Responses to HIV in sexually exploited children or adolescents who sell sex

Published Online
July 22, 2014
http://dx.doi.org/10.1016/
S0140-6736(14)60979-X

One of the crucial gaps in the current HIV response is that we are not reaching children and adolescents aged 10–17 years who sell sex, with life-saving prevention, treatment, protection, care, or support; by protection we refer to all child and social protection interventions that aim to protect rights and provide social and economic support. Under the Convention on the Rights of the Child (CRC)—the most widely ratified human rights treaty—and its Optional Protocol on the sale of children, child prostitution, and child pornography, adolescents younger than 18 years are protected from all forms of sexual exploitation and entitled to the right to health. Children are defined by the CRC as all persons aged younger than 18 years. Adolescents are defined by the UN as all persons aged 10–19 years. This Comment focuses on the HIV concerns of children and adolescents aged 10–17 years who are exploited in the sex industry through selling sex, and does not consider other forms of sexual exploitation. The term "sexually exploited children and adolescents aged 10–17 years who sell sex" describes the behaviour that renders this group at-risk of HIV and does not describe identity. Children younger than 18 years who sell sex, irrespective of the reason, are considered under international law to be sexually exploited children.

There are no accurate global estimates of the number of sexually exploited children and adolescents aged 10–17 years, nor of the subset of those who sell sex.[1] However, many studies show that substantial percentages of sex workers in many countries began selling sex aged younger than 18 years. For example, in Ukraine, adolescent girls aged 10–19 years who sell sex comprise an estimated 20% of the female sex-worker population.[2,3] Evidence also shows that this group is more vulnerable than older cohorts to health harms—including sexually transmitted infections, HIV, and violence. For example, in Ukraine in 2006, HIV prevalence among females aged 15–19 years selling sex exceeded 19%, compared to 1·4% in the general adult population.[2] Also, in eight countries in eastern and southern Africa, median HIV prevalence among sex workers younger than 25 years is 11%[3–5] (figure).

Many factors specific to children and adolescents aged 10–17 years contribute to this vulnerability, including severe circumstances of initiation and involvement, such as physical force and lack of control over their situation and finances and an inability to negotiate condom use.[6–9] Some studies show increased biological vulnerability to HIV in adolescent girls, which is linked to weaker mucosal immunity of the adolescent female genital tract.[2,3,10] Other reasons are systemic—these include legal and policy barriers to access to sexual and reproductive health and rights (SRHR) and other services; frequent contact with uniformed services such as police; and lack of confidential and adolescent-friendly HIV services.[2,3,10]

Health interventions that target sex workers aged 18 years and older generally do not address the specific needs of this group because of law and policy barriers. The interventions that do target the group often focus exclusively on the immediate removal of the child from the sex trade, rather than the provision of necessary SRHR and HIV treatment, prevention, and care.[10]

Fear of police harassment or being sent to state institutions often prevents sexually exploited children and adolescents aged 10–17 years who sell sex from

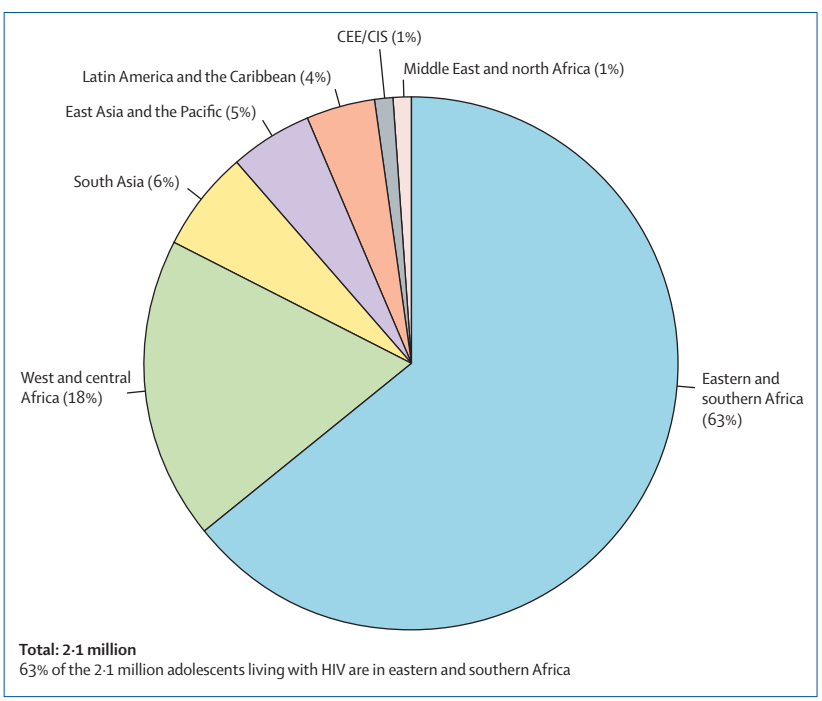

***Figure*: Estimated percentage of adolescents aged 10–19 years living with HIV, by UNICEF region, 2012**
CEE/CIS=UNICEF region of central and eastern Europe and the Commonwealth of Independent States.

