RESEARCH REPORT

CHILDREN, HIV/AIDS, AND SEXUAL EXPLOITATION:

STRENGTHENING SYSTEMS FOR THE RIGHT TO PREVENTION, PROTECTION, AND RESPONSE IN NEPAL AND TOGO

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Acronyms

AIDS:	Acquired Immunodeficiency Syndrome
ART:	Anti-retroviral therapy
ARV:	Anti-retroviral
CDC:	Center for Disease Control and Prevention, Washington, D.C.
CGHD:	Center for Global Health and Development at Thammasat University
CSEC:	Commercial Sexual Exploitation of Children
ECPAT:	End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes
FGD:	Focus Group Discussion
FRC:	Field Research Coordinator
FSW:	Female Sex Worker
HIV:	Human Immunodeficiency Virus
IBBS:	Integrated Bio-behavioral Survey
IDU:	Intravenous drug user
KII:	Key Informant Interview
MARG:	Most at risk population
MSM:	Men who have sex with men
MTCT:	Maternal to Child Transmission of HIV (PMTCT = Prevention of…)
NGO:	Non-governmental Organization
NHRC:	National Health Research Council (Nepal)
PI:	Principal Investigator
SPSS:	Statistical Package for the Social Sciences
UNAIDS:	Joint United Nations Program on HIV/AIDS
UNGASS:	United Nations General Assembly Special Session on HIV/AIDS
VCT:	Voluntary Counseling and Testing
WAO Afrique:	World Association for Orphans Africa
YPP:	ECPAT's Youth Participation Project

Operational definitions

Child: under the Convention of the Rights of the Child (1989), a child means every human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier.

Commercial Sexual Exploitation of Children: performance of a sexual act with a child with a promise of reward to the child in money or in behavior (e.g., promotion in school, better grades, a job, other favors).

Vulnerable child: a boy or a girl child at increased risk of sexual exploitation, having two or more of the following characteristics: (i) missing one or both parents, (ii) drop-out from school, (iii) living away from parents or without a visible guardian, (iv) living on the street, (v) already engaged in commercial sexual exploitation, (vi) having one or both parents infected with AIDS, (vii) coming from a family in the lowest economic quintile.

Transactional Sex: any sexual act performed for the benefit of a service or reward; often intergenerational and may be used as sexual favors to meet basic survival needs, i.e., food, shelter, and clothing; sex in exchange for economic or material support.

Intergenerational Sex: sex between a child and a person at least 10 years older.

Child safe facility: a facility where a child can go without fear of exploitation, discrimination, or stigma.

Vertical transmission of HIV infection: mother-to-child transmission of HIV virus during pregnancy, labor, deliver, or breastfeeding.

Non-vertical transmission of HIV infection: any transmission other than mother-to-child, i.e., from unprotected sex with an HIV infected person, contaminated needles or other instruments, or contaminated blood products.

HIV: Human Immunodeficiency Virus that occurs in at least two serotypes (I and II).

AIDS: Acquired Immunodeficiency Disease that occurs when the immune system of the host is destroyed by the HIV leading to opportunistic infections that can be debilitating or fatal.

OraQuick® rapid HIV antibody test: an oral test for the presence of HIV antibody in the gingival (gum) crevices of the mouth.

Acknowledgements

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Final acknowledgement goes to all of the young people who made this study possible: the ECPAT youth motivators and peer supporters in and around Kathmandu, and in Lomé and Atakpamé, who proved that good research can be done by well-trained youth as long as they are as motivated and committed to helping their peers as this group was.

Executive Summary

Children who are vulnerable to commercial sexual exploitation are also vulnerable to infection with HIV. However, because they often live on the margins of society and outside of the health system, they are rarely identified as at risk of HIV nor are they measured for HIV infection. As such, they neither appear in the numerator nor in the denominator of national HIV statistics. As a result, they may be infected without knowing their HIV status, and will only access the health system when they have developed an opportunistic infection related to AIDS. In addition, because of a lack of information on their status, programs directed at HIV/AIDS may not include children vulnerable to commercial exploitation in the key populations at risk of HIV (i.e., female sex Workers, men who have sex with men, intravenous drug users, or people receiving blood transfusions). In some cases, child protection agencies that work with children in or at risk of commercial sexual exploitation may not include HIV or AIDS prevention programs in their interventions.

In order to measure the extent of HIV infection in this group of vulnerable children and to understand how their infections could have been identified earlier, and how they could be better educated about the dangers of HIV, a study was done of HIV prevalence in 308 randomly selected vulnerable children in Kathmandu. The children were also interviewed to garner an understanding for their attitudes, knowledge and behavior related to living and work conditions, schooling, and sexual behavior in a joint project by ECPAT International and the Center for Global Health and Development of Thammasat University. An additional 151 children were also interviewed using the same survey instrument in two cities in Togo, Lomé and Atakpamé, in order to correlate responses that might predict vulnerability to HIV infection in those surroundings. The study built on the strengths of the Youth Partnership Programs that operate in both Nepal and Kathmandu through the auspices of two NGOs: Maiti Nepal and WAO Afrique.

Children between the ages of 15 and 25 years old were included in the sampling frame if they fulfilled two of six inclusion criteria that defined vulnerability (i.e., having lost one or both parents, one or both parents infected with HIV, recently dropped out of school, living on the street for more than two weeks, living away from home for more than two weeks, working on the street during school hours or at night, known to be involved in CSEC, working in the entertainment industry, or domestic workers). After receiving informed consent and assent, their HIV status was tested anonymously using a rapid, oral non-invasive HIV antibody test (OraQuick®).

Prevalence levels of HIV infection were high. In the entire sample, 11 children tested positive for HIV; for children $<$ 18 years the prevalence was 3.7%. For girls who reported being sexually active, the prevalence was 9.4%. These prevalence figures are higher than those of female sex workers (2.2%) in Kathmandu and the clients of sex workers (2%), and compare with those of men who have sex with men (3.8%). Of concern is that only four out of the 11 who tested positive

for HIV infection had been previously tested for HIV – the others have remained outside of the system, concealing a hidden epidemic unknown to the government or to the health care delivery system.

The results of the survey linked these infected children to major risk factors: coming from a poor family, having lost one or more parents, and early debut of sexual activity (≤15 years). Infection was through sexual transmission; there were no intravenous drug users or blood transfusions in the infected group. The same risk factors were found, often to a greater degree, in the Togo sample, suggesting that should those children be tested (the Government of Togo denied permission to use the rapid oral test), they would be found to have the same if not higher prevalence as those children in Nepal.

This report includes a number of recommendations, the most important of which is that every effort should be made to get these children tested through improved access to free counseling and testing services. This is the only way that AIDS can be prevented. In Nepal, there was no resistance to the use of the rapid oral test, and its advantages (i.e., no discomfort from injection, no possibility of blood contamination or contagion, easy and safe disposal of used kits, etc.) made it particularly suitable for testing in the neighborhoods or environments where these children live. It is also imperative to use this contact for the prevention of HIV infection as well, by educating children about safe sex, and by identifying a concerned adult or young person who can be a mentor or support to these otherwise marginalized and often isolated children. There is every indication that the children in Lomé and Atakpamé are at risk and efforts should be increased to reach these children with safe and confidential testing and education.

Finally, it is hoped that the significance of the high prevalence of HIV infection in this group of vulnerable children will provide the evidence needed to consider them as a key population at higher risk of HIV similar to FSWs, MSMs, and IDUs. They should be included as a priority group in local and national HIV/AIDS programs as well as programs for prevention of commercial sexual exploitation of children.

Background

Findings from an ECPAT multi-country study in 2006-7 in six African countries (Ethiopia, Kenya, The Gambia, Togo, Uganda, and Zambia) indicated that children in situations of or at high risk of sexual exploitation have very poor knowledge of HIV/AIDS, are unaware of different means of protection against infection and do not have access to information, testing, or treatment services for HIV or other sexually transmitted diseases. (ECPAT 2007) Among 700 children surveyed, those involved in commercial sex reported that, based on previous negative experiences at the hands of law enforcement, they rarely accessed social services and other forms of support due to their fear of being exposed and discriminated against, in large part due to the elusive/private nature of child commercial sexual exploitation and its illegality. Many of these children are missed by mainstream prevention and protection programs as well as by specialized HIV/AIDS initiatives and those of the child protection system. (Interagency Task Team UN Population Fund, 2008) Often, the HIV status of these children is unknown, and may only become evident when they have developed full-blown AIDS, at which point treatment is more difficult, and results less positive. Consequently, these children remain uncounted and unrecognized in programs designed to address the problem of HIV and AIDS in children. There are a multitude of youth-centered HIV programs that have been undertaken in the last fifteen years, but the majority of programs have not focused solely on vulnerable children and the interlinkages between vulnerable children and HIV.[1] Other programs have address the stigma and isolation associated with HIV within communities but have not focused exclusively on the obstacles that children face in regards to HIV-related social ostracism. (UNAIDS Best Practice Collection 2005) Similarly, many of the HIV prevention programs previously undertaken have failed to reach sexually exploited children in part because they center around education, public health, and public service systems[2] and as such are not able to reach sexually exploited children who are frequently outside the scope of every-day civic society initiatives and basic services.

The ECPAT study demonstrated the value of working with a group of peer surveyors who could not only identify and find these children, but could establish sufficient trust so that the children surveyed were willing to be open and direct about their experiences. The study, however, was designed to examine the degree of risk exposure rather than the actual prevalence of HIV infection.

Various other studies have examined child and youth risk exposure to AIDS. Most of these concentrate on children affected by AIDS (Lancet 2006), children infected with HIV from birth through Parent-to-Child Transmission of HIV (PCT) (Lindegren, Steinberg, Byers 2000; Tardieu, Rouzioux, Le Deist, Fukunaga 1990); children from families where one of the parents is either sick or has died from AIDS, children from homes impoverished because

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[1] For example, in 1998 the UN initiated a campaign "Children living in a world with AIDS". The program initiated several position papers to raise issues relating to children and families affected by the HIV epidemic with the intention of raising awareness of the complex and difficult problems now faced by many countries. See e.g. Elizabeth Reid, Children in Families Affected by HIV Epidemic: A Strategic Approach, HIV and Development Program, 2003, available at http://v2.ovcsupport.net/libsys/Admin/Documents/Children_in_Families_Affected_by_the_HIV_Epidemic_A_Strategic_Approach_1.pdf.

of the disease or where impoverishment drives them to risky behavior (De Vogli, Birbeck 2005), or children who are subject to discrimination or stigmatization because they or a member of their families is living with HIV/AIDS (Deacon, Stephney 2007; Deacon 2006). In general, these are children who are known to the system – known because of their affiliation with someone else that is HIV infected.

Most studies examine the factors that contribute to the child's vulnerability rather than measure prevalence of HIV infection. They tend to report on the characteristics of individuals that place them in key populations at higher risk of HIV exposure: Female Sex Workers (FSM), Men who have Sex with Men (MSM), Intravenous Drug Users (IDU), and people requiring blood transfusions. These are groups known for their high risk of exposure to HIV infection through unsafe sex, shared needles, multiple partners, unsafe blood supplies, etc. Some studies of children focus on defining their "vulnerability" in part by analyzing various educational/awareness and socio-economic factors that make vulnerable children more susceptible to risk behaviors and also to HIV. Accordingly, there are many studies that have examined vulnerable children's institutional knowledge of HIV, namely what it is, how it is transmitted, how it can be prevented, and how it can be treated. (Childinfo 2011) Other studies examine the socio-economic factors of vulnerable children that would make them susceptible to HIV such as their schooling, age, family and living situation[3], where they work (Gilligan, Rajbhandari 2004), and their sexual behavior and experience.

