviate the consequences.

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

- Pre-natal care, including adequate nutrition

- Home visits during the first few weeks of a child's life
- Ongoing capacity-building for parents and caregivers 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

9.4.2. 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 early childhood development facilities, for example.
- Children in conflict with the law require access to: alternatives to the criminal justice system, rehabilitation and reintegration and income-generation.

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

- Response teams comprising health care personnel, the judiciary, law enforcement, psycho-social support, civil society and health facility managers
- Early identification and linkages to appropriate support services, including:
  - Child-friendly reporting systems
  - Medical treatment
  - Court preparation and support
  - Therapy and counselling
  - Alternate care
  - Rehabilitation and reintegration

## **9.5 Implications for target audiences**

### **9.5.1 For national governments**

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

CSA remains a multi-sectoral problem requiring a multi-sectoral response and multi-sectoral coordination, especially among the health (including reproductive and mental), education, legal, justice and social development sectors. Addressing CSA should be prioritised in national growth and development strategies such as the poverty-reduction strategies and NPAs, which are subject to periodic review and revision.

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 underemphasised 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
- Facilitate the use of 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. In addition CSA needs to be addressed through continued monitoring and evaluation of strategies, policies and programmes, and governments should ensure that national policy documents reflect monitored and evaluated strategies for preventing CSA and responding to it.

### **9.5.2 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.

### **9.5.3 Overarching recommendations for civil society and advocacy groups**

Civil society organisations including women's associations, men's groups against violence, youth groups, human rights structures in the countries and NGOs should intensify efforts to combat CSA 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 to play in increasing awareness about GBV in general and CSA in particular, using the media and public fora to talk about the multi-sectoral nature of the problem, and as a major development and public health concern.

Particular attention should be paid to the states' allocation of resources to these activities, to monitoring the implementation of the various commitments to international and regional treaties and policies and programmes directed towards addressing CSA.

### **9.5.4 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

risk and protective factors. Continued research on sexual abuse that includes both boys and girls is required to accurately guide prevention and policy responses.

Research that 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 that show promise and the potential for scale-up should be evaluated.

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# **ANNEXES**

## **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

Country	Signed	Ratified/Acceded
Angola		1992
Benin	1992	1997
Botswana	2001	2001
Burkina Faso	1992	1992
Burundi		2004
Cameroon	1992	1997
Cape Verde	1992	1993
Chad	2004	2000
Côte d'Ivoire	2004	2002
Comoros	2004	2004
Congo Brazzaville	1992	2006
Equatorial Guinea		2002
Eritrea		1999
Ethiopia		2002
Gabon	1992	2007
Gambia		2000
Ghana	1997	2005
Guinea Bissau	2005	2008
Guinea	1998	1999
Kenya (ECSA-HC member)		2000
Lesotho (ECSA-HC member)		1999
Liberia	1992	2008
Madagascar	1992	2005
Malawi (ECSA-HC member)	1999	1999
Mali	1996	1998
Mauritania		2005
Mauritius (ECSA-HC member)	1991	1992
Mozambique		1998
Namibia	1999	2004

<b>Nigeria</b>	1999	2001
<b>Niger</b>	1999	1999
<b>Rwanda</b>	1991	2001
<b>Senegal</b>	1992	1998
<b>Seychelles (ECSA-HC member)</b>	1992	1992
<b>Sierra Leone</b>	1992	2002
<b>South Africa</b>	1997	2000
<b>Sudan</b>		2008
<b>Tanzania (ECSA-HC member)</b>	1998	2003
<b>Togo</b>	1992	1998
<b>Uganda (ECSA-HC member)</b>	1992	1994
<b>Zambia (ECSA-HC member)</b>	1992	2008
<b>Zimbabwe (ECSA-HC member)</b>		1995

Source: 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](mailto:vohito@africanchildforum.org)

