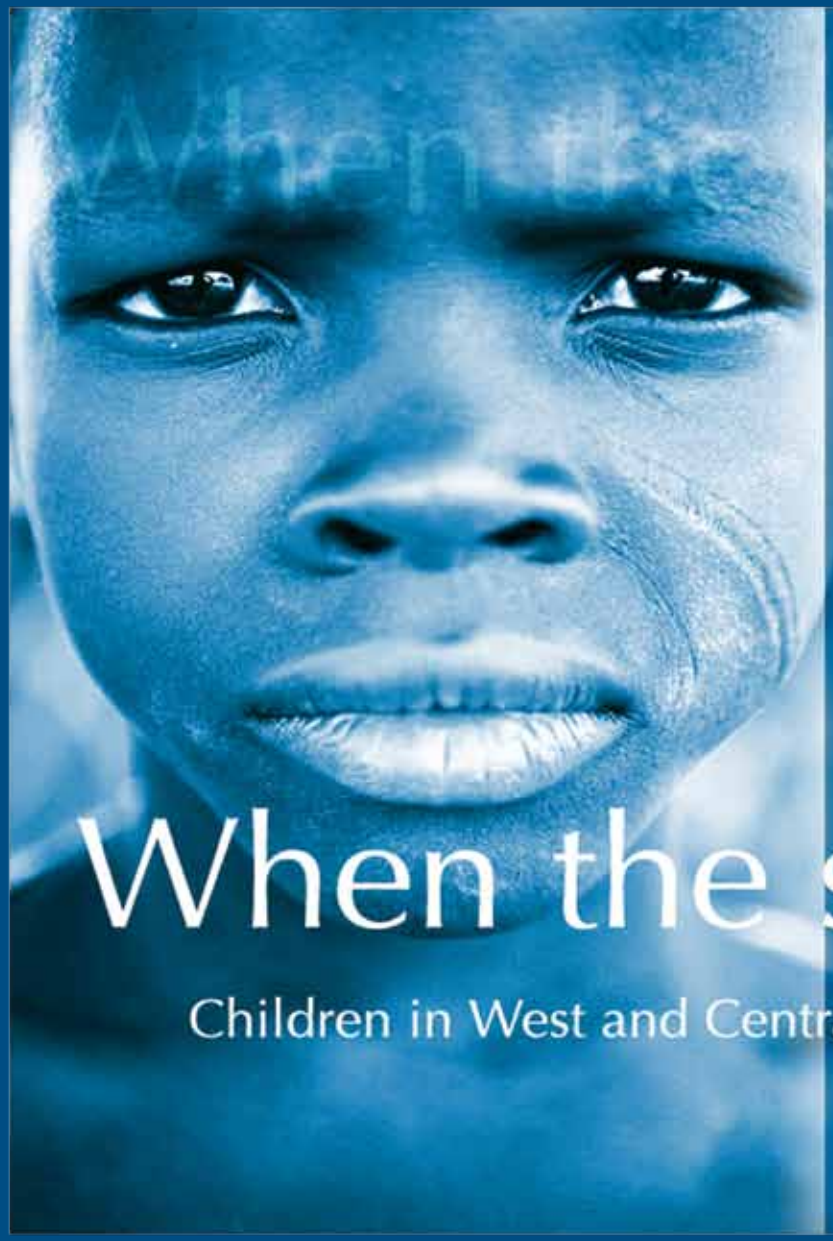

When the safety net fails

Children in West and Central Africa and the risk of HIV infection

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Children affected by HIV

"Know your epidemic and know your response" has been the mantra of HIV prevention since the publication of the guidelines by UNAIDS (UNAIDS 2007). In West and Central Africa, the profile of HIV epidemics is complex and confusing. In some communities the prevalence of HIV infection is very low. Others are experiencing a generalised epidemic at intermediate, some at very high levels. In some places HIV infection is clearly concentrated among identifiable social groups. In others there is a mixed pattern that does not seem to fit into any epidemiological model.

Where the model does not fit, a standard response is inappropriate.

HIV prevention among children and young people has been a mainstay of AIDS programming since the early 1990s. Much later, programmes for the treatment and social support of infected and orphaned children gained enormously in profile; if not in financial terms, then at least in the international rhetoric.

But children are not a homogenous group of small persons.

In the complex HIV epidemics in West and Central Africa, there are huge differences amongchildren in terms of their vulnerability to HIV infection and in terms of their access to effective HIV prevention, testing and counselling services and antiretroviral therapy.

Between January 2007 to June 2008, we conducted a study on the psychosocial needs of children and adolescents exposed to extremely difficult circumstances in Burkina Faso, Liberia, Sierra Leone, Togo, and Cameroon. It explored the psychosocial impact of trafficking, war, HIV and other particular high risk contexts. The main findings of this study are published in the booklet 'Silent Suffering – The psychosocial impact of war, HIV and other high risk situations on girls and boys in West and Central Africa' . But the study also showed us how children become vulnerable to HIV due to high rates of sexual violence and exploitation in situations of (post) war, trafficking and displacement. It illustrated how continued violence in their homes and communities diminishes their resilience. And how diminished resilience leads to risky behaviours increasing their vulnerability to HIV and other sexually transmitted diseases. In order to share these results, we decided to write up another publication to advocate for collective action on behalf of thousands of children particularly vulnerable to HIV.

These children and countless others in similar situations have received little attention in HIV responses. The standard school-based or population-based HIV awareness and education programmes neither reach them nor correspond to their particular needs. Only very recently has the international community awoken to the fact that "children affected by HIV" also includes a large number of children who, for a variety of reasons are particularly vulnerable to HIV infection (UNICEF 2008).

Available at Plan West Africa and Family Health International

About this publication

This publication is about these children. “Know your response” means knowing who is vulnerable to HIV infection and providing services to mitigate this vulnerability and to assist those who have already acquired HIV. To explore this, we spoke to more than 1,000 children and adolescents aged 8 to 20 years living in communities severely affected by war and displacement, child trafficking, or high HIV mortality - communities in which the social safety net had been severely disrupted. We enquired about their mental health and their difficult and joyful life experiences . The detailed study reports are available with Plan West Africa .

The results of our “Psychosocial Support Study” are heart wrenching. We heard story after story of severe abuse and neglect, of children who had lost the protection of their families and their communities. We talked to children who felt lonely, depressed, and excluded. Many of them were suicidal. In this publication we summarise how the experience of these children relates to their vulnerability to HIV infection – how they have become children affected by HIV. We offer recommendations for appropriate psychosocial support services to decrease their vulnerability.

