ABSTRACT
This Chapter aims to provide a comprehensive synopsis and, in some instances, a critique of recent research conducted in the field of HIV/AIDS and sexual violence focusing specifically on children's vulnerability and the consequences of the HIV/AIDS and violence nexus. In South Africa, sexual violence is aimed at the most vulnerable members of society, namely children, increasing their risk of HIV infection. Sexual violence and coercion amongst children and adolescents may increase susceptibility to HIV infection as non-consensual sex is associated with increased genital trauma and coital injuries, the likelihood of anal penetration, the vulnerability especially of adolescent girls and the age difference between partners. Research studies have shown that HIV infection rates among adolescents are on average five times higher among girls than among boys. This can be attributed to sexual violence perpetrated on children which includes: sexual abuse of children, forced sex, sexual abuse of people with mental and physical disabilities as well as sexual exploitation. Child trafficking has also been found to be another grave phenomenon that places children at risk of sexual violence and in turn increases their risk of becoming infected with HIV. Although there have been efforts to protect children through interventions, policies and the use of laws such as the Children’s Act, it is recommended that much more needs to be done to enforce and implement these policies and laws to ensure that the agencies whose responsibility it is to protect children, are functional.

Keywords: sexual violence, HIV prevalence, child trafficking, rape, disability

INTRODUCTION
“Sexual violence and coercion among children and adolescents may increase susceptibility to human immunodeficiency virus (HIV) insofar as non-consensual sex is associated with increased genital trauma and coital injuries, the likelihood of anal penetration, the vulnerability of adolescent girls and the age difference between partners” (Klot & DeLargy, 2007, p.1). Research studies have shown that HIV infection rates among adolescents are, on average, five times higher among girls than among boys (UNICEF, 2008a). According to the World Health Organization (WHO), United Nations International Children’s Emergency Fund (UNICEF) and the Joint
United Nations Program on HIV/AIDS (UNAIDS) (2009), there were 2.1 million children younger than 15 years living with HIV in 2008 (Abrams, 2009; UNAIDS, 2009). In some countries, there has been a notable decline in the number of new infections for children which could be due to the uptake of mother-to-child transmission prevention programmes as well as the probable global stabilisation of HIV prevalence among women (UNAIDS, 2008). However, at the end of 2008, 430 000 children under the age of 15 years became newly infected with HIV and approximately 280 000 children died of acquired immunodeficiency syndrome (AIDS) (UNICEF, WHO & UNFPA, 2009).

This Chapter aims to provide:

a. A synopsis of the recent research conducted in the field of HIV/AIDS and sexual violence, focusing specifically on children’s vulnerability and the consequences of the HIV/AIDS and violence nexus.

b. The latest information on risk factors associated with sexual violence and HIV.

c. Information on the impact and consequences of sexual violence and HIV.

d. A summary of HIV and AIDS prevention and intervention initiatives.

e. A description of psycho-social interventions aimed at the social protection of children as well as government policies that address HIV and children’s rights.

f. Recommendations for future projects, interventions and policy development.

HIV PREVALENCE AMONG CHILDREN IN SOUTH AFRICA

In sub-Saharan Africa, children are the most severely impacted by the HIV and AIDS epidemic (Cheng & Siankam, 2009). HIV prevalence in South Africa was noted as one of the fastest expanding epidemics in the world and has the highest number of children living with HIV, estimated at 280 000 children aged younger than 15 years living with the infection (UNAIDS, 2008). A national HIV prevalence and risk survey conducted in South Africa on children, found a 2.5% HIV prevalence among children aged 2-14 years (Brookes, Shisana & Richter, 2004). Whereas in 2005, according to the South African national household survey on ‘HIV Prevalence, Incidence, Behaviour and Communication’, an estimated 3.3% of children aged 2-14 years were infected with HIV, increasing slightly. Pettifor et al. (2004) and Shisana et al. (2005) found the HIV prevalence for adolescents between the ages of 15-19 years to be 4.8% in 2004 and 6.3% in 2005.

Even though it may seem as if the HIV prevalence in South Africa has stabilised (Department of Health [DoH], 2006, 2007b, 2008), and may in fact be declining slightly (Global Health Council, 2009; Katz & Low-Beer, 2008), more than 90% of children living with HIV have acquired the virus during their mother’s pregnancy, birth or breastfeeding – forms of HIV transmission that could have been prevented (Dorrington, Johnson, Bradshaw & Daniel, 2006; Michaels & Eley, 2007). Besides vertical transmission of HIV, contextual and environmental factors have a serious impact and causal effect on HIV infection among children in South Africa (Coetzee et al., 2005; Gisselquist, Rothenberg, Potterat & Drucker, 2002; Oguntibeju, Van Schalkwyk & Van Den Heever, 2003). The following section aims to examine the possible link of sexual violence, which includes sexual abuse, rape, forced sex, and HIV transmission/infection among children.

Linking HIV and sexual violence

According to Kotze (2010, p.1), “sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments, or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work”. Sexual violence takes place in various settings and under different circumstances. Sexual violence perpetrated
on children include: sexual abuse of children, forced sex, sexual abuse of people with mental and physical disabilities as well as sexual exploitation (Kistner, 2003; Kotze, 2010).

In South Africa, sexual violence is aimed at the most vulnerable members of society, namely children, increasing their risk of HIV infection (UNICEF, 2008b). Petersen, Bhana and McKay (2005) state that South Africa has one of the highest rates of sexual violence in the world and that adolescent girls between the ages of 12-17 years are particularly at risk. In a study conducted in 5000 classrooms for 10-19 year-olds 60.8% of 10-14 year olds and 55.2% of 15-19 year-old males reported believing that sexual violence does not include forcing sex with someone they knew (Loffell, 2004). For females, 62% of 10-14 year-olds and 58.1% of 15-19 year-olds held the same belief (UNAIDS, UNFPA & UNIFEM, 2004).

