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Policy response and service provision to child victims of commercial sexual exploitation in the West African region

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ABSTRACT

Following the three World Congresses on commercial sexual exploitation of children (CSEC) in 1996, 2001, and 2008, many African countries adopted policies against CSEC. Yet, there is almost no knowledge on the service provision to victims in these countries. A mixed research method was used to explore the responses to victims in three countries in West Africa. Convenience sampling was used to select 709 children in prostitution and 64 leaders of structures providing services to victims. A survey questionnaire was used to collect data from the children and four semi-structured interview guides were used to collect data from the leaders of the structures. The findings show that the needs of CSEC victims in West Africa diverged with those suggested in the literature, which partly explains why few victims could access any services. The service provision to victims in the region is dissimilar to care models identified in the literature, especially regarding trauma-focused care. An inadequate service provision was linked to various difficulties encountered by the structures, including the lack of understanding of particular needs of CSEC victims, lack of financial resources for support services, lack of outreach interventions, and sociocultural factors. Implications for practice, policy, and research are discussed.

KEYWORDS

child; CSEC; NGO; policy response; service providers; service provision; sexual exploitation; sub-Saharan Africa

By the "Declaration and Agenda of Action" of the first World Congress against Sexual Exploitation of Children for Commercial Purposes, held in Stockholm, Sweden, in 1996, 122 countries committed themselves to a global partnership against the commercial sexual exploitation of children (CSEC). CSEC is defined as the use of persons younger than 18 years in sexual activities remunerated in cash or in kind (ECPAT [End Child Prostitution, Child Pornography and Trafficking of Children for Sexual Purposes] International, 2008; Greijer & Doek, 2016). It includes four intersecting types: child prostitution (i.e., use of a child in sexual activities for remuneration or any other form of consideration); child pornography (i.e., the production, promotion, and distribution of pornography involving children); child sex tourism (i.e., sexual exploitation of children by men or women who travel from a developed country to one that is less developed to engage in sexual acts with children); and child sex trafficking (i.e., the trafficking in children for sexual purposes) (ECPAT International, 2008; International Programme on the Elimination of Child Labour [IPEC], 2007). Following the second World Congress in Yokohama, Japan, in 2001, and the third one in Rio de Janeiro, Brazil, in 2008, every participating country agreed at drawing a National Plan of Action (NPA) to combat CSEC. Consequently, African countries enacted substantial legislation in the line with their ratification of almost all major international conventions and protocols dealing with the rights of child victims of sexual abuse, exploitation, and trafficking. A few editions of global and regional monitoring reports by ECPAT International between 2007 and 2014, broadly document African countries' efforts of implementing their NPAs. Beyond these international policy implementation reports and similar

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ones, little research was done to explore the policy responses to CSEC by African countries and the service provision to victims. This article explores CSEC victims' awareness of and access to assistance services, and the involvement of government agencies and nongovernmental organizations in service provision to victims in Benin, Burkina Faso, and Niger, three countries in West Africa. The review of literature next provides an overview of policy responses to CSEC among countries in West Africa and describes a theoretical lens that will guide the analysis of the study findings.

Literature review

Responses to CSEC in West Africa

All the countries in the West African region ratified key international legal instruments addressing trafficking in persons, including the following: the Convention on the Rights of the Child (CRC) of 1989; the International Labor Organization's Worst Forms of Child Labour Convention (No 182) of 1999; the Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography of 2000; and the United Nations Convention against Transnational Organized Crime and its Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children of 2000 (M'jid, 2008). All these international legal texts stipulate, first, that all minors should be protected against sexual exploitation, regardless of their gender, their origin, or any other consideration; second, adults involved in the exploitation of minors should be punished with sentences appropriate to the severity of the damage caused to the victims; and finally, it is the responsibility of each state to ensure that the victims are protected.

In addition to international laws, most countries in West Africa adopted specific regional agreements. For instance, all of them ratified the African Charter on the Rights and Welfare of the Child of 1999 whose Article 27 prohibits all forms of child sexual exploitation and sexual abuse, specifically criminalizing child prostitution and child pornography. Some of these states established bilateral or multilateral agreements with countries in Central Africa to combat trafficking in children. The ratification of regional agreements by countries in the region led to significant progress with respect to harmonizing national legislation with international instruments (M'jid, 2008). In addition, legislation criminalizing sexual exploitation of minors under the age of 18 were enacted in a number of countries in the region (i.e., Benin, Burkina Faso, and the Gambia).

However, the enforcement of CSEC laws in any country in the West African region is problematic because "the number of child victims of sexual abuse and exploitation that have access to legal protection remains low, and a large number of offenders benefit from total impunity" (M'jid, 2008, p. 39). In spite of many African countries' efforts of compliance of domestic legal frameworks with international legal instruments addressing CSEC, "almost no African countries explicitly exempt children from punishment for prostitution-related crimes" (ECPAT International, 2014, p. 51). Very few states in the region adopted provisions for child-friendly measures before, during, and after criminal investigations and proceedings concerning child trafficking and sexual exploitation (M'jid, 2008). Very often, the number of reported cases of child sexual abuse and exploitation is low because there are almost no support mechanisms accessible to children that guarantee their safety. In some countries in the region, child victims must be accompanied by a relative or guardian to press charges with the police, which can discourage children who have been victims of sexual abuse or exploitation within their own families. Countries such as Benin and Cameroon have established procedures that allow the child to go to the police unaccompanied or to call a hotline number or to make a simple oral or written accusation (M'jid, 2008). Lack of birth certificates or identification disqualifies many CSEC victims for legal protection because they cannot prove they are minors. Few countries in West Africa have child protection units and juvenile courts (M'jid, 2008). Likewise, the number of professionals in the criminal-justice system who have received special training in the protection of child victims of sexual exploitation remains very low. Thus, effective application of the legislation against CSEC remains a major challenge in all the countries in West Africa because of various issues

including the following: lack of institutionalized system for complaints; weak judicial systems; reluctance of families to deal with legal issues; settling cases informally; cultural resistance; ignorance of children and their families of their rights; and impunity (M'jid, 2008).

M'jid (2008) reported that government structures' capacities in care provision, rehabilitation, and monitoring of child victims of sexual exploitation were limited because of a dependence on external financial resources and an absence of monitoring systems of collecting and processing data. Nongovernmental organizations (NGOs) spearheaded most support service provision to CSEC victims in almost all African countries, in contrast to public/governmental agencies and institutions. Most services to child victims of sexual exploitation in countries in West Africa were provided by faith-based structures, associations, or other types of NGOs, often supported by external sponsors. As a result of governments' overreliance on NGOs and NGO dependence on external resources, service provisions for CSEC victims were subject to unpredictability and unsustainability (Child Frontiers, 2011).

In fact, knowledge on services provision for victims of CSEC in sub-Saharan Africa is scarce and mostly based on summaries of policy reports. ECPAT International (2014) stated that many states in sub-Saharan Africa were placing greater priority on support services and allocating more resources for rehabilitation and reintegration of children who have experienced CSEC. In spite of improvement in accessibility to services, support services for victims are inappropriate because services generally reach only a small proportion of those indeed in need. Yet, this information was not supported with empirical research. The same report stated that many African countries lacked professionals—social workers, judges, doctors, teachers, and law enforcement—with experience on CSEC. Furthermore, there is a general lack of gender-specific support services, especially for boys, as well as specialized services to effectively meet the basic needs of victims of CSEC. Likewise, Rumbold (2008) found that the medical, psychological, and legal needs of victims were not being adequately addressed in the West African region.