The study was carried out by Plan in collaboration with the USAID-funded AWARE HIV/AIDS project of Family Health International.
See appendix 4 for references of the full length country reports.
They can also be downloaded under
www.crin.org/email/crinmail_detail.asp?crinmailID=2915

Objectives and methods of the study

Background and objectives

The HIV epidemic and the international concern about orphans have contributed to exposing the plight of children in West and Central Africa who are living on the streets, who are trafficked and/or exploited for child labour, or who are forced into combat in armed conflicts. The impact of these difficult life circumstances on the psychosocial well-being of children and the quality of existing services, however, have barely been investigated. This is why we decided to explore how children are affected, in what context and what practices exist to assist them.

The overall aims of the study were to improve the offer of psychosocial support services for children in West and Central Africa and to stimulate the creation of a network of services providers. The specific objectives were to:

- assess the mental health and psychosocial needs of children in different study sites,
- analyze the existing institutions which provide psychosocial support to children in the region,
- identify best practices and lessons learnt in the field and
- make recommendations for strengthening psychosocial support programming in the region.

A case control sample approach

Our interest was to investigate the psychosocial impact of different high risk situations in West and Central Africa such as trafficking, ethnic cleansing, armed conflict or parental loss. We short listed areas that were known to be particularly affected by one particular context and opted for the following sites:

- child trafficking for labour in Togo,
- children expelled for ethnic reasons from Cote d’Ivoire in Burkina Faso,
- loss of parents in an area with a high HIV rate in Cameroon,
- growing up without parental support in post-conflict Sierra Leone and
- former association with the fighting forces in Liberia.

In addition to these specific experiences, we assessed domestic and sexual violence in each of the study countries.

We used a matched case-control study design to investigate differences in psychosocial needs of children exposed to the high risk context (for example trafficked children in Togo or former child soldiers in Liberia) compared to a control sample of the same size - children who had never exposed

to this particular high risk context (never been involved in trafficking, no former association with fighting forces etc.). The exposure sample was matched with the control group according to age, sex and education.

Samples

We interviewed between 180 to 220 children and youths per country (90 – 110 subjects in the exposure and control sample respectively). The total number interviewed per country and the numbers of boys and girls are displayed in the figure below .

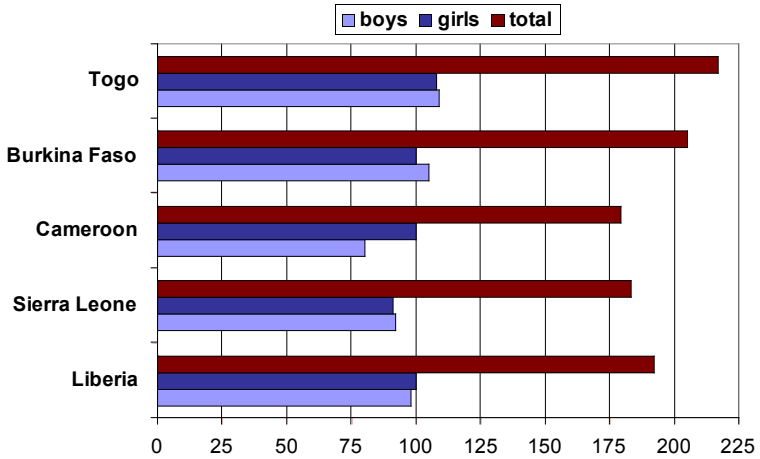


Figure 1: number of interviewed subjects per country

All per cent figures cited in later sections of this report use for calculations the denominator of the (sub-) sample of the respective study country.

Children were the only source of information for this study. For future studies, we recommend including interviews with family members and community workers in order to diversify the sources.

Preparation of data collection and tools

Before starting the field work, we presented the project to government authorities for ethical clearance and engaged highly-qualified local research teams. Basic recruitment criteria for the teams were experience in working with children, a university degree in clinical psychology - or an equivalent qualification in mental health - and fluency in vernacular languages of the study site.
Our research teams received three weeks training and preparation for their work with the children. This included an introduction to child and youth psychopathology, resilience, core mental disorder of children and youth as well as the discussion, adaptation and translation of the research tools. We used the following methods for data collection:

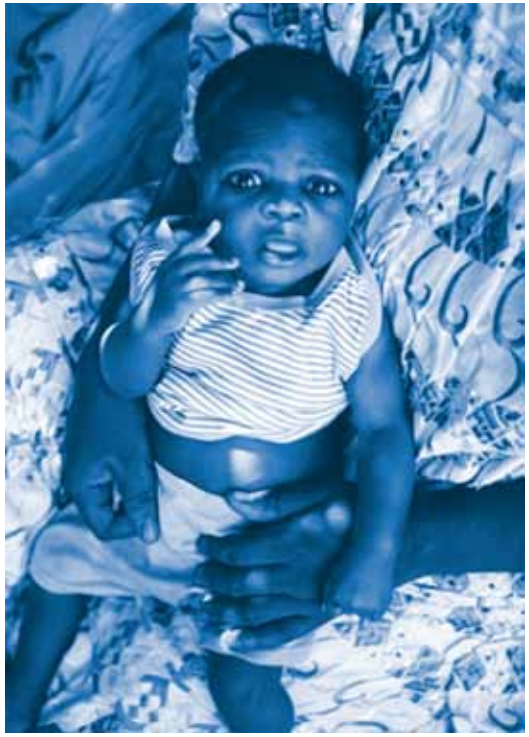
- focus group discussions,
- individual interviews,
- case studies and
- observations during the stays in the communities.

After the trainings, we carried out a pre-test of tools and field approach.
Most of our tools were developed in western cultural settings. We were aware that assessing mental health in West Africa with 'western' tools would be a delicate issue. However, when faced with disaster, children's experience of terror and helplessness is the same, wherever they are in the world. We took care to develop an assessment kit that mixed standardised questionnaires with highly participative exercises that would allow children to express their ideas and feelings freely. And we compared the responses of the exposed, or the "at-risk group", not to any set of western 'norms', but to the responses of a control group from the same society. Detailed information on the tools and recruitment of study participants is provided in appendix 2.

Support to severely affected children

Many of the participating children were in need of immediate assistance when we met them in their communities: they were subjected to life-threatening physical mistreatment and neglect or exposed to sexual abuse and exploitation. Many of these children were on the edge of committing suicide. Due to lack

of referral possibilities, we initiated a sub-project to provide assistance to all interviewed children in need of urgent help. After the data collection, our research teams were transformed into mobile psychosocial support units and remained in the field for several additional months.
They engaged the children in activities such as counselling and trauma healing, suicide prevention, traditional healing practices including fairy tales sessions and family mediations. The mobile units also offered medical and social assistance (e.g. support for school/ apprenticeship equipment and fees).
After the period of individual assistance, the children were followed up by the Social Affairs Department or local NGOs.