Sexual abuse – a form of sexual violence, is a documented mode of transmission of HIV (Mok, 1996) and according to Rehle et al. (2007) there is a probable link between HIV infection and child sexual abuse, among other factors (Lalor, 2004; Shisana, Connolly, Rehle, Mehtar & Dana, 2008). According to the South African Police Services, more than 60 children were reported to be raped a day, this includes the rape of infants and young children (Richter, Stein, Cluver & de Kadt, 2009). In a study conducted by Sigsworth, Vetten, Jewkes and Christofides (2009), the age of victims where cases of rape were reported to the police were 14.6% for children 0-11 years and 25.2% for children aged 12-17 years. Adolescent girls experience a high rate of forced sex, ranging from 39% to 66% (Petersen et al., 2005) and more than a third of girls have experienced sexual violence before the age of 18 (e.g., unwanted touching, forced sex or being exploited into sex by much older men) (Jewkes, Abrahams & Mathews, 2009). Sigsworth et al. (2009) further stated that for children aged 17 years and younger where cases of rape were reported, adolescent girls faced the greater risk, with 63.3% of victims being girls between 12 and 17 years old. Children may also experience multiple perpetrator abuse as found in a study conducted in Gauteng, where 15% of children aged 0-11 years and 18% of children aged 12-17 experienced sexual abuse by more than one perpetrator (Vetten et al., 2008). According to Berry and Guthrie (2003), the figures of child sexual abuse that are reflected in reports do not accurately reflect the situation as it is well known that recorded sexual crimes largely under-estimate the actual prevalence due to under-reporting. It is also not known how many children have been infected with HIV as a result of sexual abuse but the physical damage caused, particularly in younger children, makes such transmission more than likely (Richter & Dawes, 2008).

“Rape and child sexual abuse directly increases children’s risk of contracting HIV, since it usually involves unprotected sex. It is not known how many children have been infected with HIV as a result of sexual abuse but the violent nature of rape may result in genital injury and bleeding which increases the risk of HIV transmission (Sexual Violence Research Initiative, 2010; Stackpool-Moore, 2008). In addition, many children do not have access to post-exposure prophylaxis medication after they have been sexually assaulted” (Delany, 2005, p. 48).

The highest rates of HIV infection are seen amongst 15-19 year-old girls. The high prevalence rates amongst girls of this age reflect their physical vulnerability to infection, their vulnerability in sexual relations and the impact of gender discrimination (Lukas, 2008). Differences in HIV rates between girls and boys indicate that teenage girls are more likely to be infected by older men than by boys their own age and these age differences increase the
likelihood of sexual abuse (Pettifor et al., 2005). The Nelson Mandela/HSRC (Human Sciences Research Council) study found that children aged 2-14 years had a HIV prevalence rate of 3.3% and that aside from the vertical transmission of HIV from mother to child in pregnancy and early infancy, there are other sources that put children at risk of contracting HIV (Shisana et al., 2005). Richter, Chandan and Rochat (2009) state that the reasons for the coexistence of high rates of child rape and high levels of child and infant HIV infection include the high level of violence perpetrated by South African men against women and children generally (Richter, Manegold & Pather, 2004). Risks associated within homes, include sexual abuse as well as the lack of care and protection for the children. Schools and communities can also be unsafe, especially for children who may be unsupervised in going between school and home. In an abusive relationship women and children have a limited ability to negotiate safer sex, increasing their risk of HIV infection (Delany, 2005; Shisana et al., 2005).

Child trafficking is another grave phenomenon that places children at risk of sexual violence thus increasing their risk of becoming infected with HIV (Richter & Higson-Smith, 2004). Child trafficking is defined as the exploitation of children via sexual exploitation, forced labour, organ removal, forced marriage, forced conscription (child soldiers), illegal adoptions through abduction or sale of children (Kreston, 2007; Laczko & Gozdziak, 2005; UNICEF, 2003). World estimates show that approximately 1.2 million children are exploited through trafficking domestically and internationally for various purposes with the majority of all victims being trafficked for sexual exploitation (Kreston, 2007). Laczko and Gozdziak (2005) state that trafficking in women and children for sexual exploitation is an ever growing problem in southern Africa, especially in Lesotho, Mozambique, Malawi, Zambia, and South Africa that is said to be the destination for regional and extra-regional trafficking activities (Laczko & Gozdziak, 2005). In the year 2000, a study found between 28000 and 38000 prostituted children in South Africa, and that 25% of the prostituted population in Cape Town, South Africa comprised of children. The causes of child trafficking emanate from diverse sources such as violence against women and children, concealment of incest and rape, discrimination and devaluation of women and children, even greed (Kreston, 2007). The consequences of child trafficking includes HIV, sexually transmitted diseases (STDs), tuberculosis (TB), mental health problems, substance use and abuse, violence, including gang rape, broken bones, murder and death (Kreston, 2007).