There is a need of empirical research that examines victim and support services available, accessible, and provided to child victims of CSEC in any African countries. The present article aims to contribute to the literature by addressing the following research questions: (a) What are the key needs of CSEC victims and how aware are they about support services available and accessible to them? (b) What support services for victims are provided by governmental and nongovernmental agencies and how appropriate are the services provided? and (c) What are the key distinctive aspects and challenges in service provision to CSEC cases in the West African region as seen through a theoretical lens?

Theoretical perspective

The literature indicates three major areas of needs of victims of sex trafficking in general, and CSEC in particular: (a) emergency and safety needs; (b) ongoing needs; and (c) long-term needs (Caliber, 2007; Clawson & Dutch, 2008a, 2008c; Clawson, Dutch, & Grace, 2009; Justice Institute of British Columbia [JIBC], 2002; Macias-Konstantopoulos et al., 2015; Macy & Johns, 2011). Emergency and safety needs include (a) immediate safety, (b) emergency shelter, (c) basic necessities, (d) language interpretation, and (e) emergency medical care (Clawson & Dutch, 2008c; Clawson et al., 2009; Okech, Morreau, & Benson, 2012; Tompkins, 2014). Ongoing needs include services victims need to recover from trauma and establishing stability in their lives, including those to address (a) physical health, (b) mental health, (c) substance-abuse problems, (d) safety, (e) transitional housing, (f) immigration, and (g) legal issues (Clawson & Dutch, 2008a; Macy & Johns, 2011; Tompkins, 2014). Long-term service needs include (a) life skills, (b) language skills, (c) education and job training, (d) permanent housing, and (e) family reunification (Clawson et al., 2009; ECPAT International, 2014; Macy & Johns, 2011; Tompkins, 2014).

Challenges to address the three categories of needs can be related to, first, victims' life experiences and perceptions of services they need, and then to issues of competences and resources within the

various service provider systems. Challenges due to victims' individual issues include the following aspects: (a) victims' unwillingness to self-identify as victims of sex trafficking; and (b) victims being taught to fear law enforcement and to distrust service providers (Clawson & Dutch, 2008b, 2008c; Clawson et al., 2009; Okech et al., 2012). Challenges within service provider systems to adequately address victims' needs include (a) lack of awareness about CSEC and victims' needs, (b) unavailability or inadequacy of services for victims, (c) limited information sharing among service providers, (d) lack of coordination and consensus on service delivery, (e) lack of specialized training for service providers, and (f) lack of data and tracking to inform practice (Clawson et al., 2009; Hom & Woods, 2013; Institute of Medicine [IOM] & National Research Council [NRC], 2013; Macias-Konstantopoulos et al., 2015; Okech et al., 2012; Reid, 2010; Walker, 2013). The literature shows that support services for CSEC victims should be based on three, interconnected care approaches: (a) trauma-informed care, (b) case management, and (c) survivor-led and survivor-informed models (Clawson & Dutch, 2008a; Clawson et al., 2009; Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath, 2016; IOM & NRC, 2013; Macy & Johns, 2011).

Trauma-informed care

There is a general consensus through the literature that a multidisciplinary, trauma-informed approach embedded in a system of care model is needed for victims of CSEC (Ijadi-Maghsoodi et al., 2016). Trauma-informed care is a model of service delivery in which service providers recognize the impact of past trauma on current functioning and create a safe and supportive environment for individuals to work toward their long-term goals (Clawson & Dutch, 2008c; Clawson, Salomon, & Grace, 2008). Trauma-informed care is standard practice among service providers dealing with victims of CSEC and sex trafficking (Clawson & Dutch, 2008c; Clawson et al., 2008; Hom & Woods, 2013; Ijadi-Maghsoodi et al., 2016; IOM & NRC, 2013; Lopez, 2014; Schwarz et al., 2016). Implementing a trauma-informed model of care was found to improve identification, to diminish harm, and to enhance care of children and youth who have been sexually exploited and victimized (Ijadi-Maghsoodi et al., 2016; Macy & Johns, 2011).

Case management

The literature shows the importance of a coordinated case management that ensures victims' access to comprehensive services (Caliber, 2007; Clawson & Dutch, 2008a; Clawson et al., 2009; Macy & Johns, 2011). Securing victims' access to social, health, mental-health, human, and legal services is a complex task that cannot be achieved without collaboration among the agencies providing these services (Macy & Johns, 2011). Both service providers and law enforcement considered having a central case manager a critical service not only for victims but also for other service providers and agencies involved in any services for trafficking cases (Clawson et al., 2009; IOM & NRC, 2013; Lopez, 2014; Macy & Johns, 2011). The principal case manager or care coordinator is a single point of contact to ensure coordination of services across multiple systems of stakeholders (Burke et al., 2015; Clawson & Dutch, 2008a; Ijadi-Maghsoodi et al., 2016; Walker, 2013). In order to ensure that child victims do not reenter the child protection system as repeat victims of CSEC or as victims of other forms of abuse against children, care services must be coordinated with all care providers and stakeholders from various sectors including the education sector, the police, the health sector, the immigration sector, NGOs, and other sectors offering services necessary to provide a continuum of care for victims of CSEC (Shaw, 2008).

Survivor-led and survivor-informed model

This approach is based on two concepts: (a) the importance for victims to interact with people who have been through a similar situation and (b) the need to have victims participate in the development and implementation of service provision tailored to their needs and rights (Clawson et al., 2009; IOM & NRC, 2013; Lopez, 2014; Walker, 2013; Walker & Quraishi, 2015). A survivor-led and survivor-informed model facilitates the therapeutic process and empowers victims for decision making in later life (Claramunt, 2005; Thompstone, n.d.; Wölte & Tautz, 2007). Depending on the

level of recovery and the ability to assume responsibilities, victims' perspectives should be sought at every stage of the rehabilitation process. Thus, successful support services should provide the opportunity for a healthy or mentoring relationship with CSEC victims (JIBC, 2002). Child victims must be allowed to participate in the development of care plans setting out what care services will be provided to the child and when those services will be provided (Shaw, 2008). The involvement of victims in the development of the care plans ensures their commitment and participation in the intervention services that will be provided. Any care services for victims of CSEC must recognize and protect the rights of victims, which have often been violated by perpetrators of CSEC (Claramunt, 2005, 2007; Ijadi-Maghsoodi et al., 2016; Shaw, 2008; Thompstone, n.d.). Care services must recognize the evolving, developmental capacity of children in general, and the vulnerability of child victims of CSEC in particular (Shaw, 2008).

Effective assistance to CSEC victims requires a range of interventions, termed a continuum of services, ranging from primary prevention to assistance provision in exiting, healing, and support for those already involved (JIBC, 2002). JIBC's framework of continuum of services consists of service provision in the following six key areas: (a) global prevention strategies, (b) targeted prevention strategies, (c) harm-reduction strategies, (d) crisis intervention strategies, (e) programs to support leaving the sex trade; and (f) programs to support healing and reintegration. First, global prevention strategies include the following: economic and social policies to address CSEC; education of teachers and other staff about the realities of CSEC; implementing laws and policies that ensure prosecution of perpetrators; and supporting public awareness. Second, targeted prevention strategies include the following: education programs for children about at-risk sexual behaviors, healthy sexuality relationships, and child's rights; providing healthy alternatives for at-risk children and youth; street outreach programs; opportunities for employment and mentoring programs for adolescents and youth in care; and professional training for service providers. Third, harm-reduction strategies include HIV protection; sexually transmitted infection (STI) testing and counseling; provision of health information to at-risk groups of children; peer street outreach services; and supportive police protection. Fourth, early interventions/crisis intervention strategies include safe, supportive shelters, alcohol and drug treatment, mental-health services, and supportive police protection. Fifth, programs to support leaving include the following: drop-in centers providing emotional support and related services; legal support; safe, long-term housing; education and training programs; financial support; and economic incentives. Finally, programs to support healing and reintegration include ongoing economic assistance, ongoing psychological and emotional assistance, life skills training, and educational opportunities.

