



# Tell Me More!

Children's Rights and Sexuality in the Context of HIV/AIDS in Africa



**RFSU- The Swedish Association for Sexuality Education-** is the leading organisation in Sweden working in the field of sexual and reproductive health and rights. RFSU sees openness on sexuality as the point of entry of health promotion and prevention. Rights to sexual and health services and sexuality education are key tools in the struggle for a healthier and more equitable society. RFSU is a member of the International Planned Parenthood Federation, IPPF, which gathers family planning organisations all over the world. We implement projects to improve the sexual and reproductive health and rights in partnership with organisations in Africa and Asia. We work through education, information, service delivery and advocacy in Sweden and internationally.

**Save the Children Sweden** fights for children's rights. We deliver immediate and lasting improvements to children's lives worldwide.

Our vision is a world in which all children's rights are fulfilled. Save the Children works for:

- a world which respects and values each child
- a world which listens to children and learns
- a world where all children have hope and opportunity

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Authors: Sarah C. Thomsen  
Save the Children Sweden's Focus Africa HIV/AIDS Group

Contributor: Erik Centerwall

Photographers: Cover- Anna Kåri; p. 6, 13, 16, 25, 34, 37, 41, 43, 44- Anna Kåri; p. 5, 21, 26- Sophie Joy Mosko; p. 38- Etsub Berhanesillasie

Printer:

Many thanks for comments on earlier drafts from Ola Florin, Rebecca Popenoe, Erik Vågberg Julia Shalk, Lina Granlund and Ylva Bergman.

Save the Children Sweden - Focus Africa HIV/AIDS Group:

Eva Nordfjell

Ame David

Etsub Berhanesillasie

Sophie Joy Mosko

Shani Winterstein

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**Save the Children**

Sweden





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# Abbreviations

ABC	Abstinence, being faithful, condom use
AIDS	Acquired immune-deficiency syndrome
ANPPCAN	African Network for the Prevention and Protection Against Child Abuse and Neglect
Committee	Committee on the Rights of the Child
CSA	Central Statistical Agency [Ethiopia]
DHS	Demographic and health surveys
HIV	Human immunodeficiency virus
ICPD	International Conference on Population Development
NGO	Non Governmental Organisations
OVC	Orphans and vulnerable children
PAHO	Pan-American Health Organization
PIWH	Pacific Institute for Women's Health
PRB	Population Reference Bureau
RFSU	Swedish Association for Sexuality Education
SCS	Save the Children Sweden
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SRH	Sexual and reproductive health
UNAIDS	United Nations Program on HIV/AIDS
UN-CRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Population Fund
UNGASS	United Nations Declaration of Commitment on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation



# Preface

Young people now form the largest generation in the world with almost two billion below the age of 15. The majority lack the information and services they require to protect themselves against HIV/AIDS. There is a great need to listen to the children and note their needs in order to protect themselves from HIV/AIDS.

Save the Children Sweden and the Swedish Association for Sexuality Education (RFSU) have looked into the issue of sexuality and children's rights in relation to the HIV/AIDS epidemic in selected countries in Africa. This report provides an overview of the concept of sexuality and then summarizes the available literature regarding children's strategies for dealing with sexuality and relationships with respect to HIV/AIDS.

This report shows that some of the policies and programs directed towards children are using messages that do not correspond to children's reality. Children know that avoiding sex is the best method of protecting themselves from HIV/AIDS, but they do not regard this practice as a realistic means of prevention. The report clearly shows that children have the same concerns about sexuality as adults. They need information free from moral and judgmental positions. They need to be treated with respect when talking about sexuality issues. And they need to feel confident and secure with their information provider (often a teacher, health provider or parent).

For many children and young people, the media has become their major source of knowledge about sexuality. However, they need and want to talk about sexuality, reproduction and life issues with well-informed adults who can also make them feel positive about their life, their choices and their sexuality.

Children have the right to receive correct and accurate information and services in order to protect themselves against HIV/AIDS and to be able to grow up healthy.

Children have the right to correct information which is free from judgment so that they are able to make the best decisions on how to protect themselves against HIV/AIDS. In order to make policies and develop programmes which respond to children's needs, parents, teachers, health providers and policy makers have to listen to the views of children. We want to encourage people who work with children to rethink their perceptions and ideas. We are not protecting children by hiding or ignoring facts.



Charlotte Petri Gornitzka  
Secretary General  
Save the Children Sweden



Åsa Regnér  
Secretary General  
Swedish Association for  
Sexuality Education (RFSU)



# I. Executive Summary

This report is an overview of the strategies children adopt for dealing with sexuality and relationships in the face of the HIV/AIDS scourge in sub-Saharan Africa. It is aimed at providing stakeholders with a coherent rights-orientated and child-oriented knowledge base to advocate for the development of a sexual and reproductive health agenda. The study is grounded in the principles laid out by the United Nations Convention on the Rights of the Child<sup>1</sup> (UN-CRC).

The report summarises literature on children's perspectives and opinions on the issue of sexuality and related concerns in their lives in sub-Saharan Africa. The report uses data and information from the work of Save the Children Sweden and the Swedish Association for Sexuality Education on sexuality and children with evidence from their programmes in Africa.

It addresses eight areas concerning children and HIV/AIDS:

- Children's preferred long-term strategies of protection against HIV/AIDS
- Children's perceptions of sexual and reproductive health services
- Children's perceptions of in-school HIV preventive education and counseling
- Children's perceptions of community-based HIV preventive education and counseling
- Children's perceptions of HIV preventive information in the media
- Children's awareness and views of transactional sex
- The situation of children who express sexuality outside of the heterosexual norm
- Children's understandings of the "Abstinence, Be Faithful, Condoms" concept

## Key findings

Children are well aware of the protective benefits of abstaining from sex, of having one sexual partner and using condoms. However, they do not always adopt these strategies to avoid sexually transmitted infections (STIs).

Children see the benefits of abstaining but they do not see it as being a realistic behaviour for themselves. Faithfulness was also seen as a good option for some children, although it is not clear if children understand the term the way it was originally conceptualised. Children are not fond of condoms for the many similar reasons that make them unpopular with adults (although some of these reasons are based on misinformation).

Children have their own strategies for avoiding sex altogether, such as being involved in out-of-school activities like sports and clubs.

<sup>1</sup>The Convention of the Rights of the Child defines a child as a person under the age of 18 years.

Children often develop their own strategies for avoiding sex, such as being involved in out-of-school activities like sports and clubs in order to keep one's mind off sex, stringing men along for money but not giving sex, and having oral sex or practicing masturbation. Often they do not perceive themselves as being at risk.

Girls and boys usually perceive themselves as being governed by fairly strict gender roles, However the data regarding these perceptions is inconclusive. In some studies, girls feel they can decide over when and with whom they will have sex (but not condom use), but in others they do not feel they have any power and risk rape or other physical violence if they refuse a boy. Boys also felt restricted to gender norms about male sexual desire which they felt forced them to seek out sex with many girls.

Children do not value sexual education in schools as they perceive it as being moralistic and negative about sex. It was found that children would like to know HOW they could protect themselves as many of them are already sexually active., rather than just focusing on the biological side of sex. Children tend to receive the majority of their information about sexual and reproductive health from the media, although there is some debate as to the reliability of the information that is transmitted.

**Children's concerns with the confidentiality, privacy, and accessibility of services should be taken seriously and addressed.**

### **Effective Responses**

Based on the findings in this report, we present a number of recommendations for policy makers and programme responses:

1. Programmes should seek to understand and promote children and youth's own strategies for avoiding HIV/AIDS, and help them develop their capacities for decision making and critical thinking.
2. Traditional gender norms that may have harmful consequences, such as expectations for boys to have many sexual partners, need to be discussed and debated openly with children and adults.
3. Children's preoccupations with the confidentiality, privacy, and accessibility of services should be taken seriously and addressed. Where possible, sexual and reproductive health services for children should be free.
4. Teachers should be trained to be able to provide appropriate and interesting sexual education to children, even those who are currently abstaining. This will probably require that teachers receive training regarding their own sexuality.
5. Community-based education programs need to respect children's desire for confidential discussions with peer educators and other community members, and to present sexuality and life skills in a way that is relevant for children.
6. The media should be further engaged as a resource of reaching children with sexual and reproductive health messages.

7. Girls should be provided with economic opportunities to avoid the necessity of transactional sex relationships. The ability to gain status through transactional sex needs to be critically reflected upon together with children.
8. Given the fact that some children do not identify with the heterosexual norm, information on sexuality should be inclusive by not taking this norm for granted.
9. Children's concerns about their abilities to remain abstinent should be taken seriously.

This report provides an overview of sexual rights with a focus on children's rights including their access to sexual and reproductive health information as endorsed by relevant international conventions and policies. It looks at the concept of sexuality and sexual development of children. It reinforces the importance of engaging with children on the issue of sexuality, especially in the context of HIV/AIDS. Children need to be specifically engaged in this discussion because children are vulnerable to HIV infection, they are often sexually active and they have been in general overlooked in this field because of restrictive moral standards that deem it inappropriate to discuss the issue of sexuality with children.

## Conclusion

The report provides a clear general overview of sexuality, before focussing on children's sexuality as a constant part of their lives and something that they need to be informed of. It further highlights the shortcomings often found in programmes and research that have been carried out on the sexual and reproductive health for children, particularly regarding relating this work to children's rights. The report identifies further areas of research needed in this area including a greater focus on children's opinions and views on issues of sexuality.

After looking at children's responses to existing sexuality education and adult engagement, the report concludes that too little attention is often paid to children's own capacities and desires.

There is also a dire need to link policies and programmes directly to respond to the sexual and reproductive health needs of children in a child-friendly and participatory manner.

## 2. Introduction

"The secrets must now stop, they are killing us!"

*Brighton Mayamba of the Zambian child rights organisation African Network for the Prevention and Protection Against Child Abuse and Neglect (ANPPCAN) when discussing the importance of talking to children about sexuality, something that was previously taboo.*

The term 'children' in this report refers to all individuals under the age of 18 (UNCRC). The World Health Organisation uses the term 'young people' to denote 10-24 year olds, 'youth' for 15-24 year olds, and 'children' as 10-19 year olds (WHO, 1998), although these terms are often used interchangeably in the literature.

Throughout the world, one in six AIDS-related deaths and one in seven new HIV infections is to a child. Eighty-five percent of the world's children living with AIDS are from sub-Saharan Africa (UNICEF, 2005). Millions more children who are not infected with HIV/AIDS have been affected by the epidemic, either through the loss of a parent, teacher, or other loved one, or because of the vast economic and social upheaval that has accompanied it (Richter and Rama, 2006). Despite this enormous burden, children are still regarded as the "missing face of AIDS," and lack sufficient access to information, education and services to support their needs (UNICEF, 2005). Furthermore, children's needs are frequently interpreted by adults, despite the increasing call for more participation in decision-making from children (CRC, 2003). There also seems to be a lack of information on what children themselves think they need in order to avoid contracting HIV/AIDS, and an unwillingness to act on these needs even when they are expressed (UNFPA, 2005).

### Facts about HIV/AIDS

- The category of the population who are most at risk of contracting HIV/AIDS are those aged between 15-24 years.
- Every day there are nearly 1,800 new HIV infections in children under 15 and more than 6,000 young people aged 15–24 years are newly infected with HIV.
- Every day 1,400 children under the age of 15 die of AIDS-related illnesses (UNAIDS, 2006).
- Prevalence rates are highest in sub-Saharan Africa, and are higher among young women than young men (UNICEF, 2006).

It is vital to preventing the transmission or spread of HIV/AIDS among the general population. A key component is the recognition that children will eventually become sexually active and ensuring that even before they begin to experiment with their sexuality they have access to information to prevent transmission. In many cultures, discussing sex and sexuality with children is seen as wrong and taboo. At



the same time, communities and society are recognizing the need to discuss the issue. Despite it being difficult to talk about embarrassing and private topics in relation to sexuality and children, it is essential that they be broached in a positive and informative manner.

The majority of cases of HIV-transmission, as well as re-infections, are linked to sexual activity and reproduction (UNAIDS, 2006). Thus, dealing with HIV/AIDS prevention also means understanding people's sexuality. This includes not only their sexual practices and behaviour, but also their longing for love, sex and intimacy (Nordstedt, 2006). But, there is a general reluctance to discuss sexuality and reproductive rights, especially in relation to children. However, if the spread of HIV/AIDS is to be stopped, it will become necessary to address the issues of sexuality, gender norms and the formation of social identities.



*This report is about children's reflections on issues of sexuality and their coping mechanisms for preventing the transmission of HIV/AIDS.*

The purpose of the report is to explore the strategies that children have developed for dealing with sexuality and relationships in the face of HIV/AIDS; and to provide stakeholders with a coherent rights and youth-oriented knowledge base for the development of a sexual and reproductive health agenda for advocacy.

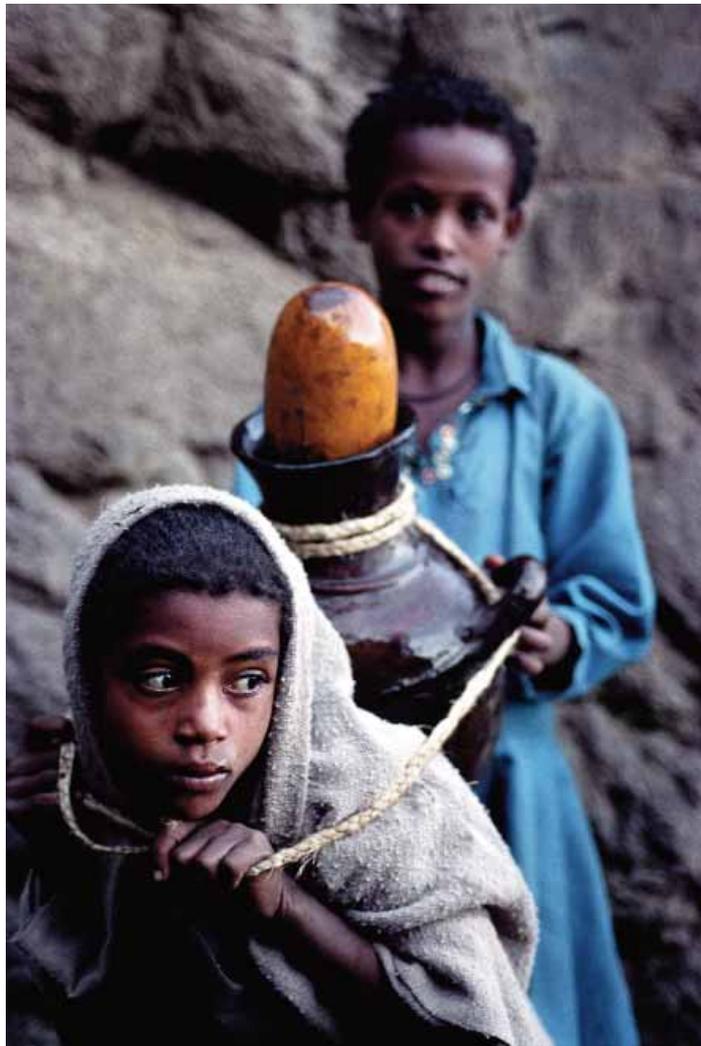
The literature review within the report looks at research on sexuality and children's rights in relation to the HIV/AIDS epidemic in sub-Saharan Africa. This review is further reinforced by the work that Save the Children Sweden and the Swedish Association for Sexuality Education has undertaken on sexuality and children in Africa.