RISK FACTORS INCREASING CHILDREN’S VULNERABILITY TO HIV/AIDS AND VIOLENCE

Lack of supervision in homes
Children have been shown to be exposed daily to a variety of risky situations that increases their vulnerability to contracting HIV. The lack of safety and protection in households expose children to the risk of being sexually abused and exploited within their communities (Lalor, 2004; Lyles, Cohen & Brown, 2009). Tinsley, Lees and Sumartojo (2004) emphasised that families have a profound impact on the health, behaviours and the status of children (Ellis et al., 2003; Roche et al., 2005). Without the support, supervision and protection of the caregiver (parents/guardians) children are more vulnerable to abuse, and are often unable to refuse unwanted sexual advances which increase their chance of contracting HIV (UNICEF, 2008b). In situations where caregivers fail to provide for or protect their children, neglect and/or maltreatment is often the result, in which case children suffer harm (physical abuse, sexual abuse, emotional abuse and exposure to domestic violence), or their safety is endangered (Dawes, Long, Alexander & Ward, 2006; Fairbank & Fairbank, 2009; Townsend & Dawes, 2004). In the case of sexual abuse, where the caregiver fails
to supervise or protect the child, neglect is defined as a child having a substantial risk of being sexually molested or sexually exploited, where the caregiver knew or should have known the possibility of sexual molestation and failed to protect the child adequately (Dawes & Mushwana, 2007). Emotional neglect in relation to violence when experienced within the family is defined as a child witnessing or being involved with family violence within his/her home environment. This includes situations in which the child directly witnessed the violence (Dawes & Mushwana, 2007). According to Petersen et al. (2005), violence against women within families in South Africa has a prevalence of physical violence raging from 19.1% to 28.4%. Children who grow up with domestic violence are at serious risk for injury and psychological trauma (Dawes et al., 2006).

National prevalence data on violence against children in homes and families is not known, and the lack of reliable information on this type of violence against children is acknowledged as a gap and a problem for countries all over the world, not only in South Africa (UNICEF, 2008b).

**Lack of supervision in schools**

“Violence and particularly gender-based violence appears to be a significant problem, both in schools and out of schools” (Brookes & Higson-Smith, 2004, p. 119). The Department of Education (2002), in a submission to a task group on sexual violence in schools, found that South African schools have become a common locale for violence and sexual abuse particularly among girls. The role of school teachers in child rape has been reported in many other African countries (Jewkes, Levin, Mbananga & Bradshaw, 2002). Girls are forced to leave school because of pregnancies fathered by teachers and because of harassment by teachers. A girl’s ability to reach her economic and social potential is thus reduced and the likelihood of subsequent dependency on sex for survival increases. In a study conducted in the Western Cape in South Africa, 24% of children aged 12-17 years old reported having been sexually assaulted in school and according to the statistics reported by the Education Labour Relations Council approximately 2 out of every 1000 educators had complaints of abuse and violence lodged against them (Dawes et al., 2006).

In an evaluation conducted by the South African Human Rights Commission in 2002, it was found that education authorities in schools were not able to adequately protect children in schools and were also not able to address cases of abuse perpetrated outside schools, even when reported to educators (Dawes et al., 2006).

Schools in other countries, not only in South Africa have become to varying degrees, violent and unsafe environments where behaviours such as bullying, substance abuse, sexual abuse, verbal abuse, gangsterism, possession of guns and weapons, vandalism as well as a host of other antisocial behaviours are ever present.

**Poverty**

Poverty and inequality are significant contributors to South Africa’s burden of violence (Seedat, Van Niekerk, Jewkes, Suffla & Ratele, 2009). South Africa is considered a middle-income country, however many South Africans are living in sub-standard conditions due to extreme poverty (Marais, Esser, Godwin, Rabie & Cotton, 2008). Meintjies, John-Langba and Berry (2008) support this; they report that more than 60% of South African children are estimated to be living in poverty. Seedat et al. (2009) suggests that in situations where there is great inequality there is an increased likelihood of escalating anger and frustration and as a result, violence might be used to gain the resources, power, and influence that others have or are perceived to have. For families affected by the HIV epidemic, poverty and limited household resources are a common occurrence (Foster & Williamson, 2000; Meintjies & Giese, 2004), where
children often suffer the brunt, as these situations present major barriers to accessing health care for young children (Smith et al., 2003). One of the aspects related to poverty stricken environments is that of overcrowding. Overcrowding increases the risk of child sexual abuse and situations for sexual violence (Richter et al., 2009). It also limits the possibility of separation between sexualised adults or teenagers and children and since co-sleeping is often necessary it may provide additional opportunities for sexual violence (Seedat et al., 2009). It is important to recognise that not all caregivers (parents and guardians) who live in poverty, abuse, emotionally neglect and/or are unable to monitor and supervise their children adequately (Townsend & Dawes, 2004).

For children who become orphaned, the situation becomes dire as poverty might exacerbate the living situation for relatives that may already be living in poor economic conditions (Ansell & Young, 2004; De Waal & Whiteside, 2003; Joint Learning Initiative on Children and HIV/AIDS-[JLICA], 2009). Some children may as a result of their poor economic conditions opt for dropping out of school in order to work to earn money; some may even take part in risky sexual behaviours in order to gain financial support (Makame, Ani & Granatham-McGregor, 2007). A national household HIV survey conducted by the HSRC in 2008 showed evidence that younger girls engage in sexual relationships for material gains (Shisana et al., 2009). It is evident that poverty continues to motivate younger girls to seek older sexual partners for financial assistance. In addition to this, some adolescent girls continue to engage in these sexual relationships with older men so that they provide food for their families (Shisana et al., 2005). This leaves these adolescent girls at risk of HIV infection, as these older sexual partners are less likely to use condoms.

In communities where economic development and opportunities are limited, commercial sexual exploitation of youth can be viewed as one of the few money-making opportunities for young females, reinforcing the norm of women having limited roles and girls being sexual objects (Lyles et al., 2009).