Methodology

Study setting

Benin, Burkina Faso, and Niger—the target countries for the study–share some geographical and historical features. Not only are the three countries located in West Africa but they also share borders, socioeconomic aspects, colonial history, the official language (i.e., French), and even human trafficking aspects. For instance, they are all source, transit, and destination countries for persons subjected to sex trafficking and labor trafficking (U.S. Department of State, 2016). Haider, Souchet, and Mathellié (2014) reported that CSEC in Benin is perpetrated or facilitated by people from almost all strata of society, including bar owners, taxi/motorbike riders, lorry drivers, teachers, and law-enforcement agents. Poverty is perceived as a strong causal factor, and the high poverty level in Benin has forced children to contribute to the family income by sometimes working in environments that make them vulnerable to commercial sexual exploitation. Some children are also reportedly pushed into prostitution by parents and other relatives. Child prostitution mainly involved girls whose families indirectly urged them to become involved in prostitution to provide income. ECPAT International (2012) reported that a significant proportion of human trafficking activity is internal in Burkina Faso.

Children are trafficked into Burkina Faso's two largest cities, BoboDioulasso and Ouagadougou, to work as domestic servants, street vendors, and in prostitution. Burkinabe children are transported to neighboring countries for forced labor or sex trafficking. Likewise, girls and women from other West African countries, especially Nigeria, are deceitfully recruited for jobs in Burkina Faso and then subjected to prostitution and forced labor.

Niger is a transit country for people from West and Central Africa migrating to North Africa and Western Europe. According to the U.S. DOS (2016), "victims from Benin, Burkina Faso, Cameroon, Ghana, Mali, Nigeria, and Togo are exploited in sex and labor trafficking in Niger. Girls are subjected to sex trafficking along the border with Nigeria, sometimes with the complicity of their families" (p. 288). Poverty is the primary motivating factor, but the aspiration for luxury goods and the opportunity to travel abroad are also risk factors. Intermediaries in child prostitution in Niger are often older sex workers while clients are mostly tourists and businessmen. The prostitution of boys is another emerging phenomenon in the country (Hounmenou, 2017).

Participant selection

Child participants

Convenience sampling was used to recruit children in prostitution from two midsize cities in the Northern part of Benin, Ouagadougou the capital city of Burkina Faso and Niamey the capital city of Niger. First, potential sites of CSEC activities (brothels, night clubs, video clubs, restaurants, hotels, open-air markets, areas outside secondary schools and vocational training centers, and parking lots for long trucks, etc.) were pre-identified. Then, pairs of field agents checked for the eligibility of children seen on the identified sites by asking three screening questions on a survey questionnaire to those who volunteered to talk to the agents. The three criteria for the selection of the children included (a) being less than 18 years old at the time of the study, (b) being sexually active, and (c) having received compensations (cash or in-kind) for engaging in sexual intercourse. Only the children who responded "yes" to the three screenings were selected for the study and consequently interviewed. Peer educators—former female sex workers—were hired to serve as gatekeepers to sites deemed unsafe for field agents or known to only insiders (i.e., brothels, strip-tease clubs, etc.) in Niger and Burkina Faso. No child participants were recruited through the help of any service-provider agencies; neither was the data collection done in the precincts of any agencies. A sample of 709 children in prostitution aged 12–17, including 261 girls in Benin, 243 girls in Burkina Faso, and 205 children in Niger including 192 girls and 13 boys, participated in this multicountry research.

Participants from public and nongovernmental structures

A convenience sample of leaders of 64 public and nongovernmental agencies, including leaders from 27 agencies in Benin, 21 in Burkina Faso, and 16 in Niger, were recruited into the study. The participant structures consisted of four major categories of organizations: governmental/institutions and public agencies; health departments and agencies (public and nongovernmental); law enforcement and criminal-justice departments and agencies; and NGOs and similar organizations. The geographical coverage of the participating structures was urban, national, regional, or international. Participants from governmental institutions were leaders in various ministries (i.e., social affairs, labor, justice, and interior affairs) as well as public institutions such as child services agencies and secondary schools. Even though most health structures and all the criminal-justice/law-enforcement structures were public agencies, they were considered separate categories in this study. Participants from the health-care structures included physicians, hospital administrators, and public-health program managers. Representatives from criminal-justice/law-enforcement structures included police commissioners (municipal, judicial police, or special police unit for children) and judges for children. Participants from NGOs were leaders and officials from organizations or networks of organizations involved in the protection of children. Most of the 64 participants were recruited

among stakeholders, representatives, and officials who attended workshops organized by the research team and the study sponsors for a presentation of the project prior to the data collection. Other participants were selected based on the activities, responsibilities and geographical coverage of their structures regarding issues of child protection and CSEC in their respective countries.

Data collection and analysis

In each of the three target countries, two teams of 12 trained field agents, headed by a coinvestigator, collected data from child participants for 5 days. The research in the three countries was coordinated by one international investigator assisted by four national coinvestigators. All the field agents had college-level education; they had field agent experience with children and spoke, in addition to French, at least one major dialect spoken in the city where they were posted for the study. All the members on the research team in each country took part in a 5-day training on the following areas: research ethics considerations regarding child victims of sexual exploitation, protocols for assistance to participants; and linguistic competence needed to administer the survey questionnaire either in French or two local dialects in which the questionnaire was translated.

A descriptive, mixed research method was used in this study. First, a survey questionnaire was used to collect data from the child respondents. Nine close-ended questions and one open-ended question in a 60-item survey questionnaire were used to explore the children's reasons for being in prostitution, awareness of and access to services they needed, and their intent and conditions to leave prostitution. Most interviews with the children were conducted in day time in the main research office and satellite offices in some city neighborhoods, in private spaces in restaurants, or places chosen by participants and deemed appropriate by field agents in the target cities. Second, four semi-structured interview guides were used to explore the activities, experiences, and contributions of structures regarding services to CSEC cases within the last 5 years before the study. All the interviews with representatives of organizations were conducted in their offices by the principal investigator and the four coinvestigators.

The SPSS 20 quantitative data analysis software (IBM Corp., 2011) was used to process and analyze the data collected from the child survey. Descriptive statistics and univariate and bivariate analyses of the survey data, based on frequency, mean and standard deviation, and cross-tabulations, were conducted. The data of the semi-structured interviews with the 64 organization leaders were tape-recorded and transcribed. Thematic analysis of the interview data was conducted. The transcribed data were scrutinized to identify key concepts related to the research questions about the support service structures. Codes were assigned for each key concept identified. The following five major themes that emerged from the transcripts were analyzed: (a) activities and programs of intervention of the structures in the field of CSEC, (b) categories of child populations served, (c) challenges in providing services to children, (d) experiences of interagency collaboration regarding issues of CSEC, and (e) recommendations for strategies to improve services for victims of CSEC.