The report provides an overview of sexual rights with a focus on children's rights including their access to sexual and reproductive health information as endorsed by relevant international conventions and policies. It looks at the concept of sexuality and sexual development of children. The report includes a summary of children's reflections on issues of sexuality and their coping mechanisms for preventing the transmission of HIV/AIDS. Based on these findings, the report makes recommendations for effective responses that would support children's existing coping mechanisms and enhances their ability to protect themselves.

### 3. Study Settings

The literature review prioritised the countries in sub-Saharan Africa in which RFSU and Save the Children Sweden are active: West Africa (Côte d'Ivoire, Senegal), East and Central Africa (Kenya, Tanzania, Uganda, Ethiopia and Sudan) and Southern Africa (Zambia, South Africa).

Table 1 provides a brief overview of the key indicators of sexual activity and its consequences in these countries. It is important to note that specific data are unavailable for children under 15 years old. Most data combine 15-24 year olds in one group which makes it impossible to determine information specifically for children. It should be noted that these figures are compiled from studies conducted at different times so they are not completely comparable.



*Between 10-18% of females and 11-17% of males aged 15-19 years have sex before the age of 15.*

### Some basic statistics

- The proportion of youth aged 10-24 years old in the countries of interest is between 31-36%.
- Illiteracy levels among youth aged 15-24 years vary widely in the region: from 3% for boys and 4% for girls in Kenya, to 36% for boys and 52% of girls in Senegal.
- The proportion of females aged 15-19 years who has ever been married is between 24-30% in the selected countries, except for South Africa (4%) and Sudan (11%).
- Knowledge about consistent condom use varies from 53-83% for both males and females aged 15-24 years in all of the selected countries. The exception is in Sudan - 12% for females (information for males unavailable).
- Between 10-18% of females and 11-17% of males aged 15-19 years in the selected countries were reported as having sex before the age of 15.
- The countries with the highest level of reported sex before the age of 15 years were Ethiopia, (41% of females and males) and Kenya (31%). Only 5% of South African females were least likely to report sex before age 15 years.
- Estimated HIV prevalence in the adult population (ie 15-49 years) is between 6-7% in four of the countries. It is much lower in Senegal (0.9%) and Sudan (1.6%), and much higher in Zambia (17%) and South Africa (18.8%).
- HIV prevalence among 15-24 year olds is between 0.4-18.1% with the lowest prevalence in Senegal and Sudan, and the highest in Zambia and South Africa.
- Proportion of all HIV-infected individuals who are under the age of 15 years is between 8-12%,. South Africa is the only exception with 4.4%.

**Table 1: Selected statistics on children and youth in the study countries (all figures are percentages)**

Variable	West Africa		East and Central Africa					Southern Africa	
	Côte d'Ivoire	Senegal	Kenya	Tanzania	Uganda	Ethiopia	Sudan	South Africa	Zambia
<i>Background characteristics</i>									
Proportion of population 10-24 years old <sup>1</sup>	35	34	35	34	34	33	32	31	36
Proportion 15-24 yr old males illiterate <sup>2</sup>	26	36	3	5	12	34	14	8	14
Proportion 15-24 yr old females illiterate <sup>2</sup>	41	52	4	8	23	44	22	8	24
Proportion females 15-19 ever married <sup>1</sup>	25	28	20	24	32	30	11	4	27
<i>Knowledge</i>									
Proportion females 15-24 knowing that one can protect herself from HIV by consistent condom use <sup>2</sup>	53	49	--	62	68	37	12	83	59
Proportion males 15-24 knowing that one can protect himself from HIV by consistent condom use <sup>2</sup>	--	--	--	72	81	63	--	--	69
<i>Sexual experience</i>									
Proportion females 15-24 who had sex before age 15 <sup>3,4</sup>	14.5	--	14.5	10.1	12.2	41.5	--	5	17.5
Proportion males 15-24 who had sex before age 15 <sup>3,4</sup>	13.3	--	30.9	10.7	16.3	40.3	--	12	--
<i>HIV/AIDS</i>									
Estimated HIV/AIDS prevalence 15-49 <sup>3</sup>	7.1	0.9	6.1	6.5	6.7	0.9-3.5*	1.6	18.8	17
Estimated HIV/AIDS prevalence 15-24 yr olds <sup>2</sup>	5.6	0.4	10.8	5.8	3.3	6.1	2.1	18.1	14.5
Proportion of all HIV-infected who are 0-14 yrs old <sup>3</sup>	9.9	8.1	11.5	7.9	11.0	7.1-16.9*	8.6	4.4	11.8

1 PRB, 2006

2 UNFPA, 2005b

3 UNAIDS, 2006

4 Figures for South Africa from Pettifor et al, 2004

\* Preliminary data; 2006 data pending

## 4. Towards a Rights-Based Approach

This report is based on the premise that all individuals (including children) have sexual rights. Save the Children Sweden and RFSU use a rights-based approach in their programmes that is based on internationally agreed-upon values and beliefs regarding human rights. This section explores these rights and how they are applied to meet the best interest of the child.

The World Health Organisation (WHO, 2004) noted that sexual rights are composed of existing human rights that are laid out in national and international human rights documents. These rights include the right of all persons, free of coercion, discrimination and violence:

- To the highest attainable standard of sexual health, and to access to sexual and reproductive health services;
- To seek, receive and impart information related to sexuality;
- To sexuality education;
- To respect for bodily integrity;
- To choose their partner;
- To decide to be sexually active or not;
- To consensual sexual relations;
- To consensual marriage;
- To decide whether or not, and when, to have children; and
- To pursue a satisfying, safe and pleasurable sexual life.

### 4.1 Children's rights

The relevant international human rights used in this report are located in the United Nations Convention on the Rights of the Child (1989)<sup>2</sup>, which was later interpreted by the Committee on the Rights of the Child<sup>3</sup> in “The General Comment on HIV/AIDS and the Rights of the Child” (CRC, 2003). The basic principle of a rights-based approach is that it identifies the State as a duty bearer.

**Accountability of the State:** All countries that have signed and ratified the United Nations Convention on the Rights of the Child (UN-CRC) have agreed to uphold the principles contained in the document. Furthermore, “*they have the main responsibility for bringing about the realisation of children's rights and are accountable both to the international community and to all people living within their borders*” (SCS, 2005, p.37). This does not mean that countries have to enable these rights themselves. They can call on others agencies for help. However, the ultimate responsibility in ensuring that children's rights, are upheld rests with the individual countries, and thus all accountability should also be found there.

<sup>2</sup> Hereafter referred to as the “UN-CRC.”

<sup>3</sup> Hereafter referred to as the Committee. The Committee is an independent monitoring body tasked with reviewing reports from states on their children's rights and interpreting the Convention through General Comments to guide states in the fulfillment of children's rights.

The responsibility in ensuring that children's rights are upheld ultimately rests with the State.

With regard to children's sexual rights and the role of the State, the Committee on the Rights of the Child (Committee) issued "The General Recommendation 4 on Adolescent Health and Development in the Context of the Convention of the Rights of the Child." The Committee specified that governments are obliged to take certain actions to protect adolescent's right to sexual and reproductive health and that the governments must:

*"Provide children with access to sexual and reproductive information, including family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs)"* (p. 28); and

*"Develop effective [HIV/AIDS/STI] prevention programmes, including measures aimed at changing cultural views about children's' need for contraception and STD [Sexually Transmitted Diseases] prevention and addressing cultural and other taboos surrounding adolescent sexuality"* (CRC, 2003b, p. 30).

**Right to non-discrimination:** Article 2 in the Convention obliges countries to ensure the fulfilment of all rights for every child without discrimination on any grounds. The Committee highlights this right in HIV/AIDS prevention in relation to stigma, taboos and negative judgments based on sexually active girls or sexual orientation. The Committee points out the obligation of countries to recognize the harmful impact of such stigmas and judgments on the vulnerability of boys and girls to HIV/AIDS and to promote programmes that are designed to change such harmful attitudes.

**Best interest of the child:** Article 3 of the UN-CRC states that *"the best interest of the child shall be a primary consideration"* in all actions undertaken by the State. The Committee provides this as evidence for all countries to place children at the centre of their HIV/AIDS responses. The best interest of the child is usually considered to be fulfilling the right to survival, the right to participation, and the right to non-discrimination.

**Right to survival:** Article 6 pertains to children's right to survive into adulthood in all ways. The Committee has interpreted this article as indicating the need for countries to address children's sexuality, even if this is contrary to society's generally perceived notions of what is acceptable for children. The rationale is that some traditional practices, such as early and forced marriage, are harmful to children and may increase their risk of acquiring HIV. In order to prevent such risks, children should be provided with proper education and information about their sexuality.

**Right to participation:** Article 12 in the UN-CRC says that children have the right to have their views respected. In relation to HIV/AIDS, the Committee said that children should be actively involved in the design, implementation and monitoring of HIV/AIDS policies and programmes. In particular, *"A variety of approaches are likely to be necessary to ensure the participation of children from all sectors of society, including mechanisms which encourage children, consistent with their evolving capacities, to express their views, have them heard, and given due weight in accordance with their age and maturity"* (CRC, 2003, p. 4).



**Right to information:** Article 17 in the UN-CRC refers to the child's right to access information that will promote his or her social, spiritual and moral well-being and physical and mental health. In General Comment 3 on "HIV/AIDS and the Rights of the Child" the Committee emphasized that: *"Effective prevention programmes are only those that acknowledge the realities of the lives of children, while addressing sexuality by ensuring equal access to appropriate information, life skills, and to preventive measures"* (CRC, 2003a).

**"Effective prevention programmes are only those that acknowledge the realities of the lives of children."**

**Right to health and health services:** Article 24 of the UN-CRC states that all children have the right to the "highest attainable standard of health" and medical care. This includes access to preventative care such as sexual education and family planning education and services (art 24f). The Committee has interpreted both articles 17 and 24 as supporting access to, and provision of, correct age-appropriate information that is necessary for protection from HIV infection. This does not allow for misrepresentation, withholding or censoring of information that is necessary for the right to life, survival and development of the child.

### International Agreements

In addition to the UN-CRC, there are other international agreements concerning children and HIV/AIDS that should be mentioned here.

**ICPD Programme of Action:** In 1994, The International Conference on Population and Development (ICPD) Programme of Action was adopted by 179 countries. It reaffirmed the right of children (defined as being aged 10-19 years) to sexuality education in order to increase the likelihood that young people will be able to use this information to protect themselves (ICPD 1994). The justification for this programme was that "young people do not regard their own sexuality as a problem, but as an asset and something positive" (Lindahl, 1995, p.19).

**UNGASS Declaration:** In June of 2001, the United States General Assembly held a special session on HIV/AIDS, which resulted in a Declaration of Commitment on HIV/AIDS (UNGASS). Although this document is not child or youth-specific, a number of important references to youth were made. It was reaffirmed that the full participation of youth living with HIV/AIDS in national programming is necessary to create an effective response to the disease. In relation to information and access to services, the declaration stated that *"By 2010, at least 95 per cent of young men and women aged 15-24 have access to the information, education, including peer education and youth-specific HIV education, and services necessary to develop the life skills required to reduce their vulnerability to HIV infection"* (UNGASS, 2001, p.21). Finally, the declaration affirmed the necessity of ensuring girls' and boys' access to sex education in school and strengthening family planning and sexual health programmes.

## 5. Sex and Sexuality

Perceptions regarding sex and sexuality can often be a barrier to discussion on HIV/AIDS prevention due to a lack of information of these concepts. This section deals with the understanding of sex and sexuality in order to arrive at a clear basis from which to explore children's understandings and perceptions of the issues.

Sex refers to the biological characteristics that define humans as female or male. Sexuality is everything that goes into making you a human being. This includes sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is a central aspect of being human throughout life (WHO, 2004). It is restricted by laws, moral standards, family and personal values and social norms that are determined by the distribution of power and decision-making in society (Instituto Promundo, 2002; WHO, 2004).

Sexuality is not a topic on its own. It is inextricably linked to self-esteem, body image, identity, ideas about love, dating, 'hooking up', breaking up, pleasure, marriage, and ideas of what is right and wrong. Sexuality is one part of a larger continuum of thinking about identity and how humans share their most intimate and vulnerable feelings with others.

Discussing and learning about sexuality is about working with beliefs, myths and values about love, sex and gender. It is also about working with expectations, hopes and fears on why individuals will be able to discover their own sexuality and ideas about love and how they can express that love and sexuality in interaction with others. Working with sexuality also means working with issues of identity, as sexuality is an integrated part of every individual's personality and identity. Nordstedt (2006) claims that sexuality is not only about knowledge and facts, it is also very much about basic existential questions such as:

- Am I good enough?
- Who am I?
- Am I normal?
- Will I find someone to love and someone who will love me?
- What does sex feel like?
- What is love actually about?

In all cultures and countries around the world, sex and sexuality are sensitive issues, connected to intimacy, secrets and things to enjoy and things to regret. Sexuality is something private: the acts, the fantasies, infatuations, the emotions that go with sexuality, shame and guilt, fright, but also the passion and the enjoyment. What a person wants and what they refrain from, create the attitudes toward sex and sexuality. What society wants and portrays creates the values that control sexuality. And what is respectively private and officially accepted does not suit everybody.