THE IMPACT OF HIV/AIDS AND SEXUAL VIOLENCE ON CHILDREN WITH SPECIAL NEEDS

Orphanhood and child-headed households
Children, especially orphaned children are particularly vulnerable to abuse, exploitation and violence (UNICEF, 2008b). Different actors (government, non-governmental organisations [NGOs], faith-based organisations and community-based organisations) of development have been promoting strategies of care for orphans and vulnerable children (Thurman, Brown, Richter, Maharaj & Magnani, 2006). UNAIDS (2004) define an orphan as a child under the age of 15 years who has lost his/her mother to AIDS. Due to the toll that HIV and AIDS has taken on the adult population in South Africa, approximately 1.5 million children are orphaned as a result of parents or caregivers having died of AIDS. Therefore as a consequence of HIV and AIDS, there are increasing numbers of child-headed households, where children are left without adult supervision or care (Maqoko & Dreyer, 2007). Unlike children residing with their parents, some orphaned children live in conditions with no one to look after them and protect them. For example Kistner (2003) suggests that orphaned children are often taken in by neighbours and relatives increasing their risk of exploitation which includes withholding of resources or abuse of their entitlement to a child care grant (Bray, 2003). Studies investigating the relationship between household organisation and sexual risk behaviour suggest that adolescents not residing with both birth parents may be at increased risk of early sexual intercourse (Davids, Nkomo, Mfecane, Skinner & Ratele, 2006; Delany, 2005; Engle, 2008; Pettifor et al., 2004; Tinsley et al., 2004).
The impact of sexual violence and HIV on children is particularly severe as child-headed households increase; children are being forced to seek employment to care for themselves and/or their siblings, exposing themselves to abuse and exploitation (Dawes, van der Merwe & Brandt, 2007; UNICEF, 2008b). Often the work done by children is poorly paid, physically and emotionally difficult, and hazardous to their health and futures (Rau, 2003; Simbayi et al., 2006). In many of the households affected by HIV and AIDS, children have also assumed the responsibility of decision-making, thus transforming their roles within families and households (Embree, 2005; Lyons, 2008). Children become heads of households because they are left with no choice but to do so (Brookes et al., 2004). Some children take care of their parents and younger siblings who are sick and dying from AIDS related diseases, work long hours doing household tasks, and some children engage in income-generating work in order to support the families (Lyons, 2008; Munthali, 2002). In the end, many children drop out of school to the detriment of their own health and developmental needs to take on roles as parent, nurse and provider (Guest, 2001; Monash & Boerma, 2004; Simbayi et al., 2006). “For the children growing up in these communities even those who are uninfected, and who have no family members that are infected – HIV and AIDS negatively affects their lives” (Lyons, 2008, p. 3).

**Disabled children**

In South Africa, according to a census conducted in 2001 (Statistics South Africa, 2005) the data showed that there were 2 255 982 people with various forms of disability. The most recent surveys which provide some data on the prevalence of disability are shown to be between 5 and 5.9% (Statistics South Africa, 2005). People who are disabled are exposed to the same risk factors of HIV as every non-disabled person (Elliot, Utyasheva & Zack, 2009; South African National Aids Council [SANAC], 2008). However, disabled persons experience a double burden with regard to HIV and AIDS in that they are exposed to increased risk of infection, as well as reduced access to prevention, treatment and care services (UNAIDS, WHO & OHCHR, 2009).

Young girls, as well as older women who are disabled, either living in institutions or at home are often exposed to sexual violence and exploitation because of their physical vulnerability to attack, the level of dependency on others for care, which in some cases are the perpetrators (Banda, 2006; Groce, 2003; Interagency Coalition on AIDS and Development [ICAD], 2008; Rohleder, Swartz, Eide & MacGregor, 2009; SANAC, 2008). Because of the widespread misconception that disabled people are asexual, “many children are deprived of formal (at school) and informal (at home) education on sexual and reproductive health. This educational gap leaves people with disabilities in a vulnerable position, and can result in an inability to negotiate safer sex” (ICAD, 2008, p.1). There are a vast number of international research studies that suggest that persons with disabilities are at an increased risk of vulnerability for sexual violence (Rohleder et al., 2009). However, there are no current studies that provide data on HIV and violence that focus on disabled children within South Africa. The latest national HIV survey suggests high rates of HIV prevalence among disabled adults (Shisana et al., 2009). This suggests a need to design preventative interventions for this risk group, especially children.

**Children living on the street**

Although there seems to be minimal recent South African research studies that looks at the vulnerability of HIV-infection amongst children living on the street, previous studies show that this group of children are particularly susceptible to HIV-infection (Kruger & Richter, 2003; Roy, 1998; Richter & Swart-Kruger, 1995; van Rooyen & Hartell, 2002). Children living without their parents or familial support, who
are impoverished and with no one to care for them, may be forced to live on the streets and therefore are at considerable risk of abuse and sexual violence (Sexual Violence Research Initiative, 2010). According to the 2001 census data, the number of children living on the streets was recorded at 2,189 with their ages ranging between 10 and 17 years of age (Statistics South Africa, 2001). Although the census data does not disaggregate the population of children living on the streets by sex, the Presidency (2009) states that boys between the ages of 13 and 16 years were reported as the predominant group. In the absence of adult support, children living on the street have a solitary task of fending for themselves and by so doing become vulnerable to sexual exploitation. For instance, living on the streets and engaging in ‘survival sex’ means sexual activity is likely to start at a younger age (Rotheram-Borus, Becker, Koopman & Kaplan, 1991), with multiple sexual partners and in the absence of condom use as clients tend to prefer and are willing to pay more for sex without a condom (Kruger & Richter, 2003). Due to the dire conditions children live under on the streets, their prime concern is likely to centre more on survival than the risk of being HIV-infected (van Rooyen & Hartell, 2002). Once infected with HIV, due to their poor health, and the fact that they are less likely to seek medical attention in the event of illness (Kruger & Richter, 2003) may mean that progression of HIV into AIDS is likely to take place at a faster rate than the case may have been if a nutritious diet had been followed (Matulessy, Florina & Asmuni, 1994) and medical attention had been sought.