These studies share many similarities with those aimed at gaining a better understanding of children at risk of commercial sexual exploitation (CSEC), trafficking, or abuse. However, the two bodies of literature on HIV/AIDS and CSEC tend to stay separate with little crossover between the two. Few studies related to CSEC consider the question of HIV infection, and studies of HIV and AIDS in children rarely dwell on the similar risks to that group in terms of commercial sexual exploitation. When studies consider both topics, the questions are usually related to vulnerability and not to prevalence of HIV infection.

Earlier research in pediatric HIV infection in children focused on the 90% of children who had acquired HIV through maternal to child transmission. However, as the numbers of infected children increased, it became apparent that there were more infected children than there were infected mothers. (Hiemstra, Rabie, Schaaf, Eley, Cameron, Mehtar 2004; Okinyi, Brewer, Potterat 2009) Various theories have been advanced to explain these increased numbers including sexual exploitation as well as transmission through contaminated needles in immunization programs, hospital acquired infections, etc. (Drucker, Gisselguist, Potterat, Rothenberg 2002) There are no large-scale studies that have tried to match the behavioral characteristics of children vulnerable to CSEC with actual prevalence of HIV infection. Nor have there been studies that examine the risk and health seeking behavior of children infected with HIV who are not members of accepted key populations at higher risk of HIV exposure.

The importance of separating HIV from AIDS is a key element that is at the heart of this

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[2] For example, in the latest UNICEF 2011 Report, Opportunity in Crisis: Preventing HIV from Early Adolescence to Young Adulthood, there is much discussion about the importance of education, particularly sex education in schools, stating that sexuality education can increase knowledge and contribute to more responsible sexual behavior. The UNICEF report points out that in 2007, 88 out of 137 reporting countries included HIV education as part of the primary school curriculum, and 120 included it in secondary schools. While the report discussed the lack of educational access of children with disabilities, there was no mention of the frequent lack of access to schooling and sexual education that vulnerable children who are sexually exploited experience.

[3] For example there has been extensive writing about the linkage between poverty and children and HIV, see e.g. Alayne Adams, Alec Irwin, and Anne Winter, Home Truths Facing the Facts on Children, AIDS, and Poverty, Final Report of the Joint Learning Initiative on Children and HIV/AIDS, François-Xavier Bagnoud, Center for Health and Human Rights, Harvard University,2009 available at http://www.harvardfxbcenter.org/pdf/JLICA%20Final%20Report.pdf.

study. In the past, HIV/AIDS was considered one entity, since HIV infection, prior to anti-retroviral therapy (ART), inevitably led to AIDS and to death. Prevention of HIV infection through safe sex, non-sharing of needles, safe blood supply, and reduction in the number of sexual partners was the only prevention of AIDS. Now, with available and effective therapy, the prevention of HIV and the prevention of AIDS represent two separate entities: prevention of HIV infection through the traditional interventions mentioned above and prevention of AIDS through early diagnosis by safe and confidential testing, timely and appropriate introduction of ARTs with follow-up care, support to guarantee adherence to treatment regimes, and identification and treatment of opportunistic infections, should they arise.

The risky behavioral characteristics – sexual and health seeking – of the population studied by ECPAT in Africa and the growing problem of non-vertical transmission of HIV infection are the factors that stimulated this study. The first challenge was how to find out the extent of the problem of HIV infection in a population not identified as being at higher risk of exposure. This step was considered essential in order to lobby the health establishment, those working in HIV and AIDS, child protection agencies, and the Government itself to give more attention to this group of vulnerable children. Identifying the extent of the problem was deemed to be an essential first step in understanding in more detail the behavior that can lead to HIV infection, and the behavior that can lead to AIDS. Eventually it is hoped that the information gained from the study will help develop strategies to improve the access of marginal children to appropriate and child-safe health care delivery and testing facilities.

HIV and AIDS in Nepal

Nepal is defined as a "least developed country," suffering from poor socio-economic conditions due to illiteracy, unequal geographical distribution, and political instability. (UNDP 2011) Since the first detection of HIV infection in 1988, the problem has increased despite efforts from the Government, NGOs and international donors. (Southon, Gurung, 2005) Hence, from a low prevalence state, it has shifted to a concentrated epidemic. The prevalence is high among most-at-risk populations (MARP): female (2.2% prevalence in Kathmandu) and male sex workers (5.2% prevalence in Kathmandu), clients of sex workers (2% prevalence), injecting drug users (20.7% prevalence in Kathmandu), men who have sex with men (3.8% in Kathmandu), migrants and their spouses and their children, and street children. The migrant population warrants special attention as it is estimated to account for 40% of the total population infected with HIV. (UNAIDS 2010)

According to the National Centre for AIDS and STD Control (NCASC), by August 2010, 16,262 people in Nepal had been diagnosed with HIV, although estimates for the adult population put the figure much higher, at 70, 253 (UNAIDS 2010). This difference in numbers is due to inadequate surveillance, poor data recording systems, and the ostracized and marginalized nature of those who are at high risk, such as street children

and irregular migrants. Among the infected, it is estimated that 6.5% are children and adolescents; almost every case identified is through vertical transmission from mother to child.

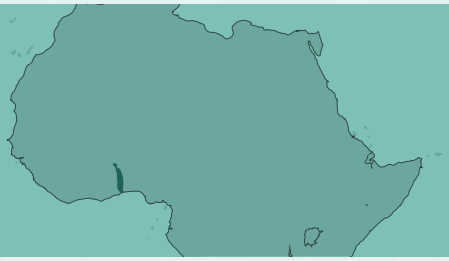
It is likely that a large number of less visible children are vulnerable to HIV infection due to political instability, forced participation in armed uprisings, loss of parents due to HIV/AIDS or other causes, and poverty. The loss of both parents often forces children and adolescents to leave home and work in neighboring countries like India or in risky employment within Nepal. Data has clearly shown that the prevalence rate of HIV varies among migrant workers depending on their location: 0.8% in far western districts and1.4% in western districts. However, the prevalence in spouses of male migrant workers gives an ominous indication of the direction the epidemic is moving: 3.3% in far western districts. (UNAIDS 2010) However, prevalence data for children going to work and/or migrating has not been collected.

Another indicator of vulnerability – having lost one or both parents to AIDS or other causes – is also significant in Nepal where, according to the International Labor Office, the estimated number of orphans in Nepal in 2010 was 804,000. At times, Nepalese orphans end up becoming street children who are thrust into street subculture and exposed to high-risk activities such as injecting drug use (IDU) and random sexual encounters. Local NGOs estimate that of over 500 street children identified in Kathmandu and Pokhara, over 78.5% of the male children had engaged in high risk sexual behavior, and 60% of the male children who used drugs, shared needles. (Britten 2010)

A recent survey of the knowledge, attitudes and practices of Nepali teenagers and street children revealed that premarital unsafe sex was accepted in young adolescents (13-19yrs old) (UNICEF 2001) with peer pressure acting as a strong determinant for risky sexual behaviors and needle sharing. (Southon 2005) The study also showed less knowledge of HIV/AIDS and misconceptions about the transmission of HIV infection (UNICEF 2001).

Increasingly in Nepal there is a thriving commercial sex sector. In the Kathmandu Valley, there are approximately 11,000-13,000 females engaging in commercial sex, with as many as one third of the women likely to be under the age of 18. (Basnyat, Aguettant 2010) Knowledge of ways to prevent sexual transmission among the women and youth is poor with only 30% having a firm understanding of HIV and its prevention. (Basnyat, Aguettant 2010)

Although the Government of Nepal is aware of the HIV/AIDS crisis in Nepal, there been few actions implemented to prevent the risky behavior of these children and adolescents; there is also a lack of systematic HIV data in this group. (OurSansar 2010) There seems to be a gap in the dissemination of information and inadequate support from the health system. The hope is that through the outcome of this research the extent of the problem will be defined in a way that could help in the development of policies and programs targeting children at risk.



HIV and AIDs in Togo

According to UNICEF, in 2007, 130,000 people in Togo were infected with HIV, with a prevalence rate of 3.3%. (UNICEF 2010) The prevalence in males and females aged 15-24 is estimated at 0.8% and 2.4%, respectively. Ten thousand children under 15 are estimated as living with the AIDS virus. (AIDS Factsheet Togo 2008) Many of these infections, particularly in those under 5, are likely to be the result of maternal to child transmission of the virus (vertical spread). However, there is an established and growing link between child trafficking and HIV/AIDS within Togo, particularly as it relates to vulnerable children, such as children who have been orphaned due to HIV/AIDS.[4] The high number of children infected is said to be due to children and youth's low level of awareness as far as HIV/AIDS is concerned and a limited understanding on how to follow protection guidelines. Efforts to protect HIV/AIDS-affected children from exploitation and abuse in Togo are often compromised by the deep stigma with which these children live. (Cohen 2003) Based on data from previous studies and discussions with partner organizations in Togo, there is grave concern that a large number of vulnerable children and those already involved in exploitative sexual activity may already be infected with HIV. (Lindegren, Hansen, 1998; Brody, Gisselquist, Potterat, Drucker 2003)

The prostitution and trafficking of children for sexual purposes, as well as the trafficking of children for labor purposes and subsequent abandonment on the street are serious problems in Togo. A small study on prostitution among minors in Lomé in early 2005 in four zones of the city conducted by the NGO "Carrefour de Développement" showed that 105 girls were prostituting themselves to survive. Girls are the most victimized, but lately boys, with the increase in reporting of homosexual behavior in the country, are also known to be victims. There is ample evidence of sexual abuse within the home, in the community, at school, and in the workplace. (Carrefour De Developpement Association 2005) There is also evidence of the child sex tourism phenomenon in Togo (Martin-Achard, Bonnaud, 2008; ECPAT Togo, 2011), where young are forced to eke out a living from relationships with tourists in hotels and guesthouses. Sexual abuse of children by adult Togolese men, sexual abuse and exploitation of schoolgirls by male teachers, (Morgan 2006) and incest are said to be widespread in the country. (ECPAT Togo 2007) The government in Togo is aware of much of this problem, and has developed a program and the production of manuals for HIV/AIDS prevention. In addition, HIV/AIDS prevention is taught in schools as part of the Population and Family Life Education curriculum.

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[4] Jonathan Cohen, Borderline Slavery: Child Trafficking in Togo, Human Rights Watch, 11 Vol. 15, No. 8 (A) (2003). . The potential for AIDS-affected children to contract HIV and other sexually transmitted infections as a result of child trafficking has been described as a: "[a] vicious circle is created because these children, left to their own resources without moral, financial or emotional support, are vulnerable and susceptible of sinking into delinquency (theft, drugs) and prostitution only to meet the same fate as their parents, that is to die of AIDS. Akolatse and Djonoukou, "Analyse de la situation des orphelins," p. 36. Girls may be more likely to contract HIV as a result of labor exploitation, as occupations such as prostitution or domestic work expose them to sexual violence and coercion as well as unprotected sex generally. See, e.g., UNICEF, "Child Domestic Work"; Human Rights Watch, "In the Shadow of Death," p. 16.

Research Partners

The Center for Global Health and Development at Thammasat University is a center for research and continuing education in the Faculty of Public Health at Thammasat University in Bangkok, Thailand. The center specializes in multidisciplinary research studies designed to maximize policy relevance and utilization both within and between countries, and continuing education programs that integrate topics and teaching methods from the various Faculties of Thammasat University.