*Sexuality is more than about sex. It is about love, self-esteem, identity, and gender.*

## 5.1 Sexual development

Everybody is born with the ability to experience feelings of lust, for intimacy and to become sexually aroused. However, the way people express sexuality and love will differ according to age, gender role, power, upbringing and education, social environment and expectations, self-awareness and self-esteem, opportunities and health status (Nordstedt, 2006).

In humans, mature sexual desire usually begins to appear with the onset of puberty. Sexual expression can take the form of masturbation or sex with a partner. Sexual preferences among children can vary greatly. Sexual activity in general is associated with a number of risks, including sexually transmitted diseases (including HIV/AIDS), emotional distress, and pregnancy through failure or non-use of birth control. This is particularly true for children as they are often not emotionally mature or financially self-sufficient.

**Positive or negative first exposure to sex has a strong influence on the course of sexual discovery.**

### How do children express their sexuality?

Children express their sexuality differently depending on their cultural background, access to information, social and economic status and their experience of sexual abuse. Each child should be introduced to sex and sexuality at a different age depending on their own physical and psychological development. Evidence has also shown that positive or negative first exposure to sex has a strong influence on the course of sexual discovery and practice throughout life.

However, for the majority of children, there are standard phases they go through when discovering their sexuality. It is not a standard for all children but the general path to discovery that is often taken. Peel Public Health (2007) list the following stages in Table 2.

**Table 2: The different stages of children's sexual development**

<p>Birth to Age 2</p>	<ul style="list-style-type: none"> <li>● Learn about love and trust through loving relationships with parents and their caregivers.</li> <li>● Explore their bodies, including their genitals.</li> <li>● May have erections or lubricate vaginally.</li> <li>● Experience genital pleasure.</li> <li>● Begin to learn expected behaviours.</li> <li>● Begin to notice differences between the bodies of boys and girls, children and adults.</li> </ul>
<p>Ages 3 to 5</p>	<ul style="list-style-type: none"> <li>● Become very curious about bodies, and the differences between boys and girls.</li> <li>● May play house, or doctor or other forms of body exploration or "sex play" with friends.</li> <li>● Learn that they are either male or female.</li> <li>● Learn about male/female roles by observing others.</li> <li>● Enjoy learning about and talking about body parts and functions.</li> <li>● Find adult bathroom activities very interesting.</li> <li>● May ask questions about pregnancy and birth such as: "Where did I come from?"</li> <li>● May learn words related to sex and try using them.</li> <li>● May mimic adult sexual behaviour.</li> <li>● May begin to masturbate.</li> </ul>
<p>Ages 6 to 8</p>	<ul style="list-style-type: none"> <li>● Begin to have strong friendships with children of the same sex.</li> <li>● Be affected by stories they hear in the media (e.g. about AIDS or abuse).</li> <li>● Have definite ideas about male and female roles.</li> <li>● Have a basic sexual orientation and identity.</li> <li>● Want to be like their peers; for example, boys may feel pressured to choose the type of toys and activities that other boys choose.</li> <li>● May engage in name-calling and teasing.</li> <li>● May continue with sex play.</li> <li>● May begin to masturbate.</li> </ul>

Ages 9 to 12	<ul style="list-style-type: none"> <li>• May begin the changes of puberty.</li> <li>• Become more modest and want privacy.</li> <li>• Continue to value same sex friendships.</li> <li>• May experience increased sexual feelings and fantasies.</li> <li>• Develop crushes on friends, older teens, teachers, rock stars, etc. Romantic feelings may be directed towards the same sex and / or the opposite sex.</li> <li>• May take part in sexual exploration with peers.</li> <li>• May masturbate to orgasm.</li> <li>• May have to face decisions about sex and drugs.</li> </ul>
Ages 13 to 18	<ul style="list-style-type: none"> <li>• Complete the changes of puberty.</li> <li>• Place great value on independence.</li> <li>• Experience increased sexual feelings and desire physical closeness with a partner.</li> <li>• May face peer pressure to be sexually active whether or not they feel ready.</li> <li>• May change close friendships in favour of romantic relationships.</li> <li>• May make choices which lead to pregnancy or sexually transmitted diseases</li> <li>• May have to face violence in relationships (sexual harassment, date rape).</li> </ul>

## 5.2 Masculinity, femininity and its relation to sexuality

The unequal balance of social power between young men and women, combined with the patterns of risk behaviours among young men, suggests a responsibility and potential for young men to play a key role in shaping the future of the HIV/AIDS epidemic. Various studies have affirmed that gender norms are among the strongest underlying social factors that influence sexual behaviours. Norms related to masculinity and sexuality, such as those which claim male sexual needs are uncontrollable, multiple partners as evidence of sexual prowess, and dominance over women (both physical and sexual) can place young men and women at high risk of HIV/AIDS and perpetuate cycles of violence (Barker and Ricardo, 2005).

Male and female sexuality are constructs of society. The stereotypes about male and female sexuality have the purpose of connecting sexuality to reproduction, and of confirming male power and control. This creates double standards and myths regarding young men's sexuality and pushes them into risk-taking behaviours. Often societies expect girls to abstain, not be interested in sex and passively wait for the man to court her. Men and boys are supposed to be strong, have many sexual partners, get what they want through forms of aggression and have a lack of sensitivity for feelings. The strict gender norms hinder dialogue, healthy relationships and positive sexual relations.

**Male and female sexuality are constructs of society. The stereotypes about male and female sexuality have the purpose of connecting sexuality to reproduction, and of confirming male power and control.**

*Men and boys have the responsibility and potential to play a key role in shaping the future of the HIV/AIDS epidemic.*



### 5.3 Sexual identity

Sexual identity is our ability to be attracted to or fall in love with the opposite or same sex. There is a continuum of ways in which individuals relate to one another. A majority of people have heterosexual relationships, meaning they are attracted to the opposite sex. Others are bi-sexual, meaning they are attracted to both the same sex and the opposite sex. Homosexuality involves attraction to a person of the same sex (Centerwall and Laack, 2004). Sexual orientation is not always constant in life, a person may experience periods in life where they are more attracted to persons of the opposite sex and other periods when they are more attracted to persons of the same sex.

In most societies, the norms are based on heterosexual relationships and, thus, hinder the open expression of homosexuality even though global studies have shown that at least 3-7% of all populations are homosexual (Kontula, 2004; Samelius and Wågberg, 2005). Homosexual young women and men often recognize their attraction for persons of the same sex early in life, sometimes even before puberty. Because of the stigma against homosexuality, many are not open and can be in heterosexual relationships because of social expectations to enter family life and have children although they are not comfortable in doing so.

There also instances of men having sex with men as a replacement or substitute for having sex with women in an all-male environment. A study done in Senegal has shown that the first sexual encounter with a man among male respondents usually occurred at an average of 15 years old (CNLS, 2002). Studies have also shown that there is often a much higher HIV/AIDS prevalence rate among this unrecognised group.

## 6. Linking Children, Sexuality and HIV/AIDS

In addition to the rights of children, this report focuses on children's perspectives and strategies of coping with HIV/AIDS. This section looks at why it is so important that we link discussions on HIV/AIDS prevention to children and their sexuality.

### Children are vulnerable to HIV/AIDS

Children are vulnerable to HIV/AIDS for economic, social, political and biological reasons, many of which are directly or indirectly caused by adults. Approximately 300,000 children under five die of AIDS-related illnesses every year because of shortcomings in services to prevent mother-to-child infections (UNICEF 2005). Older children are made vulnerable by adults through a lack of access to information about HIV/AIDS and sexual and reproductive health services. Girls are particularly vulnerable to HIV/AIDS because of their anatomy, their tendency to have relationships with older men who are more likely to be infected already, and their inability to affect their sexual relationships due to dominating views of gender roles (Bankole et al, 2004; UNFPA and Population Council 2006). Thus, adults are often part of the problem, rather than the solution, for children.

### Some children are sexually active

Despite the unpopularity of this notion among some adults, many children are sexually active. Recent studies have shown that 46% of girls and 37% of boys between the age of 15 and 19 years in sub-Saharan Africa have had sex (Bankole et al 2004). Further, an analysis of Demographic and Health Survey data from 14 countries in the region showed that at least 15% of girls reported having sex before their fifteenth birthday (UNFPA and Population Council 2006). Sexual initiation under the age of 15 varies widely between countries, ranging from 4% in Rwanda to 36% in Niger (UNAIDS, 2006). However, it should be noted that since most studies are not undertaken with children under 15, they must rely on older children's memories of their age at first sex, which could be biased. Finally, there is evidence from the region that children as young as 6 or 7 years have had some sexual experience through play (Pattman and Chege, 2003a and 2003b; Simpson, 2002).

### Children have been overlooked in this field

Children under the age of 15 have often been neglected in the field of HIV/AIDS prevention. The majority of the focus in the field of HIV/AIDS has been on young people aged 15-24. This is probably because in many countries in Africa this is the age period during which the majority of young people become sexually experienced (Bankole et al 2004). However, as we have seen above, many children under 15 have experienced sex, and are thus vulnerable to HIV/AIDS. Despite their sexual

One major reason that children under 15 have been overlooked in HIV/AIDS programmes is likely due to the difficulty for adults to accept children's sexuality.

Information that adults provide about children's sexuality is often expressed in terms of "risk" and "vulnerability," rather than in "opportunities" and "resources."

activity, however, these children are not usually targeted by sexual and reproductive health programmes and services. Nor are they included in most nationally-representative health surveys, such as the Demographic Health Surveys (DHS). The reasons for this include respect for social norms concerning children under 15 years, ethical concerns, questions of the validity of young children's responses concerning sex, and the large sample sizes needed to capture the number of sexually active children (UNFPA and Population Council 2006). Children between 7-10 years old are the least likely to be addressed by surveys or programmes, as in most countries it is not considered appropriate to speak to such young children about issues concerning sex and sexuality (Webb and Elliott, 2000).

One major reason that children under 15 years have been overlooked in HIV/AIDS programmes is likely due to the difficulty for adults to accept children's sexuality. Pattman and Chege (2003a and 2003b) tell an anecdote about adults' reactions to their study on children which revealed that children as young as 6 and 7 years old were playing sexual games that were mimicking adults' sexual activity. Adults were reportedly extremely uncomfortable with these results, and even questioned the data as it simply seemed unbelievable to them that children would be so aware of sex. This anecdote reveals an attitude that is perhaps natural, but also clearly harmful in the long-run for children. If adults do not want to see that children are aware of, and sometimes practicing, sex, it is unlikely that they will be willing to commit to providing resources to provide children with the information and services they need (and have a right to) in order to protect themselves from HIV/AIDS.

### **Children benefit from early information and education**

Although children, especially those under 15, have not received enough attention in the field of HIV/AIDS prevention, there is a growing understanding that the earlier they are reached with messages the more likely they will be ready to meet the challenges that await them when they become sexually mature (Sedlock, 2000; UNFPA and Population Council 2006). Working with this group of children using age-appropriate information and methods of communication could provide them with the skills they need to meet these challenges. However, the interpretation of what children want and need is often not provided by children themselves, but by well-meaning adults. Furthermore, the information that adults provide about children's needs is often expressed in terms of risk and vulnerability, rather than in opportunities and resources.

## 7. Sexuality Education

Some of the most effective ways of engaging with children on the issues HIV/AIDS prevention is by providing them with effective information. This section investigates the role of sexuality education in enhancing children's ability to protect and understand themselves.

Sexuality education, which is sometimes called sex education or sex and relationships education, is the process of acquiring information and forming attitudes and beliefs about sex, sexual identity, relationships and intimacy, human sexual anatomy, sexual reproduction, sexual intercourse and other aspects of human sexual behavior. It is also about developing young people's skills so that they make informed choices about their behaviour, and feel confident and competent about acting on these choices. It is widely accepted that young people have a right to sex education<sup>4</sup>, partly because it is a means by which they are helped to protect themselves against abuse, exploitation, unintended pregnancies, STIs and HIV/AIDS (Forrest, 2002).

Sexuality education is NOT about learning how to have sex or encouraging children to have early sex. It is not only about the dangers and risks of sexuality nor is it about making children scared of their own and others' sexuality. Sexuality education should be about confirming feelings and explaining sensations of the body in order to create strategies to understand a sexuality that is safe and secure. It is to effectively educate children in the values and moral standards which are important as well as acknowledging that children are sexual beings who, probably, sooner or later, will engage in sex with another person. Moreover, children are bombarded each day with scenes and images of sex in the media, thus the importance of giving them information based on facts and provide answers to and base discussions on questions children have.

Sexuality education has, by tradition, been connected to the understanding of reproduction and to moral values preaching restraints and abstinence until marriage. This does not respond to the reality and concerns of children and is not seen by them as a realistic approach to lead healthy sexual lives (Pattman and Chege, 2003a).

Enabling children to understand that sexual identity is the most important method for protecting children against unwanted pregnancies and STIs. The ability to adopt a positive view toward sexuality enables the decision to make the responsible choices that are the theme of sexuality education. Contrary to popular belief, studies have revealed that children who have access to non judgmental sexual education delay their first intercourse (RFSU 2004).

Sexual education in Africa has increasingly focused on stemming the growing HIV/AIDS epidemic. According to UNFPA (2003), most governments on the continent have established HIV/AIDS education programmes which often lack effective implementation due to the fact that:

<sup>4</sup> United Nations Universal Declaration of Human Rights [www.un.org/rights/HRToday](http://www.un.org/rights/HRToday)  
European Convention on the Exercise of Children's Rights  
<http://conventions.coe.int/Treaty/EN/Treaties/Html/160.htm>  
United Nations Declaration on the Rights of the Child, [www.un.org/rights/HRToday](http://www.un.org/rights/HRToday)  
United Nations General Assembly, Declaration of commitment on HIV/AIDS August 2nd 2001  
[www.un.org/ga/aids/docs/aress262.pdf](http://www.un.org/ga/aids/docs/aress262.pdf) and International Planned Parenthood Foundation  
[www.ippf.org](http://www.ippf.org)

Sexuality education is not about learning how to have sex or encouraging children to have sex early.

Sexuality education should be about confirming feelings and explaining sensations of the body in order to create strategies to understand a sexuality that is safe and secure.

Contrary to what most people think, studies have revealed that children who have access to non judgmental sexual education delay their first intercourse.

When asked, children in Kenya and South Africa do not appreciate the way that sexual education is taught in schools and churches and are uncomfortable asking questions.

- Sexuality education is often based on moralistic judgments which promote a negative perspective about sex;
- Children are instructed in sex education and are often not given opportunities to participate in open discussions;
- Insufficient quantities of educational materials;
- The topics of sexual transmission and sexuality are not covered;
- Lack of effective teacher training ; and
- Clear gender bias in trainings which reinforce stereotypes.