**CONSEQUENCES AND IMPACT OF HIV/AIDS AND VIOLENCE**

Sexual violence in childhood or adolescence increases the likelihood of becoming engaged in various risky sexual behaviours such as early sexual debut, having multiple sexual partners and engaging in unprotected sex (Bhana, Zimmerman & Cupp, 2008; Sexual Violence Research Initiative, 2010). Firstly, adolescents are at risk of having first consensual sex at a younger age (Kistner, 2003; Kotze, 2010). The risks of earlier sexual debut have serious consequences for youth which include a higher likelihood of having multiple partners, lower likelihood of condom use at first sex and higher overall number of sexual partners, including high biological susceptibility to HIV infection of adolescent and young girls (Berry & Hall, 2009; Michel & Glynn, 2007; Myer et al., 2010; Shafer et al., 2008; Shisana et al., 2009). According to Pettifor et al. (2004) delaying age at first sex is one of the critical factors that can contribute to the decline in HIV prevalence. According to Reddy et al. (2003) in a national study conducted at high-schools – 14% of learners reported sexual debut before the age of 14 years, while more males (25.4%) reported having their first sexual experience younger than 14 years old, compared with their female counterparts (5.6%). Pettifor et al. (2004) found 80% of all youth aged 15-24 years reported having sex before 15 years of age. For males, 12% were more likely to report having sex at an early age (less than or equal to 14 years) compared with females at 5% (Pettifor et al., 2004). In a study conducted by the HSRC, it was found that a small proportion of young people had started having sex before the age of 15 years. However, with regard to gender, more males aged 15-24 years old reported having sex before the age of 15 years compared with their female counterparts (Shisana et al., 2009). Factors linked to early sexual debut usually include the unlikely use of contraceptives and therefore unplanned pregnancies may occur (Baumgartner, Waszak Geary, Tucker & Wedderburn, 2009; Geary et al., 2008).

Secondly, having multiple sexual partners and engaging in unprotected sex has, through empirical research studies, been shown to be one of the factors promoting HIV transmission and is at the root of the HIV epidemic (Berry & Hall, 2009; Kalichman et al., 2007; Pettifor et al., 2005; Shelton, 2009; UNICEF, 2009). Eaton, Flisher and Aarø (2003) state that between 10% and 30% of sexually active
young people have more than one sexual partner at a given time, and that males usually engage in multiple partnerships compared to females. Berry and Hall (2009) confirm this in a study where they found that only 3% of young women in the 15-19 year age group reported having more than one sexual partner in the previous year, as opposed to 8% of males (De la Torre, Khan, Eckert, Luna & Koppenhaver, 2009).

Researchers have found that there are various reasons as to why young men and women engage in multiple sexual relationships, and one of the most common explanations provided is that multiple sex partnerships satisfies the diverse economic needs that young men and women experience (Kistner, 2003; Leclerc-Madlala, 2008; Muula, 2008; Shelton, 2009). This is where transactional sex comes into play, which Shelton (2009, p.1) is described as, “a social norm of expectation of gifts and economic support from men as part of a sexual relationship, in part expressing value, commitment, love, and respect”. The widespread practice of multiple relationships continues to contribute to the high levels of HIV infection among females, especially young females (De la Torre et al., 2009).

Thirdly and lastly, for individuals that have experienced forced sex in intimate relationships – it is often difficult because of the unequal power dynamic in such relationships to negotiate condom use and proposing the use of a condom (Blanc, 2001; Mercer et al., 2009; Pettifor et al., 2004; UNICEF, 2009). This is further intensified when the sexual partner of these young girls are older men, with intergenerational sex occurring when younger females or males have sex with older sexual partners (Aldo, 2009; Jewkes et al., 2002). In South Africa, Shisana et al. (2005) found that 29.5% of girls aged 15-19 years were infected with HIV and were in sexual relationships with partners 5 years and older. These relationships are largely premised upon material gain linked to materialism and consumption, with studies revealing that the greater the economic asymmetries between partners and the greater the value of a gift, service, or money exchanged for sex, the less likely the practice of safer sex (De la Torre et al., 2009; Shelton, 2009; UNICEF, 2009).

Apart from social and economic impacts, children affected by AIDS are themselves highly vulnerable to HIV infection. Their risk of infection arises from the potential early onset of sexual activity, commercial sex and sexual abuse resulting in a range of health consequences both in the short- and long-term which include, HIV, sexually transmitted infections, unwanted pregnancies, and Post Traumatic Stress Disorder (PTSD), to name but a few (Kotze, 2010).

A safety network for children affected by HIV and sexual violence is created by established patterns of extended families, across multiple generations and in multiple locations, and by communities with reciprocal obligations among their members (Simbayi et al., 2006). However, affected households and children need relief through material help as well as assistance with labour, care-giving and emotional support. Children who slip through these safety nets become highly vulnerable and exposed, and include street and working children, as well as children in child-headed households (Simbayi et al., 2006).