ECPAT International is an international NGO that has been working at the forefront of global initiatives to combat the commercial exploitation of children (CSEC) since 1991 with a key mandate to support and monitor the implementation of the Stockholm Agenda for Action against CSEC. It is the only globally recognized Network of Child Rights Organizations that has a specific focus on commercial sexual exploitation with currently 82 member groups in 75 countries. It has been working through partner organizations in Nepal since **2005**.

Maiti Nepal is a NGO that was established in 1993 and is dedicated to the welfare of girls and women who are sexually abused, those who are exploited through prostitution, and those who are living with HIV/AIDS. It operates prevention, transit, and rehabilitation homes in high-risk areas of Nepal where girls are in danger of CSEC and trafficking. An executive board governs Maiti and a senior management team oversees daily operations. Major achievements include: the World Children's Prize in 2002 awarded by the Queen of Sweden and the Reebok Human Rights Award

WAO Afrique – Togo, is an ECPAT network member group and has helped establish a regional network against child trafficking and child domestic labor. Since 2002, ECPAT International has provided financial support for the position of a sub-regional coordinator, based at WAO Afrique, to enhance efforts and increase visibility of CSEC issues in the West Africa Francophone sub-region. WAO Afrique has also created a regional research and information centre based in Togo in collaboration with the African Network for the Prevention and Protection against Child Abuse and Neglect (ANPPCAN) to address the information gap on child trafficking.

Research Objectives

This study had the following objectives:

1. To identify the magnitude of the problem of non-vertical HIV infection in children at risk of or already involved in commercial sexual exploitation in order to provide evidence for program policy, design, resourcing, and implementation.
2. To identify the factors that prevent vulnerable children from accessing voluntary counseling and testing for HIV and AIDS, and other sexually transmitted diseases in order to increase their access to testing, diagnosis, and care.

Research Questions

1. What is the prevalence of HIV infections among vulnerable children at risk of or already involved in CSEC?
2. What is the knowledge of HIV infection and AIDS and attitudes towards the health system among vulnerable children at risk of or already involved in CSEC that impact on their health seeking behavior?
3. Do measures taken to improve the child friendliness and safety of health and other HIV testing facilities lead to an increase in the number of vulnerable children at risk of or already involved in CSEC who get tested for HIV?[5]

[5] This last research question is part of the three-year design of the research and is to be measured in the second and third years only.

Methodology

Research design

The design of this study is in three parts according to the research objectives listed above:

1. In order to identify the magnitude of the problem of non-vertical transmission of HIV infection in children at risk of or already involved in commercial sexual exploitation, an anonymous prevalence survey of a randomly selected sample of vulnerable children ages 15-25 years was done in Kathmandu using the OraQuick® rapid test of antibodies to HIV I and II from a gingival swab[6].

2. In order to identify the factors that prevent vulnerable children from accessing voluntary counseling and testing for HIV and AIDS, a survey was done in Kathmandu (Nepal), Lomé (Togo) and Atakpamé (Togo) of the attitudes, knowledge and practices of vulnerable children ages 15-25 years. In Kathmandu, the survey was administered at the same time and to the same children as the HIV antibody prevalence survey.

3. In order to get more details on health seeking behavior, focus group discussions (FGDs) and key informant interviews (KII) were conducted by each of the participating youth partnership groups and NGOs, supervised by the Field Research Coordinator.

Study sites

In order to develop an approach to the problem of children vulnerable to HIV infection that could be generalized to other countries in the developing world, this study was conducted in Africa (Togo) and Asia (Nepal). The choice of the two countries was based on the presence of well-established ECPAT youth programs that had been able to reach and work with vulnerable children, and on the representativeness of the countries with regard to the joint problems of commercial sexual exploitation of children and HIV infection.

Within Togo, the study was conducted in two urban settings: the national capital Lomé (population of 837,437; metro population 1.57 million) and Atakpamé (population 84,979). Lomé was chosen as it has the highest rates in the country for both CSEC and HIV/AIDS. Atakpamé is approximately 150 km north of Lomé, along the major north-south highway in the country, which forms a major truck route and artery for movement of people, and is also a site of commercial sexual exploitation. Both have active youth organizations working within the ECPAT network of partners as a part of the YPP project.

In Nepal, the prevalence survey and related interviews were done in the urban setting of Kathmandu (population 989,273). It was conducted in three districts: Kathmandu, Bhaktapur, and Lalitpur. The survey drew from

[6] The prevalence survey with the oral antibody test kit was only conducted in Nepal as the government approved its use there, while the government of Togo refused its use.

populations in these districts. The city is known for its large migratory population with both inward and outward migration and trafficking. It is also known for its large number of children and youth living in the streets and working in hazardous labor conditions.

Within each city, subjects were identified in clusters surrounding each of the partner NGOs who worked with vulnerable youth, and who were committed to fighting CSEC.

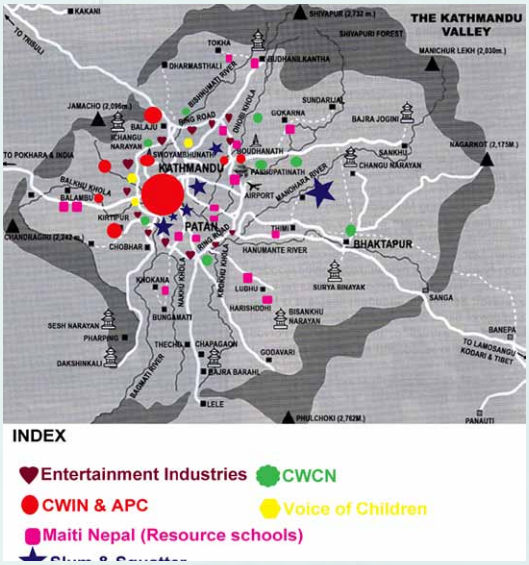

Figure 1: Map of Kathmandu

Sampling frame

During the training that preceded each country survey, participants were asked to arrive at a consensus of **inclusion** and **exclusion** criteria that would be used to identify "vulnerable children." This list was shared between countries for consistency and agreed upon. Each NGO member was then given the list of inclusion criteria and asked to use their peer supporters to identify all children and youth (15-25 years old) in their catchment area fulfilling at least two of the criteria. The identified children and youth were not only those already enrolled in the program run by the NGO, but were from the area around the NGO offices.

In Togo, an overall population of 3300 vulnerable children was identified; in Nepal, approximately 4900 vulnerable children were identified (see inclusion criteria below).

Inclusion criteria

Included in the sampling frame were all children and youth ages 15-25 years old considered poor by the local community NGO and living in Kathmandu, Lomé, or Atakpamé who fulfill two or more of the following criteria:

- Having lost one or both parents
- One or both parents infected with HIV
- Recently dropped out of school
- Living on the street for more than two weeks
- Living away from home for more than two weeks
- Working on the street during school hours or at night
- Known to be involved in CSEC, working in the entertainment industry, or as a domestic worker

Exclusion criteria

Excluded from the sampling frame were children and youth from families considered well-off by the local NGO who fulfill any one the following criteria:

- Living with both parents at home
- Living outside of Kathmandu, Atakpamé, or Lomé
- Children who are mentally or developmentally unable to comprehend the questions or appropriately, or to give assent to participation

Sampling method

A cluster sample method was used, with probability proportional to size used to determine the number of subjects to be drawn from each cluster. The clusters were formed in the catchment areas of the NGOs that participated in the study and were located in different zones of each city (as an example, see map of Kathmandu).

Sampling procedure

In each city, the study sites were mapped showing the locations of NGOs and other organizations working in all geographic sectors. In Lomé, NGOs were invited to participate in the study in order to capture populations in key areas of the city. The mapping exercise in Kathmandu (see map) shows (i) areas of high risk behavior (e.g., entertainment industries), (ii) partner NGO sites used for identifying the sampling frame, and serving as the locus of clusters for sampling, and (iii) places of high density of vulnerable populations. The catchment area of each NGO was then mapped showing streets, houses, schools, and other dwellings. Within these catchment areas, vulnerable children were identified and the location where they usually worked or spent the night was noted on the map.

Once the sampling frame had been determined, vulnerable children and youth aged 15-25 (this population was stratified between children aged 15-17, and youth aged 18-25) were selected from each of the clusters identified by the five participating NGOs from the different zones of each city. In Togo, a decision was taken to focus only on the 15-17 year olds in the sampling frame. Using probability proportional to size method guaranteed that the number of subjects drawn randomly from each cluster was weighted against the number of children identified in the sampling frame from that NGO's catchment area. In this way, an NGO that covered a wider area and identified more children for the sampling frame drew a larger sample than the other NGOs. Children's names were put in a hat. The Field Research Coordinator supervised the blindfolded drawing of the sample. Selected children were then approached for consent and assent to participate in the study.

Sample size estimation

Sample size estimation was based on the formula:

$$n = \frac{z^2_{\alpha/2} P (1-P)}{d^2}$$

Where:

- n = minimum number of respondents/ sample required
- z = standard normal deviation at 95% confidence level (1-α), (Z=1.96)
- P = proportion of vulnerable children estimated to be HIV infected.[7]
- d = 10% standard error
- α = significance level

$$n = \frac{(1.96)^2 (0.50 \times 0.50)}{(0.1)^2} = 96$$

This generated a sample size of 96 was the sample size for each stratum. However, in order to compensate for the lack of total randomization caused by the cluster effect, a design effect factor of 1.5 was used to increase the sample size accordingly (96 x 1.5 = 144). In addition, based on the preliminary reports of several community based NGOs, it was estimated that 10% of children selected would refuse to be either tested or interviewed. Therefore, an additional 10% was added to the sample (144 + 14.4 = 158.4). This was rounded up to give a sample size of 160 per stratum. Therefore, the total sample for the two strata was 320 children and youth

[7] As this number was not known, by standard convention the proportion was estimated as 50% in order to select the highest sample size.

per country, giving an estimated total sample size of 640.

Instruments

1. **Survey of prevalence of HIV infections in vulnerable children in Kathmandu:** The OraQuick® Rapid Antibody Test for HIV-1/2 is an oral test for HIV antibodies to serotypes I and II detected in the crevices of the gums (gingival) around the teeth. It is performed with a special swab in a single circular motion that wipes both upper and lower gums. The swab is attached to an indicator strip that is placed in a vial containing a developer solution. The test should be read between 20-40 minutes after being taken. The test has a sensitivity of 99.6% (i.e., it correctly identifies HIV infected people 99.6% of the time) and a specificity of 99.8 (i.e., it correctly identifies non-infected people 99.8% of the time) with a positive predictive value of 100, and a false negative rate of 0.1. (Doyle, Levison, Gardner, 2005; CDC 2004; O'Connell, Merritt, Malia, VanCott, Dolan, Zahwa 2003)

Figure 2: OraQuick® test kit

The test was **not** used to diagnose HIV infection in individual children[8]. Each child was tested only once, and the test results were identified with a five-digit randomly selected number that was not linked to the child's name but was the same code as that used to identify the child or youth's responses on the survey. The test was not repeated on a child or youth, nor were HIV+ results confirmed through other testing procedures. The instrument was only for an estimate of prevalence of HIV infection in this vulnerable population and, as such, was considered to have satisfactory precision for that purpose. The result of the survey were expressed in percentages: i.e., prevalence = the number of children who are HIV infected ÷ the total number of children sampled x 100.