Traumatised children

Four common traumatic experiences increase the vulnerability of West and Central African children and adolescents to HIV:

- Living through armed conflict and in post-conflict situations
- Being trafficked
- Experiencing domestic violence
- Experiencing sexual violence

These four types of experience have a direct and an indirect relationship to HIV vulnerability:

- As a direct cause they place young persons in situations that increase the risk of sexual contact (whether voluntary or coerced) by removing their physical, social or economic protection.
- As an indirect cause they result in impaired mental and emotional health. Children who have low self esteem, who are severely depressed or who are in a constant state of high anxiety may try to escape their suffering through drugs, running away from home, or engaging in transactional sex. Their strategy of escape increases their risk of exposure to HIV infection.

Conflict and post-conflict experiences

Girls formerly involved with fighting forces in Liberia and Sierra Leone frequently started to engage in transactional sex after the war.
The majority of children we interviewed in Sierra Leone and Liberia had been severely traumatised by the experience of war. They had witnessed murder and rape, had lost loved ones, or had themselves participated in the fighting. All of the youngpeople exposed to this type of severe trauma showed signs of long-term mental health impairment.
The children's contact with armed conflict was also associated with high levels of sexual violence. Many of the children interviewed had experienced rape, gang rape, forced prostitution or sexual slavery. In Liberia, more than 60 percent of girls and almost 15 percent of boys formerly associated with the fighting forces had suffered sexual violence. Many girls had been raped at a very young age, often pre-puberty. These girls were emotionally highly vulnerable. After the war, they were more likely to engage in risk-taking sexual behaviours such as transactional sex.

Liberian girl, 18 years (captured by rebel fighters at age 11)
"I had no alternative but to go with the rebels. I used to be the sex partner of many. They all wanted me as their wife. I was given drugs in order to be brave and to continue obeying them. I stayed with them for 13 months. One day, when we went for another attack, we fell into the hands of government troops. They captured me and this time they forced me to live with them as their sex-mate."
She was freed during the disarmament process, but as her parents were killed during the war, she had no one to look after her and is still at risk: "Sometimes I go with men and they give me money or food for that. I often feel like an outcast and think about killing myself."

Even in refugee camps, their risks were not diminished. Almost a third of the Liberian and Sierra Leonean girls who had lived in refugee camps in Guinea said they had had sex with camp workers in return for money, clothes, food or material for shelter.

Child trafficking

Among the girls we interviewed in Togo who had been trafficked, 33 percent had been raped and 18 percent had been forced into prostitution during their time away from home.

In some regions of Togo, child trafficking is imbedded in a culture of migration. Children commonly leave home for the cities or for neighbouring countries to work as domestic servants, farm labourers or in markets or restaurants. Families are approached by intermediaries pretending to act in the child's best interest. Many children simply disappear from school and never come back, or return severely physically or emotionally harmed.

We interviewed young people in Togo who had worked as trafficked child labourers abroad. More than 90 percent of the girls and 40 percent of the boys had experienced physical violence during the time of trafficking. The experience of sexual violence among these girls was considerably more common than among their non-trafficked peers. While abroad, the girls were isolated from their community and family support structures. They were at a high risk of acquiring sexually transmitted infections, including HIV.

In some communities, it is part of the tradition to send girls away to gain their dowries. If they come back empty handed, pregnant or with a child, they disgrace their family.

Many who were sexually abused during their stay abroad are ostracised by their family and community when they return.

Togolese girl, 13 years (trafficked at age 11 to work as a domestic servant)

"One night I was sleeping and suddenly I heard someone come into my room. I woke up and there was my mistress's son who wanted to sleep with me. He forced me, and all I could do was to push him away, screaming all the time. It was only when my mistress arrived that he got off me and went back to bed."

Violence in the homes

More than 80 percent of the children in our five-country study had experienced physical abuse, verbal abuse or neglect in their homes.

Our study revealed alarmingly high rates of domestic violence in all five countries. More than 80 percent of the children we interviewed, boys and girls alike, had experienced physical or verbal abuse or neglect in their homes. Many of them had been subjected to all three forms at once, as shown in the figure from our study report in Liberia below. In those countries that had not recently experienced war (Cameroon, Togo and Burkina Faso), domestic violence emerged as the major factor making girls vulnerable to HIV infection. Some of the girls who suffered severe neglect told us that they resorted to transactional sex in order to pay their school fees or to meet basic needs for food and clothing. But the main effect of domestic violence on vulnerability to HIV infection is through the low self esteem and high levels of anxiety and depression that it generates in abused children. Children become vulnerable when they try to escape their suffering through risky behaviours such as drug abuse, sleeping in the street or staying with complete strangers

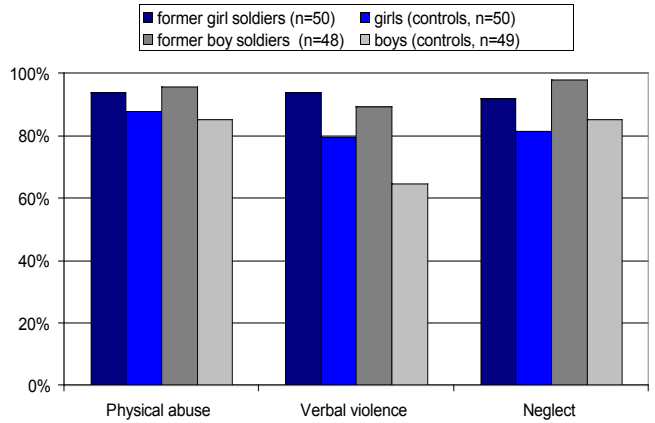


Figure 1: Life-time exposure to different types of violence in the exposure and control group disaggregated by sex

The main forms of domestic violence assessed were:

- Physical violence – being punched, kicked or slapped in the face, being tied up or locked up, being burned deliberately with hot water or cigarettes, being hit with belts, whips or sticks, resulting in broken limbs, burns or cuts that were often left untreated.
- Verbal abuse – repeated insults, demeaning remarks or threats, including threats of death.
- Neglect – withholding food, drink or clothing and being ignored. Neglect was particularly often mentioned by children who were fostered by relatives.

Cameroonian boy, 15 years

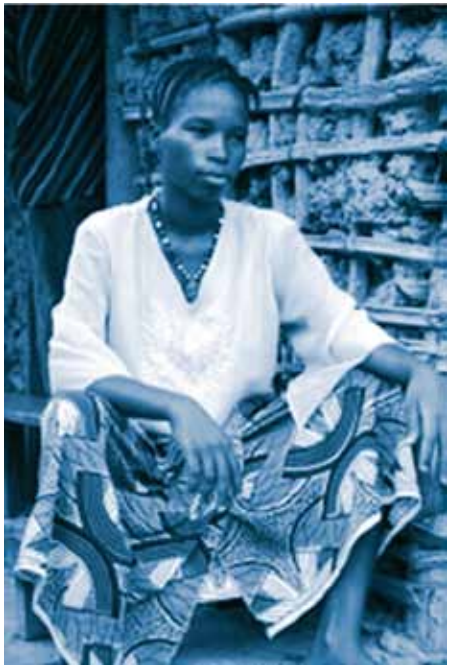
"My uncle came back one afternoon and met me sleeping. He started beating me up because he thought that I refused to go to the farm whereas I was sick. I succeeded to escape from the room and he picked up a machete and started chasing me with it, shouting that he was going to kill me. I ran and succeeded to escape from him. That night I slept in the bush because I was so afraid."