### Annex 3: Age at first marriage from DHS and MICS

Country	% of women aged 20 - 49 married before 15 yrs (DHS)	% of women aged 20 - 49 married before 18 yrs (DHS)	% of women aged 20 – 24 married before 18 yrs (MICS)
<b>Benin (2006)</b>	9.7	40.3	34 (2000-08)
<b>Botswana (1998)*</b>	3.1	15.7	10 (1998–07)
<b>Burkina Faso (2003)</b>	6.7	57.5	48 (2000-08)
<b>Burundi (1987)*</b>	3.4	26.5	18 (2000-08)
<b>Cameroon (2004)</b>	20.1	52.1	36 (2000-08)
<b>CAR (1994-95)*</b>	21.5	56.7	61 (2000-08)
<b>Chad (2004)</b>	34.9	72.3	72 (2000-08)
<b>Comoros(1996)*</b>	15.2	41.4	30 (1998-07)
<b>Congo Brazzaville (2005)</b>	7.7	30.3	31 (2000-08)
<b>Congo DRC (2007)</b>	11	42.3	39 (2000-08)
<b>Côte d'Ivoire (1998-99)*</b>	13.8	40.9	35 (2000-08)
<b>Eritrea (2001)</b>	19.7	48	47 (2000-08)
<b>Ethiopia (2005)</b>	31.4	61.8	49 (2000-08)
<b>Gabon (2000)</b>	12.7	36.6	34 (2000-08)
<b>Ghana(2008)</b>	6.8	31.5	22 (2000-08)
<b>Guinea (2005)</b>	23.5	70.8	63 (2000-08)
<b>Kenya(2003)</b>	7.5	30.5	25 (2000-08)
<b>Lesotho (2004)</b>	4.5	31.8	23 (2000-08)
<b>Liberia (2007)</b>	14.2	44.2	38 (2000-08)
<b>Madagascar (2008 – 09)</b>	11.2	42.2	39 (2000-08)
<b>Malawi (2004)</b>	13.6	50.5	50 (2000-08)
<b>Mali (2006)</b>	23.6	66.7	71 (2000-08)
<b>Mauritania (2000 – 01)</b>	29.3	50.5	35 (2000-08)

<b>Mozambique (1997)*</b>	21.7	55.1	52 (2000-08)
<b>Namibia (2006 – 07)</b>	2.4	9.6	9 (2000-08)
<b>Niger (2006)</b>	37.4	78.4	75 (2000-08)
<b>Nigeria (2008)</b>	21.9	46.1	43 (2000-08)
<b>Rwanda (2005)</b>	2.2	17.6	13 (2000-08)
<b>Senegal (2005)</b>	13.5	45.5	39 (2000-08)
<b>Sierra Leone (2008)</b>	22.2	56	56 (2000-08)
<b>South Africa (1998)*</b>	2.8	12.7	6 (2000-08)
<b>Sudan (1989 – 90)*</b>	22.1	44.4	34 (2000-08)
<b>Swaziland (2006 – 07)</b>	2.5	12.2	5 (2000-08)
<b>Tanzania (2004 – 05)</b>	8.5	42.6	41 (2000-08)
<b>Togo (1998)*</b>	10	37.9	24 (2000-08)
<b>Uganda (2006)</b>	15.9	52.5	46 (2000-08)
<b>Zambia (2007)</b>	10.9	46.3	42 (2000-08)
<b>Zimbabwe (2005 – 06)</b>	7	33.8	34 (2000-08)

Source: MEASURE DHS Stat Compiler

\*Data from before 2000 was used in the absence of more recent information.

**Annex 4: Percentage of age 15- to 24 females who think that wife beating is completely justified<sup>2</sup>**

Country (DHS Year)	%
Benin 2006	8.9
Burkina Faso 2003	16.6
Cameroon 2004	8.6
Congo Brazzaville 2005	24.4
Congo DRC 2007	15.6
Ethiopia 2005	28.3
Ghana 2008	3.2
Guinea 2005	25.5
Kenya 2003	9.4
Lesotho 2004	6.7
Liberia 2007	7.4
Madagascar 2008 - 09	1.5
Malawi 2004	4.3
Mali 2006	15.9
Mozambique 1997	13.3
Namibia 2006 - 07	3.7
Niger 2006	32.8
Nigeria 2008	22.3
Rwanda 2005	2.6
Senegal 2005	16.4
Sierra Leone 2008	17.2
Swaziland 2006 - 07	0.9
Tanzania 2004 - 05	12.0
Uganda 2006	12
Zambia 2007	7.8
Zimbabwe 2005 - 06	5.9

Box 2 :  
Women who answered yes to all of the following five questions:

Wife beating is justified if 1) wife goes out without telling husband  
2) wife neglects children  
3) wife argues with husband  
4) wife refuses to have sex with husband  
5) wife burns the food

Source: Population Council. The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young Population. Accessed at: <http://www.popcouncil.org/publications/serialsbriefs/AdolExpInDepth.asp>