2. **Survey of knowledge, attitudes, and health seeking behavior by vulnerable children with regard to HIV testing in Kathmandu, Nepal.** In order to understand the reasons for the failure of vulnerable children to access facilities for voluntary counseling, testing and care of HIV, the children and youth in both countries (including those in Nepal who had consented to the oral test) were asked some simple *but not identifying* background questions in order to develop a profile of the sample population with regard to age, status of parents (living or deceased), health seeking behavior (including HIV test history of the child and reasons for going or not going for testing), history of infectious diseases, and treatment history, etc. The questionnaire was identified with the same randomly selected five-digit number that identified the oral sample. (See annex)

[8] The OraQuick® test can be used for diagnosis, but, as with other HIV tests it must be repeated in order to validate the results.

3. **Key Informant Interviews and Focus groups discussions** on topics of attitudes around health seeking behavior were conducted in Kathmandu. The list of Key Informants was drawn up by the participants of the three-day training at the onset of the study. Focus Group discussions were held with groups of 15-17 year olds, and 18 – 25 year olds separately, as well as with the nursing staff of local hospitals, testing centers, and clinics. These discussions allowed a more in-depth understanding of attitudes and behavior than could be gained from the brief structured questionnaires taken during the prevalence survey.

4. **Pre-testing** of all research instruments used in both countries was done during the pre-survey training in order to test reliability and assess the validity of the questionnaire. The trainees, all of whom had field experience in the topics being assayed, reviewed each question. Subsequent to the training, the questionnaires were **field tested** with a small number of subjects to once again examine any possible problems with reliability or validity. **Translation** was done from English to Nepali, with a back translation to guarantee accuracy.

Data collection, training and supervision

Data was collected by teams of trained field researchers under the supervision of the field research coordinator, and youth motivators from the ECPAT YPP program. In general, youth motivators and peer supporters did the surveys from that program. youth Motivators and peer supporters are in many cases experiential youth (i.e., youth who have been involved in CSEC themselves) who come from the communities in which they work. For this reason, they were particularly well suited to establishing a trusting relationship with the subjects and in eliciting straightforward answers to the most difficult questions.

The training on questionnaire administration, focus group discussion technique, and use of the OraQuick® test was done by the principal investigator from the Center for Global Health and Development, assisted by the field research coordinator and the ECPAT YPP Project Coordinator in a three-day training held in Lomé and Kathmandu. The training involved role plays of interviews and focus group discussions, lectures on HIV antibodies and how they relate to the OraQuick® test, discussion of the principles and concepts of randomization and sampling, and data reporting and recording.

The field research coordinator supervised the data collection, including the sample selection, identification of sample subjects, and, in Kathmandu, the prevalence survey.

Local site for data collection

In Kathmandu, the children who assented to the swab and the questionnaire were asked to come to a local NGO site, where both swab and interview could be done confidentially. An independent research assistant in a room or place separate from the one where the specimen was taken read the results of the samples.

In both countries, the questionnaire was administered in a separate place that offered

privacy and confidentiality, and, in the case of Kathmandu, in order to guarantee that there would be no association between subject's identity, his or her responses to the interview, and the results of the rapid antibody test. In addition, in Lomé and Atakpame, a nurse was present who screened children for any intercurrent illnesses or health problems.

Facilitators trained by the principal investigator during the three-day training conducted focus groups.

Data analysis

Data entry

Data from the questionnaires was manually recorded in the field and coded according to responses developed during pre-testing and subsequent field-testing. Coded answers from the manually recorded survey were entered on an Excel spreadsheet at the field level where some preliminary analysis was done. The Excel spreadsheets were then sent to the Center for Global Health and Development where staff from the Center cleaned the data and entered it into SPSS (v. 16) for further analysis.

Data from the focus group discussions and the key informant interviews from Nepal was manually recorded and processed.

Classification

A specimen from the OraQuick® test was considered HIV + if two lines (one a control, the other a positive reaction) were clearly visible on the indicator strip 20-40 minutes after being immersed in the developer solution. A negative reading was recorded if only the control line was visible. The test was invalidated and repeated if neither line was visible after 40 minutes.

Statistical techniques

Quantitative Data: Prevalence was measured as a proportion of HIV+ test results over a denominator of all tests taken. Analysis of the questionnaires used a combination of descriptive statistics (i.e., frequencies, percentages, means, and standard deviations) as well as other analytical tests (i.e., chi-square, logistic regression) to look for correlations.

Qualitative Data: Focus group discussion results were recorded by hand and summarized in separate reports; these separate reports were then collated in a final report.

Ethical Considerations

Institutional clearance

The Research Protocols and all instruments were submitted for ethical clearance and approved by the National Health Research Council (NHRC) of Nepal (Reg. no. 47/2011), the Comitéde Bioéthique pour la Recherche en Santé of the Ministry of Health, Togo (No. 0355/2011/MIS/CAB/DGS/DGLET/CBRS), and to the Human Research Ethics Committee of Thammasat University (COA no. 041/2544).

Informed consent and assent

In both countries, parental/guardian consent was required for the participation of children under the age of 16 years. In the absence of a parent or a guardian, in accord with international convention, the head of an organization working for children and youth in the neighborhood of the child could give proxy consent for participation (Coyne 2010). In each case, participation was not approved without the assent of the child or youth. (De Lourdes, Larcher, Kurz, 2003) This was requested after a thorough explanation of the details of the study and the test were made to the subject. Children and youth who were literate were given an assent form to read, explaining the details, reasons and risks of the study, and to indicate their assent by signature or verbally. (Broome, Kodish, Geller, Siminoff 2003) When verbal assent was used, a signature of a witness was affixed to the assent form if the child wished not to have his/her name associated with the study.

Verbal assent is accepted in studies with children where identification may pose a risk to the child, and yet where the dangers of the test are considered minimal. (WMA 2008; Harvard 2010)

Confidentiality

Because of the stigma and discrimination faced by people in all societies who test positively for HIV infection, any study that involves testing for HIV infection must employ the highest standards in order to protect the privacy of the individual and the confidentiality of results. Furthermore, any study that has children as subjects (with or without HIV infection as the study question) has an ethical imperative to protect them from physical, psychological or emotional harm. This study raised both of these issues.

Confidentiality in this study was protected by the anonymity of every aspect of the study process. Samples were collected anonymously and recorded by number and not by name so that no results could be associated with the name of any child; responses to the interview questionnaire were kept separate from the sample specimen, and did not bear the name of the child. All data recorded in the primary Excel spreadsheets were under the five-digit serial number. There was no master list linking the serial number with the name of the child.

In addition, all records from interviews were destroyed at the conclusion of the study.

Risks

There were five risks identified at the planning stage of this research: (1) children would be stigmatized by participation in this study, (2) where the rapid test was used, their HIV status would be disclosed, (3) they would want to know the results on-site, (4) they would be harmed by the test itself, and (5) the test specimens would be a danger to the public health of the community. In each case, steps were taken to prevent any of these from becoming problems.

1. **The child or youth will be stigmatized by participation in this study.** Children were brought by hired vehicle to the study sites, so that neither questionnaires nor the rapid test were conducted in the community itself.

2. **There will be disclosure of HIV status.** Because of the strict anonymity of the study, no child or investigator (including the PI and the FRC) discovered his or her HIV status.

3. **Children and youth will want to know the results.** Most respondents demanded to know the results of the study. They were told it was not possible because of the anonymity of the testing procedure to identify a child with a test result. Half of the respondents asked to know where they could go to be formally tested and were referred to a nearby VCT testing site for free testing.

4. **The child or youth may be harmed by the test itself.** As the test did not involve any injection or use of any instruments that were painful or invasive in their administration or dangerous if contaminated this was not a problem. In addition, since the procedure tested the presence of antibodies to HIV and not the presence of the virus itself, neither investigator nor subject was exposed to the HIV virus in the implementation of this survey. The person doing the test practiced good hygiene and wore protective gloves in order to guarantee no transmission of other infection from or to the child.

5. **The test specimens may represent a danger to the community.** As mentioned above, since the test measured the presence of antibody and not the presence of the virus, the specimens themselves were harmless with regard to transmission of HIV. Nevertheless, all used specimens were collected in a hazardous material box and disposed of at a central location by incineration.

Benefits to the child and youth

Participation in any field research by a child must be of demonstrable benefit to that child. (Morrow, Richards 1996) The benefits in this case are the following:

1. **Access to free counseling, testing and treatment for HIV.** Each child tested was given information on where to go for free counseling and testing for HIV.

2. **Access to free primary health care for any intercurrent infections detected on the day of the survey.** In Kathmandu, 15 respondents needed primary medical services for headache, minor laceration, and fever. All were provided free care. In Lomé and Atakpamé, a nurse was present to care for any minor ailments that the child might be suffering from.

Limitations of the Study

It was difficult to identify all vulnerable children living in the three city sites as the numbers are large and the number of NGOs engaged in working with vulnerable children and youth are small. In addition, many children questioned why they were being included in the study, asking to know why they were "vulnerable." The enlistment of various community NGOs who were known to the children and youth was effective in identifying those children who were included in the sampling frame. In Kathmandu, the fact that only 28 children (8.2%) refused to participate suggests that the questions of most participants were answered to their satisfaction.

The age limits of the study (all children were between 15 and 25 years) prevented the researchers from knowing the prevalence of HIV infection in even younger children. Experienced workers in this field suggested from the onset that the lower age limit should be eight or nine years. This was born out by the history of respondents who recorded eight years as their age at first sexual experience. In addition, increasing the sample size would have strengthened the findings of the study, particularly as the numbers of infected children became small in the process of stratification by age.

While the use of an anonymous study was essential to protect the confidentiality of each child and to avoid any possible negative effect of stigmatization or discrimination, it was of concern to all investigators that the 11 children who were found to be HIV+ in Kathmandu could not be notified for re-testing and, if necessary, started on therapy. A solution to this limitation in the future might be to give each child/youth his or her five-digit identification number so that they could go to a nearby VCT center (where the test results could be transferred) to check their status in a protected environment and in the presence of a trained counselor.

Difficulties arose in the Togo study when the government did not approve the use of the OraQuick® test kits on the basis that they were experimental. The government requested 400 kits to test in the field, before they could arrive at a decision to use them in the study. This information came as the fieldwork was about to begin, making it impossible for the field team to be able to comply and still remain within the one year time frame, and within the budget of the project.

Results

As the prevalence survey was done in Nepal, those data will be presented first, with comparison presented between characteristics and behavior of the overall sample with those who were found positive for HIV infection. The more qualitative results from both Togo and Nepal were important for indicating attitudes toward the health services and health seeking behavior, as well as sexual practices and knowledge of HIV and AIDS transmission and prevention. Comparisons must be made cautiously between the two countries since the Togo sample is of only one stratum (15-18 year olds) compared to the larger and older age range of the Nepal sample.

Sample descriptive (Nepal)

As per the preliminary analysis of data, the **sampling frame** was comprised of 4922 vulnerable children and youth between the ages of 15-25 years, who fulfilled two or more of the inclusion criteria. The **sample** was made up of 350 children and youth, of these, 28 refused to take part in the study, nine records had significant data discrepancies, and five records were duplicate and dropped from the analysis. Therefore this analysis is based on 308 completed records. It must be noted that there is further analysis that needs to be done on this data that will yield more information. This will be done when all data is re-checked and time is given for analysis.

Togo: The sampling frame was comprised of 3300 vulnerable children. A sample of 320 children was drawn, nine children refused to take part and were withdrawn, leaving the final number of 311. The local research team opted to approach children < 15 years of age (ages 11-14 years) instead of using the sample plan of 15-25 year olds as in Nepal. Unfortunately, the consent for the study did not cover this age group and as a result, 160 children under 15 years of age were dropped from the final analysis.