Human subject protection

Potential risks for participation of children in this research were addressed in three ways. First, an international research advisory board for the study, consisting of experts in child protection, reviewed the research proposal. Second, the proposal was presented at meetings of the international research team with national stakeholders, in each of the three countries, for feedback and suggestions to address privacy and protection concerns regarding the participation of children in the study. Third, the research proposal was submitted for review to the office of research ethics at a public university in Burkina Faso. All the child respondents gave oral assent after reading or being read the assent form. No names or personal identifiers were collected from any child participants at any point of the data collection. They were compensated for their time with T-shirts, caps, and packages of condoms provided by partner organizations that provided HIV-prevention services. Child participants were also provided a list of referral resources. Parental consent for participation of children in the study was not possible due to various

issues related to research with this hard-to-reach population. Victim and support services agencies and child-protection police units were represented on the advisory board for this research project in the three countries. The representatives of the 64 structures gave informed written consent before being interviewed. The principal investigator for the study also received a formal approval from his university's Institutional Review Board in the United States to subsequently disseminate the research findings.

Study limitations

There are some limitations to the findings of this study. The findings about the children in this study are not representative of all victims of CSEC in the target cities or countries because of the use of convenience sampling. The collected data were primarily based on respondents' self-reports. Thus, social desirability bias was likely to affect child participants' responses. Still due to the use of convenience sampling, the 64 institutions and organizations that participated in the study are not representative of all the support structures in any of the three target countries nor do they represent the population of service providers in the West African region. The finding about law enforcement admitting to taking many children into custody is not representative of the law enforcement agencies in any of the target countries for the study. Considering that the data collected were originally in French, some translated quotes from the interviews with leaders of institutions and organizations might not accurately reflect statements some of them made. The fact that the data were collected in three countries that share borders and other characteristics does not imply an amalgam in any part of the findings. These limitations hardly affect the validity of the findings of the study and the merit of the research to be the first of its kind to explore service provisions to CSEC victims in West Africa.

Results

Characteristics of child participants

Most of the 709 child respondents were citizens of the country where they took part in the study. In Benin, 77% of the 261 child respondents were from this country and 23% from six other countries. In Burkina Faso, 63% of the 243 child participants were natives of this country, 30% from Nigeria, and 7% from other countries. In Niger, 93% of the 205 children were natives. The age range for all the child participants in the three counties was 11–17 years. The mean age of the child respondents in the Benin sample was 16 years (SD = 1.1), and 16 years too in the Niger sample (SD = 1.0), whereas in Burkina, the mean age was 16.5 years (SD = 0.8). In Benin, 8% of the 261 child respondents were child mothers, against 38% of the respondents in Burkina Faso, and 25% of the 192 girls in the Niger sample. Between 19–40% of the respondents in the three countries had at least one family dependent, including 19% of the respondents in Benin, 39% of the respondents in Burkina Faso, and 40% of the respondents in Niger.

Poverty was the underlying major factor of the involvement of the majority of the child respondents in the sex trade in the three countries. For instance, 32% of the respondents in Benin, 23% of those in Burkina Faso, and 18% in Niger reported being involved in the sex trade due to a lack of parental support. One out of every three respondents in Burkina Faso and Niger reported practicing prostitution to help their parents. Issues of bill and debt payment was reported by 24–57% of all the respondents. Support for their own children was also mentioned as a reason for prostitution by 23% of the respondents in Burkina Faso and 12% of those in Niger. Most respondents (33–60%) reported the desire for trendy electronic devices as another motivating factor for their involvement of the sex trade. Respondents who reported practicing prostitution because forced by pimps were found mostly among those in Burkina Faso (14%).

Table 1. Distribution of Child Respondents Based on Access to Services and Types of Assistance Received.

	Benin	Burkina Faso	Niger
Variables			
Respondent received assistance from support structures (NGOs, social and health services agencies, child protection, police units, etc.)	(*n* = 261)	(*n* = 243)	(*n* = 205)
Yes	55	60	54
No	206	183	151
*Types of assistance respondent received from support structures**	(*n* = 55)	(*n* = 60)	(*n* = 60)
Awareness about STIs and HIV/AIDS	50	43	52
Help to leave prostitution	19	32	28
HIV/AIDS screening and condom acquisition	–	5	1
Services that do not respond to my actual needs	1	15	–
Basic health care	–	6	–

*Data based on multiple-choice response.

Victims' access to services and perspectives on alternatives to CSEC

The findings show that few of the respondents received any support from child protection and welfare structures, including social services agencies, health-care clinics, child-protection police units, and NGOs, etc. As displayed in Table 1, only 55 of the 261 children (21%) in the Benin sample, 60 of the 243 children (25%) in the Burkina Faso sample, and 54 of the 205 children (26%) in the Niger sample reported accessing some support services. Thus, three out of every four children (i.e., 540 children, 76% of all the child respondents in the study) reported not having accessed or received any assistance services. In each of the two cities where the study took place in Benin, there was only one public social service center, but no special police units or judges for children. The three types of support services accessed by the respondents who reported receiving assistance included to a large extent, awareness about sexually transmitted infections (STIs) and HIV/AIDS, and counseling for alternatives to prostitution. Only a few respondents from Burkina Faso reported getting free HIV-screening services and condom acquisition. In the same country, 15 of the 60 respondents who accessed services reported that the assistance received was not appropriate to their actual needs. Overall, prevention services about STIs and HIV/AIDS and assistance to quit prostitution were the major types of services received by the few child victims (less than 25% in the three countries) who reported getting any attention from any support services to address their needs.

As shown in Table 2, 172 of the 261 respondents in Benin (66%) indicated their desire to leave the sex trade, whereas 35 respondents did not consider doing so, and 54 other participants did not know whether they would leave the sex trade. In contrast to Benin, almost all the respondents in both Burkina Faso (94%) and Niger (94%) indicated their intention to quit the sex trade. In the three countries, most of the respondents who discussed with someone the possibility to abandon prostitution did so primarily with friends and family members. In contrast, only a few respondents discussed the prospect of quitting the sex trade with professionals in any assistance agencies. A key finding was that 83 of the 261 child participants in Benin, 95 of the 243 respondents in Burkina Faso, and 53 of the 205 participants did not have any opportunity to discuss with any person their intent and plan to leave the sex trade.

The findings about respondents' perspectives on conditions and motivations to quit the sex trade showed getting a job as the most desired alternative reported by most child participants (see Table 3). As a respondent said in general comments, "I need to have a good job that can help meet my needs. So, I am looking for help to leave this practice." Another one commented, "I wish your organization would help me pay my sewing training and open my studio. Otherwise, I do not know if anyone can really help me in my family." In a similar tone, a 15-year-old girl in Benin stated, "I would like your organization to help me with money to do small business because I am a beggar's daughter and I am the only one who supports my family." As the latter two comments indicate, some child respondents believed that the organizations that sponsored the study could potentially

Table 2. Distribution of Respondents Based on Category of People Consulted and Conditions for Quitting Prostitution.