Sexual violence

In Togo, more than 60 percent of the girls and 25 percent of the boys reported that they had been sexually abused at least once in their lifetime.

Sexual violence increases the risk of HIV infection directly and indirectly. It exposes children to the virus and it inflicts long-lasting psychological harm, sometimes leading to risk-taking behaviour later in life.The experience of sexual abuse was related to us by girls and boys, but far more commonly by girls.

Many girls, and some boys, cited sexual violence as the most terrifying experience of their lives. It was most common during times of conflict and in post-conflict periods. But it was not unique to situations of conflict. In Togo, for instance, more than 60 per cent of the girls and 25 per cent of the boys reported that they had been sexually abused at least once in their lifetime. In Cameroon, the proportion was 21 percent for girls and 5 percent for boys. As highlighted in the figure below, the samples are small and 50% out of 100 does not necessarily mean 50% out of 2000. Much bigger, longitudinal studies will be needed to establish whether or not our findings are more generally applicable. Nonetheless, we deliberately didn't choose children to prove a case - and from this one might infer that the experiences the children describe might not be restricted to them alone.



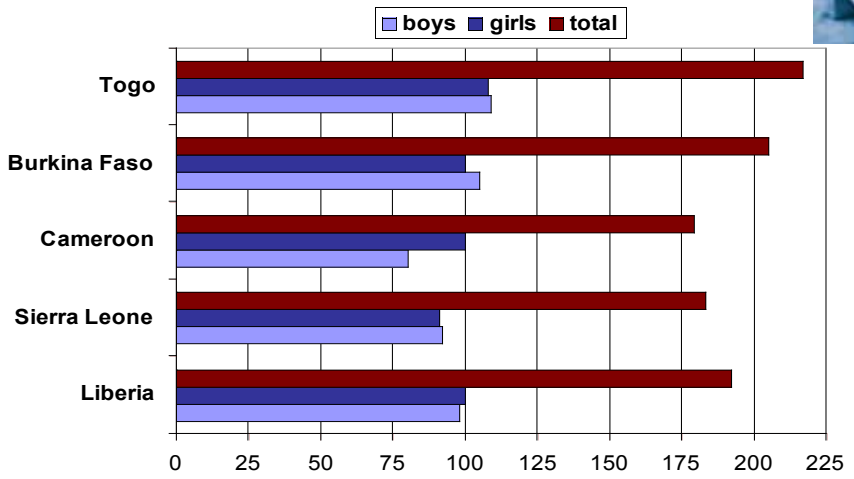


Figure 2: Rates of sexual abuse in the five countries disaggregated by sex

Sexual abuse is defined as either being raped or being touched against one's will in an intimate body part by a much older person. It does not include transactional sex.

husband. In other cases, girls were given in marriage to the abuser in order to preserve the family honour. For boys, the event was hushed up because of the double stigma of sexual abuse and same sex intercourse. The long-term effects of sexual abuse among girls included early sexualisation and an increased likelihood of engaging in risk-taking sexual behaviour in the future. The taboos to talk about sexual abuse among boys are so strong that little is known about the long-term consequences. While assistance for sexually abused girls in the countries studied was grossly insufficient, there was none available for boys. Further research into the consequences of sexual abuse among boys is needed in order to develop strategies to assist them.

Togolese girl, 17 years

My life entirely changed when I was 15. At that time, a young man from our neighbourhood forced me to make love to him. He asked one of my brothers to send me over pretending that he would like me to buy some things for him. When I arrived, he was in his room and asked me to enter. But when I entered, he closed the door and forced me to sleep with him. I tried to defend myself with all my strengths and
I screamed, but no one came to help me. After this incident, my way of doing things has changed. I did not tell my grandmother and she doesn't understand why I changed. Since this happens, she beats me more often for small things, for example, when she was talking to me and I did not pick up quickly what she wanted. She hits me with a stick or a spatula. She throws things at me, plates, small stones and several times her torch."