OraQuick® test results and estimated prevalence of HIV for Nepal

In Nepal , the OraQuick® test was given to 308 subjects, 11 of whom were found

Table 1: Estimated HIV prevalence for Nepal sample and sub-samples based on OraQuick® test results

Sample	n	Prevalence*	Lower 95% Confidence Interval	Upper 95% Confidence Interval
Entire sample	308	3.6	1.9	6.0
Children <18 yrs	164	3.7	1.5	7.3
Children who had a sexual relationship history (Q55=1)	172	6.4	3.4	10.7
Sexually active females (Q55=1 and Q2=2)	53	9.4	3.5	19.2
Sexually active males (Q55=1 and Q2=1)	119	5.0	2.0	10.0

*per 100 individuals, or as percent.

The calculation of prevalence of those with a history of a sexual relationship was made because all of the 11 subjects who tested HIV+ reported being sexually active, while none reported intravenous drug use, nor blood transfusions. The prevalence of HIV infection in children – although smaller than the prevalence of HIV infection in the entire sample – is bounded by confidence intervals that indicate a statistically and functionally significant result.

Characteristics of HIV+ subjects

Education and economic status

Of the entire Nepal sample, made up of 182 males and 126 females between the ages of 15 and 25 (mean = 17.8 yrs), 9.7% never attended school, and 42% describe themselves as coming from poor families but who know families who are worse off (16%), or as very poor, the worst off among families of friends and neighbors (25%). 6.7% of those who said they never attended schools were found to be HIV+ versus only 3.2% of those who had attended school. Similarly, none of those who were found to be HIV+ came from the families who considered themselves doing better than their friends and neighbors. More than half came from the two lowest categories of economic self-assessment.

Family health/Living/Working

69.4% of the sample report that their father is still alive, and 74.7% report the same for their mother. 17.8% report having a sick family member in the household. 6.7% of those who had a sick member in the household tested positive for HIV; in households where there was no family member was sick, only 2.8% were found to be HIV+. Among the 11 subjects who were found to be HIV+, one of them (a 17 year old female) had lost both parents (no report of AIDS as the cause), and another (a 16 year old male) knew that both parents were HIV infected.

Over half (54.7%) of the entire sample report living outside their family home: on the street, an institution or a "foster home." All of those who were HIV+ were living away from their family home, and 45.5% report living on the street. 76.4% of the entire sample and 100% of those infected say they have a job that earns money, including earning by begging, picking pockets, petty theft, cleaning temples, as a dancer in a bar, or as a *dohori* singer.

Sexual behavior

55.8% of the entire sample reported having had a sexual relationship, with the first sexual relationship between the ages of 8 to 22 years of age (mean 14.9; Std Dev 2.6). Of these, 38% reported their first sexual relationship before the age of 15. Of those whose tests were positive, all reported being sexually active, with the first sexual encounter between the ages of 10-18 years. Of those individuals in the entire sample who reported a sexual relationship (172), 51 said it was not their choice (16.6%). Of interest is that of those who said it was not their choice, nearly 10% were HIV+, as opposed to those who said it was their choice where only 5% were HIV+.

14.9% of the entire sample said they had been forced to have a sexual relationship at some time in their lives; nearly 11% of these were HIV+. However, for those who had not been forced into having a sexual relationship, only 3.7% were found to be HIV+. The question about transactional sex will need to be re-analyzed as the coding includes having a sexual relationship with someone in order to get money as well as bartering sex for favors. 12.9% of the sample reported having transactional sex at some stage in their lives; this percentage falls if "money" is not counted as the transactional reward. For those engaged in transactional sex, three times as

many were HIV+ (8.1%) as those who were not (2.8%).

Substance abuse

41% of respondents reported using alcohol and 43.7% reported using drugs. Of the latter, only 2% reported using intravenous drugs ("brown sugar"); most reported regular use of marijuana, cigarettes, and dendroits (i.e., glue sniffing.) None of the HIV+ subjects reported using intravenous drugs.

Health seeking, HIV knowledge, and HIV Testing

Most of the participants (~98%) reported choosing to go to a health facility when they are sick. This proportion falls significantly for those who are HIV+. Only 45.5% reported going to a government health facility when they were sick. One young woman (18 years old) reported that she had never been to a health facility, as she had heard that the health personnel abused the patients; another participant (a 24 year old male) only goes to the hospital with the help of the local NGO.

Of the entire sample, 87.6% claimed knowledge of the various ways that HIV infection was transmitted. 89% knew what a contraceptive was, and 52% said they used a condom, but only one third of those said that they used it regularly. A more discouraging finding was that all of the 11 HIV+ subjects were able to describe how HIV infection is transmitted, and all were aware of the benefits of using a condom, but none reported using a condom consistently.

16.3% of the entire sample has been tested for HIV in the past; 36% of the HIV+ subjects have been tested. None reported being aware of their HIV status at the time of the survey. Of those tested throughout the sample, most choose to go to the government hospital rather than the VCT center.

Additional (Preliminary) qualitative data

According to the key informant interviews and the focus group discussions, the obstacles to health care are (i) money, (ii) the time constraints of the workplace, and (iii) the lack of trust in medical staff due to widespread rumors of abuse. There is, in addition, a perception that these children and youth do not know how to use the system either in terms of seeking out appropriate caregivers, or in navigating a government hospital once they are there. Furthermore, once inside, they are frequently discriminated against because of their appearance and cleanliness. This discrimination deters young people from seeking help at health facilities and has the potential of interfering with their health care providers' ability to perform. This means that, even though some of the key informants indicated that all children vulnerable to CSEC should be tested for HIV, the feeling is that they will not go because they do not feel comfortable or confident in those surroundings.

Findings from the Togo survey

Education and economic status

In general, respondents in Togo rated themselves almost entirely in the lowest two quartiles when asked about the economic status of their families. Only 7.4% rated themselves as doing about the same or better economically than the families of friends and neighbors, versus 57.4% of respondents in Nepal. In the Togo sample, 58% rated themselves as very poor, i.e., the worst off among friends and neighbors; in Nepal that number was only 25%. School attendance, however, was found to be better in the Togo sample: 98.1% reported having attended school; in Nepal the number was 90.3%.

Family health/living/working

A major difference was seen in the number of children who had experienced a loss of a parent. In Togo, only 44.6% reported that their father was alive (compared to 69.5% in Nepal). In both countries, approximately one quarter reported the death of the mother. In Togo, 19.6% of children reported that someone in the family was sick; in Nepal 14.6% reported sickness in the family. Fewer children in Togo reported having a paid job (26% versus 74.7% in Nepal), but those who did work were engaged in jobs with greater sexual vulnerability: 11.5% worked in massage parlors, or "cabin" restaurants (i.e., restaurants with private rooms for eating and being "served.") The percentage of those in Nepal who worked in these occupations was only 3.1%.

Sexual behavior

46.8% of males, and 50.7% of females 15-18 years old in Togo reported having had a sexual relationship (reported age range: -16 years), nearly 47% of which were before the age of 15 years. Of those children, 30% reported that it was penetrative, (i.e., "putting something in the private parts of your body") and 18% said it involved kissing private parts of their body. In addition, 23% of respondents said that they had been forced to have sex at some point in their lives. In this latter finding there was no significant difference between boys and girls. Of those children who reported a penetrative sexual act, 70.6% reported using some form of contraception. 80% responded "yes" when asked if they knew what a contraceptive was. Of those who had had a sexual encounter, over 90% knew how someone got infected with HIV. An additional finding is that only 9% of children interviewed in Togo had been tested for HIV infection. (The proportion in Nepal was 16%).

Correlation between economic status and age of first sexual encounter

An unexpected finding in the Togo survey was the negative correlation between age at first sexual encounter and the child's self-assessment of the economic status of the family. This means that the higher the child's assessment of economic status was, the earlier they reported becoming sexually active. When male and female results were combined, this was a statistically significant result; it was also significant for males alone, though not for females alone. The identification of who was the initiator of the sexual act was not done for this correlation.

Early initiation of sexual activity in both countries

As mentioned above, in both countries a large proportion of those children who reported having had a sexual encounter said that it happened before the age of 15 years. Early age of sexual debut has been shown to have a high predictive value for HIV infection. (Pettifor, van der Straten, Dunbar, Shiboski, Padian 2004) In the present study, 5 of the 11 children who tested positive

Table 2: Age and nature of first sexual encounter in children < 15 years

	First sexual encounter< 15 years (no.)				Reports penetrative 1st sexual encounter		
	M	F	Total	(% of all sexually active)	M	F	Total (% of <15 1st sexual encounters)
Nepal	49	17	66	(38.37)	39	16	55 (83.33)
Togo	30	26	56	(46.67)	12	8	20 (35.71)

for HIV infection reported their first sexual experience between the ages of 10 and 14 years. Nine of the 11 (81%) reported their first experience at 15 years or less. With this in mind, the young age of sexual debut in Togo (47% before the age of 15 years) takes on considerable significance. In addition, in Togo over 35% of those who were sexually active before 15 years of age reported that the first encounter involved penetration of their private parts. In Nepal, this figure was 83%. Of note is the predominance of young boys as subjects of these sexual encounters in both countries, especially in penetrative first sexual encounters.

Discussion and Conclusion

The most important finding of this study is the high prevalence of HIV infection in the Nepal study population. An HIV prevalence of 3.6% in the entire population of vulnerable children and youth (15-25 years), of 3.7% in the pediatric age group (children <18 years), and of 6.4% among all of those who were sexually active, places this group in a category of higher risk of HIV. These prevalence figures are higher than those of FSWs (2.2%), of the clients of sex workers (2%), and compare with those of MSMs (3.8%). Of concern is that only four out of the 11 positive for HIV infection had been previously tested for HIV – the others have remained outside of the system, concealing a hidden epidemic unknown to the government or to the health care delivery system. Of those who were found to be HIV+, a large proportion live on the street – an environment known to be at high risk of both CSEC as well as HIV infection (as reported in the 2002 survey of street children done by Child Workers in Nepal [CWIN]). (OurSansar, 2010) A decade later, though the prevalence may have decreased, the problem persists. The rates of HIV testing in both countries were low for this age group: 16% in Nepal, and 9% in Togo.

> *Government and other relevant stakeholders must ensure that responses to HIV/AIDS target the rights of all children and reaches those living in difficult circumstances, including children at greatest risk of being pushed into commercial sexual exploitation. Government health care and outreach services must offer free and confidential HIV/AIDS and STD education, testing, counseling, and clinical services for high risk target groups of children.*

Most of the criteria that define vulnerability to HIV infection seem to be borne out in our analysis (although statistical significance will require a larger sample size in the future): non-school goers, families with a sick member, children coming from poorer families, young people forced into sex, or having their first encounter despite their reluctance, early age of sexual debut – all had a higher percentage of HIV+ subjects. In addition, a reluctance to use health facilities or to be tested for HIV infection was also more common in those respondents who were HIV+.

The other disturbing finding in this study is the high level of knowledge about HIV transmission demonstrated by all of the HIV+ subjects. The study is not able to determine what the level of knowledge was of these respondents at the time they were infected. However, it seems clear that knowledge is not enough to prevent HIV infection. It must be supported by the provision of accessible, affordable and trusted services that will actually prevent HIV infection, or, in the case of these 11 subjects, the development of AIDS.