	Benin	Burkina Faso	Niger
Variables			
Respondent intends to quit prostitution	(*n* = 261)	(*n* = 243)	(*n* = 205)
Yes	172	228	193
No	35	4	5
Doesn't know yet	54	11	7
Person respondent discusses with for advice or help to quit sex work*	(*n* = 226)	(*n* = 239)	(*n* = 201)
No one	83	95	53
A friend	112	105	112
A family member	47	33	47
A boyfriend/prostitution intermediary	11	37	5
A social service professional	14	26	3
A religious leader	12	16	2
An adult sex worker	8	22	2
A client	–	3	3
Potential conditions for respondent to quit prostitution*	(*n* = 226)	(*n* = 239)	(*n* = 201)
If I get married to a person I love	128	99	91
If I find another activity	95	146	157
If I receive economic assistance	94	76	70
If I receive social assistance	43	44	39
If I repay my debts	37	10	6
If I find a foster care family	30	45	3
If I can be reunified with my family	8	34	5
If I save enough money for small business		16	12
Other		10	6

*Data based on multiple-choice responses.

Table 3. Distribution of Respondents Based on their Perspectives on Addressing Prostitution.

	Benin (*n* = 261)	Burkina Faso (*n* = 243)	Niger (*n* = 204)
*What needs to be done to address child prostitution?**			
Raise parents' awareness about child prostitution	148	116	45
Educate children about their rights	75	58	39
Surveying and training children in prostitution	93	99	103
Prevent child trafficking	55	50	29
Educate children about risks and dangers of prostitution	208	103	116
Provide assistance to children in prostitution	15	38	43
Other	5	8	14

*Data based on multiple-choice responses.

provide alternatives for child victims to quit prostitution. Most of the participants in the three countries sought social and economic assistance to abandon prostitution. They perceived that receiving some welfare assistance would help them abandon prostitution. As a 17-year-old girl in Burkina Faso stated in her comments, "I just want a little help to get out of this situation because I've never thought that one day I would sell my body to survive to pay for my education. I want to go to college, but it's hard for me without any help." It is notable that many girls perceived that finding and marrying a person they loved might motivate them to quit the sex trade, which implies that most of them would rather be in a situation of early marriage than prostitution.

In addition to highlighting a pervasive issue of poverty and a lack of assistance programs for CSEC victims in the target countries, the findings point to a lack of opportunities and safe contexts for child respondents to be listened to and counseled about leaving the sex trade. Some respondents appeared abandoned by their families while others felt overlooked by agencies responsible for protecting children. As one boy respondent said in his comments, "Thanks to this survey, I hope social services centers will think about children like me who have no one to count on." In the same line of thought, a 15-year-old girl in Niger commented, "I would like to see many organizations like yours that can allow us to talk about our daily difficulties in life. May God help you in this work to save girls like me."

As shown in Table 3, regarding children's perspectives on strategies and actions to prevent child prostitution and to assist victims, most respondents in Benin (80%) and Burkina Faso (42%) considered it a priority to educate children about the risks and dangers of CSEC. As one child in Benin commented, "I want your NGO to help us, maybe by raising our awareness about the dangers of prostitution." The second most important action perceived by respondents was the need to survey all prostituted children and provide vocational training to them. A significant number of the children stated the importance of educating children about their rights and of preventing child trafficking. Likewise, many child respondents, especially in Benin (57%) and Burkina Faso (48%), stressed the need to raise the awareness of parents and caregivers about children's vulnerability to CSEC and the consequences this issue had on children's health.

Characteristics of the support service structures

Support and victim services for CSEC include services provided by an array of government agencies and nongovernmental organizations to child victims and survivors. Providers of these services include individuals and programs such as: case managers, social workers, child protection officers; child welfare agencies; programs specifically designed to address CSEC (e.g., direct care/service providers, advocacy organizations); programs that provide services to CSEC victims without recognizing their situations (e.g., runaway/homeless youth shelters); and programs that provide services to victims but lack resources and plans to appropriately respond (IOM & NRC, 2013). The 64 structures that participated in the present study consisted of four major categories: public structures, law-enforcement and criminal-justice structures, health-care structures, and NGOs and associations. Each of the 64 structures was represented by one leader or official. Participants from the public structures were from three ministries (social affairs, justice, and labor) and other public agencies. Representatives from the health-services structures included physicians, managers of clinics, hospitals, and public-health departments. Respondents from law-enforcement and criminal-justice structures included police officers, judicial police officers, child protection police unit commissioners, gendarmerie chiefs, and judges for minors. Participants from NGOs included executive directors and program officers from international organizations. Table 4 displays the four categories of structures and their geographical coverage for each target country.

Structures' areas of intervention and input in services for CSEC cases

The primary focus of this section is on the experiences and efforts of the four types of structures whose work on sex trafficking and child issues directly or indirectly relates to the provision of victim and support services to victims/survivors of CSEC in the target countries for the study.

Table 4. Distribution of Structures by Category of Work and Geographical Coverage.

	Benin	Burkina Faso	Niger	Total
Variables	*n*	*n*	*n*	*n*
Category of structures				
Public institutions	6	4	3	13
Health-care structures	5	4	4	13
NGOs and associations	11	9	6	26
Criminal justice/law enforcement	5	4	3	12
Total	27	21	16	64
Structures' geographic coverage of intervention				
International coverage	3	2	–	5
National coverage	4	8	8	20
Province coverage	4	4	5	13
Urban coverage	16	7	3	26
Total	27	21	16	64

Public institutions

Thirteen governmental institutions and public agencies from the three countries participated in this study. The six public institutions in Benin included two departments in the ministry of social affairs, a public secondary school, two social services centers, and the social welfare division in a city government. The four public institutions in Burkina Faso included three ministerial departments (justice, labor, and social affairs) and a city hall social welfare division. The three institutions in Niger included a regional agency dealing with women's empowerment and child protection, a child-protection department in the ministry of social affairs, and a social service agency.

As shown in Table 5, the public structures in the study targeted seven categories of children, including child victims of abuse, child victims of CSEC, and juvenile offenders. While child victims of abuse and orphans were the primary focus of the public structures in Benin, victims of child labor and street children were the major targets of services by public structures in Burkina Faso. In contrast to Benin and Burkina Faso, public structures in Niger reported targeting not only street children and child victims of maltreatment, but also those involved in prostitution. Services provided by the public structures in Burkina Faso primarily focused on the capacity buildling (47% of the services) of NGOs and first responders such as gendarmes, police officers, and social service providers. In contrast, the key areas of services of public structures in Benin and Niger were awareness campaigns and education about child trafficking. Commenting on awareness campaigns the Ministry of Social Affairs in Benin did within the last 5 years before the study, the respondent from this institution said:

> Every year, the Direction of Children, Adolescence and Families, and Protection of Human Rights organizes in each province workshops to raise the awareness of managers of hotels, restaurants, cinema theaters, cyber cafe, video clubs, and night clubs about issues of child prostitution.

Health care structures

Health care providers have an opportunity to assist victims of CSEC in practice settings such as emergency departments, primary-care clinics, school clinics, shelters, specialty clinics, community health centers, health department clinics, STI screening centers, etc. The respondents in the three countries in this study included five physicians, four clinic and hospital managers, and two public-health program managers. They were representatives of 11 health-care structures in this study, including five in Benin, three in Burkina Faso, and three in Niger (see Table 6). The five health-care structures in Benin included a major hospital, two primary-care clinics, and two public-health departments dealing with sexual health, STIs, and HIV/AIDS. The six health-care structures in

Table 5. Distribution of Public Structures Based on Categories of Children Served and Types of Services Provided.