INTERVENTIONS FOCUSING ON HIV AND AIDS: THE SOCIAL PROTECTION OF CHILDREN’S RIGHTS AND SOCIAL SECURITY

According to Sampson (2010), the main role and aim of social protection for care and support are rallied toward economically disadvantaged and vulnerable populations, such as financially constrained homes and more especially, children affected by AIDS. Social protection also offers a role in transforming
the prospects for those less poor including AIDS-affected households with labour potential.

Community care forums, and NGO intervention programmes across South Africa are working together with various governmental departments, in some cases with the DoH and the Department of Social Development (DSD) in providing treatment and care services to children and their families affected by HIV. The NGOs provide much needed psycho-social support and poverty relief to vulnerable families burdened by HIV and AIDS (see Boxes to follow). Services include providing counselling, orphan support, home-based care, material assistance, assistance with applications for grants/welfare and income-generating projects as well as other forms of assistance (Rohleder et al., 2009). Furthermore, organisations assisting with the processing and distribution of child benefits (welfare grants), cash transfers as well as school assistance packages also increases children’s school attendance as education remains the single most effective HIV prevention asset (Nolan, 2009). According to Guthrie (2006, cited in the Organisation for Economic Co-operation and Development report, 2009) the child support grant in South Africa has increased school attendance and nutrition levels, while impacting positively on income poverty at household level.

According to Richter et al. (2004), it was noted that there were specific areas such as neglect, sexual abuse, maltreatment and exploitation, where children were insufficiently protected. Since then several intervention programmes have come to thefore to assist and alleviate the conditions under which children have suffered as a result of abuse and exploitation. Home-based carers have been placed in many communities across South Africa by NGOs in order to monitor, assist and report children living under abusive conditions (Ogden, Esim & Grown, 2004). Furthermore, volunteers, faith-based organisations, educators and community

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### National NGO interventions for children affected by HIV

**The Children in Distress Network (CINDI)**
Some of CINDI projects include:
- **Child Advocacy Project (CAP):** CAP’s goal is to ensure that children and their caregivers’ access relevant, user-friendly information in respect of their rights.
- **CHIP (Child Intervention Panel)** seeks to respond to delays experienced by children within the child care system. The panel aims to ensure administrative justice for children and their caregivers.
- **The Singatha School Uniform Fund** seeks to provide, through CINDI members, vulnerable children with school uniforms if their attendance at school is jeopardised by their being unable to afford the cost of a school uniform.

http://www.cindi.org.za/

**AIDS Foundation**
Care of orphans and vulnerable children interventions: e.g., early identification of vulnerable children and succession planning, facilitating kinship and community foster care, assistance with social grant applications, psycho-social support (bereavement counselling and play therapy) and monitoring the well-being of children.

http://www.aids.org.za/

**KidzPositive**
Improving the health of HIV-positive children in Southern Africa. To generate funds for the grassroots support of mothers and children affected by HIV/AIDS. Aim is to become a regional source of financial support for organisations providing care for significant numbers of affected families. The name of this Fund was inspired by the positive spirit and actions of these people.

http://www.kidzpositive.org/about_overview.html

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members, have come together to provide assistance in reporting cases of child abuse and violence.
### The CHILDREN’S HIV/AIDS NETWORK (CHAIN)

**Aims of CHAIN:**
- To develop and maintain a database of organisations concerned with children affected and infected by HIV/AIDS in the Western Cape.
- To disseminate pertinent information about HIV/AIDS.
- To facilitate co-operation, networking, joint programmes and rationalisation of services to children infected and affected by HIV/AIDS.
- To facilitate / promote education and training aimed at changing community perceptions, increasing HIV/AIDS awareness and promoting multi-sectoral responses.
- To facilitate policy and legislative analysis and development on issues related to children who are infected or affected by HIV/AIDS.
- To facilitate lobbying and advocacy on pertinent issues.

[http://web.uct.ac.za/depts/chu/mch16g.rtf](http://web.uct.ac.za/depts/chu/mch16g.rtf)

### Cotlands

Care to vulnerable children, with services ranging from home based care of HIV-positive children through to end stage palliative care for children with AIDS. Emphasis is placed on supporting the child and their family in the community through various outreach programmes, which include home based care, orphan care, counselling services, and nutrition. The residential component is only used in emergency situations for acute, chronic and terminally ill children who cannot be cared for at home or children who have been orphaned or abandoned.


### HOPE world-wide South Africa

Key services provided include psycho-social support to both children and adults, educational support to children, food and nutritional support to children and their families. Assistance is also provided by obtaining legal documentation required to access social grants, and referrals are undertaken for those services that the programme is unable to provide. The OVC programme has adopted innovative approaches to ensure the quality of its services (Ching’andu, Njaramba & Welty-Mangxaba, 2008).

### St Francis Care Centre

**CHILDREN’S SECTION**

Provides a home for 30 abandoned or orphaned children from birth to 7 years of age. A professional team of medical staff, teachers and a social worker take care of the children to ensure their well being and the development of their full potential. The children aged between 3-7 years attend a nursery school on the premises.

**ANTI-RETROVIRAL CLINIC**

This clinic was opened on 1st September 2004 and offers free counselling, testing and treatment to all members of the community. To date more than 2000 patients have visited the clinic for counselling and testing and 748 of these have been started on anti-retroviral treatment with very encouraging results. The anti-retroviral drugs are provided free as a result of donations received from American PEPFAR (The Presidents Emergency Plan For Aids Relief) funding.

**HOME BASED CARE**

The centre has an active team of care helpers providing home based care to persons infected and affected by HIV/AIDS in the Greater Ekurhuleni communities. Clients currently receiving assistance include HIV/AIDS patients, orphaned children, child headed households and families affected by the pandemic.