Community-based approaches and peer-to-peer informal networks should be established to help ensure that knowledge and skills of prevention and access to trusted health care services is shared amongst young people and vulnerable groups.

Hotlines or helplines providing information on HIV/AIDS support services should be made readily available.

The inability to do the prevalence study in Togo was a missed opportunity. However, even without being able to correlate responses to the questionnaire with the outcome of the rapid HIV antibody test, the information gained from interviews of children in Lomé and Atakpamé sheds light on their vulnerability and can be used to advocate for improved measures for child protection and health. Hence, correlating the Togo findings with those in Nepal, particularly with the Nepal children identified as HIV infected, suggests a highly vulnerable population of children in Togo. Children in Togo reported being employed in more sexually hazardous jobs; and, although fewer children reported having had a sexual relationship in Togo (approximately 49% in Togo to 55% in Nepal), the data came from a younger aged cohort (15-18 versus 15-25) with more than a third reporting that their first sexual encounter involved penetrative sex.

This vulnerability is seen most in the high proportion of children who report their first sexual experience before the age of 15 years. (See Table 2) Here the ability to relate Togo's data to the findings of the Nepal prevalence survey should alarm the public health and child protection advocates in Togo to the great danger their children face. In Nepal, 45% of those who were HIV + had their sexual debut before the age of 15. The fact that nearly half of the entire sample in Togo reported their first sexual encounter before the age of 15 years strongly suggests that the problem of HIV infection in that country may be equal to or worse than Nepal's high prevalence rates.

Early education interventions in schools and peer education and the building of life skills for out-of-school adolescents are important approaches to encourage safe practices in relation to reproductive health, sexuality, and sexual behavior. Youth groups, clubs, and peer networks are useful entry points to foster ownership and self-commitment to achieve positive behavior change.

A positive finding in both the Togo and the Nepal sample was the high percentage of children who reported having ever attended school (98% in Togo and 90% in Nepal). In her research on vulnerability in children, Engle identifies education as one of the key characteristics of resilience that can be seen to balance factors of risk and reduce vulnerability. (Engle, Castle, Menon, 1996)

Poverty levels (by self-assessment) were higher in Togo than in Nepal, and there were more families where either one or both parents was either dead or sick. These are two key markers of vulnerability and of these, the poverty assessment may be the more important and the most ominous for children in Togo. Akwara, et al., explored the data contributing to the identification of vulnerable children. At the end of their analysis, they concluded that a multivalent approach was needed but one that incorporated household wealth as a key predictor of child vulnerability. (Akwara 2010)

Prevention programs should be strategic and prioritize interventions that analyze and address the root causes of the spread and impact of HIV/AIDS such as poverty, gender inequality, lack of economic livelihood options and discrimination. Special assistance should be provided for the most vulnerable children and their families to ensure their access to basic government services and social security schemes.

What are the next steps to be taken after this first stage of the study? Every effort must now be made to work within the same populations of children and youth in both countries to increase their ability and willingness to use HIV testing services. There are at least 11 and probably more new cases of HIV in the Nepal community (and an untold number in Togo), none of them on antiretroviral therapy and therefore all of them prone to the development of the opportunistic infections of full-blown AIDS. They must be identified through work with the entire community. The use of the OraQuick® test was well accepted by these children. Is there a place for it or a similar test in the public health system of Kathmandu? With more time and experience, can the Government of Togo initiate a rapid testing procedure that could be used easily and safely in the community to identify the HIV status of their vulnerable children?

Governments must assess carefully the reasons why vulnerable children and youth are reluctant or fail to undergo testing. The use of a screening technique such as the OraQuick® test offers a quick, safe and confidential way to access support services that can improve behavior change or help identify those that need antiretroviral therapy.

A word on the process: this kind of study is only possible if the research team can identify and reach the vulnerable children in the community. This step alone is difficult. Once it is accomplished, establishing sufficient mutual trust to allow for an open and honest exchange is even more difficult, unless you come from the community, are raised in the same environment, and can share an understanding of the same experiences. A senior researcher from Bangkok or any major city even within Nepal or Togo will not be able to do this. Vulnerable children and youth simply do not trust people in authority since they are the ones who have consistently exploited them.

The strength of this project has been the partnership between an academic institution and the group of young people – many of them with first-hand experience of sexual exploitation, some of them from the streets, some of them HIV infected – enlisted and trained by ECPAT who are known and trusted in their own communities. Their motives for doing this work are without question: they genuinely want to give back to the other young and vulnerable children their knowledge and experience of moving out of the circumstances and environment that makes them vulnerable to dangerous practices. Their motivation was obvious in the rigorous training they underwent about concepts that would challenge a first year public health student: randomization, probability proportional to size, confidentiality, interview techniques (prompting vs. probing), ethics and so on. With appropriate training and supervision they performed as responsible professionals in the field. It will be important to sustain training and knowledge levels in research techniques among these young people, recognizing that they are a valuable resource in the community capable of finding answers to other questions of importance.

The participation of children and young people is an effective entry point for addressing reproductive health issues and for strengthening the design and implementation of research and HIV/AIDS related programs. With the appropriate support and training, empowered children and youth can act as key agents for change within their communities and through national level advocacy

The participation of children and young people is an effective entry point for addressing reproductive health issues and for strengthening the design and implementation of research and HIV/AIDS related programs. With the appropriate support and training, empowered children and youth can act as key agents for change within their communities and through national level advocacy.
The strategy is in place to move into the next phase. The next step is to build on the positive indication that almost all of these young people in both countries will use government facilities when they are sick. The challenge is to get them to use them when they are well. There can be no financial barrier to accessing the VCT center or government hospitals. Efforts must be made to make these facilities more friendly and safe for vulnerable and marginalized children and youth. In the focus group discussions in Kathmandu, the subjects themselves are telling us that they want to have confidence that the people who staff the health care system will accept them. The work ahead is evenly divided between the health care delivery system and the community it serves.
In summary, the high prevalence levels of HIV infection in vulnerable children measured in Nepal suggest that children who are vulnerable to commercial sexual exploitation, whether affected by AIDS or not, should be identified and considered a key population at higher risk of HIV similar to FSWs, MSMs, and IDUs. Furthermore, the disturbing constellation of similar characteristics found in vulnerable children in Lomé and Atakpamé (i.e., high poverty rates and early sexual debut in particular) link them to the infected children in Nepal and suggest that the prevalence in Togo once measured will be as severe or greater than that found in Nepal. As such, there must be a concerted effort in both countries to test all vulnerable children for HIV infection, to provide preventive services for those who remain negative and to provide appropriate treatment with ARVs for those unfortunate ones who are positive.
With confirmation of these findings through future studies in different settings (and with increased sample sizes) these recommendations could be extended to all children everywhere who are vulnerable to commercial sexual exploitation.

Further research is required to confirm the incidence, scale and linkages of children's vulnerability to HIV/AIDS and sexual exploitation. Governments, donors and NGOs must do more to mainstream programs and interventions that reach this particularly hard to reach group of children.

Annexes

Annex A: Information from respondents who were found to be HIV+

Table 3: Detailed profile of HIV + respondents

S.No. (sample ID)	Age (yrs)	Sex	Inclusion criteria	Risk behavior	Knowledge of HIV and contraceptives	Living condition	Parents health condition	Health seeking Behavior	Remarks
1. 91018	24	M	Had dropped out of school Living away from home and parents Living on the street for many years	Consumes alcohol (every alternate day) and consumes cigarette and marijuana (every day) Practices unsafe sex	Aware about benefits of condom use but does not use condoms correctly or consistently Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Lives in temple area, park	Parents are alive but does not know much about their health condition, as he has been away from home for long time	Consults health facility with the help of an NGO whenever he has a problem	Married Categorizes his economic situation as poor Picks reusable garbage Has been sexually active since he was 17
2. 23467	16	M	Living away from home and parents Living on the street Had dropped out of school	Consumes alcohol often and gets drunk. consumes cigarette and marijuana everyday	Aware about benefits of condom use but does not use condoms correctly or consistently Knows that HIV is transmitted through exchange of syringes, multiple sex partners, and unsafe sex	Lives on the street (temple area, old abandoned house)	Both parents have remarried. They do not have regular contact.	Never been to hospital or any health facility	In a relationship Regards his economic situation as similar to those around him Picks re-usable garbage Helps at a temple to collect money Has worked in a dance restaurant in the past Has been sexually active since he was 13

S.No. (sample ID)	Age (yrs)	Sex	Inclusion criteria	Risk behavior	Knowledge of HIV and contraceptives	Living condition	Parents health condition	Health seeking Behavior	Remarks
3. 45493	17	F	Both parents are dead and has no adult guardian Lives with friends Engaged in CSE	Consumes alcohol everyday	Aware about benefits of condom use but forgets to negotiate about condom when she is drunk Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Lives in rented house	Both parents are dead	With help of an NGO, she has gone to government hospital for treatment for jaundice	Unmarried Categorizes his economic situation as poor Works in hotel as waitress Was sexually abused by hotel staff at the age of 14, and has been sexually active since that age
4. 20928	16	M	Living away from home and family Living on the street Both parents are dead Dropped out of school	Used to use alcohol, but has stopped in the last few months Smokes cigarettes everyday	Aware about benefits of condom use but does not use condoms correctly and consistently Knows that HIV can be prevented by using condom correctly and consistently	Lives in temple area	Both parents had HIV	Has never attended a health facility despite a chronic skin condition	Unmarried Categorizes his economic situation as poor Works in the funeral area of the temple Has been sexually active since he was 15
5. 71792	18	F	Living away from home and family Engaged in CSE	Does not consume alcohol	Aware of benefits contraceptives and condom but does not use it consistently Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Lives in foster house	Does not know much about parental health	Has never been to a health facility as she had heard that hospital staff abuse the patients	Unmarried Categorizes her economic situation as poor Works in a stall and engages in CSE Had been tested for HIV a year ago Has been sexually active since she was 15

S.No. (sample ID)	Age (yrs)	Sex	Inclusion criteria	Risk behavior	Knowledge of HIV and contraceptives	Living condition	Parents health condition	Health seeking Behavior	Remarks
6. 46561	17	M	Living away from home and family Living on the street Dropped out of school	Consumes alcohol, cigarette, marijuana everyday	Aware of benefits contraceptives and condom but does not use it consistently Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Living on the street (temple area)	Does not know much about parental health	Has never attended a health facility as has never had cause to	Unmarried Regards his economic situation as similar to those around him Picks re-usable garbage
7. 47629	16	M	Living away from home and family Living and working on the street Dropped out of school	Smokes cigarettes regularly	Aware of benefits contraceptives and condom but does not use it consistently Knows that HIV is transmitted through unsafe sex	Lives on the street	Does not know much about parental health	Goes to a health facility whenever he has cause to	Unmarried Regards his economic situation as similar to those around him Has several jobs (hotel, bus, shop) Has been sexually active since he was 11
8. 63651	22	F	Living away from home and family Dropped out of school Engages in CSE	Does not consume alcohol	Aware of benefits contraceptives and condom but does not use it consistently Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Lives in rental house	Mother is unwell (suffers from COPD)	Goes to a health facility whenever she has cause to and gets tested for HIV regularly	Married Categorizes her economic situation as poor Works in a dance bar Has been sexually active since she was 15 Was last tested for HIV three months before