It has become clear that sexuality education should start with issues of identity appropriate to age. Sexuality must be discussed in the context of love, self-esteem, relationships and identity. Important topics that should be covered in all sexuality education are gender, homo-bi-hetero-transsexual relations, ethnic and religious aspects, socio economic status, physical and psychological abilities and disabilities and age. Sexuality education should be realistic and inclusive rather than exclusive (Nordstedt, 2006). Sexuality education has traditionally focused on factual and scientific explanations of the sex act. It is important that sexuality is discussed within the context of emotions, psychology, social pressure, gender perspectives and cultural norms.

One aspect that has become clear is that those teaching about sexuality must be open, willing and able to question their own sexual identity and critically analyze their own thoughts, feelings and values on the subject. Once this is done, they must be willing to put these aside when discussing with young people so that the dialogue is open and non-judgmental. To be effective, sexuality education must create trust and begin with the realities of children and young people.

Nordstedt (2006) writes that the most effective way to discuss sexuality with children and young people is to:

- Have a positive view on sexuality;
- Be non-judgmental;
- Be affirmative; and
- Be realistic and work within the cultural norms.

The content of the education should be participatory and interactive. The children should have the opportunity to discuss and reflect on what they are learning. The content should be based on clear facts and scientific research and should make clear differentiations between what are values and what are facts.

Instead of focusing on the biology of sex and its negative aspects, children want more information on how they can lead happier and healthier sexual lives.

## 8. Children's Perspectives

The children's perspectives emerged from an extensive literature review on sexuality and children's rights in relation to the HIV/AIDS pandemic in sub-Saharan Africa. The purpose of this section is to illustrate children's perspectives on seven areas concerning children and HIV/AIDS.

### 8.1. What are children's imagined/preferred long-term strategies of protection against HIV/AIDS?<sup>5</sup>

#### Strategies for avoiding HIV/AIDS

Young people frequently mention condoms and abstinence, and to a lesser degree faithfulness, as methods of protection from HIV (these three behaviours are explored more completely in section 8 below). Traditional medicine was also mentioned as a source of protection against STIs in some countries.



Children's strategies for avoiding sex usually involve participating in an activity in order to avoid boredom or avoid situations that put them at risk/temptation of having sex. In a few cases, they also mentioned oral sex and masturbation.

*Children said the best way they found to avoid sex is by being involved in recreational activities and doing school work.*

#### Avoiding sex

Young people see possibilities for avoiding situations that would lead to sex (Amuyunzu-Myamongo et al, 2005; Mash and Kareithi, 2005; Maticka-Tyndale et al, 2005; Nzioka, 2004; Thomsen et al, 2006). Strategies for maintaining abstinence and avoiding situations that make sex tempting usually involved keeping themselves physically or mentally disengaged from sex by participating on activities such as schoolwork, drama, sports, card games, and clubs. These activities were proposed as alternatives to activities such as going to the market, beach or movies, which are

<sup>5</sup> The studies that were found in the review of this topic were fairly representative of sub-Saharan Africa, although they did not cover four of the focus countries for this study (Senegal, Côte d'Ivoire, Sudan, Ethiopia). Most of the sub-questions on this topic were answered except whether or not interventions are designed after taking children's' needs and desires into account.

associated with casual and unplanned sexual encounters. One young female said: *“I shall avoid groups which are fond of those things like practicing sex I shall refrain from these things by doing exercises, reading or being busy with work so that I may be able to avoid those issues”*(Thomsen et al, 2006).

Staying away from boys when they are about to menstruate (and feeling sexy) was also a strategy for girls to avoid sex in Zambia (Fetters et al, 1998). Additional strategies for avoiding sex included avoiding groups with a negative influence, earning more money, eating better, studying more and reducing their alcohol intake. Young people felt that one could avoid prescribed sexual scripts by providing girls with opportunities to generate income, and encouraging the value of virginity and celibacy as being better than what the boys could provide.

Religion was often cited as a way to preserve virginity. Muslim girls in Kenya primarily referred to the strict prohibitions of mixing with boys (which are upheld by their parents), implying that they did not have to have strategies for avoiding sex because they are already protected by their religion (Pattman and Chege, 2003). Church-attending youth in South Africa who were successful in abstaining also mentioned socializing with peers with similar protective values about abstaining and having male friends who could explain to them how boys really think about girls (as opposed to what they say to girls). They also felt that girls with strong personalities, dreams and goals were said to be more successful in avoiding unwanted sex (Mash and Kareithi, 2005). Thus, having an active religious life was also identified by youth as “providing alternative interpretations of adolescence, gender roles, and life goals, as well as providing activities which were consistent with abstinence from ‘playing sex’” (Maticka-Tyndale et al, 2005, p. 38). In Kenya girls turned to prayers to avoid being infected with STIs and HIV (Nzioka, 2004).

Oral sex and masturbation were also mentioned in two studies in Kenya, where girls seemed to be more concerned about avoiding pregnancy than STIs or HIV (Balmer et al, 1997; Nzioka, 2004). Males admitted to practicing masturbation, but only in cases of sexual frustration, such as when their girlfriends were menstruating. For both girls and boys, feelings of pleasure when masturbating were mixed with embarrassment and shame, and therefore it was avoided.

### Gender norms

Gender norms were discussed by youth in terms of their ability to say no to sex, negotiating condom use and forced marriage. The data were mixed in terms of girls’ perceptions of their ability to control how and when they would have sex. In one study of Kenyan schoolgirls, girls did not feel able to say “no” to sex (Maticka-Tyndale et al, 2005). Rather, it was seen as a part of life or an expectation from society that they should satisfy men and boys. In that context, if a girl refused, she risked rape or other physical violence (Maticka-Tyndale et al, 2005, Mash and Kareithi, 2005). However, in their review of the literature on transactional and cross-generational sex, Luke and Kurtz (2002) found that girls say they have some power over when and with whom they would have sex. Some strategies that they used to avoid having sex were to milk older men as much as possible without giving sex and offering false promises. Importantly, however, they were not as successful in negotiating safe sex.

Girls may be able to have a say in how or with whom they will have sex, but they do not feel able to negotiate condom use.

Boys also feel trapped by gender norms that dictate their necessity for always wanting sex.

A study of sub-Saharan African youth found that males felt that it was the responsibility of young women to ensure condom use. However, girls in this study, as in the other studies in Africa, did not feel that they had the power to insist on condoms, particularly within the institution of marriage (Amuyunzu-Myamongo et al, 2005).

Traditional gender norms were not only seen as harmful to women. In several studies, boys indicated that they felt forced to engage in frequent sex with many partners and other risky behaviours by their sexual urges and by society (Maticka-Tyndale et al, 2005; Ethiopia 2007). Young men in Ethiopia felt that they were expected to stay outside of the house, which led them to get involved in risky activities such as drug-taking and violence:

*“When we stay home and are unemployed they call us womanish and too soft. Therefore, we just wander around not to have that name and this will expose us to drug abuse.”*(Ethiopia, 2007)

These same young men, who were involved in a gender equity group in Addis Ababa, indicated how hard it was to break out of gender norms, such as helping with cleaning and other chores at home:

*“If a boy wants to get involved in domestic work such as cooking, which is very important for his future life, the family will address him as womanish and will force him to go out to play with his peers. They will also say to him ‘Just do a man’s job and leave this to the girls.’”*(Ethiopia, 2007)

Similar gender norms were found in Senegal, where both parents and adolescents reiterated that it was girls who should stay at home so they could remain virgins, while it was the boys who should go out and discover life (PIWH, 2002).

Finally, forced marriage and widow inheritance were provided as gender-related risks for HIV/AIDS by rural Tanzanian youth (Masatu et al, 2005). Widow inheritance is the practice in some cultures whereby a woman is obliged to marry her brother-in-law if her husband dies. This is considered risky in cases where the woman’s husband died of AIDS, which means that the widow could also be infected, and then pass this to her brother-in-law. Forced marriage was said to be risky by Tanzanian youth because in some tribes girls are forced to marry men who may be HIV-infected:

*“It is the parents who sometimes plunge their daughters into trouble. When they see a certain rich man with money, a car, etc., they quickly accept marriage of their daughter to this man though they may know that he is HIV-infected. The daughter will enter into forced marriage because of wealth of her husband-to-be”* (Masatu et al, 2005, p.37).

### **Myths about protective strategies**

Not all of children’s protective strategies were necessarily protective against HIV/AIDS. Adolescents in Zambia held several harmful myths about ways to protect themselves. For example, young people thought that 12 to 15 year old girls and boys did not need to use condoms because they were too young to worry about STIs (Fetters et al, 1998). Further, some young people thought that as long as their partners were attractive or healthy looking they were safe.

## 8.2. What are children's perceptions of sexual and reproductive health services?<sup>6</sup>

The following issues were important to children when visiting sexual reproductive health services:

### Confidentiality and privacy

Youth value getting reproductive health information from health care providers (except in Ethiopia), but sometimes felt shy asking them questions (Amuyunzu-Myamongo et al, 2005). One reason was that they were trained to maintain confidentiality and they may not know them personally. On the other hand, lack of privacy and confidentiality was also mentioned by youth as a negative aspect of STI-related and voluntary counselling and testing (VCT) services (Amuyunzu-Myamongo et al, 2005; Berhane et al, 2005; Flaherty et al, 2005). In particular, youth are afraid of being seen by parents or people they know and becoming embarrassed. As one female student said:

*"The big fear is that the health worker will reveal everything to the parents. We fear going to the health unit because of the parents. Maybe the parents will see the boy or girl going to the health unit"* (Flaherty et al, 2005, p.35).

Traditional healers were seen as having an advantage in this respect, as they did not request as much personal information. In Zambia, these practitioners (ngangas) were also preferred because they did not require you to take off your clothes, nor were you required to make an appointment:

### Provider attitudes and accessibility

Young people complained about the costs of services and being treated poorly by health care personnel, who shouted at them and humiliate them (Berhane et al, 2005; Flaherty et al, 2005). However, it is not known how many of those who expressed these opinions had actually accessed such services.

### What youth want

The kinds of services that youth want are providers with good communication skills and good morals (Flaherty et al, 2005), special hours, younger health care provider of the same sex as the client, and discounted fees for children (Berhane et al, 2005). However, it should be noted that not all youth express the same preferences, indicating that these differences must be taken into account when designing youth-friendly reproductive health services.

Boys in Zambia made the following recommendations to improve clinic utilisation that underscore these desires (Fetters et al, 1998, p.28):

- The "medical scheme" (Zambian National cost recovery programme) should be abolished;
- The nurses at the clinic should not insult the boys who visit the clinic for treatment of STIs;

<sup>6</sup> Only Ethiopia, Uganda and Kenya were represented in the literature.

- Clinic staff should stop eating while attending to patients;
- Have more doctors at the clinic in order to reduce congestion;
- Clinic staff should prescribe the correct treatments;
- Clinic staff should not “hide” medicines; and
- Privacy and confidentiality should be assured.



*When asked what children want in terms of sexual health services, they want staff with good communication skills and good morals, special hours, younger health care providers of the same sex as the client and discounted fees.*

### Parents’ opinions about services

The two studies in Senegal were unique in asking parents what they thought about SRH services for adolescents (Synergie Banlieue, 2007; PIWH, 2002). Parents felt that young people should only be provided with information about the dangers of STIs, but not on actual testing and treatment or providing the means to protect oneself (Synergie Banlieue, 2007). Their reasons were “young age (25%), fear that such services would promote promiscuity (21%), early sexual relations (18%), infidelity (17%) and prostitution (9%)” (PIWH, 2002).

### 8.3. What are children’s perceptions of in-school HIV/AIDS preventive education and counselling?<sup>7</sup>

#### Education too technical

For church-attending youth in South Africa, schools were a major source of sexuality and HIV education (Mash et al, 2005). However, young people perceived the information on sexuality they received as being too uniform and not suited to the variations in development between children of the same age. Furthermore, young people reported that schools focused too much on the biological side of HIV/AIDS and the need for safe sex. Instead they wanted more information on

**Teachers are often embarrassed, adopting a moralistic and negative approach to sex.**

<sup>7</sup> We found that most studies that evaluate school-based sex education focus on the impact of the information, and not on what children themselves think. We found no relevant studies from Côte d’Ivoire, Senegal, Uganda, Ethiopia, or Sudan.

HOW to abstain from sex and still have a relationship with someone. The messages that schools gave on HIV/AIDS prevention were also seen as contradictory and “a joke”, where students were encouraged to both use condoms and abstain. In Kenya, a fourth-form female student noted:

*“Last year during AIDS awareness week our class decided that we would not endure another academic lecture and so we interrupted the speaker and asked real questions about bone (sex). The speaker stammered and got confused then said we were too young to know the stuff we were asking. But we insisted on knowing stuff like how to really bone for pleasure not for reproduction [laughter]. The speaker said she couldn’t talk to us anymore because we were being unruly, though we really were not. She left the room and our teacher came and gave us a msomo (lengthy scolding) and so we were back to square one – learning everything we already knew and being taught nothing we wanted to know. They say they are giving us sex-education but they are not” (Mbugua, 2007, p.1087).*

Significantly, Pattman and Chege (2003a) noted during data collection for their research, that young people used focus group discussions to get information on sex and sexuality that they felt was not available from their teachers or parents.