	Benin (n = 5)	Burkina Faso (n = 4)	Niger (n = 3)
Variables	%	%	%
Categories of children with which the public institutions and agencies dealt			
Child forced labor	15.0	34.0	–
Child marriage victims	5.0	–	–
Child in conflict with the law	5.0	12.0	13.0
Street children	15.0	22.0	24.0
Prostituted children	15.0	15.0	25.0
Orphans	20.0	5.0	13.0
Victims of maltreatment and abuse	25.0	12.0	25.0
Areas of services provided by public institutions and agencies for children			
Family reintegration	13.0	–	9.0
Legal assistance	17.0	14.0	9.0
Capacity building of NGOs about CSEC	8.0	47.0	–
Counseling	13.0	–	9.0
Awareness campaigns	21.0	13.0	19.0
Medical assistance	8.0	—	9.0
Education	17.0	16.0	18.0
Vocational training assistance	8.0	14.0	18.0
Housing	–	–	9.0

Table 6. Distribution of Health-Care Structures Based on Areas of Main Activities.

	Benin (n = 5)	Burkina Faso (n = 3)	Niger (n = 3)
Main areas of activities	%	%	%
Awareness about STI/HIV	40.0	50.0	55.0
Family planning and sexual health care	24.0	35.0	33.0
Primary health care	21.0	15.0	22.0
Public health	15.0	–	–

Burkina Faso and Niger included two public-health programs, two national centers for prevention and interventions about STI/HIV, and two community health centers.

The findings show that awareness campaigns about STI/HIV was the main service related to CSEC provided by the health-care structures from any of the three countries in the study. The three areas of services reported by the structures were family planning, sexual health, and primary health care. Three health-care structures in Benin and two in Niger also reported having providing counseling services for girls and women victims of sexual violence. The three structures in Burkina Faso reported having provided sexual health care and education to girls in prostitution in the 5 years before the study, including information about STIs and HIV/AIDS, HIV screening, access to free condoms, etc. Yet, no statistics were provided on the number of victims served. The representatives of five health facilities (hospitals and clinics) reported that their structures had specialists trained for special care for sexual violence. As a physician in Benin stated:

> For victims of sexual assault who are referred to us, we often perform a gynecological examination. We also provide them medical certificates for criminal and legal proceedings. Most girls and women who come here want to be screened for HIV. The test is free. Yet, few of them ever come back for their test results. Unfortunately, we do not have any way to track them if the test is positive.

Respondents from only 3 of the 11 health-care structures reported some statistics on CSEC cases their organizations assisted. A respondent in Burkina indicated that the hospital of which he was an administrator provided emergency medical care to a dozen victims of CSEC within the last 5 years prior to the study. Some of the victims, who experienced violence by clients through gang-raping, were brought by the police. Another one from Benin reported that his clinic assisted over 20 CSEC victims, primarily for issues of STIs and rape. Four structures in Benin and two in Niger were also reported as having at least one trained medical health professional specialized for CSEC-related medical care.

Criminal justice and law enforcement structures

Law enforcement agencies and criminal justice departments play a crucial part in assistance to victims of trafficking by their protection and prosecution responsibilities. Officials from 12 criminal justice/law enforcement structures were interviewed for the study. In Benin, the five participants included two police commissioners, two gendarmerie company chiefs, and the deputy director of the Central Office for the Protection of Minors (OCPM)—a division of the police responsible for child protection. The four participants in Burkina Faso included two police commissioners, the head of a regional police division for child protection, and a judge for children. The three respondents in Niger included the head of the child and women's protection unit in the central police department in Niamey (the capital city), a judge for children, and a gendarmerie officer. In total, leaders of 10 law-enforcement agencies and two juvenile court judges participated in the study.

Table 7 displays the categories of CSEC cases for which the criminal-justice and law-enforcement structures provided assistance services. The findings show that agencies in the three countries provided services about child maltreatment, sexual abuse, and child prostitution. It was also found that the criminal justice and law enforcement agencies in Burkina Faso provided substantial services about child labor trafficking, while those in Niger did so about child sexual assault (50% of their CSEC services).

As displayed in Table 8, only 4 of the 10 law enforcement agencies reported having staff members who are responsible for CSEC cases, including one agency in Burkina Faso, two agencies in Niger,

Table 7. Distribution of Criminal-Justice/Law-Enforcement Structures Based on Categories of CSEC Issues Addressed.

	Benin (n = 5)	Burkina Faso (n = 4)	Niger (n = 3)
Categories of CSEC issues addressed	%	%	%
Child maltreatment and sexual abuse	29.0	35.0	25.0
Child prostitution	24.0	10.0	25.0
Child trafficking	18.0	35.0	–
Child marriage	29.0	20.0	–
Child sexual assault/rape	–	–	50.0

Table 8. Descriptive Statistics on CSEC-Related Training, Number of Children and pimps Arrested, and Cases Processed by the Structures Within the 5 years Before the Study.

	Benin (n = 5)	Burkina Faso (n = 4)	Niger (n = 3)
Variables	*n*	*n*	*n*
There are specialized officers for CSEC cases in the structure.	1 structure	1 structure	2 structures
Number of people on the structure staff focusing primarily on CSEC-related cases.	1 structure: 1 staff	1 structure: 9 staff	2 structures: (a) 4 staff (b) 2 staff
Number of structure staff who received specific training on CSEC in the last 5 years.	2 structures	None	1 structure
The structure has taken prostituted minors into custody or to jail.	1 structure	1 structure	2 structures
Number of CSEC cases of boys with whom the structure has ever dealt.	None	None	None
Total number of CSEC cases handled by the structure within the last 5 years.	3 structures: (a) About 30 cases per year (b) 10 cases (c) 2 cases	1 structure: About 100 cases	1 structure: About 125
Number of CSEC cases that resulted in arrests of minors in prostitution in the last 5 years	3 structures: (a) Rarely (b) About 100 (c) None	2 structures: (a) 95% (b) None	2 structures: Data not provided
Number of CSEC cases that resulted in arrests of intermediaries/ pimps in the last 5 years.	4 structures: (a) No cases (b) About 100 (c) 2 cases (d) About 50% of cases	2 structures: (a) About 75% (b) 100%	1 structure: About 40

and one in Benin. Yet, only two law enforcement agencies in Benin, one in Niger, and none in Burkina Faso reported having any staff who had received specialized training in CSEC in the last 5 years prior to the study. One of the two juvenile court judges interviewed for the study reported having received some training about CSEC, yet, only a few months before the present study. That judge admitted having routinely overlooked CSEC cases in child abuse caseloads on which she made decisions until a recent workshop on child sexual exploitation organized by an international organization. That judge reported a specific case of a 14-year-old girl who managed to get to her office to plead for help after being sexually assaulted by three soldiers and being refused help at the local police station:

> After listening to the girl, I asked how she managed to get to my office and she said someone told her I was the only person who could help her. I told the girl to go back to the police station for help, and that there was no assistance I could provide her. It was only after attending a recent training on child sexual exploitation that I realized the unfortunate error I made by not having tried to assist the poor girl then.

These comments illustrate pervasive issues of lack of training for decision makers and professionals in the criminal justice system about CSEC in some countries in the region. Five law-enforcement agencies reported numbers of CSEC cases they had handled within the last 5 years prior to the study,

including three structures in Benin (42 cases), one structure in Burkina (about 100 cases), and one in Niger (about 125 cases). None of the law-enforcement agencies in any of the three reported handling cases of boy victims of CSEC.