S.No. (sample ID)	Age (yrs)	Sex	Inclusion criteria	Risk behavior	Knowledge of HIV and contraceptives	Living condition	Parents health condition	Health seeking Behavior	Remarks
9. 30137	19	M	Living away from home and family Dropped out of school Lives and works on street	Consumes dendroits, cigarettes, and IDU everyday	Aware of benefits contraceptives and condom but does not use it consistently Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Lives in an institution (Bisauni-VOC) at present but often returns to the street	Has little information on his parents	Consults a doctor whenever he has cause. Has been treated for syphilis	Unmarried Regards his economic situation as similar to those around him Has several jobs (picks re-usable garbage, hotel, hotel) Has been sexually active since she was 13
10. 34150	15	F	Living away from home and family Dropped out of school Lives and works on street	Consumes alcohol, dendroits, cigarette	Aware of benefits contraceptives and condom but does not use it consistently Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Lives on the street	Does not know much about them. The father has married another women and lives separately, and the mother works as a garbage-picker and maid	Consults a doctor at the government hospital whenever she has cause	Unmarried Regards his economic situation as similar to those around him Has several jobs (picks re-usable garbage, begs, picks pockets, hotel)
11. 18792	20	F	Living away from home and family Has been working in the entertainment industry Dropped out of school	Consumes alcohol everyday and often gets drunk	Aware of benefits contraceptives and condom but does not use it consistently Knows that HIV is transmitted through exchange of syringe, multiple sex partners, and unsafe sex	Lives in apartment with relatives	Father has been ill with liver disease for many years	Never consults a doctor	Married Regards her economic situation as similar to those around her Has been working in the entertainment industry for over four years Has been sexually active since she was 18

Annex B: Summary of analysis of responses by HIV+ subjects compared to non-HIV+ subjects

Table 4: Comparison of HIV infected with HIV non-infected respondents in Nepal (n=308)

Characteristic	OraQuick Positive (n=11)	OraQuick Negative (n=297)
Demographic		
[Q2] Gender n(%)		
1=Male	6 (3.3)	176 (96.7)
2=Female	5 (4.0)	121 (96.0)
[Q3] Age (years)		
Valid N	11	294
Min	15	15
Max	24	25
Mean	18.18	17.82
StdDev	2.822	2.658
[Q22] How would you rate the economic status of your family? n(%)		
1=very poor, the worst off among families of friends and neighbors	3 (3.8)	75 (96.2)
2=poor, but I know some families who are worse	3 (5.8)	49 (94.2)
3=about the same as the families of friends and neighbors	5 (3.2)	151 (96.8)
4=doing better than the families of friends and neighbors	0 (0.0)	21 (100.0)
999=don't know	0 (0.0)	1 (100.0)
[Q23] Have you ever attended school?		
1=Yes	9 (3.2)	269 (96.8)
2=No	2 (6.7)	28 (93.3)
Sexual Behavior		
[Q55] Have you ever had a sexual relationship? n(%)		
1=Yes	11 (6.4)	161 (93.6)
2=No	0 (0.0)	136 (100.0)
[Q57] If yes, how old were you when you first had a sexual relationship? (years)		
Valid N	11	160
Min	10	8
Max	18	22
Mean	14.80	14.91
StdDev	2.359	2.668
[Q64] Was your first sexual relationship one made by choice?		
1=Yes	6 (5.2)	109 (94.8)
2=No	5 (9.8)	46 (90.2)
[Q65] Has anyone ever forced you to have a sexual relationship with them?		
1=Yes	5 (10.9)	41 (89.1)
2=No	6 (3.7)	155 (96.3)
[Q67] Have you ever forced anyone to have sexual relationship with you?		
1=Yes	3 (10.3)	26 (89.7)
2=No	7 (3.7)	181 (96.3)
[Q78] Have you ever had a sexual relationship with someone in exchange for favors or money? n(%)		
1=Yes	3 (8.1)	34 (91.9)
2=No	7 (2.8)	242 (97.2)
Other influential factors		
[Q10] Is your father alive?		
1=Alive	9 (4.2)	205 (95.8)
2=Not Alive	2 (2.2)	88 (97.8)
[Q15] Is your mother alive?		
1=Alive	9 (3.9)	221 (96.1)
2=Not Alive	2 (2.7)	71 (97.3)
[Q112] Have you ever been tested for HIV/AIDS?		
1=Yes	4 (8.0)	46 (92.0)
2=No	7 (2.8)	242 (97.2)
[Q121] Is anyone else in your family sick?		
1=Yes	3 (6.7)	42 (93.3)

Characteristic	OraQuick Positive (n=11)	OraQuick Negative (n=297)
2=No	7 (2.8)	241 (97.2)
[Q33] Do you have a job that earns money? [Do you have more than one job? Ask the following questions for each job]		
1=Yes	10 (4.3)	220 (95.7)
2=No	0 (0.0)	71 (100.0)
[Q34] [If yes] What sort of job is it?		
1=Picks re-usable garbage	2 (9.1)	20 (90.9)
2=Waitress	1 (9.1)	10 (90.9)
3=Dance bar	1 (10.0)	9 (90.0)
4=Dohori singer	1 (25.0)	3 (75.0)
5=Massage Parlour	0 (0.0)	2 (100.0)
6=Cabin restaurant	0 (0.0)	5 (100.0)
11=Others….please specify	5 (2.9)	170 (97.1)
[Q48] Do you consume alcohol?		
1=Yes	6 (4.8)	119 (95.2)
2=No	5 (2.8)	174 (97.2)
[Q52] Do you take any other drugs or medicines?		
1=Yes	7 (5.3)	125 (94.7)
2=No	4 (2.3)	170 (97.7)

Annex C: Survey Instrument

[Site]
[SampleNumber]
[Sample code]
[Q2] Gender
[Q3] Age (Years)
[Q4] What is your marital status?
[Q4_11Txt] What is your marital status? 11 Others…please specify
[Q5] Where do you live at present?
[Q5_4Txt] Where do you live at present? 4 specify institution
[Q5_11Txt] Where do you live at present? 11 specify others
[Q6] Where do you usually sleep at night?
[Q6_11Txt] Where do you usually sleep at night? 11 specify others
[Q7_1] Who else sleeps there? (Multiple responses possible) -- 1) Parents
[Q7_2] Who else sleeps there? (Multiple responses possible) -- 2) Prostitutes
[Q7_3] Who else sleeps there? (Multiple responses possible) -- 3) Brothers/ sisters
[Q7_4] Who else sleeps there? (Multiple responses possible) -- 4) Relatives
[Q7_5] Who else sleeps there? (Multiple responses possible) -- 5) Street Children
[Q7_6] Who else sleeps there? (Multiple responses possible) -- 6) Nobody
[Q7_11] Who else sleeps there? (Multiple responses possible) -- 11) Others…please specify
[Q7_11Txt] Who else sleeps there? (Multiple responses possible) -- 11) Others…please specify
[Q8] [if living in a family house or apartment ask:] How many people live in the same household?
[Q9] What is their relationship to you?
[Q10] Is your father alive?
[Q11] [if yes] What is your father's occupation?
[Q12] Educational background of your father?
[Q13] Monthly income of your father?
[Q14] [if no] what did he die of?
[Q15] Is your mother alive?

[Q16] [if yes] What is your mother's occupation?
[Q17] Educational background of your mother? (Class)
[Q18] Monthly income of your mother?
[Q18Denom] Denomination of monthly income of your mother?
[Q19] [if no] what did she die of?
[Q20] [if both of your parents are alive] What is the status of your parent_s relationship?
[Q21] Who is your primary caretaker?
[Q22] What would you say is the economic status of your family?
[Q23] Have you ever attended school?
[Q24] Are you in school right now?
[Q25] [If yes] In the past two weeks, how many days did you attend school? (Days)
[Q26] Is this more then, less than, or the same as usual for you?
[Q27] Which standard (class) have you finished?
[Q28] At what time do you start school in the day?
[Q29] At what time do you end school each day?
[Q30] How do(es) the teacher(s) treat you in school?
[Q31] [If not] After which class/standard did you leave school? (Class)
[Q32] Why did you leave school?
[Q33] Do you have a job that earns money? [Do you have more than one job? Ask the following questions for each job]
[Q34] [If yes] What sort of job is it?
[Q34_11Txt] [If yes] What sort of job is it?
[Q35] Who is your employer?
[Q36] What does he/she do if you are late for work?
[Q36_11Txt] What does he/she do if you are late for work?
[Q37] What does s/he do if you make a mistake at work?
[Q37_11Txt] What does s/he do if you make a mistake at work?
[Q38] [If in the entertainment industry] Who are your customers/clients?
[Q39] What do they pay you to do?
[Q40] If you work, for how long have you been working?
[Q41] How many days in the past two weeks have you worked? (Days)
[Q42] Is this more then, less than, or the same as usual for you?
[Q43] How many hours do you work each day? (Hours)
[Q44] What hours each day do you work? (Togo variable missing)
[Q45] Do you have any spare time for yourself? (Togo Q44)
[Q46] [if yes] How many hours each day would you consider to be free time? (Togo Q45)
[Q47] What do you do in your free time? (Togo Q46)
[Q48] Do you consume alcohol? (Togo Q47)
[Q49] [If yes] How often? (Togo Q48)
[Q50] Do you get drunk? (Togo Q49)
[Q51] If yes, how often? (Togo Q50)
[Q52] Do you take any other drugs or medicines? (Togo Q51)
[Q53] If yes, which ones? (Togo Q52)
[Q54] If yes, how often? (Togo Q53)
[Q55] Have you ever had a sexual relationship? (Togo Q54)
[Q56] If yes, was it with a man, woman or both? (Togo Q55)
[Q57] If yes, how old were you when you had sexual relationship at first time? (Years) (Togo Q56)
[Q58_1] Can you please tell me about it? Which of the following did it involve? -- 1) Kissing you? (Togo Q57)
[Q58_2] Can you please tell me about it? Which of the following did it involve? -- 2) Touching private parts of your body? (Togo Q57)
[Q58_3] Can you please tell me about it? Which of the following did it involve? -- 3) Kissing private parts of your body? (Togo Q57)
[Q58_4] Can you please tell me about it? Which of the following did it involve? -- 4) Putting something in your private parts of your body? (Togo Q57)