*Most children find that sexuality education in schools is too technical and too negative and does not answer their questions or give them the information they need to protect themselves.*



### **Education too negative**

Interviews with young people in Kenya indicated that they viewed sex education in schools as primarily communicating negative perceptions of sex (Pattman and Chege, 2003b). For example, girls aged 15 and 16 years said that they mostly received warnings about the bad consequences of sex rather than how to lead healthy lives. Some of the lessons that boys aged 13 and 14 years said they learned from school teachers were that “girls can bring diseases to us” and “don’t have sex because of HIV/AIDS” (Pattman and Chege, 2003a). Similarly, girls in Uganda reported that senior women teachers talked about avoiding boys:

*“We were girls of Primary Class 6. She told us that we are not supposed to spend a lot of our*

*time with boys. The problem is that you never know when the devil can come and you agree to have sex” (Kinsman et al, 2000, p.160).*

Unfortunately, sometimes the information that youth receive from their teachers is not correct, as this comment reflects:

*“[We were taught] that if anyone has got AIDS, we must avoid them. If he is a man and you are a girl you must never go near him. If this patient is at home, his things must not be used by other people. He must be isolated” (Kinsman et al, 2000, p.160).*

### Teachers’ perspectives

Interviews with teachers in the region revealed that teachers were often embarrassed to talk about sex, and often adopt a moralistic approach to sex to protect themselves. This may explain why they presented only the negative aspects of sex. For example, South African life skills teachers felt to some extent that HIV/AIDS education would encourage early experimentation with risky behaviours (Peltzer and Promtussanonon, 2003). These comments from Senegalese teachers illustrate the problem: *“Certains enseignants ont un véritable complexe devant les élèves et préfèrent faire la leçon de géologie (Some teachers have a hard time talking [about sex] with their students and prefer to hold geology lessons).”*

*“Avec le volume horaire, je profite des leçons de morale pour glisser juste des mises en garde (Due to time constraints, I just focus on moral aspects in order to make them aware of the problem)” (Synergie Banlieue, 2007, p. 20).*

In Rwanda, teachers preferred to teach sex education in French rather than in Kinyarwanda as a way of avoiding embarrassment (Pattman and Chege, 2003a). Teachers clearly needed more instruction on how to discuss issues of sexuality and sex while not becoming embarrassed, as indicated in this quote from a female teacher in Botswana:

*“I remember one student wanted to know if I have ever used a female condom, and how it feels. I told them that I have never used it and that they should not become personal when we talk about these things” (Pattman and Chege, 2003a, p.58).*

Teachers’ inability to discuss issues related to sex may also be related to their lack of knowledge and their own realisation that young people are bored by their explanations. Teachers in Tanzania and Rwanda felt that they did not have the proper skills to teach HIV/AIDS as these topics are not included in their training curriculum. On the other hand, a quantitative study of life skills teachers in South Africa revealed that teachers said they felt moderately comfortable teaching about HIV/AIDS and thought they had the ability to do so. However there were serious gaps in their knowledge of HIV/AIDS. For example, 25% of them thought that HIV could be contracted by mosquito bites (Peltzer and Promtussanonon, 2003).

Teachers in Botswana also felt that students had been bombarded with so many messages about death and suffering related to HIV/AIDS that they began to block it out:

*“Like last week, I called the drama group. The play was to be about HIV/AIDS. I did not tell them the theme, because I knew that if I mentioned HIV/AIDS, no one was going to turn up. I even told the teachers that they should not tell them that it was about HIV/AIDS. So they came. When they arrived and realised what were going to deal with, some left the place”* (Pattman and Chege, 2003a, p.68).

Teachers do seem to understand that they need to find ways to present information about sexuality and sexual and reproductive health in a way that is meaningful to youth, instead of merely emphasizing the negative aspects. At the same time, teachers are very much aware of parents’ and religious leaders’ objections to sexuality education and the encouragement of boy-girl friendships as a uniquely Western idea (Pattman and Chege, 2003a; Peltzer and Promtussanonon, 2003). Furthermore, as Mbugua (2007) points out, teachers are often products of the same traditional sexual socialisation processes that made it impossible for their own parents or teachers to talk to them.

### **Gender aspects in sex education**

Pattman and Chege’s study also revealed significant effects of gendered influences in the way that sexuality and HIV/AIDS is taught in schools. For example, teachers reported that girls became more timid when discussing sexuality, whereas boys became bolder. In some classes, when issues about HIV/AIDS or sexuality was discussed in mixed groups, girls said they kept quiet because they were afraid of being ridiculed by the boys. This is found in the following observation of an AIDS awareness lesson in a school in Kenya:

*“Girls were quiet and shy, reserved, looked down when certain words were being mentioned, i.e. ‘sex’, ‘sexually active’, ‘sexual intercourse’. Boys got most of the attention from the teachers throughout the lesson. No attempt was made to engage girls in discussion; they were often forgotten. One girl was active but not noticed by the teacher”* (Pattman and Chege, 2003a, p.60).

Kenyan girls also reported boys “making dirty jokes” when they incorrectly answers questions in class, even when not discussing issues around sexuality. This indicated that gender issues in the classroom were widely present even in non-sexual education classes.

## **8.4. What are children’s perceptions of community-based (including civil society and religious institutions) HIV/AIDS preventive education and counselling?<sup>8</sup>**

Children in Uganda and South Africa are just as concerned about confidentiality of community-based services as they are with health services.

### **Desire for confidentiality**

Youth aged 14-19 years in Uganda mentioned youth clubs and centres and peer educators as preferred sources of information (Amuyunzu-Myamongo et al, 2005). They particularly liked discussion groups because of the opportunities to ask questions. One negative aspect of community-based information for youth in Uganda

<sup>8</sup> We found few studies in the target countries that focused on children’s own perceptions of community-based sexual education. We found no relevant studies on this topic from Côte d’Ivoire, Senegal, Ethiopia, or Sudan.

was the possibility that peer-to-peer information would not be considered confidential. This fear of lack of privacy and confidentiality was repeated in another Ugandan study, although few had actually accessed community-based services (Flaherty et al, 2005). The youth in that study lamented the general lack of any trusted information on reproductive health. Church-going adolescents in Uganda said that they would feel more comfortable receiving SRH information from people outside of their church:

*“As long as it is conducted by somebody from outside our Church because we will be a bit free to ask some questions”* (Kangara 2005, p.10).

### **Lack of relevance**

Church-attending youth in South Africa did not think that the Anglican church they attended had influenced their sexual decision-making processes (Mash and Kareithi, 2005). This opinion was borne out by the results of a survey with the same population that showed that there were no differences in sexual activity between the youth who had received sexuality instruction in church and those who had not. One reason given by youth for the lack of impact of church-based sexuality education was a top-bottom educational approach, with the older members of the church providing the education. As one female wrote on her survey:

*“People in their twenties are best placed to teach young people about their sexuality. Older people are honestly gross. Who wants to hear about sex from their parents’ friends?”* (Mash and Kareithi, 2005, p.33).

The youth also criticised the church’s expectations of them to abstain or marry (Mash and Kareithi, 2005; Pattman and Chege, 2003a). They saw it as being unrealistic and an unattainable goal. At the same time, some young people – particularly girls – idealised the church’s position on sex, and held it up as a model for their behaviour (Pattman and Chege, 2003a).

### **Positive impact**

A recent study in Ethiopia on children attending boys groups explored their own experiences of increased awareness of gender and SRH issues. In focus groups, the boys described how they felt they have benefited from the groups:

*“Whenever I think of my future and married life it will be based on equality. My children will have also a better view than myself and that is a lot dependent on me. It is up to me to shape children who strongly believe in gender equality”* (Ethiopia, 2007, pp.26-27).

### **Community programme representatives’ own perceptions**

One study in Kenya asked three pastors or elders about their perceptions of SRH education. Who agreed it was important but did not feel they could speak about sensitive topics:

*“I think we should let young people talk about these things among themselves because personally, I cannot talk about sex to young people”*

Children see the church’s position of no pre-marital sex as an ideal, but they do not feel that it is realistic for them.

“...how can I talk about sex to my own daughters? It is not possible. I am a Christian” (Kangara 2005, p.10).

## 8.5. What are children’s perceptions of HIV/AIDS preventive information in the media?<sup>9</sup>

### Children receive most of their information on SRH from the media

Youth in Sub-Saharan Africa said that the media is their major source of information on reproductive health, and the one they most prefer (Amuyunzu-Myamongo, 2005). They preferred the radio in particular because it is reliable, reaches a wide audience, it is accessible, and parents can also listen at the same time. The negative aspects of radio are that they don’t discuss these issues every day, not everyone has a radio and one cannot ask questions. Newspapers were particularly mentioned in Uganda, where the inserts “Straight Talk” and “Young Talk” are widely known by the youth. Although they preferred this source of information, they identified barriers to its use, such as lack of money or access to the newspapers, information in the wrong language and illiteracy. Ugandan youth also appreciated dramas and theatre because they are entertaining, encourage communication with others and are accessible to youth who cannot read.

Media is often the main source of information on reproductive health.

### Media is not always seen as the most credible source of information

Although children say they receive most of their SRH information from the media, one study found that they regard the media as the one of the least credible sources of information (next to religious leaders and friends). In this study children reported that the most credible source of information on condoms, other contraceptives, STIs and HIV/AIDS was health care workers (Masatu et al, 2003). The most credible source of family life information was reported to be parents.

In light of this somewhat contradictory and limited evidence it is difficult to draw conclusions about the media as a source of information sexual and reproductive health for children.

## 8.6. What are children’s awareness and views of transactional sex?<sup>10</sup>

### Transactional sex

Young people generally understood the offering of a gift as an invitation or, more commonly, an obligation for sex (Maticka-Tyndale et al, 2005). They regarded sex as a valuable commodity that was not to be given away for free. It therefore meant that gifts were not accepted unless the receiver planned on reciprocating with sex. A study in Zambia found that virtually all sex among children was associated with some form of gift or payment to the girl. The following example illustrates these exchanges:

<sup>9</sup> Most of the reviewed studies on this topic only asked about youth’s exposure to media, and not their perceptions of it.

<sup>10</sup> There is a rich literature on sub-Saharan African children’s perspectives and awareness of transactional and cross-generational sex.



*“One 13 year-old had sex with two girls; to the first one he gave a pencil and she agreed to have sex in return. To the second one he proposed while playing hide and seek and she agreed. He gave the first one K500 and the second bananas and sweets after having sex with them. He mentioned that one of the girls had given him bubble gum and the second nyama nyama (‘skin to skin’ sexual intercourse) as ‘gifts’”(Fetters et al, 1998, p.17).*

Transactional sex was also reportedly encouraged by some parents, both covertly and passively, in order to obtain items that were needed by the family.

*“Several groups of boys and girls narrated instances when a mother or grandmother would ask the girl to seek sex partners so that there is some money at home and they can have enough food to eat. However, it was mentioned that the girl would not be told directly to go and have sex but a mother could pass comments like ‘sure ti gona nanjala na bakazi balipo pano’ (Surely how can we sleep on empty stomachs when there are girls in the house?)”(Fetters et al, 1998, p. 18).*

Girls were expected to elicit money from their peers in exchange for sex as well as from older men (Amuyunzu-Myamongo et al, 2005). However, peers were not always the same age. Kenyan schoolchildren aged 11-16 years told researchers that the normal age for initiating both dating and sex was 11-15 years of age, but that the norm was for boyfriends to be at least 2-4 years older than the girl. This age difference was preferred by girls because of the greater financial capacities of older boys and men. Boys preferred it because of their desire for “fresh,” “innocent,” and “unknowning” sexual partners (Maticka-Tyndale et al, 2005).

However, in another study, boys reported that they were obliged to turn to younger girls for sex because girls their age were more interested in older men (Pattman and Chege, 2003a). Many boys expressed frustration that girls their age were only interested in boys and men who could provide material wealth and status to them:

*“Some of the girls are just time pushers. They just waste your time. All they want is your money and so they look for a boy who has money. All girls just want money” (Pattman and Chege, 2003a, p.89).*

*“For boys our age, it is difficult to have sexual intercourse with girls our age because in junior school, you go for senior secondary or first year university. Girls our age have relationships with seniors because you have to be high, well knowing, so girls go for these because they see you as immature, and that you wouldn’t know some things” (Pattman and Chege, 2003a, p.103).*

Boys’ solution to this was to have sexual relationships with girls who were younger than them, and thus easier to manipulate:

*“Even here in school, like us Form 3s, its’ easier to get girls in lower classes because they think we know everything. It’s easier proposing to a Form 1, and she is likely – 90% she will say ‘yes’ – because she will be afraid or because she thinks I am hard” (Pattman and Chege, 2003a, p.103).*

Boys often perceived girls’ attraction to older men as forcing them to become “sugar daddies” themselves.

Transactional sex is very common in sub-Saharan Africa. Girls are not usually able to negotiate condom use in transactional or cross-generational sexual relationships.

## Cross-generational sex

Sub-Saharan African youth characterised sex with older men and women<sup>11</sup> as being motivated almost exclusively for money or gifts (Amuyunzu-Myamongo et al, 2005; Longfield et al, 2002; Luke and Kurtz, 2002). Some girls appreciated older partners' sexual experience, but most girls did not have thoughts of marrying their older partners. The most common reasons girls gave for engaging in cross-generational sex were economic survival, to provide opportunities for the future and to increase status among one's peers (Longfield et al, 2002; Luke and Kurtz, 2002). As this Zambian girl says:

*"Sometimes it's because of peer pressure, when you are with your friends they like boasting that 'I am going out with a guy who gives me anything that I ask for, and you might think that you are doing nothing when you are going out with a schoolboy so you also do what your friends tell you. They boast that 'I have this, my boyfriend bought it for me – I don't go out with school guys, I go out with working class' (Pattman and Chege, 2003a, p.107).*

In addition, some said they pursued such relationships for emotional reasons such as support, mentoring, and security:

*"Girls prefer old men because, they say, they have the 4Cs – Cell phone, Car, Cash and four Cornered shoes. With these they know that they have all the necessities...when you are stranded on the way, you can just call him on his cell because he is always with it. Then he can come and pick you up with his car, and buy you lunch since he has got cash. And when he comes out of the car, the first thing you will see are his four cornered shoes" (Pattman and Chege, 2003a, p.104).*

Older female partners were also discussed by 16-18 year old boys in Zambia, but in a comic way. Boys told stories about 'lizard ladies,' who lure boys into their rooms to kill a lizard and then seduce them:

*"Maybe you, somebody calls you [to come to her house]. At the house, she manipulates you. You see what I mean? She calls you maybe in her bedroom to come, and maybe just come and kill this lizard for me (lots of laughter)...and you go there...just to find a big lizard naked. (Hoots of laughter)" (Pattman and Chege, 2003a).*

Although the boys indicate that they are trapped into these situations and unable to extricate themselves, the stories were always told in a humorous way to indicate that everyone understood that boys are always interested in sex, and thus there was no real coercion. Boys indicated that the best way to avoid these situations is to not go to the homes of these women.

## Risk perception

Longfield et al (2002) found that young women recognised substantial risks with conducting cross-generational relationships, but these were mostly related to being discovered by the wife of the man or from parents or other boyfriends. Pregnancy was mentioned, but infection with STIs or HIV was not considered a great risk of such sexual relationships. Their rationale for this is that older men were considered stable and less likely to "move around." This was reiterated by a comprehensive lit-

<sup>11</sup> Both "sugar daddies" and "sugar mummies" were discussed by young men and women in Uganda and Zambia.

erature review of cross-generational sex in sub-Saharan Africa which found little evidence that girls think about risks of HIV/AIDS in such relationships (Luke and Kurtz, 2002). The fact that children do not perceive themselves as being at risk of HIV/AIDS in these relationships perhaps explains why we did not find any information about children's perceptions of the usefulness of HIV/AIDS preventative efforts in this area.