accessing HIV and other services. This prevention of access contributes to them being driven underground, becoming invisible, excluded, and more vulnerable.[2] Contradictory age-of-consent laws further muddy the waters—age of consent for marriage, consensual sex, and HIV testing and medical care can be different. Some countries allow children to consent to sex before adulthood but do not allow independent access to HIV testing before age 18 years.[11]

Article 5 of the CRC acknowledges the evolving capacities of children. However, different approaches to their evolving capacities can result, for example, in 10–17 year olds being able to access contraceptives before the legal age of consent to sex. In this case health workers who provide such services are legally obliged to report underage sex to authorities.[12]

We can move away from this inaccurate and false tension towards a new approach: one which recognises that all children and adolescents aged 10–17 years have a right to access information and rights-based health and other services which address their holistic needs. The CRC clearly articulates that children younger than 18 have a right to "the enjoyment of the highest attainable standard of health" (article 24) and that "the best interests of the child should guide all actions concerning them" (article 3)—the key underlying principle by which State Parties shall determine action for, with, and on behalf of children. The Committee on the CRC has further interpreted obligations of governments—that people younger than 18 years have a right to participate in decisions that affect them; be free from HIV and discrimination; and that children who are sexually exploited should be able to access comprehensive SRHR services.[13] In addition, the Convention restricts protective and judicial interventions against children and adolescents aged 10–17 years, through its due process and minimum intervention principles, which require that proceedings against children be used only where appropriate, as a measure of last resort, and that placements be undertaken for the shortest appropriate period of time and subject to periodic review (Article 37[b]–[d], Article 40).[14] These provisions are critical, because at national level the continued existence of law-enforcement-based interventions for this group—such as involuntary rehabilitation and forced detention—clearly violate their rights and often further exposes them to health harms, including harassment, extortion, abuse, and rape.[15]

Key programmatic HIV elements can make a difference for this group, namely safe and confidential access to all SRHR services and commodities, including services that are flexible, mobile, and involve peer outreach and education. These include: comprehensive sexual education; access to condoms, lubricant, contraception, and safe and confidential testing for sexually transmitted infections and HIV including testing through street and peer outreach; HIV treatment including prevention of vertical transmission and related care; treatment for opportunistic and co-infections; safe abortion and maternal care; post-rape and sexual violence medical services, such as postexposure prophylaxis; vaccinations for, eg, hepatitis and human papillomavirus; harm-reducing services for adolescents who inject drugs; and hormone replacement therapy for transgender adolescents. SRHR services can be interwoven with other voluntary services, including housing, education, job skills training, mental health services, reunification with families, legal services, and protection. Peer support is essential to allow children and adolescents aged 10–17 years to discuss their issues and create their own solutions. The evolving capacities of adolescents should be taken into account to determine the most appropriate interventions to support them. The needs of 10–13 year-olds, for example, might be quite different from those of 14–17 year-olds, many of whom could have been surviving outside a family setting for years, managing their day-to-day lives as de facto adults.

HIV and child protection communities can also join forces to draw attention to, and condemn, the abuses perpetrated by involuntary detention— in line with the clear recommendation of the Global Commission on HIV and the Law that such compulsory detention and rehabilitation centres should be shut down.[16]

It is also important to focus the resources of the global community on addressing specific knowledge gaps: better strategic information so that programmes can be designed based on real estimates of the size of this group, with disaggregation by sex, age, geographical location, and their unique circumstances; and implementation science to show which approaches work best for this population, including those with overlapping vulnerabilities, such as those who also use drugs or are homosexual, bisexual, or transgender.

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It is of course essential that evidence and rights-based efforts should be improved to protect children from all forms of sexual exploitation, including preventing them from ever getting involved in selling sex. It is crucial, however, that programmes and policies for sexually exploited children and adolescents aged 10–17 years who sell sex are not merely based on assumptions. Instead, policy makers, programmers, researchers, and youth organisations should work together to ensure that adolescents are involved at all levels of programme and policy design, implementation, and evaluation, so that the response is shaped by their realities, needs, and aspirations.

Craig McClure, Caitlin Chandler, Susan Bissell
UNICEF, New York, NY 10017, USA (CM, SB); and HIV Young Leaders Fund, New York, USA (CC)
cmcclure@unicef.org

We declare no competing interests.

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