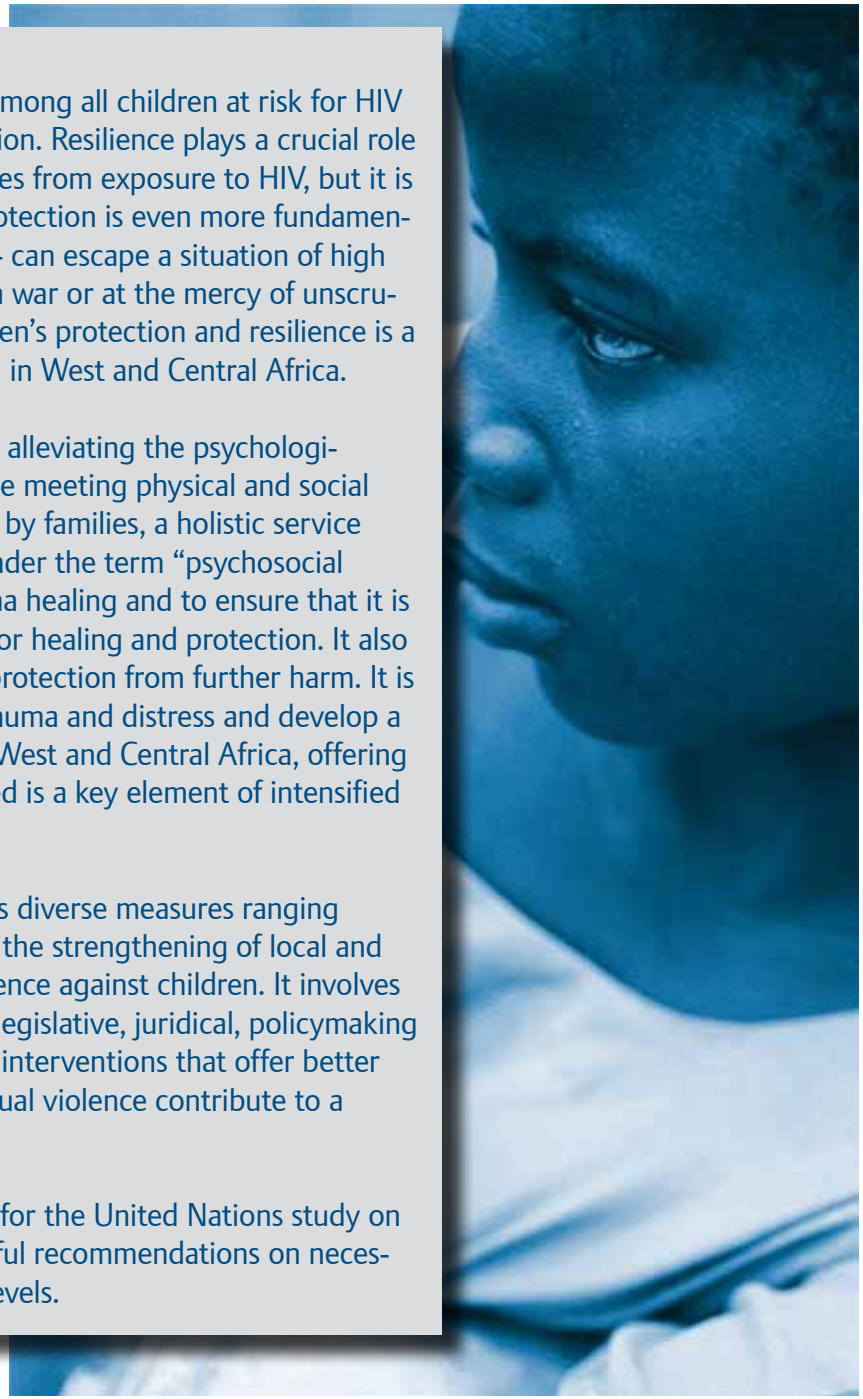
Risk, resilience and protection

We identified two key commonalities among all children at risk for HIV infection: lack of resilience and protection. Resilience plays a crucial role in helping children to protect themselves from exposure to HIV, but it is easily eroded by trauma and abuse. Protection is even more fundamental: no child – whether resilient or not - can escape a situation of high risk for HIV infection if caught amidst a war or at the mercy of unscrupulous traffickers. Strengthening children's protection and resilience is a priority for appropriate HIV prevention in West and Central Africa.

Strengthening resilience is achieved by alleviating the psychological effects of trauma and suffering while meeting physical and social needs. Where these needs are not met by families, a holistic service programme is required, summarised under the term "psychosocial support". It includes counselling, trauma healing and to ensure that it is locally adapted also traditional rituals for healing and protection. It also includes shelter, food, education, and protection from further harm. It is aimed at helping children overcome trauma and distress and develop a sense of belonging, trust and hope. In West and Central Africa, offering psychosocial support to children in need is a key element of intensified HIV prevention.

Protecting children from abuse requires diverse measures ranging from prevention to peace building and the strengthening of local and international commitments to end violence against children. It involves multifaceted actions in administrative, legislative, juridical, policymaking and institutional functions. All types of interventions that offer better protection from trauma, abuse and sexual violence contribute to a better HIV prevention.

The Report of the independent Expert for the United Nations study on violence against children provides useful recommendations on necessary protection measures at different levels.



The gender dimension of childhood trauma

Experiences of boys

Overall, boys and girls experienced similar levels of trauma. However, the boys we interviewed were often more likely than girls to have experienced verbal and physical abuse, including being kicked, hit with an object, tied up or threatened with death, and they were more often exposed to life-threatening events. In Burkina Faso, for instance, 35 percent of the boys reported that they had had objects thrown at them and 16 per cent that they had been wounded with a weapon. In countries experiencing conflict, boys who had been involved with combatants experienced particularly high levels of trauma, often in the context of their own participation in armed combat or in the massacre of civilians.

Sexual abuse was considerably more common among girls, but a significant proportion of boys also reported that they had been abused, particularly during conflict situations. In Liberia, where 8 percent of boys reported that they had been raped, all but one of these instances had taken place during the war.

Among boys who had been trafficked, the risk of domestic or sexual violence was considerably lower than among girls. But there was a much higher risk of becoming involved in substance abuse, affecting one in 10 of those we interviewed. Boys were also more likely to develop conduct disorders, stealing, vandalising or brutalising others, endangering themselves and those around them.

The direct risk of exposure to HIV infection among this group of traumatised boys is not as high as it is among girls. The risk arises through the long-term consequences of impaired socialisation and dysfunctional coping mechanisms employed by these boys to relieve their own suffering in the absence of any form of external assistance.

Sierra Leonean boy, 17 years (7 years when his father was killed)

"I was a very small boy when the RUF attacked my village in the early morning hours. My parents took me to Foya in Liberia. After a year, NPFL rebels violently invaded the town. They killed my father in a big ceremony and ate his raw body. My mother escaped that night and went into hiding. I was left in the bush. When she came to search for me the next day, she was taken away by rebels and made a bush wife. She moved with me later to Guinea to Fallango camp in Nongoa. A few years later, she was killed by rebels in Guinea. No one cares about me now and I have no family left."

Experiences of girls

Girls are exposed to the same childhood trauma as boys, but there are two important differences: their increased exposure to sexual violence and exploitation, and their reduced ability to take control of their lives because of their status in society.

Girls are on the lowest level of communities' hierarchies. They have few possibilities to take charge of their lives in order to escape distressing or harmful situations. After they have experienced sexual abuse, they are more likely to be stigmatised and blamed by the community. Their family and community, who are supposed to be their main source of protection, may force them into an early unwanted marriage or subject them to harmful practices such as female genital cutting.

Trying to escape from this institutionalised violence brings the girls into even more precarious situations. They run away from home or engage in transactional sex in order to survive on their own.

The following factors make girls in West and Central Africa disproportionately more vulnerable to HIV infection:

- Exposure to sexual violence – Girls are more likely to be sexually abused than boys. This abuse is common and occurs in many different situations.
- Lack of protection – Girls trying to escape violence in their own home or community have few, if any, means to take charge of their lives. They become ready victims of child traffickers or sexual predators.
- Unsupported motherhood – Young girls in West and Central Africa who become pregnant have to leave school communities. With no skills and no family support, trading sex may become their only option. If they are unmarried, they may be ostracised by their families.
- Impaired mental health– The girls we interviewed in our study suffered particularly high levels of anxiety, depression, post-traumatic stress and poor self-esteem. This is likely to affect their ability for self-care and self-preservation as discussed in the next chapter

See www.unviolencestudy.org

Burkinabe girl suffering from major depressive disorder, 17 years

"I am going to school and to church. But this is not hindering me from thinking that life has no meaning. After the separation of my parents, the crisis in Cote d'Ivoire, the death of my mother, followed by the death of my father five months later, the death of my grandfather two years later and my current living conditions...it is too hard. I feel like crying when I think about my future. I can't finish my food any more; I have no appetite. I have lost a lot of weight. I can't sleep, I wake up during the night and in the morning, I can't get up. I am tired all the time. My grades have fallen and I failed my last exam. I feel worthless. I feel guilty about the death of my parents and I would like to die like them."

Revolutionary United Front, a rebel formation
National Patriotic Front of Liberia led by Charles Taylor

Transactional sex

In all West and Central African countries, the highest prevalence of HIV infection is found among female sex workers. In Togo, for instance, the estimated HIV prevalence among adults is 3.3 percent, while 29.3 percent of female sex workers are estimated to be living with HIV (UNAIDS 2008).