## 8.7. What is the situation of children who express sexuality outside of the heterosexual norm?

We found only one study in sub-Saharan Africa that looked at the situation of individuals under 18 years who express their sexuality outside of the heterosexual norm. The study concerned street boys in Mwanza, Tanzania and their practice of kunyenga, or penetrative anal sex (Lockhart, 2002). This practice seems to be the norm for street boys, 98% of whom had experienced it. Kunyenga is practiced either as a sexual initiation to the street as a gang rape, or as waking up to find that a sleep-mate is having anal sex with him. These acts were characterised by violence and physical dominance. Street boys could also engage in mutually consenting acts which often did not involve actual penetration and was seen as a type of play.

Boys in the study did not consider kunyenga as homosexual activity or even sex. Boys who were classified as 'girl-men' were subject to physical abuse and were social outcasts. For this reason, street boys saw no danger of acquiring HIV/AIDS, as this was seen as a disease that could be acquired exclusively from females. If the boys were only having sex within their close-knit network, this might be true. But the author found that between the ages of 11 and 18 years, street boys engage in sex with both sexes, which could provide a bridge from the general population to the population of street boys.

In conclusion, the author felt that kunyenga should be seen as a type of survival sex<sup>12</sup>, since street boys are dependent on one another for survival, and the only way to be accepted into the group is to accept its rituals. He advocates for more understanding of the survival strategies of street boys in urban areas of the region, as well as a greater understanding of the practice of anal sex between both males and females.

## 8.8. What are children's understandings of the Abstinence, Be Faithful, Condoms-(ABC) concept?<sup>13</sup>

### Understanding of "abstinence"

A study in Kenya found that 46% of youths supplied the correct definition of abstinence as "not having sex" (Pulerwitz et al, 2006). However, there were conflicting results from the focus groups. Some male youths said that the community saw ab-

Other research shows that children outside the heterosexual norm feel invisible because their issues are either ignored or condemned.

<sup>12</sup> This is to be contrasted with the notion of 'survival sex' as being sex traded for money, favours or goods which was not mentioned in the referenced study.

<sup>13</sup> There is a growing literature on children's perceptions and understandings of abstinence, faithfulness and consistent condom use. We did not find any studies on this topic from Côte d'Ivoire, Senegal, Sudan, Ethiopia or Zambia.

stinence as being abnormal, while others said a person who abstains is considered holy and a role model. In general, abstinence was talked about by sub-Saharan African youths as an important way of avoiding HIV/AIDS. This was not necessarily linked to abstinence before marriage, particularly in Uganda and Malawi. It was seen as a strategy to be pursued after being diagnosed with an STI. For this reason, VCT sites were seen as an aid to becoming abstinent.

*Children often thought “being faithful” meant being honest or trustworthy rather than being monogamous.*



**Faithfulness was seen as a good option for some children, although it is not clear if children understand the term the way it was originally conceptualised.**

**Children are not fond of condoms for most of the same reasons that many adults are, although some of these reasons are based on misinformation.**

#### **Understanding of “being faithful”**

23% of youths in Kenya correctly defined “being faithful”. Youth usually confused the term “being faithful” with being loyal, honest or trustworthy (Pulerwitz, 2006). In Tanzania some youths were unclear about the meaning of “being faithful,<sup>14</sup>” even after leaving a session with a VCT provider where they said that they would “be faithful” with their steady partner, but use condoms with other sexual partners (Thomsen et al, 2006). Being faithful or ‘fidelity’ is seen as a strategy to employ after having been tested for HIV and young men often expressed doubt that their female partners were actually being faithful, even if they said they were (Mash and Kareithi, 2005).

#### **Understanding of “consistent condom use”**

In Kenya, 13% of youth correctly defined “consistent condom use” (most youth gave opinions, mainly negative, about condom use instead of defining it). Female youth talked about how condoms have ‘virus’ or ‘small holes that can allow the virus to go through’ (Pulerwitz, 2006). In Senegal, over one quarter of adolescent girls and almost 40% of boys believed that it was possible to re-use a condom (Synergie Banlieue, 2007). Young men in South Africa saw condoms as being unreliable or ineffective, primarily due to rumours that they contain dangerous fluids that can cause diseases (Mash and Kareithi, 2005). Although youths felt that it was important to use them, most did not like them due to fears that they would break, they were ineffective or even dangerous, they give less pleasure and that they convey a lack of trust to one’s partner.

<sup>14</sup> Sex with a mutually monogamous partner, where both partners know their HIV status.

Tanzanian rural youths were also skeptical about the effectiveness of condoms and they expressed frustration over the contradictory information received from the government and NGOs (“condoms are good”) and the church (“condoms are bad”) (Masatu et al, 2005). In addition to doubting their effectiveness, Zambian adolescents felt that condoms were inappropriate for young people because they were too big (Fetters et al, 1998).

### **Abstinence not realistic for sexually active youth**

Abstinence and being faithful were largely viewed as laudable behaviours, but not necessarily realistic (Amuynuzu-Myamongo et al, 2005; Pulerwitz, 2006; Synergie Banlieue, 2007). Some young people felt that abstinence was promoted by adults to keep youths from enjoying themselves, such as this young Ugandan male:

*“Usually relatives tell you only problems of condoms even when you are using a condom, that it is not safe. It is not safe. They say you should abstain, so relatives control you”* (Amyunzu-Myamongo et al, 2005, p. 27).

Similarly, church-attending youths in Cape Town, South Africa valued the concept of virginity in principle, but found it difficult to maintain, like this young woman:

*“I was a virgin when I was confirmed last year in October and I wore a white dress and a veil. That was my goal. But now, three months later, I am sexually active. It is alright because I was a virgin at confirmation, and now my boyfriend needs me”* (Mash and Kareithi, 2005).

Finally, young people considered abstinence to be unrealistic, and thus unacceptable as a method of prevention of STDs and HIV (Hulton et al, 2000; Pattman and Chege, 2003a). Abstinence was seen as unrealistic because it was against the “force of nature,” in addition to being seen as unacceptable by male members of the family and friends.

*“L’abstinence est presque impossible chez un garçon et même si certaines filles le peuvent elles ne sont pas nombreuses (Abstinence is almost impossible for boys and even if some girls can do it, they are not the majority)”* (Synergie Banlieue, 2007, p.24).

### **Having sex provides social and personal benefits**

A study in Uganda revealed that virginity is not always presented as the often unattainable ideal of children. A minority of girls in secondary school felt strongly that virginity was good because it protected one against negative events such as unwanted pregnancy, getting a bad reputation or eventual marital discord:

*“There is a time I got very ill. I was in Primary class 7 and everyone around thought I was pregnant. I was taken for several medical check ups to see if I was pregnant. But inside me I was firm and very confident because I knew I was not pregnant. I had never had sex with anyone. Even though I was ill, I knew I was not pregnant. I was proud and confident. I was not scared. I was sure that I was innocent. Whenever my aunties asked, there was no boy I could mention because I had never had sex. If I was not a virgin, I would have got into a panic wondering which of my last lovers was responsible. I would have got frightened and so would my parents”* (Kinsman et al, 2000, p.159).

Children see the benefits of abstaining from sex but they do not see it as being a realistic behaviour for themselves.

However, these girls were in the minority. The majority of the interviewed girls regarded virgins as social anomalies who were to be despised because of their lack of experience and even their lack of ability to take care of themselves hygienically:

*“Virgins are usually dirty. They reach their periods when they don’t know what to do because they are not aware of the days. She will get leakages and won’t know how to go about everything.”*

*“She pretends that she is well informed but when she gets married, she does the opposite of what should be done. She cannot please her husband in bed”* (Kinsman et al, 2000, p.159).

Girls who were not virgins, however, saw themselves as having more status in school and being generally happier than their virgin schoolmates:

*“Facilitator: What do you think of having a friend who is not a virgin and is ever with boys?”*

*Girl: I think that is a better person.*

*Girl: That is why such girls have many friends in school. Even if it is elections for the prefects, it is such girls that get most votes”* (Kinsman et al, 2000, p.160).

### **Intention to employ ABC**

Tanzanian youth leaving a session with a VCT or other reproductive health provider said the behaviours they were most likely to change in the next six months were being faithful (57%) and increasing condom use (26%). Only 16% said they were most likely to abstain (Thomsen et al, 2006). These results were substantiated by subsequent in-depth interviews with a subset of the youths.

### **Adults’ perspectives**

The few studies interviewing adults in sub-Saharan Africa indicated that most parents feel that children should receive information about sexual and reproductive health, but that information should be restricted to abstinence and being faithful. Providing information on condoms was seen as something that would promote promiscuous behaviour (Synergie Banlieue, 2007; Kangara, 2005; PIWH, 2002; Amuyunzu, 1997).

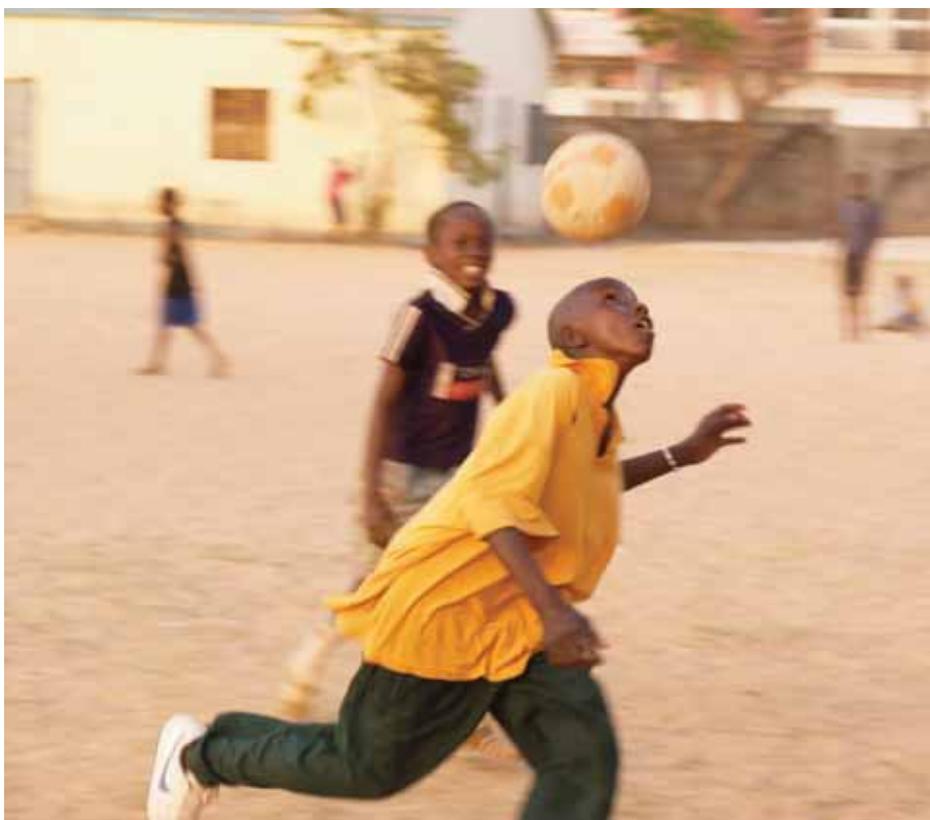
## 9. Effective Responses

The above literature review and programmatic work of Save the Children Sweden and RFSU suggests various strategies which would benefit children in sub-Saharan Africa in their struggle to avoid HIV/AIDS. These strategies are grounded on the principles of effective and relevant sexuality education and coping mechanisms. The following recommendations provide a framework for policy and programme responses.

### Strategies of protection

- Programmes should promote and support children's own strategies for staying healthy, such as providing opportunities for children who would like to abstain from sex to occupy themselves after school with sports, drama and clubs.
- Sexually active girls should be provided with skills in explicit negotiation of condoms. Training in life skills usually includes negotiation, which could help, provided that it overtly deals with sexual behaviour.
- Gender stereotypes around male sexuality highlight the need to develop programmes that target boys' masculinity and sex as well as dealing with dangerous myths around manliness, such as the need for many sexual partners.

Children in sub-Saharan Africa have their own strategies for avoiding STIs, HIV and unintended pregnancy.



Recreation is one of the key strategies children use to avoid sex.

### Sexual and reproductive health services

- Children's preoccupations with confidentiality and privacy should be taken seriously and addressed. Even children who have not visited sexual and reproductive health services should be reached with messages informing them about the confidentiality of services such as VCT.
- Children's concerns about accessibility of services, both in terms of distance and cost, should be addressed. Where possible, sexual and reproductive health services for children should be free.
- Providers of sexual and reproductive health services should be trained in the provision of youth-friendly services in order to address negative attitudes.



*An effective means of teaching about sexuality seems to be providing children the space to discuss it among themselves, with a non-judgemental adult guide as support.*

### School-based sex education

- Teachers should be trained to provide appropriate and interesting sexual education to children.
- Teachers should themselves receive training to become comfortable with their own sexuality.
- Creative ways of getting children to ask questions about sex should be explored.

### Community-based sex education

- Community-based education programmes also need to respect children's desire for confidential discussions with peer educators and other community members.
- Faith-based organisations have a strong potential to influence young people who are looking for ways to avoid risky behaviours. Thus, these organisations should be helped to find ways to discuss sexuality and life skills in a way that seems relevant for young people.

### **The media**

- The media should continue to be used as a means of reaching children with accurate and correct sexual and reproductive health messages.

### **Transactional sex**

- Interventions targeting men involved in transactional sex with young girls should be developed.
- Girls should be provided with economic opportunities to avoid the necessity of transactional sex relationships.
- Girls should be made aware of the relative risks of engaging in sex, particularly unprotected sex, with older, married men.

### **Non-heterosexual expressions of sexuality**

- Given the fact that some children do not identify with the heterosexual norm, information on sexuality should be inclusive by not taking this norm for granted.
- Governments that have ratified the CRC should ensure that children are given fact-based health messages, whether by public bodies or non-governmental organisations, in accordance with the CRC.