The respondents from seven law enforcement agencies in the three countries indicated that cases of CSEC rarely led to arrests of underage children. In contradiction, the findings show that two law enforcement agencies in Benin, one in Burkina Faso, and one in Niger, which handled CSEC cases, had taken into custody substantial numbers of minors in prostitution in the last 5 years prior to the study (see Table 8). A police commissioner among the respondents in Benin reported about CSEC cases that resulted in dozens of arrests of minors in prostitution. As he explained:

> Last year, before I was appointed here, they used to routinely round up and take into custody dozens of girls and women found late at night looking for customers along the major streets in the city. They were usually released the following day [. . .. . .]. Now, we often take young women we rescue to partner NGOs in the city.

However, most respondents were quick to point out that children in prostitution were not treated as criminals by law enforcement. Seven of the 10 law-enforcement agencies—four in Benin, two in Burkina Faso, and one in Niger—reported taking into custody various numbers of intermediaries involved in CSEC, especially managers of brothels and "pass houses" within the same time period (see Table 8). A notable observation is that Benin and Burkina Faso were not only the countries with most arrests of minors in prostitution but, more important, they were the ones with substantial numbers of arrests of intermediaries of CSEC and sex traffickers. Thus, it can be speculated that law enforcement agencies sometimes took prostituted children into custody to have information that could help arrest and indict intermediaries. As one respondent explained, "sometimes these girls are arrested for the need for the purpose of investigation of criminal cases, and then released to social services agencies and NGOs for assistance." Yet, none of the two juvenile court judges in this study reported any prosecution of CSEC cases.

NGOs and associations

The findings show a high presence of NGOs among the support service structures (26 of the 64 structures in the study). The NGOs included direct service providers, faith-based organizations, advocacy organizations, and community organizations that served other populations, and international organizations. The activities of some of the NGOs dealing with CSEC were integrated into broader service ranges about child protection, while others focused on all forms of human trafficking (e.g., sex trafficking and labor trafficking) and the range of populations affected (e.g., minors and adults), or primarily on CSEC cases. The geographical service coverage of some NGOs were local, urban, or national while others had regional or international in scope.

The 26 NGOs included 11 in Benin, nine in Burkina Faso, and six in Niger. These 26 structures included five international organizations, including International Organization for Migration (OIM), CARE Benin/Togo, Terre des Hommes (TdH), Save The Children, and United Nations Children's Fund (UNICEF). They intervened in the three countries mostly as major funding organizations. More specifically, they provided funding to victim services organizations through grants and technical assistance to program grantees and supported the provision of services at the local, regional, and national levels. Funds they provided to local NGOs also contributed to develop public outreach and awareness campaigns and interagency partnerships.

The 21 other structures had experience of services in various areas including direct care and services, outreach and public-awareness initiatives, training for victim and support service professionals, and prevention programs regarding child protection. They provided services in more than two areas of intervention, as shown in Table 9. The CSEC related areas of programs of most NGOs in Benin were advocacy for child's rights, advocacy against child labor and sex exploitation, and education of vulnerable groups of children.

Most NGOs in Burkina Faso had programs focusing not only on the education of vulnerable groups of children but also social assistance and health-care for orphaned children and family

reunification and social reinsertion of juvenile delinquents. In contrast with Benin and Burkina Faso, the primary areas of the programs of NGOs in Niger were HIV/AIDS prevention and intervention and direct care for victims of human trafficking and gender-based violence. The structures in Benin and Burkina Faso also had programs focusing on HIV prevention but at a lesser level than those in Niger. The findings show that 37% of the children served by the NGOs in Niger were involved in prostitution, against 23% for NGOs in Benin and 19% for those in Burkina Faso for the same issue. Likewise, 27% of the work of the NGOs in Niger focused on street children, against 13% for NGOs in Benin and a similar percentage for NGOs in Burkina Faso. However, more NGOs in Benin and Burkina Faso dealt with child victims of forced labor and orphans than those in Niger.

The findings regarding specific interventions the NGOs reported having provided to children and their families within the 5 years prior to the study show that three NGOs in Burkina Faso and five in Benin developed substantial efforts for awareness campaigns about CSEC. In Benin, two other NGOs reported providing legal assistance to approximately 10 victims of CSEC in efforts to bring their exploiters and perpetrators of sexual abuses to justice. In contrast, NGOs in Niger appeared to have provided more medical care and HIV-prevention assistance to children in prostitution. Other specific interventions reported among the NGOs included reunification of CSEC victims with their families, and economic assistance to child survivors of prostitution through vocational training and support for income-generating activities. Findings about some challenges for the 64 structures in efforts to provide services to victims of CSEC are presented below.

Challenges

A major challenge reported by respondents from the three countries as limiting the efforts of public structures for the implementation of their programs and services for vulnerable children was the limited availability of financial resources. Other factors mentioned by most participants in Burkina Faso and Niger as limiting their structures' activities include lack of enforcement of laws related to CSEC by the government and the difficulty to get community groups involved in awareness campaigns initiated to sensitize them on the prevalence of CSEC and how to prevent it. Health structures' challenges for serving children victims of sexual abuse and sexual assault included a lack

Table 9. Distribution of NGOs Based on Areas of Activities and Interventions and Categories of Children Served.

	Benin (n = 11)	Burkina Faso (n = 9)	Niger (n = 6)
Variables	%	%	%
Areas of programs and interventions			
Care for victims of trafficking and gender-based violence	11.0	8.0	28.0
Advocacy for children's rights	22.0	–	14.0
Advocacy against child labor and sexual exploitation	17.0	15.0	–
Education of vulnerable groups	17.0	25.0	–
Social/family reinsertion of child offenders	11.0	20.0	–
Advocacy against violence women	5.0	–	–
Capacity building training about children and women's issues	3.0	–	14.0
Social services and health care for children victims of AIDS	–	20.0	–
HIV/AIDS prevention and intervention programs	–	–	30.0
Other	14.0	12.0	11.0
Categories of vulnerable of children served			
Victim of trafficking	5.0		–
Victim of forced labor	26.0	25.0	9.0
Victim of prostitution	23.0	19.0	37.0
Victim of forced marriage	5.0	13.0	9.0
Victim of child maltreatment		–	–
Orphan	23.0	29.0	18.0
Street children	13.0	14.0	27.0
Abandoned/rejected children	5.0	–	–

of specialists for care resulting from gender-based violence, the reluctance of most parents and families to seek emergency medical care for child victims of sexual assaults, and fear of victims to seek help in health centers, etc. As a hospital administrator in Benin explained:

> Our staff are not well trained to provide special services for most cases of sexual assaults we often receive…. Another problem is that families bring child victims of sexual assault to hospital when it is often too late. Even we successfully save the victim's life, the biggest problem for them is not physical. In fact, we do not have anyone specialized in mental health and counseling who can help victims deal with trauma they experience.

Obstacles criminal justice/law enforcement structures in the three countries encountered in combating CSEC can be put in five major areas: (a) limited financial and technical resources, (b) limited opportunities for training about CSEC, (c) lack of collaboration from families and communities, (d) issues of assistance to CSEC victims after rescue, and (e) political factors. Issues of limited resources include (a) inadequate means of criminal investigations, (b) lack of funding for immediate support services for CSEC victims, and (c) lack of transportation for most interventions for CSEC cases. The lack of cooperation from families is related to sociocultural taboos linked to sexual abuse, the reluctance of victims' families to cooperate with investigations, and stigmatization of community members reporting sexual abuse or exploitation cases to law enforcement. Issues related to assistance to victims after rescue include limited information for referral services and absence of identification documents on child victims of CSEC rescued. Political issues relate to the lack of political motivation to enforce laws against child sexual exploitation, the tendency to rely on international donors for most CSEC-focused programs, and political corruption hampering most investigations of CSEC cases. As a police commissioner in Burkina Faso stated:

> Sometimes, we face unwelcome interference of politicians or traditional and religious leaders in the legal proceedings of cases of sexual violence on minors, because they try to protect sexual offenders, who eventually go scot-free.