**Annex 5: State of the ratifications of the Optional Protocols to the UN Convention on the Rights of the Child in sub-Saharan Africa**

Country	Armed conflict	Sale of children
Angola	Yes	Yes
Benin	Yes	Yes
Botswana	Yes	Yes
Burkina Faso	Yes	Yes
Burundi	Yes	Yes
Cameroon	Signed only	Signed only
Cape Verde	Yes	Yes
Central African Republic	No	No
Chad	Yes	Yes
Côte d'Ivoire	No	No
Comoros	No	Yes
Congo Brazzaville	No	Yes
Democratic Republic of Congo	Yes	Yes
Djibouti	Signed only	Signed only
Equatorial Guinea	No	Yes
Eritrea	Signed only	Yes
Ethiopia	No	No
Gabon	Signed only	Yes
Gambia	Signed only	Yes
Ghana	Signed only	Signed only
Guinea Bissau	Signed only	Signed only
Guinea	No	No
Kenya *	Yes	Signed only
Lesotho *	Signed only	Yes
Liberia	Signed only	Signed only
Madagascar	Yes	Yes
Malawi *	Signed only	Yes
Mali	Yes	Yes

<b>Mauritania</b>	No	Yes
<b>Mauritius *</b>	Yes	Yes
<b>Mozambique</b>	Yes	Yes
<b>Namibia</b>	Yes	Yes
<b>Niger</b>	No	Yes
<b>Nigeria</b>	Signed only	Signed only
<b>Rwanda</b>	Yes	Yes
<b>São Tomé and Príncipe</b>	No	No
<b>South Africa</b>	Yes	Yes
<b>Senegal</b>	Yes	Yes
<b>Seychelles *</b>	Signed only	Signed only
<b>Sierra Leone</b>	Yes	Yes
<b>Somalia</b>	Signed only	No
<b>Sudan</b>	Yes	Yes
<b>Swaziland *</b>	No	No
<b>Tanzania *</b>	Yes	Yes
<b>Togo</b>	Yes	Yes
<b>Uganda *</b>	Yes	Yes
<b>Zambia *</b>	Signed only	Signed only
<b>Zimbabwe *</b>	No	No

Source: United Nations Treaty Collection.

Armed Conflict ([http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-11-b&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11-b&chapter=4&lang=en))

Sale of Children ([http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-11-c&chapter=4&lang=en](http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11-c&chapter=4&lang=en))

\*Member of ECSA-HC. Swaziland is a member but has not ratified the African Charter.

## Annex 6: Child-friendliness index ranking of African countries

Country	Ranking	Level of child-friendliness
Mauritius*	1	Most child-friendly
Namibia	2	
Tunisia	3	
Libya	4	
Morocco	5	
Kenya*	6	
South Africa	7	
Malawi*	8	
Cape Verde	10	
Rwanda	11	
Burkina Faso	12	
Madagascar	13	
Botswana	14	
Senegal	15	
Seychelles*	16	
Mali	18	
Lesotho*	19	
Burundi	20	
Uganda*	21	Fairly child-friendly
Nigeria	22	
Tanzania*	23	
Gabon	24	
Mozambique	25	
Togo	26	
Zambia	27	
Mauritania	28	
Ghana	29	
Djibouti	30	
Dem. Rep. Congo	31	

<b>Niger</b>	32	
<b>Cameroon</b>	33	Less child-friendly
<b>Congo (Brazzaville)</b>	34	
<b>Angola</b>	35	
<b>Côte d'Ivoire</b>	36	
<b>Zimbabwe*</b>	37	
<b>Equatorial Guinea</b>	38	
<b>Sudan</b>	39	
<b>Sierra Leone</b>	40	
<b>Benin</b>	41	
<b>Ethiopia</b>	42	
<b>Comoros</b>	43	Least child-friendly
<b>Guinea</b>	44	
<b>Swaziland*</b>	45	
<b>Chad</b>	46	
<b>Liberia</b>	47	
<b>São Tomé and Príncipe</b>	48	
<b>Gambia</b>	49	
<b>Central African Republic</b>	50	
<b>Eritrea</b>	51	
<b>Guinea-Bissau</b>	52	

Source: African Child Policy Forum. 2008. *The African Report on Child Wellbeing: How Child-Friendly are African Governments?* Addis Ababa: The African Child Policy Forum.

\* Member of ECSA-HC

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