### OLIVE LEAF Foundation

Enabling sustainable community development in five provinces in South Africa and five other sub-Saharan countries. Various interventions promote gender equality, care and support for orphans and vulnerable children and education, and capacity to build effective communities that are able to cope with the AIDS pandemic.

[www.olf.org.za](http://www.olf.org.za)

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**Sexual Violence and HIV**
RAPCAN Protecting Children’s Rights
RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect) is a registered section 21 Company, non-profit organisation and public benefit organisation based in Cape Town. RAPCAN’s work is focused on the prevention of child victimisation and offending and the promotion of children’s rights, and operates locally, at provincial and national levels in South Africa, as well as in the region and internationally. RAPCAN’s work includes primary, secondary and tertiary prevention approaches to the following issues within the children’s rights arena:
• Child sexual abuse
• Corporal and humiliating punishment
• Child offending, especially sexual and violent offending

www.rapcan.co.za/

CHILD WELFARE South Africa (CWSA)
On a national level, CWSA initiatives for children and our constitutional obligations to affiliates are delivered through five programmes aimed at:
• Creating safe and caring environments for children and promoting community mobilisation for the effective protection of children.
• Strengthening and developing capacity in member organisations providing services to children and families.

This programme, named by communities as Asibavikele: Let’s Protect Them, is a CWSA nationally coordinated project that facilitates community care and support for children orphaned and made vulnerable by HIV and AIDS. The programme trains volunteers to mobilise and involve communities in the identification and care of orphans and vulnerable children, the sensitising of communities to the rights of children and establishes foster care homes and safe homes. Between 2005 and 2006, the project trained 696 community volunteers and identified 8 524 orphaned and vulnerable children in need of Asibavikele’s comprehensive service package. From 2006 to 2007 a further 545 volunteers were trained and an additional 10 141 children reached. From 2007 to 2008, seventeen more sites were established, 15 949 orphans reached and 1 758 volunteers trained. A further 80 sites are planned for the 2008-2009 period. A partnership between CWSA and the Thokomala Orphan Care Organisation has seen foster care homes established in communities, staffed by foster mothers and monitored by social workers linked to the Asibavikele programme.

http://www.childwelfaresa.org.za/

CHILD LINE
Childline is an effective non-profit organisation that works collectively to protect children from all forms of violence and to create a culture of children’s rights in South Africa. Programmes delivered through the provincial offices include: Crisis Line; child rights, prevention and education; training of volunteers; training of other professionals who work in child protection and children; therapy for abused and traumatised children and their families; court preparation for child witnesses; networking and coordination; as well as advocacy.

http://www.childlinesa.org.za/

TEDDY BEAR CLINIC for abused children
The Teddy Bear Clinic is a non-profit organisation dedicated to ensuring abused children are protected and rehabilitated. Providing therapy, counselling, assistance, love, comfort, safety and ongoing support to children who have been abused. The Teddy Bear Clinic does not only work with children, but with parents and communities empowering them with knowledge and skills to help put an end to child abuse. Proactive approaches to schools are taken to provide education to the learners and training to the teachers in order to prevent any abuse that may happen in their day-to-day lives.

Children
Children are helped from all walks of life from ages 3 - 18. Visiting schools and equipping the children with knowledge on how to handle various situations. By educating children their awareness of sexual, physical and drug abuse is increased.

Parents
Because there is an understanding that abuse affects everyone in a family environment, assistance is provided to parents who are affected by child abuse.
To help parents understand what their children have undergone, counselling and therapy is offered.

Communities
Communities are assisted by equipping them with information on how to deal with abuse by running workshops and training. Most of the volunteers are from the communities assisted.


THUTHUZELA CARE CENTRES
The Thuthuzelas in operation in public hospitals in communities where the incidence of rape is particularly high are also linked to the sexual offences courts, a new and unique South African anti-rape intervention. As part of the strategy, a specialised Sexual Offences Court is staffed by a committed cadre of prosecutors, social workers, investigating officers, magistrates, health professionals and police, and located in close proximity to the Thuthuzela.

www.npa.gov.za

GOVERNMENT POLICIES ADDRESSING THE PROTECTION OF CHILDREN IN SOUTH AFRICA

Policies addressing the social protection of children’s rights
A number of policies address children’s rights and social protection:

• The Children’s Act (No. 38 of 2005) and the Children’s Amendment Act (No. 41 of 2007): the objectives – protecting children from maltreatment, abuse, neglect, or degradation – to promoting the protection, development and well-being of children.

• The Sexual Offenses Amendment Bill (B50B/2003) of 2006 – includes a clause on transitional provisions relating to trafficking in persons for sexual purposes. The Bill was included to comply with South Africa’s international obligations and to deal with the rapid growth of the global phenomenon (Kreston, 2007).

Other legislation addressing the protection of violence against children includes:

• The Prevention of Family Violence Act (No.133 of 1993).

• The Domestic Violence Act (No. 116 of 1998).

• The Schools Act (No. 56 of 1996).

According to Dawes and Mushwana (2007), the establishment of provincial protocols and child protection committee’s were set up in all provinces in South Africa for the management of child abuse. However, practical application of the committees is questionable and their functioning varies. Other key policies that the South African government has implemented to ensure the care and protection of children include: the Child Support Grant and The Foster Child Grant (Barnes, Noble, Wright & Dawes, 2008; Budlender, Proudlock & Jamieson, 2008).

Policies addressing HIV and AIDS
The South African government has adopted a range of legislative measures and has formulated a number of policies to ensure the survival of children in South Africa. Policies to ensure optimal support for mothers and children are the following (DoH, 2007a):

• Maternal, Child and Women’s Health.