Most of the girls and young women who sell sexual favours can hardly be called "sex workers". They trade sex for money, food, or clothing when the opportunity arises, in order to survive, in order to escape a distressing situation in their home, in order to be able to feed their children, or in order to find a husband. This is what we call "transactional sex".

Whatever their reason, for offering sex against compensation, this common coping strategy of girls who have suffered childhood trauma places them at very high risk for acquiring HIV infection.

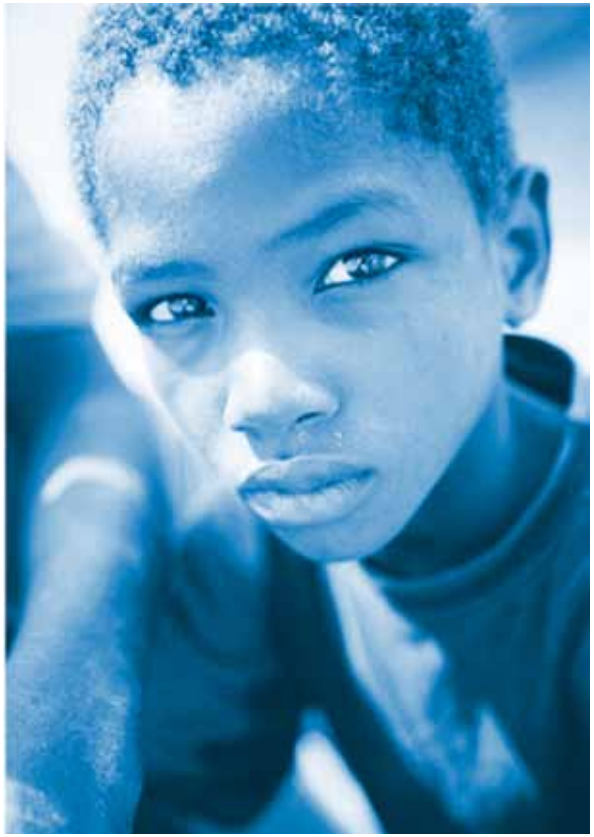
The impact of childhood trauma on mental health

Traumatic experiences in childhood result in impaired mental health and low self-esteem. In Sierra Leone more than 40 percent of children we interviewed were at high risk of suicide.

Many of the children in our study showed signs of poor mental health, impaired development and low self-esteem as a result of the violence, abuse, discrimination and exploitation they had experienced.
Poor mental health and low self-esteem weaken a young person's resilience, making them more vulnerable to HIV infection.
We found that children living in communities recovering from long periods of civil war had particularly high levels of mental health problems. For example, in Sierra Leone more than 40 percent and in Liberia about 20 percent of all interviewed children had made recent suicide attempts and/or had planned how they would do so. Among those who had lost their parents during the war, 65 percent were actively suicidal.
The mental disorders we most frequently identified among the children included chronic depression, post-traumatic stress disorder, and conduct disorders. However, the specific forms and levels of impairment and distress varied considerably from one community to the next – a fact that highlights the importance of locally specific knowledge in advocacy and programming.
We also found that children living with vulnerable or marginalised caregivers were particularly likely to have mental or emotional problems. This group included children living with parents or foster parents who were infirm, had mental health problems, were selling sex, or were living in abject poverty.

Childhood trauma	Experience of war, trafficking, domestic violence, or sexual abuse
Mental and emotional problems	Conduct disorders, depression, post-traumatic stress disorders, low self esteem
Behavioural manifestations	Suicide attempts, dropping out of school, isolation and exclusion, violence towards others
Increased vulnerability to HIV infection	Spending extensive periods on the street, substance abuse, running away from home, coming in conflict with the law, selling sex, becoming a target for child trafficking, engaging in sexual violence

Cameroonian boy, age 11
"I have very few friends, and even they often reject me since I lost one leg in an accident. Since the death of my parents, I am maltreated by my aunt. What frustrates me most is her refusal to let me see my brothers and sisters. They are my only family and the only people with any love for me. To my aunt, I am nothing. I often think about killing myself – I just don't see how my life could get better."



Community responses

Communities play a vital role in the support of children who are at risk of HIV infection. But they often lack information, capacity and resources. We want to see community groups receiving the necessary support to ensure that their responses meet the needs of the most vulnerable children.

Communities and families provide most of the support to children in need through informal family and social networks and through traditional structures and local groups. The vast majority of children in need are supported entirely with resources mobilised within communities without any international or government assistance. This has been well documented (Foster 2005). Although international support for HIV programmes has more than doubled since this report was published, we found that the situation of "the poor helping the destitute" described by Foster had not changed substantively in the communities we studied.

Community responses we observed during our study varied from community to community but commonly included:

- **Family support:** extended families provide an important form of support to vulnerable children – particularly grandparents, but also aunts, uncles, brothers, sisters, or others who are part of the wider family but who may not be blood relatives (for example, the sister of a girlfriend of the child's father).

- **Traditional rituals:** community members often perform ceremonies to comfort individuals, to make them strong for challenges ahead or to protect them from harm. In North Western Cameroon, families share special meals, create memorials, or engage traditional healers to perform rituals to help children overcome the loss of a parent. In some parts of Sierra Leone and Liberia, families organize a rite to facilitate the passage of the deceased to the other side of the "river". Some families in Togo arrange protective rites before sending the children away with a trafficker including elements like prayers and blessings, conferring of supernatural powers to the child, animal sacrifices or the consultation of ancestral spirits.

- **Traditional laws**: most social and family matters in West and Central African societies are settled by chiefs and traditional courts rather than by the formal court system. They include matters of inheritance and the allocation of responsibility for the care of children.

- **Community- and religious groups:** almost all communities have a variety of groups and organisations that are providing social support to community members in need.

Family and community self-help initiatives are irreplaceable. But they have serious limitations. They often seek to protect and preserve the family or the community as a whole, at the expense of the well-being of the individual child. Raped girls, for example, are often married to the perpetrator to re-establish peace between families. Other children are forced into systems of trafficking and exploitation as cheap labour so the families have one head less to nourish or can use the money for urgent needs. These children are sacrificed for the greater good of the family or the community.

Traditional community institutions do not always act in the best interest of children. Practices such as female genital cutting, child marriage, child trafficking, or severe corporal punishment may be integral parts of a community's tradition.

Exclusion is as much a feature of community life as mutual support. Children with severe mental problems, adolescents who participated in armed combat, children of sex workers, or children in families affected by HIV may be excluded from community life or even chased from the village.

Foster care

A connection of family or extended kinship does not necessarily make for a happy home. We found many examples of inappropriate fostering, of children being pushed into households where they were not welcome and where they were profoundly unhappy. In communities facing economic hardship, or with high numbers of orphans, traditional foster-care systems are deteriorating.