[Q58_5] Can you please tell me about it? Which of the following did it involve? -- 5) Putting something in your mouth? (Togo Q57)
[Q59] Have you been involved in doing any of these things to someone else?
[Q60_1] If yes, which ones? (Togo Q59) -- 1) Kissing you?
[Q60_2] If yes, which ones? (Togo Q59) -- 2) Touching private parts of your body?
[Q60_3] If yes, which ones? (Togo Q59) -- 3) Kissing Private parts of your body?
[Q60_4] If yes, which ones? (Togo Q59) -- 4) Putting something in your private parts of your body?
[Q60_5] If yes, which ones? (Togo Q59) -- 5) Putting something in your mouth?
[Q61] How old were you when that first happened? (Years) (Togo Q60)
[Q62_1] When these were done to you, which of them did you like? (Togo Q61) -- 1) Kissing you?
[Q62_2] When these were done to you, which of them did you like? (Togo Q61) -- 2) Touching private parts of your body?
[Q62_3] When these were done to you, which of them did you like? (Togo Q61) -- 3) Kissing Private parts of your body?
[Q62_4] When these were done to you, which of them did you like? (Togo Q61) -- 4) Putting something in your private parts of your body?
[Q62_5] When these were done to you, which of them did you like? (Togo Q61) -- 5) Putting something in your mouth?
[Q63_1] Which did you not like? (Togo Q62) -- 1) Kissing you?
[Q63_2] Which did you not like? (Togo Q62) -- 2) Touching private parts of your body?
[Q63_3] Which did you not like? (Togo Q62) -- 3) Kissing Private parts of your body?
[Q63_4] Which did you not like? (Togo Q62) -- 4) Putting something in your private parts of your body?
[Q63_5] Which did you not like? (Togo Q62) -- 5) Putthing something in your mouth?
[Q64] Was it your choice to have the first sexual relationship? (Togo Q63)
[Q65] Did anyone ever force you to have a sexual relationship with them? (Togo Q64)
[Q66] How old were you when that happened? (Years) (Togo Q65)
[Q67] Did you ever force anyone to have sexual relationship with you? (Togo Q66)
[Q68] Do you know what contraceptive is? (Togo Q67)
[Q69_1] What kind of contraceptives do you know about? (Togo Q68) -- 1) Condom (male)
[Q69_2] What kind of contraceptives do you know about? (Togo Q68) -- 2) Condom (female)
[Q69_3] What kind of contraceptives do you know about? (Togo Q68) -- 3) Oral Pill
[Q69_4] What kind of contraceptives do you know about? (Togo Q68) -- 4) IUD
[Q69_5] What kind of contraceptives do you know about? (Togo Q68) -- 5) Spermicidal gel
[Q69_11] What kind of contraceptives do you know about? (Togo Q68) -- 11) Other
[Q70] When you had the sexual relationships you mentioned above, did you or the other person you had the relationship with use any contraception? Particularly for those things that involved putting themselves into you, or you putting yourself in someone else? (Togo Q69)
[Q71_1] [If yes] What kind of contraceptive did you use? (Togo Q70) -- 1) Condom (male)
[Q71_2] [If yes] What kind of contraceptive did you use? (Togo Q70) -- 2) Condom (female)
[Q71_3] [If yes] What kind of contraceptive did you use? (Togo Q70) -- 3) Oral Pill
[Q71_4] [If yes] What kind of contraceptive did you use? (Togo Q70) -- 4) IUD
[Q71_5] [If yes] What kind of contraceptive did you use? (Togo Q70) -- 5) Spermicidal gel
[Q71_11] [If yes] What kind of contraceptive did you use? (Togo Q70) -- 11) Other
[Q71_11Txt] [If yes] What kind of contraceptive did you use? (Togo Q70) -- 11) Other
[Q72] [If condom is not mentioned] Why do you not use a condom? (Togo Q71)
[Q73] [If condom is mentioned] Do you use a condom every time you have a sexual relationship? (Togo Q72)
[Q74] If No, why not? (Togo Q73)
[Q75] Do you know the benefits of using condoms? (Togo Q74)
[Q76] Can you tell me what they are? (Togo Q75)
[Q77_1] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 1) Syphillis
[Q77_2] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 2) Gonorrhoea
[Q77_3] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 3) HIV
[Q77_4] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 4) Chlamydia
[Q77_5] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 5) (HPV) Cancer of Cervix
[Q77_6] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 6) (Trichomonas) Vaginal Discharge

[Q77_11] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 11) Other
[Q77_11Txt] Do you know what diseases you can get if you have sex without a condom? (Togo Q76) -- 11) Other
[Q78] Have you ever had a sexual relationship with someone in order to get a favor or money from them? (Togo Q77)
[Q79_1] [If yes] What was the favor? (Togo Q78) -- 1) Job, Job interview or Promotion
[Q79_2] [If yes] What was the favor? (Togo Q78) -- 2) Good grade in class
[Q79_3] [If yes] What was the favor? (Togo Q78) -- 3) Gift
[Q79_4] [If yes] What was the favor? (Togo Q78) -- 4) Money
[Q79_5] [If yes] What was the favor? (Togo Q78) -- 5) Food
[Q79_6] [If yes] What was the favor? (Togo Q78) -- 6) Place to stay/ Accomodation
[Q79_11] [If yes] What was the favor? (Togo Q78) -- 11) other
[Q80_1] What did that person ask you to do? (Togo Q79) -- 1) Kissing you?
[Q80_2] What did that person ask you to do? (Togo Q79) -- 2) Touching private parts of your body?
[Q80_3] What did that person ask you to do? (Togo Q79) -- 3) Kissing Private parts of your body?
[Q80_4] What did that person ask you to do? (Togo Q79) -- 4) Putting something in your private parts of your body?
[Q80_5] What did that person ask you to do? (Togo Q79) -- 5) Putting something in your mouth?
[Q81] How old were you when that happened? (Years) (Togo Q80)
[Q82] Has it happen more than once? (Togo Q81)
[Q83] When was the last time it happened (Togo Q82)
[Q84_1] [If money was involved] When you got money for the sexual relationship, who did you give it to? (Togo Q83) -- 1) Pimps
[Q84_2] [If money was involved] When you got money for the sexual relationship, who did you give it to? (Togo Q83) -- 2) Police
[Q84_3] [If money was involved] When you got money for the sexual relationship, who did you give it to? (Togo Q83) -- 3) Matron
[Q84_4] [If money was involved] When you got money for the sexual relationship, who did you give it to? (Togo Q83) -- 4) Family
[Q84_5] [If money was involved] When you got money for the sexual relationship, who did you give it to? (Togo Q83) -- 5) Own Cost (food, cloth, recreation, moving and others)
[Q84_11] [If money was involved] When you got money for the sexual relationship, who did you give it to? (Togo Q83) -- 11) Others
[Q85] Are you sick right now? (Togo Q84)
[Q86] If yes, what are you sick from? (Togo Q85)
[Q86_11Txt] If yes, what are you sick from? (Togo Q85)
[Q87] If yes, how long have you been sick? (Togo Q86) (Days)
[Q88] Have you gone to get care and treatment anywhere? (Togo Q87)
[Q89_1] Where did/ do you go to get care and treatment (Togo Q88) -- 1) Government Hospital
[Q89_2] Where did/ do you go to get care and treatment (Togo Q88) -- 2) Private Hospital
[Q89_3] Where did/ do you go to get care and treatment (Togo Q88) -- 3) Clinic
[Q89_4] Where did/ do you go to get care and treatment (Togo Q88) -- 4) Traditional healer
[Q89_5] Where did/ do you go to get care and treatment (Togo Q88) -- 5) Do not go to any facility- self treatment
[Q89_11] Where did/ do you go to get care and treatment (Togo Q88) -- 11) others
[Q89_11Txt] Where did/ do you go to get care and treatment (Togo Q88) -- 11) others Text
[Q90] (if name is given) Why did you choose to go there? (Togo Q89)
[Q91] If answer is _did not go_, Why did you choose not to go to these other places for diagnosis or treatment? (Togo Q90)
[Q92] When was the last time you were sick? (Togo Q91)
[Q93] What was wrong? (Togo Q92)
[Q93_11Txt] What was wrong? (Togo Q92) 11) Other [Text]
[Q94] did you go somewhere for treatment? (Togo Q93)
[Q95_1] Where did/ do you go to get care and treatment (Togo Q94) -- 1) Government Hospital
[Q95_2] Where did/ do you go to get care and treatment (Togo Q94) -- 2) Private Hospital
[Q95_3] Where did/ do you go to get care and treatment (Togo Q94) -- 3) Clinic
[Q95_4] Where did/ do you go to get care and treatment (Togo Q94) -- 4) Traditional healer
[Q95_5] Where did/ do you go to get care and treatment (Togo Q94) -- 5) Do not go to any facility- self treatment
[Q95_11] Where did/ do you go to get care and treatment (Togo Q94) -- 11) others
[Q95_11Txt] Where did/ do you go to get care and treatment (Togo Q94)
[Q96] If name is given, why did you choose to go there? (Togo Q95)
[Q97] If answer is _did not go_, Why did you choose not to go to these other places for diagnosis or treatment? (Togo Q96) [Text]

[Q98] When you go to the doctor/hospital/clinic, does someone go with you? (Togo Q97)
[Q99] If yes, Who goes with you? (Togo Q98)
[Q100] Does that person stay with you all the time while you are at the doctor? (Togo Q99)
[Q101] When you are in the doctor_s office / clinic / hospital, are you ever alone with the doctor? (Togo Q100)
[Q102] Have you ever had bad experience in doctor's office/clinic/hospital? (Togo Q101)
[Q102_1Txt] Have you ever had bad experience in doctor's office/clinic/hospital? (Togo Q101)
[Q103] Have you ever heard of one of your friends having a bad experience in a doctor_s office / clinic / hospital? (Togo Q102)
[Q104] If Yes, Can you please tell what it was? (Togo Q103)

KNOWLEDGE OF HIV/AIDS AND TESTING
[Q105] Do you know what VCT (Voluntary counselling and testing) is? (Togo Q104)
[Q106] Do you know of a center that offers voluntary confidential counseling and testing for HIV? (Togo Q105)
[Q107] [if yes] Have you ever gone to this place to have VCT for HIV? (Togo Q106)
[Q108_1] If no, why not? (Togo Q107) -- 1) Fear of needles
[Q108_2] If no, why not? (Togo Q107) -- 2) Fear of doctors/nurses
[Q108_3] If no, why not? (Togo Q107) -- 3) fear of results
[Q108_4] If no, why not? (Togo Q107) -- 4) Fear of stigma
[Q108_5] If no, why not? (Togo Q107) -- 5) Feeling that there was nothing that could be done even if I found out I was infected
[Q108_6] If no, why not? (Togo Q107) -- 6) Previous bad experiences in counseling facilities
[Q108_7] If no, why not? (Togo Q107) -- 7) Place is too far away
[Q108_8] If no, why not? (Togo Q107) -- 8) Costs too much
[Q108_11] If no, why not? (Togo Q107) -- 11) Others
[Q109] Do you know how someone gets infected with the HIV/AIDS germ? (Togo Q108)
[Q110] [If yes], please tell me how someone gets infected with the HIV/AIDS germ. (Togo Q109)
[Q111_1] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 1) clinic
[Q111_2] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 2) hospital
[Q111_3] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 3) television
[Q111_4] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 4) school
[Q111_5] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 5) friends
[Q111_6] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 6) parents
[Q111_11] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 11) Others
[Q111_11Txt] Where did you learn about the transmission of HIV/AIDS? (Togo Q110) -- 11) Others [Text]
[Q112] Have you ever been tested for HIV/AIDS? (Togo Q111)
[Q113] [If yes] Where did you go to be tested for AIDS? (Togo Q112)
[Q113_11Txt] [If yes] Where did you go to be tested for AIDS? (Togo Q112)
[Q114] [If yes] When was that test done? (Togo Q113) [Months]
[Q115] How did they let you know what the results were? (Togo Q114)
[Q115_11Txt] How did they let you know what the results were? (Togo Q114)
[Q116] [If face to face, or in writing] Where did you go to get the results? (Togo Q115)
[Q116_11Txt] [If face to face, or in writing] Where did you go to get the results? (Togo Q115)
[Q117] Did the people where you were tested answer all of your questions BEFORE you were tested? (Togo Q116)
[Q118] Did they answer your questions AFTER you were tested and found out the results? (Togo Q117)
[Q119] Do you know if your parents (father and mother) have ever been tested for HIV? (Togo Q118)
[Q120] Do you know if your mother was tested for HIV while she was pregnant? (Togo Q119)
[Q121] Is anyone else in your family sick? (Togo Q120)
[Q122] If yes, Who is sick? (Togo Q121)
[Q123] How long has that person been sick? (Togo Q122)
[Q124] Do you know what he/she is sick from? Please tell me? (Togo Q123)
[Q125] Do you have any questions you want to ask me? (Togo Q124)
[OraQuick®] Results.

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