• Infant and Young Child Feeding Policy (2008).

• HIV and AIDS and STI National Strategic Plan (2007-2011) (further discussed below).

• A policy on quality health care for South Africa (2008).

• School Health Policy for South Africa.

• Policy guidelines for Youth and Adolescent health.

In 2006, the National DSD implemented the policy framework for Orphans and other Vulnerable Children affected by HIV/AIDS (OVCAHA). The framework has six key strategies which in brief focus on strengthening families, mobilising and strengthening communities, ensuring policies and programmes are put in place, assuring access to essential services, raising
awareness and advocating supportive environments, engaging civil society and businesses in communities, to the care and protection of orphan and children made vulnerable by HIV and AIDS (DSD, 2005).

In 2007, a revised HIV and AIDS National Strategic Plan (NSP) were officially approved by the government of South Africa (HIV & AIDS and STI National Strategic Plan 2007-2011, 2007). The NSP contains four priority areas which comprise 19 goals (see Table 1). Of the 19 goals outlined in the plan, nine goals have been integrated with objectives and interventions which mention or affect children directly (see Table 2). Unlike the previous plan, the 2007 NSP presents objectives which addresses HIV prevention and treatment, legislation, social security, education, mental health, and developmental monitoring (DoH, 2007a; Michaels & Eley, 2007).

South Africa faces a vast number of challenges especially within the health care system and where the burden of HIV infection is on the increase every year, there are resources that exist in South Africa that can enable the improvement of HIV prevention, care and treatment, as well as the successful implementation of the HIV and AIDS and STI Strategic Plan (Michaels & Eley, 2007).

**CONCLUSION AND RECOMMENDATIONS**

The chapter illustrates a gap not only in research on children and HIV but also in the link between violence and HIV among children. This gap is even more evident among vulnerable children such as children living with disabilities, those living on the street and orphaned children. It is a fact that children remain vulnerable not only to sexual violence and infection with HIV but to other kinds of abuse at the hands of adults including trafficking and prostitution. To date, there have been efforts to protect children through policies and use of laws such as the Children’s Act, however much needs to be done to enforce and implement these policies, including plans to ensure that the agencies whose

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The high rates of violence against children reported in this Chapter are alarming in a country that has laws that should protect children but seem to be failing to reduce levels of violence and incidents of violent crimes against children. This may suggest a need for specialised enforcement agencies, such as the child protection unit, to focus on crimes against children more directly.

With regards to the prevention of HIV and sexual violence it is of concern that access to post-exposure...
prophylaxis is still limited for children who are survivors of rape and sexual abuse. More research should be done in this area and education campaigns should focus on promoting help seeking behaviour among parents and caregivers whose children are sexually abused or raped. This should be among the priority areas that should be focused on to ensure that children exposed to sexual crimes and violence are protected from being infected with HIV.

Lastly the protection of children at home and schools seems to be a critical area of intervention. Statistics presented in this chapter illustrate that homes and schools often provide an entry point for perpetrators especially in households without caregivers, as is the case of orphans and other vulnerable children. Welfare agencies need to ensure that children access social grants to ensure that they are not victimised by those offering help or food in exchange for sexual favours. Interventions should also ensure that adults in the community begin to adopt families left destitute and ensure that the protection of these children become a community prerogative not just a state responsibility.

Recommendations for developing interventions and possibly informing policy:

- Child-focused research need to be conducted in South Africa and research needs to include questions on HIV, sexual abuse, sexual norms, violence and risk factors in large-scale national surveys and linking interventions to outcomes (Dawes et al., 2007; Noble, Wright & Cluver 2006).
- The South African Police Services crime statistics team needs to adequately train staff to capture information so that updated and reliable information from their side is made accessible to the public.
- As it was found that education authorities in schools were not able to adequately protect children in schools as well as not able to address cases of abuse perpetrated outside schools, even when reported to educators – this needs to be immediately addressed, especially in cases where educators are the abusers.
- The government should identify the reduction in violence and injuries as a key goal and develop and implement a comprehensive, national intersectoral, evidence-based action plan (Seedat et al., 2009).
- Primary prevention interventions need to be developed that addresses sexual violence by taking environmental factors and societal norms that contribute to its occurrence in the

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Key messages

- Violence against children and the association with HIV and AIDS epidemic is inter-linked on a number of levels as both a cause and a consequence.
- HIV prevalence in South Africa was noted as one the fastest expanding epidemics in the world and has the highest number of children living with HIV in the world with an estimated 280 000 children below the age of 15 years living with the infection.
- Child trafficking is another grave phenomenon that places children at risk of sexual violence and in turn increasing their risk of becoming infected with HIV.
- Young girls as, well as older women, who are disabled, either living in institutions or at home are often exposed to sexual violence and exploitation because of their physical vulnerability to attack, their level of dependency on others for care, which is some cases are the perpetrators.
- Several intervention programmes have come to the fore to assist and alleviate the conditions under which children have suffered as a result of abuse and exploitation.
- Legislation and of policies addressing children’s rights and social protection include: the Children’s Act (No. 38 of 2005) and the Children’s Amendment Act (No. 41 of 2007); the Sexual offenses Amendment Bill (B50B/2003) of 2006; the Prevention of Family Violence Act (No.133 of 1993); the Domestic Violence Act (No. 116 of 1998) and the Schools Act (No. 56 of 1996) – aiming to protect children from maltreatment, abuse, neglect, or degradation.
first place.

- Primary prevention approaches need to be developed that addresses child sexual abuse and exploitation that promotes safe, healthy environments and behaviours, reducing the likelihood of abuse in the first place (Lyles et al., 2009).

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