This is particular the case for post-conflict countries where many family networks have become dysfunctional during the war. In Sierra Leone and Liberia, households still comply with their traditional duty to accommodate the children of relatives, but many provide little more than a roof over their head. The fostered children are left to fend for themselves or exploited at home, denied their right to education and pushed into relationships with older men that might be of benefit to the guardian. Others are obliged to resort to transactional sex, petty crime or a life on the street to meet their basic needs.

Sierra Leonean girl, 14 years
"My parents were killed by the Guinean rebels when I was very young and I lived for the time of the war in the refugee camp of Nongoa [in Guinea]. I am still with my aunt, but she is very hard on me and treats me different than the other children. She locks me up for long times, denies me food, and when she gets angry at me she punches me in the face, throws things at me or takes a stick to hurt me. Two years ago, my aunt gave me to a police officer who made promises to her that he will take care of me. He had sex with me and than disappeared because he was transferred to another area. We don't know where he is and now I am disgraced. Ever since I feel dirty."

Finally, community institutions are not static. Our study confirmed previous reports that traditional child protection mechanisms in West and Central Africa are gradually disappearing, particularly in urban areas (Massart 2006).

The responses of governments and non-governmental agencies

Most psychosocial support initiatives in West and Central Africa narrowly target orphans or children in families living with HIV. They leave out the majority of children who are at high risk of HIV infection and who need psychosocial support to build their resilience. We recommend a more inclusive and sophisticated assessment of genuine need.

AIDS education and awareness programmes for children and adolescents have been a mainstay of HIV prevention since the beginning of the epidemic. HIV care and support initiatives emerged much later, and they initially ignored the needs of children. With the publication of the report "Children on the Brink" in 2002, the world's attention started to focus on the situation of children orphaned by AIDS (UNAIDS, UNICEF, USAID 2002). But it did not take long to realise that this focus on "AIDS orphans" was missing the target by a wide margin.
In 2004, a consensus document signed by all major international children's agencies stated: "a much larger number (than children orphaned by AIDS) have been made vulnerable by the impact of HIV/AIDS. This vulnerability is due to poverty, hunger, armed conflict and harmful child labour practices, all of which fuel and are fuelled by the epidemic" (IATT 2004 p.8) The term "vulnerable children" has since gained prominence, but it still lacks a clear definition.

The national situation assessments of children affected by HIV usually just examine the situation of orphaned children. The international initiatives to finance programmes for "orphans and vulnerable children" ask for indicators on how many orphans are receiving services. Although in the rhetoric orphans are usually associated with "vulnerable children", these vulnerable children are not defined, are not visible, cannot be counted, and consequently receive little attention.
As part of our research we conducted on site institutional analyses of 23 organisations providing psychosocial support for children in 10 West and Central African countries. Many organisations in the region offer "psychosocial support services". On closer examination, however, most of these are very superficial counselling programmes, or activities such as paying school fees or delivering food supplements.

Few organisations in West and Central Africa have a holistic approach to psychosocial care, addressing the psychological, developmental, and physical needs of children.

They work mostly in capital cities and serve a few hundred children at best. Criteria for selection are often unclear, as are concepts about how to monitor the outcomes of their work. In many cases, the criteria of eligibility, programme targets, and monitoring indicators are dictated by international donor agencies and have little relevance to the situation of children on the ground.

The most common indicators to measure progress in programmes for orphans and vulnerable children used by international agencies

UNGASS (The United Nations General Assembly Special Session on HIV/AIDS) (UNAIDS 2005)

- Percentage of orphaned and vulnerable children whose households received free basic external support in caring for the child. (To be reported only by countries with high HIV prevalence)

- Ratio of current school attendance among orphans to that among non-orphans aged 10–14. (To be reported by in all countries)

PEPFAR (The President's Emergency Plan for AIDS Relief) (PEPFAR 2007)

- Number of orphans and vulnerable children (OVC) served by an OVC program, disaggregated by sex
- Number of providers/caregivers trained in caring for orphans and vulnerable children
- Number of OVC receiving food and nutritional supplementation through OVC programs

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (suggested output indicator) (Global Fund 2008)

- Orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child (number and percentage)

Working with children experiencing trauma and mental health problems requires special skills.

We had concerns about the level of training among the field workers in many of the organisations we reviewed. At times we queried whether some of their work was doing more harm than good Because most international funding for the psychosocial support of children comes through HIV funding channels, the services overwhelmingly focus on orphans and on children living with HIV. Children who may be particularly vulnerable to HIV infection because of trauma and daily suffering are simply not eligible for support. Programmes that select children only if they are infected or directly affected by HIV carry a large potential opportunity cost. They divert resources, staff, and attention away from more sophisticated responses that target those children who are genuinely at risk.
The difficulty of identifying those children most in need of services is exacerbated by the fact that the characteristics of children particularly vulnerable to HIV differ from one community to the next. Once an issue affecting children receives visibility through the work of a local organisation, programmes are started to target "trafficked children", "AIDS orphans", "children of sex workers", "children affected by war", etc. However, these children may be difficult to identify in different contexts, and their vulnerability may well be no greater than that of other children in the community who do not to fit into the neatly labelled package, and who may actually be more numerous.
The problem was highlighted by UNAIDS in 2007: "One of our biggest challenges in the AIDS response for children is the failure to access the key data on children necessary for designing effective programmes. We urgently need to know more about how AIDS affects different children at different stages of childhood so that we can respond better to their needs." (Sidibe 2007)

Conclusion and recommendations

West and Central Africa is home to ever-growing numbers of children who are vulnerable to HIV as a result of trauma and abuse. Psychosocial support for these children is a key investment in HIV prevention, especially in countries where the prevalence of HIV is low.

The technical and financial capacity to respond to the psychosocial needs of the thousands of severely affected children in the region is very limited.
Resources are targeted too narrowly to specific categories of children, primarily linked directly to their experience with HIV. This, however, misses all those who are particularly vulnerable to HIV infection because their family and community safety nets are no longer intact.The children's vulnerability to HIV stems from two causes: sexual abuse exposing them directly to HIV infection, and physical and psychological trauma affecting their emotional and mental health, reducing their resilience, and resulting in behaviours that are likely to expose them to HIV. These children are in need of protection and holistic psychosocial support to help them manage their emotions, find safer solutions to their difficulties, and take control of their lives.
Our study in five countries of the West and Central Africa is a snapshot of some groups of young people in need of psychosocial support. Across West and Central Africa there are many more vulnerable young people who are not being reached by services. They will remain excluded if we continue to direct funding towards pre-defined categories of 'key groups'.

It is time that we invert the analysis and throw out the convenient labels. The children in need of psychosocial support, the children who are vulnerable to HIV infection, the children who are in the full sense of the term "affected by HIV" are those who are physically and emotionally traumatised and who lack the family and community support to deal with this trauma. We need to re-think our approach to make it child-centred rather than centred on a virus or a label

Recommendations

Psychosocial support as a key for HIV prevention and care

Psychosocial support is a holistic activity of identifying those children and adolescents whose family and community safety nets are failing, and providing them with the psychological, medical, social, educational and legal assistance to protect them from further harm and to build their resilience. It should be recognised as a key component of HIV prevention and care, because failing safety nets are both a cause and a consequence of HIV epidemics.