### **Abstinence, being faithful, using condoms**

- Children's concerns about their abilities to remain abstinent should be taken seriously.
- Even children who choose to abstain, need to receive information on how to protect themselves from HIV/AIDS, given that nearly all individuals will eventually become sexually active.
- More sensitive efforts should be made regarding the "be faithful" message, or it should be dropped altogether.
- Efforts should focus on reducing sexual partners and mutual HIV testing before unprotected sex.

## 10. Areas for Further Research

Extensive gaps in information were found while conducting this literature review. In order to help stakeholders and policy makers to design programmes that will address children's own expressed needs, more information should be collected on:

- Children's desires for programmes to prevent HIV/AIDS.
- Children's perceptions of existing sexual and reproductive health services.
- Children's views on counselling on matters of sexual health, pregnancies and contraceptives.
- Children's opinions on the need for sexual and reproductive health services where these are not already available.
- Children's perceptions of the information they receive in school and community-based HIV-preventive education and counselling, including their ability to get answers to their questions and the feasibility of implementing the advice they receive.
- Children's perceptions of HIV-preventive media information.
- The perspectives of children expressing sexuality outside of the heterosexual norm.

In addition to these topic areas, we recommend the following changes in general approaches to research on HIV/AIDS in sub-Saharan Africa in order to strengthen the current knowledge base:

### **Studies of youth should present data disaggregated by age.**

There were several interesting studies that could not be included because they only presented results for youth aged 15-24 years (e.g. Longfield, 2004) or some other age group that groups children with young adults (e.g. Kaufman and Stavron, 2004). This makes it impossible to specifically determine children's perspectives and strategies in contrast to older youths aged between 18 and 24 years. At the very least, youth responses should be categorised into 10-14, 15-19 and 20-24 age groups. However, a more systematic method would be to base age categories on theories of adolescent development<sup>15</sup>. Ultimately, programme evaluators should base their decisions about which age groups to present on the objectives of the evaluation, the type of data being presented, and the cultural context (Lansdown, 2005). Such disaggregating will give programme and policy makers a better picture of the differences in needs and experiences in the different age groups (Andersson-Brolin and Radetzky, 2002).

### **More studies are needed with children from 7-14 years old.**

The lack of studies of young children 7-14 years has been remarked upon elsewhere (UNFPA and Population Council, 2006). Reasons for this gap are difficulties in convincing parents that discussing sex with children does not encourage them to have

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<sup>15</sup> For example, using several prominent theories as a basis, the Pan American Health Organisation (PAHO) has suggested the following age group categories: Preadolescence (9-12 for girls, 10-13 for boys), Early adolescence (12-14 for girls, 13-15 for boys) Middle adolescence (14-16, 15-17 for boys), and Late adolescence (16-18 for girls, 17-18 for boys) (UNFPA and Population Council, 2006). While these categories may be too specific for many studies, they do indicate the wide range of developmental stages within the established age groups, particularly that of 15 to 19 year olds.

sex, that they usually already have some kind of sexual experience (Pattman and Chege, 2003a and 2003 b) and in obtaining ethical clearance for conducting such studies. However, there is clearly a need (if not a moral obligation) for such studies. The prevalence of HIV in 15-24 year olds is as high as 18% in some of the countries of interest. Between 5-40% of youth in the same countries say that they have had sex before the age of 14 (Table 1). Clearly, children are being exposed to the virus from a young age.

Even those who are not sexually active are probably aware of HIV/AIDS given that prevalence ranges from 2-19% in their population category. There is a particular need for more studies of children under 10 years of age. The few studies that have been conducted with children under 10 years, primarily look at children as orphans and vulnerable children (OVCs) or children who are HIV positive. Few studies look at children's experiences of sexuality or understandings of HIV below this age<sup>16</sup>. Such studies can provide information on children's strategies for avoiding HIV/AIDS, which can inform programmes with children who have not been infected, but who risk becoming so if they do not get access to information and services.



*More research needs to be conducted on children between 7 and 14 years old.*

### **Studies of children should take a promotive, rather than a risk/vulnerability perspective.**

The vast majority of the studies that address children and HIV/AIDS have a risk-avoidance approach. Researchers usually ask questions of children to describe their sexual knowledge and behaviours, allowing the researchers to determine their level

<sup>16</sup> A notable exception is Pattman and Chege's (2003a) study, which interviewed six year old children in Zambia and found that children were very aware of "sex."

of risk. But very few studies take the perspective that children have their own strategies that can promote health and that these strategies can be incorporated in programmes to reduce HIV/AIDS (Kelly et al, 2001). Studies of children should take into account the fact that children in many sub-Saharan African countries have their own experiences with HIV/AIDS and may have their own strategies for dealing with it. A promotive approach to research questions, rather than a risk-avoidance one, may uncover important strategies that can be used in interventions with children. Such studies have become more common in Western countries, where research on topics such as resiliency can be found.

#### **More studies presenting children's own perspectives are needed.**

A limited number of studies presented the opinions of children. All but one of these studies used qualitative methods – usually focus group discussions – indicating the usefulness of such methods in eliciting children's own perspectives, as opposed to the majority of studies on youths' risk and protective behaviours that employ fixed response questionnaires. Thus, more qualitative studies to determine children's perspectives are needed.

#### **Efforts should be made to collect a minimum of data from under-represented countries**

No relevant studies in the literature from Côte d'Ivoire, Senegal, and Sudan. It may be that there are unpublished reports that are not listed in the databases or web sites that were searched. A study with more time and resources may have uncovered such reports through correspondence with agencies, organisations or academic institutions in these countries. However, if we were unable to locate the information easily, it is doubtful if policy makers and other stakeholders would have ready access to it either.

#### **More recent data are needed**

Many of the studies that have been carried out in this area are from the early and late 1990s (Kelly et al, 2001). Given the impact that HIV/AIDS has had on sub-Saharan African culture and society, it would not be valid to rely on these studies of youths' perspectives and strategies for avoiding HIV/AIDS. More studies are needed to see if or how the epidemic has changed the perspectives of children in more recent times.

## II. Concluding Remarks

One of the most important conclusions that can be drawn from this report is that it is vital to strengthen children's self-esteem, their capacity to make decisions for themselves and their ability to think critically around common misconceptions. Children and youths have their own strategies for avoiding undesirable sexual and reproductive health outcomes such as HIV/AIDS and unwanted pregnancies. However, instead of promoting these strategies, adults have focused on the negative aspects of youths' relationships. This is reflected, for example, in the type of sex education that children say they receive, which is perceived to be judgmental and unhelpful. Adults are often the gatekeepers of information for children and youths. If youths are to receive positive messages about sexuality, adults' own capacities to communicate such messages will have to be addressed first.



*It is vital to strengthen children's self-esteem, their capacity to make decisions for themselves and their ability to think critically around common misconceptions.*

Another example of this negative focus that adults have on adolescent sexuality is the overwhelming dominance of studies on transactional and cross-generational sex in the literature. There is no doubt that this is a topic of importance for the field of HIV/AIDS prevention. Indeed, this body of knowledge has allowed us to draw significant conclusions and recommendations for programmes and policies. However, it also seems symbolic that the topic that has received the most attention from the child's perspective is a primarily negative one (or at least it is seen so by many). It would seem that a conceptual shift is necessary both in programmes and research in regards to children's' own evolving capacities and rights to have positive sexual relationships (Lansdown, 2005).

Children have not been consulted and programmes do not take their perspectives into account. Children are not receiving the information they need in order to protect themselves against HIV/AIDS. Such consultations will be necessary if States are to respond to the epidemic.

Another key issue from this study is the need to engage boys and men in order to further the agenda of gender equity. Much of the focus tends to be on teaching girls how to 'just say no.' However, it is clear from this study that this is not enough. Girls engage in transactional relationships for reasons other than love and affection. They also frequently do not feel that they can insist on condom use, particularly if there is some kind of power differential involved. Furthermore, boys are often caught in similarly harmful gender norms such as ideas of masculinity being related to having many sexual partners and initiating sex when one is very young. Frank discussions with both boys and girls about the nature of gender norms and expectations may help youth to understand how and why they act, and what the consequences are for others' health and welfare.

Finally, this study was based on the premise, as embodied in the Convention on the Rights of the Child and other key U.N. documents that children have certain rights in relation to their sexual and reproductive health. Countries that have ratified the Convention have the responsibility to ensure that these rights are upheld. In looking at the results of this study through the lens of these key agreed-upon rights of children, it appears that this has not been achieved in the studied countries. Children have not been consulted on their opinions of what they need, programmes do not take their perspectives into account, and they are not receiving the information they need in order to protect themselves against HIV/AIDS. Such consultations will be necessary if countries are to effectively respond to the epidemic.



## Tell Me More!

## 12. References

- Amuyunzu-Myamongo, M., Biddlecom, A.E., Ouedraogo, C., Woog, V. 2005. Qualitative evidence on children's views of sexual and reproductive health in sub-Saharan Africa. Occasional Report No. 16. New York: The Alan Guttmacher Institute.
- Andersson-Brolin, L. and Radetzky, C. 2002. HIV/AIDS. A review on how HIV/AIDS is addressed within the monitoring process of the UN Convention on the Rights of the Child. Stockholm: Save the Children Sweden.
- Balmer, D.H., Gikundi, E., Billingsley, M.C., Kihuhho, F.G., Kimani, M., Wang'ondou, J., Njoroge, H. 1997. Adolescent knowledge, values, and coping strategies: Implications for health in sub-Saharan Africa. *Journal of Adolescent Health*;21:33-38.
- Bankole, A., Singh, S., Woog, V. and Wulf, D. 2004. Risk and protection. Youth and HIV/AIDS in sub-Saharan Africa. New York: Alan Guttmacher Institute.
- Barker, G. and Ricardo, M. 2005. Young men and the construction of masculinity in sub-Saharan Africa: Implications for HIV/AIDS. *Conflict and Violence*.
- Berhane, F., Berhane, Y., Fantahun, M. 2005. Children's health services utilisation patterns and preferences: Consultation for reproductive health problems and mental stress are less likely. *Ethiopian Journal of Health Development*;19(1):29-36.
- Centerwall, E. and Laack, S, 2004. Young men as equal partners. RFSU, PPAZ and UMATI p. 41.
- Central Statistical Agency [Ethiopia] and ORC Macro. 2006. Ethiopia demographic and health survey 2005". Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.
- Convention on the Rights of the Child, Adopted and opened for signature, ratification and accession by General Assembly 44/25, of 20 November 1989. Entry into force September 2, 1990, in accordance with article 49.
- Committee on the Rights of the Child [CRC] 2003a. General comment No. 3 (2003) HIV/AIDS and the rights of the child. 32nd session, 2003. New York: United Nations.
- Committee on the Rights of the Child [CRC] 2003b, General Comment No. 4: (2003) Adolescent health and development in the context of the convention on the rights of the child. 33rd Session, 2003 New York: United Nations.
- Fetters, T., Mupela, E., Rutenberg, N. 1998. Youth talk about sexuality. A participatory assessment of adolescent sexual and reproductive health in Lusaka, Zambia. Lusaka: Care Zambia and The Population Council.
- Flaherty, A., Kipp, W., Mehangye, I. 2005. 'We want someone with a face of welcome': Ugandan children articulate their family planning needs and priorities. *Tropical Doctor*; 35:4-7.

Forrest, S. 2002. Sex education that works. Sex Education Forum, UK & Annabel Kanabus, AVERT, UK.

Hulton, L.A., Cullen, R., Wamala Khalokho, S. 2000. Perceptions of the risks of sexual activity and their consequences among Ugandan children. *Studies in Family Planning*;31(1):35-46.

Instituto Promundo, 2002. Project h: Working with young men series 21-25.

Joint United Nations Programme on HIV/AIDS [UNAIDS] 2006. 2006 report on the global AIDS epidemic. Geneva: UNAIDS.

Kangara, L.W. 2005. The church, youth and sexuality in Kenya. *Sexuality in Africa Magazine* 2(2):8-10.

Kaufman and Stavron. 2004. 'Bus fare please': the economics of sex and gifts among young people in urban South Africa. *Culture, Health and Sexuality*;6(5):377-391.

Kelly, K., Parker, W., Oyosi, S. 2001. Pathways to action. HIV/AIDS prevention, children and young people in South Africa. A literature review. Lusaka: Save the Children.

Kinsman, J., Nyanzi, S., Pool, R. 2000. Socializing influences and the value of sex: the experience of adolescent school girls in rural Masaka, Uganda. *Culture, Health and Sexuality*; 2(2):151-166.

Lansdown, G. 2005. The evolving capacities of the child. Florence: UNICEF Innocenti Research Centre.

Kontula O., 2004 Bi- and Homosexuality in the National Surveys in Europe. In Digoix M & Festy P (eds): Same sex couple partnerships and homosexual marriages: A focus on cross-national differentials. Documents de travail no 124, Ined 2004.

Lindahl, K. 1995. Sexual and reproductive health rights – in relation to the Cairo conference (ICPD 1994). Stockholm: RFSU.

Lockhart, C. 2002. Kunyenga, 'real sex,' and survival: assessing the risk of HIV infection among urban street boys in Tanzania. *Medical Anthropology Quarterly* 16(3):294-311.

Longfield, K., Glick, A., Waithaka, M., Berman, J. 2002. Cross-generational relationships in Kenya: couples' motivations, risk perception for STIs/HIV and condom use. PSI Working Paper No. 52. Washington, D.C.: Population Sciences International.

Longfield, K. 2004. Rich fools, spare tyres and boyfriends. Partner categories, relationship dynamics and Ivorian women's risk for STIs and HIV. *Culture, Health and Sexuality*; 6(6):483-500.

Luke, N., Kurz, K.M. 2002. Cross-generational and transactional sexual relation sin sub-Saharan Africa: prevalence of behavior and implication for negotiating safer sexual practices. New York: International Center for Reproductive Health and Women.

Nordstedt, J. 2006. Sexuality and Children's Rights Training with Save the Children Sweden. Dalhem: Janne Nordstedt Consulting.

Masatu, M., Kvåle, G., Klepp, K-I. 2003. Frequency and perceived credibility of reported

sources of reproductive health information among primary school adolescents in Arusha, Tanzania. *Scandinavian Journal of Public Health*;31:216-223.

Masatu, M., Ndeki, S., and Mwampambe, R. 2005. Young people's sexual behaviour and knowledge about HIV/AIDS: Life of people living and affected with HIV/AIDS; and community response to HIV/AIDS. Arusha: Centre for Educational Development in Health Arusha (CEDHA).