Child-centred targeting

Psychosocial support should be accessible to all children in need rather than be targeted at children who fit a particular label or category. Need can be determined by the social situation of children, their mental and emotional status, or by their behaviour (for instance children who have dropped out of school, girls who are involved in transactional sex, young people who take drugs, children living with handicapped caretakers, children who are excluded from community life, boys who engage in violent behaviour etc.).

Effective psychosocial support

Governmental and non-governmental organisations providing psychosocial support should be thoroughly trained in working with traumatised and mentally disturbed children.
They should have the capacity to act decisively on child protection issues and to provide holistic support, meeting the psychological, developmental, and physical needs of vulnerable children and adolescents.

Gender-sensitive programmes

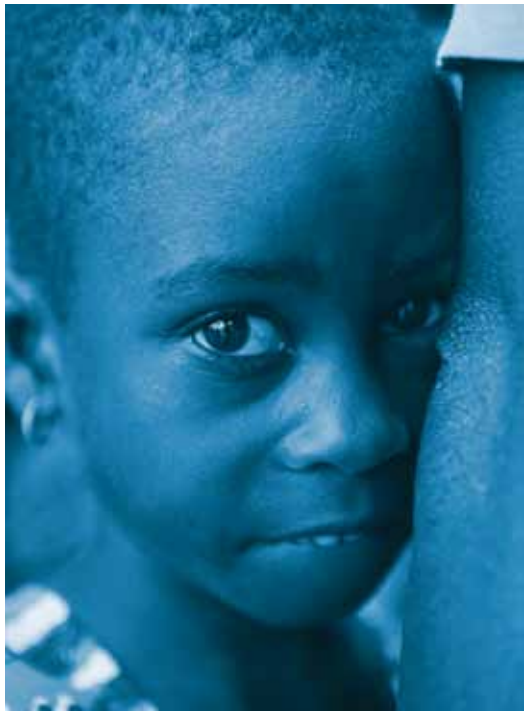
Psychosocial support programmes for children should be gender specific, addressing the different life experiences and needs, and supporting the different coping strategies of boys and of girls. Girls who have been raped need psychological support, medical care, and often assistance in raising their children. Much more needs to be known about the needs for psychological support and health care of boys who have suffered sexual violence.

Community-centred responses

Because the types of traumatic experiences of children, their manifestations, and their long-term consequences differ from location to location, community-based groups and organisations are the key for providing appropriate and effective psychosocial support. They need to be supported and trained in recognizing and mitigating the symptoms of abuse. At the same time, state agencies need to be strengthened to provide training and supervision of community actors, to recognise the limitations of local responses, and to provide rapid direct support on issues that cannot be effectively dealt with locally (for instance through mobile teams).

Effective national and local child protection policies that include HIV prevention

National, regional and local government child protection policies and laws, as well as activities such as periodic reports on the implementation of the Child Rights Convention, should explicitly address issues related to HIV risk and impact, including the links between violence against children and their vulnerability to HIV infection. Integrating the issue of HIV infection in a general framework for child protection should replace the practice of developing assistance programmes for children according to pre-determined categories.



Appendix

Appendix 1: Recruitment of study participants

The researchers spent at least two months living in a succession of villages in the research areas. When our researchers arrived in a new community and had obtained the consent of the local authorities, their first step was to organise a gathering for as many children as possible. The children would play games or sing songs, and then the researcher/s would tell short stories about children in difficult situations, and elicit remedies from the children. Recruitment proceeded from these gatherings and focus group discussions.

Researchers would identify children who met the various criteria (age, gender, affected or not by the critical event), talk to them about the research, and get written consent of the children and their parents or guardians. The children needed to be at least eight years old and be interested in doing the interview. The cut-off ages varied - in Cameroon it was 18; in Sierra Leone, Liberia, Burkina Faso and Togo, 20. All data collection and dissemination activities respected the children's right to anonymity and confidentiality. Before doing the formal interview, researchers would spend time with the child, to establish a relationship of trust. Individual interviews took around three hours; they started with eliciting background information, and moved on to the questionnaires and interviews described in appendix 2.

Appendix 2: Research tools

Focus group discussions

We developed a moderation guideline containing five short stories in which a child is suffering from a difficult living situation. The researcher in the role of the moderator tells the story and asks the children to share what kind of feelings the story's main character experiences and what remedies they propose for his/her difficulties. The short stories address different situations of distress such as the loss of a parent, domestic violence or difficulties in schools.

In depth individual interviews

The table below summarizes the objectives of and the tools used during the individual interviews. The researchers applied the questionnaires in interview form and filled in the answers of the participants.

	Target indicators investigated	TOOL
1	Introduction of the research to parents and the child as well as signature of written consent	Research introduction and written consent record
2	Socio-demographic and background information including questions on the high risk context of the study site (trafficking, life and departure from Cote d'Ivoire, HIV and loss of parents, war related experiences)	Semi-structured interview: Socio-demographic data questionnaire
3	Emotional wellbeing and resilience	Emotional well-being questionnaire of CARE/ SCOPE & Family Health International [1]
4	Potentially traumatic life experiences (life-time and during the last month); identification of most traumatic life event, assessment of current post-traumatic symptoms	UCLA PTSD Index (DSM IV) [2] completed by a domestic violence checklist from Catani, Schauer et al. [3, 4] and a question assessing transactional sex
5	Short and long-term memory performance	Complex figure from Rey Osterrieth [5]
6	Strength and difficulties of children	Strength and Difficulties Questionnaire (SDQ) [6]
7	Self-esteem	Rosenberg's self esteem Scale [7]
8	Axis I mental disorder of the DSM IV-TR	Structured clinical interview : M.I.N.I. KID English version 5.0 [8]
9	Additional exploration of attitude, feelings and behaviour of the child during the interview	Observation sheet

Table below: Tools used for the individual interviews

Case studies

We implemented the case studies with the support of a tool named "life-line-exercise". The exercise represents a playful way of establishing a life trajectory of a child with the help of a rope, flowers and stones and facilitates the documentation of important life events of the child in a chronological order. Further information about the method is available in the booklet "Narrative Exposure Therapy. A Short-Term Intervention for Traumatic Stress Disorders after War, Terror, or Torture" (Schauer, Neuner et al. 2004).

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* The psychosocial impact of parental loss and orphanhood on children in an area of high HIV prevalence: a cross section study in the North West region of Cameroon

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Alice Behrendt
May 2008

*Mental health of children formerly associated with the fighting forces in Liberia: a cross section study in Lofa County

Alice Behrendt
May 2008

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