Mash, Rev. R., Kareithi, R. 2005. Youth and sexuality research ages 12-19 years in the diocese of Cape Town, South Africa. Cape Town: Fikelela AIDS Project.

Maticka-Tyndale, E., Gallant, M., Brouillard-Coyle, C., Holland, D., Metcalfe, K., Wildish, J., Gichuru, M. 2005. The sexual scripts of Kenyan young people and HIV prevention. *Culture, Health & Sexuality*;7(1):27-41.

Nzioka, C. 2004. Unwanted pregnancy and sexually transmitted infections among young women in rural Kenya. *Culture, Health & Sexuality*;6(1):31-44.

Pacific Institute for Women's Health (PIWH). 2002. Youth sexuality. Action research from Burkina Faso and Senegal. Los Angeles.

Pattman, R., Chege, F. 2003a. Finding our voices. Gendered and sexual identities and HIV/AIDS in education. Africa: Young Voices Series No. 1. Nairobi: UNICEF.

Pattman, R., Chege, F. 2003b. "Dear diary I saw an angel, she looked like heaven on earth": sex talk and sex education. *African Journal of AIDS Research*;2(2):99-108.

Peltzer, K. Promtussanon, S. 2003. HIV/AIDS education in South Africa: teacher knowledge about HIV/AIDS: Teacher attitude about and control of HIV/AIDS education. *Social Behavior and Personality*;31(4):349-356.

Population Reference Bureau [PRB] 2006. The world's youth 2006 data sheet. Washington D.C.: PRB.

Pulerwitz, J., Lillie, T., Kiragu, K., Apicella, L., McCauley, A., Nelson, T., Ochieng, S., Mwarogo, P., Kunyanga, E. 2006. ABC messages for HIV prevention in Kenya: clarity and confusion, barriers and facilitators. Paper presented at The 2006 HIV/AIDS Implementers' Meeting of the President's Emergency Plan for AIDS Relief, Durban, South Africa, June 12-15, 2006.

Peel Public Health 2007 Raising Sexually Healthy Children - Sexual Development: What to Expect. July 2007 <http://www.region.peel.on.ca/health/commhlth/parov1yr/develop.htm> (accessed 23/09/2007).

Report on the international conference on population and development 1994 [ICPD 1994]. A/CONF.171/13: Report of the ICPD (94/10/18).

RFSU 2004. Breaking through: A guide to sexual and reproductive health and rights. ICPD – the Foundation for the Millennium Development Goals. Stockholm; Swedish Association for Sexuality Education.

Richter, L. and Rama, S. 2006. Building Resilience: a rights based approach to children and HIV/AIDS in Africa. Focus Africa: Save the Children Sweden.

Ross, D.A., Dick, B., Ferguson, J. (Eds) 2006. Preventing HIV/AIDS in young people. A systematic review of the evidence from developing countries. Geneva: World Health Organisation.

Samelius, L and Wagberg, E. 2005. Sexual orientation and gender identity issues in development. Stockholm: SIDA November, pg. 13.

Save the Children Sweden [SCS]. 2005. Child rights programming. How to apply rights-based approaches to programming. Second edition. Lima: Save the Children Sweden.

Senegal National AIDS Control Council [CNLS] 2002. Meeting the Sexual Health Needs of Men Having Sex With Men in Senegal. Dakar: Institute of Environmental Sciences, UCAD, Population Council Horizon Programme/USAID.

Simpson, A. 2002. "The measure of a man. Boys, young men and dangerous ideologies of masculinity in the time of HIV/AIDS. Stockholm: Save the Children Sweden.

Synergie Banlieue and Save the Children. 2007. Etude de base sur les connaissances attitudes et pratiques des adolescents de Pikine en santé reproductive. Rapport provisoire. Dakar.

Thomsen, S., Lugina, H., Katz, K., Reynolds, H., Johnson, L., Reuben, E., and Kaaya, N. 2006. Voluntary counselling and testing for youth and linkages to other reproductive health services: Risks, perceptions, and needs for youth in Tanzania. YouthNet Working Paper No. 5. Research Triangle Park: Family Health International/YouthNet.

United Nations Children's Fund [UNICEF] 2003. Children: the missing face of AIDS.

United Nations Children's Fund [UNICEF], 2007. Children and AIDS: a stocktaking report. Unite for Children, Unite against AIDS.

United Nations General Assembly Special Session on HIV/AIDS [UNGASS] 2001. Declaration of Commitment on HIV/AIDS.

United Nations Population Fund [UNFPA] and Population Council 2006. Investing when it counts. Generating the evidence base for policies and programmes for very young children. New York: UNFPA.

UNFPA 2005a. Our voice, our future. Young people report on progress made on the UNGASS declaration of commitment on HIV/AIDS.

UNFPA 2005b. Country profiles for population and reproductive health. Policy developments and indicators 2005. Annapolis: UNFPA and PRB.

UNFPA 2003. State of the World's Population 2003. New York: UNFPA.

Webb, D. and Elliott, L. 2000. Learning to live. Monitoring and evaluating HIV/AIDS programmes for young people. London: Save the Children.

WHO 2004. Sexual health – a new focus for WHO. Progress in Reproductive Health Research, No 67. Geneva: UNDP/UNFPA/WHO/World Bank Special Programme for Research, Development and Research Training in Human Reproduction (HRP).

WHO 1998. The second decade. Improving adolescent health and development. Geneva: World Health Organisation, Adolescent Health and Development Programme, Family and Reproductive Health.



## 13. Appendix: Methodology

### Identification of information

Information relevant to the study questions was identified through a systematic review of the databases PubMed, Popline, Google/Scholar and Eric, using keywords 'adolescents/children', 'adolescent health', 'parents', 'sex education', 'HIV prevention/HIV infections', 'qualitative research', 'Africa south of the Sahara', and 'research'. All items published in the last five years on the topic of adolescent sexual and reproductive health that are found in Popline (over 400 references) were also reviewed. In addition, all available issues of several journals such as Medical Anthropology Quarterly, Reproductive Health Matters, and Culture, Health and Sexuality were searched for relevant papers. Authors who were identified as having published works that may contribute to the review were personally contacted. Finally, in order to gain access to non-peer-reviewed reports, the web sites for the following organisations were systematically searched for relevant documents: Advocates for Youth, Africa Regional Sexuality Resource Centre, (U.S.) Centers for Disease Control, Development Gateway, Family Health International/YouthNet, Global Youth Coalition on HIV/AIDS, Ipas, Population Council, Save the Children, The Alan Guttmacher Institute, Uganda DISH, UNAIDS, UNFPA, UNICEF and WHO.

### Study Selection Criteria

The following criteria were used to select studies for review:

- Children's own perspective;
- Children's protective strategies, rather than risk and vulnerability for HIV;
- Children aged 7-19 years (in order to include the studies that use 15-19 as an age group); and
- Research conducted with youths from the seven countries of interest (unless something from the region was of vital importance for children);
- Finally, in order to ensure that the information was relevant for children in sub-Saharan Africa in 2006, we looked at research that was published or conducted in the last ten years.

Using these criteria, the search generated 24 articles/reports, which are summarised in Table 2 (Appendix).

Table 2: Studies selected for inclusion in the literature review

Authors	Year published	Year study conducted	Age range	Population	Countries of study	Method of data collection and sample size	Relevant topics included <sup>17</sup>	Comments
Amuyunzu-Myamongo et al.	2005	2003	14-19	In- and out of school, rural and urban	Burkina Faso Ghana Malawi Uganda <sup>2</sup>	55 Focus group discussions	I, II, IV, V, VI, VII	
Balmer et al	1997	?	12-22	In- and out of school.	Kenya (Nairobi)	Group discussions held over 6-month period (n=216)	I	Impossible to separate out results for children.
Berhane et al	2005	2000	10-24 (89% 15-19)	In-school	Ethiopia (Addis Ababa)	Self-administered survey (n=2,656)	II	
Ethiopia	2007	2005	Youth: 14-19	In-school +Parents	Ethiopia (Addis Ababa)	2 focus group discussions In-depth interviews (8 youth, 4 mothers)	I, IV	
Fetters et al	1998	1996-1997	10-19	In- and out of school	Zambia	Participatory Learning for Action (including focus groups) +Survey (n=1,634)	I, II, VI, VII	

<sup>17</sup> I – Children’s strategies of protection against HIV/AIDS

II- Children’s perceptions of sexual and reproductive health services.

III- Children’s perceptions of in-school HIV-preventative education.

IV- Children’s perceptions of community-based HIV-preventative education.

V- Children’s perceptions of HIV education in the media.

VI – Children’s perceptions of transactional sex and sugar daddies.

Authors	Year published	Year study conducted	Age range	Population	Countries of study	Method of data collection and sample size	Relevant topics included <sup>17</sup>	Comments
Flaherty et al	2005	?	females 14-20 males 15-18	Rural and semi-urban secondary schools	Western Uganda	4 Focus group discussions	II	
Hulton et al	2000	1997	17-18	In- and out of school.	Eastern Uganda	12 focus group discussions	VII	
Kangara	2005	2004?	Adolescents	Church-going boys and girls + pastors	Kenya	2 focus group discussions; 3 interviews with pastors/church leaders	IV	
Kinsman et al	2000	?	14-17	Secondary school girls	Uganda (Masaka district)	Role plays, 3 focus group discussions, one-on-one interviews	III, VII	
Lockhart	2002	1997-1998	8-20	Street boys	Mwanza, Tanzania	Semi-structured interviews (n=75)	VIII	

Authors	Year published	Year study conducted	Age range	Population	Countries of study	Method of data collection and sample size	Relevant topics included <sup>17</sup>	Comments
Longfield et al	2002	2000	15-19	Sexually active rural/urban/out-of-school females	Kenya	8 focus group discussions	VI	
Luke and Kurtz	2002	1983(?) - 2002	10-26	Girls and young women	Sub-Saharan Africa	45 qualitative and quantitative studies	I, VI	Literature review of transactional and cross-generational sex
Masatu et al	2003	1998	11-19	Secondary school pupils	Tanzania (Arusha)	Self-administered survey (n=1,247)	V	
Masatu et al	2005	2004	“adolescents and youth”	Attend secondary school	Tanzania	Focus group discussions (n=?)	I, VII	Combined adolescents’ responses with community actors and women aged 20-30. Hard to separate out adolescents’ responses.
Mash and Kareithi	2005	2004-2005	12-19	Attend Anglican church.	South Africa (Cape Town diocese)	Survey (n=1,306)	I, III, IV, VII	

Authors	Year published	Year study conducted	Age range	Population	Countries of study	Method of data collection and sample size	Relevant topics included	Comments
Maticka-Tyndale et al	2005	2002	11-16	Primary school.	Kenya (Rift Valley and Nyanza)	28 single-sex focus group discussions	I, VI	Looked at the “scripts” that young people follow when initiating sexual encounters
Mbugua	2007	1996 and 2003	Adolescents	Fourth-form female students and secondary school teachers	Kenya	In-depth interviews <sup>18</sup> (10 in 1996 and 4 in 2003) with teachers. Focus groups (3 in 1996 and 1 in 2003) with students	III	Also interviewed mothers of female students
Nzioka	2004	2000	15-19	In-school girls	Eastern Kenya	8 focus group discussions	I	
Pacific Institute for Women's Health (PIWH)	2002	1999-2001	12-20	Adolescents' parents	Senegal (Dakar and Pikine)	? focus group discussions, 822 adult interviews	I, II, III	Combined adolescents' responses with community actors and women aged 20-30. Hard to separate out adolescents' responses.
Pattman and Chege	2003a	2001	10-18 (6-18 in Zambia)	In- and out-of school	Botswana, Kenya, South Africa, Tanzania, Rwanda, Zambia, Zimbabwe	In-depth interviews <sup>18</sup> (n=191), 28 focus group discussions, observations, diaries	I, III, IV, VI	

<sup>18</sup> These numbers are approximate. Exact sample sizes not available in report.

Authors	Year published	Year study conducted	Age range	Population	Countries of study	Method of data collection and sample size	Relevant topics included <sup>17</sup>	Comments
Peltzer and Promtussananon	2003	2002	21-61	Secondary school teachers	South Africa	Self-administered survey	III	
Pulerwitz et al	2006	2004	13-19	In-school	Kenya (Nakuru)	8 focus group discussions	VII	
Synergie Banlieue and Save the Children Sweden	2007	2005	10-19	Boys + girls + parents + teachers	Senegal (Dakar)	Survey (n=529), 8 focus groups with children; 2 with parents; 2 with teachers	I, III, VII	
Thomsen et al	2006	2004	15-17	VCT and RH clinic attending boys and girls	Tanzania (Dar es Salaam)	Surveys (n=100)	I, VII	Subset of data on 719 youth aged 15-24





**FOCUS AFRICA**  
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Focus Africa is a collaborative initiative among Save the Children Sweden's three regional offices in Africa and the Head Office in Stockholm. The aims of the initiative are to enhance awareness among people in Sweden regarding the situation of children living in Africa, increase advocacy on children's rights in Africa and Sweden and to build Save the Children's own capacity through experience- and knowledge-sharing among the three African regional offices.

Focus Africa has four thematic areas of focus: HIV/AIDS, children in armed conflict and disasters, child poverty and The African Charter on the Rights and Welfare of the Child. The initiative cooperates with local partners and organisations in order to strengthen civil society and achieve lasting improvements in children's lives.

Lasting change must come from within, not from outside.

**For further information contact:**

**Riksförbundet för sexuell upplysning**

The Swedish Association for  
Sexuality Education  
Box 433 I  
102 67 Stockholm Sweden  
Tel: +46 8 692 07 00  
info@rfsu.se, www.rfsu.se

**Save the Children Sweden**

SE- 107 88 Stockholm, Sweden  
Phone: +46 8 698 90 00  
info@rb.se, www.rb.se

**Save the Children Sweden**

Southern Africa Regional Office  
SAQA House, Floor 3  
1067 Arcadia Street  
Pretoria, South Africa  
Phone: +27 12 342 0222  
postmaster@za.rb.se

**Save the Children Sweden**

Eastern and Central Africa  
Regional Office  
Box 19423  
202 KNH- Nairobi, Kenya  
Phone: +254 20 386 5888  
info@ecaf.savethechildren.se

**Save the Children Suède**

West africa Regional Office  
BP 25934  
Dakar- Fann  
Senegal  
Phone: +221 33 869 18 00  
savedakar@orange.sn



**Save the Children**  
Sweden