The NGOs in the study reported various challenges in their efforts to help child victims of sexual abuse or exploitation. Lack of funding was the biggest issue reported by the respondents. As a leader from a major NGO in Burkina Faso stated:

> Often, there is no funding for follow-up assistance to children, because the funds are punctual and time-limited. Most of the time, funding we get from donors is through government agencies, and we have to bribe people there to get part of the money entitled for our work.

Another issue reported by participants in Niger is families' refusal to collaborate with organizations providing assistance to their children. As a leader of a major social service organization put it, "child victims of sexual assaults and exploitation are often marginalized and rejected by their own families, which puts a lot of stress on the modest resources of our agency regarding long term assistance." Another participant in Niger explained that "parents rarely cooperate, and sometimes, some of them even condone the sexual exploitation of their own daughters." Some respondents reported that child victims too were often obstacles to support services to them. As a respondent in Benin said:

> I don't think that our outreach efforts are paying. Children we help are on the move all the time. And it is not easy to identify them because few of them will tell you their real age, simply because most of them do not know it.

Not all the respondents from NGOs viewed police as partners in efforts to help victims of CSEC. A leader of the biggest NGO providing services to CSEC in a major city in Benin stated that

> It is difficult building cases of sexual assault when police commissioners refuse to consider some crucial information because they fear for their position. Worse, even though we are the biggest NGO providing assistance services to children in prostitution in this city, the police here do not want to collaborate with us.

Interagency collaboration

Collaboration between the public institutions, law enforcement, the courts, and service providers (health and social services, etc.) is an essential component of outreach, engagement, and retention in services for trafficking victims (Hammond & McGlone, 2014). Almost all the public institutions in the study reported collaborating with other structures for assistance or advocacy services about CSEC. The public structures in the study in Burkina Faso were members of the Network of Institutional Child Protection Services (SIP), a national coalition of public institutions involved in child protection.

Eight of the 11 health care structures reported having sometimes received referrals from law enforcement agencies and/or NGOs. In Benin, three structures reported having collaborated with religious associations and traditional leaders for awareness campaigns about health consequences of sexual abuse and exploitation of girls. As one respondent in Benin explained:

> Sexual abuse and exploitation of underage girls is still going on in some communities in this city. I cannot count how many cases of young girls experiencing heavy bleeding or infections due to sexual violence that my service received this year. My staff and I have met with the elders in two neighborhoods a couple of time to discuss the traumatic consequences of the practice, but in vain.

All the 11 health-care structures reported having collaborated with and received more technical support from international organizations than their own governments.

Ten of the 12 law enforcement/criminal justice structures—police and gendarmerie–reported having often collaborated with Health care agencies and NGOs. The collaboration of these structures with other agencies can be put in three categories of partners based on the level of services: first, NGOs, second, child protection services, and, third, other government and city hall branches. Stressing the importance of collaboration of the police with NGOs, a police commissioner at the headquarters of the Benin Central Office of the Protection of Minors (OCPM) stated:

> Police collaboration with NGOs is crucial for referrals, care for minors, family reintegration and even legal proceedings. Without the help of such support partner organizations, I do not know what we can do with all those girls we rescue. […] We routinely refer girls to Soeurs Salésiennes, Terre des Hommes, SOS [i.e., SOS Children's Villages, ESAM [i.e., *Enfants Solidaires d'Afrique et du Monde*], and a few others around here.

Exception to the five international NGOs in the study, each of the 21 other NGOs in the study reported having collaborated with at least three other organizations for assistance services to CSEC victims. The findings of the interviews also indicated a strong intracollaboration among the NGOs themselves in carrying out their activities and programs. They also reported having successful collaboration with public-health centers, child-protection services, courts, police, and ministries responsible for child protection in their respective countries. Contributions of the NGOs provided as part of interagency collaborations involved the following: providing assistance to cases referred by partner organizations, contributing financially to mutual small projects, or providing technical support for joint activities.

Nineteen of the 26 NGOs that participated in the interviews reported being members of at least one major local or national coalition of organizations involved in child-protection activities. For instance, 8 of the 11 NGOs in Benin were members of RESPESD (Network of Structures Working for the Protection of Vulnerable Children) and five were members of CLOSE (Liaison Committee of Social Organizations for Child Protection); two groups of organizations that have played a forefront role in most initiatives or projects about vulnerable children in Benin for the last 10 years. Six of the nine NGOs in Burkina Faso were members of CIJER (Coalition of Actors Dealing with Street Children and Youths), whereas five were also members of RSDPF (Girl Protection, Rights and Solidarity Network) and three were part of REPO (Network of Protection of Children in Ouagadougou)—three major coalitions of NGOs that deal with vulnerable children in Burkina Faso. As for the six NGOs in Niger, five of them were part of CONAFE (Coalition of African

NGOs on Behalf of Children), a major coalition of organizations that has played a central part in most initiatives or projects of assistance to vulnerable children in the country.

Discussion

The findings show that the key needs of the child respondents in the three countries of the study do not quite fit in the components of the three categories of needs indicated in the literature (i.e., emergency and safety needs; ongoing needs; and long-term needs). Emergency and safety needs include (a) immediate safety, (b) emergency shelter, (c) basic necessities, (d) language interpretation, and (e) emergency medical care (Macy & Johns, 2011). Based on the findings of this study, most respondents were engaged in prostitution mostly because of the lack of basic needs and the need to help their families or their own children. The children hardly had any significant need for immediate safety, emergency shelter, or language interpretation for various reasons including the following: (a) most of them were natives of the country when they participated in the study, (b) the majority of them lived with parents or relatives while they engaged in the sex trade, (c) very few of the children were under the control of any pimps, and (d) most of the children practiced transactional sex (TS), a subset of prostitution. TS is defined by Greijer and Doek (2016) as "as a commodified relationship in which sexual acts are exchanged for goods, cash, or benefits, often linked to economic survival, educational achievement, enhancing one's economic opportunities, or boosting one's social status" (p. 32).

Ongoing needs include services necessary for victims to recover from trauma and establish stability in their lives. Such services include those to address (a) physical health, (b) mental health, (c) substance-abuse problems, (d) safety, (e) transitional housing, (f) immigration, and (g) legal issues (Macy & Johns, 2011). The findings do not confirm the literature that establishes that almost all victims of CSEC experience trauma induced by their exploitative situation (Clawson et al., 2008; Macy & Johns, 2011). Most of the ongoing needs mentioned above were not among the key needs of most child respondents in this study, including issues of substance abuse, safety, transitional housing, and legal issues. However, health care could be considered a key service need for victims of CSEC in the region, especially because of the high risks and prevalence of sexually transmitted infections (STIs) and HIV/AIDS among children in the sub-Saharan African region (Guiella & Madise, 2007; Hounmenou, 2016a, 2016b; World Health Organization [WHO], 2015). Most health care services received by the child respondents who were provided any assistance (i.e., 55 of the 261 children in Benin; 60 of the 243 children in Burkina Faso, and 54 of the 205 children in Niger) were primarily for awareness about sexually transmitted infections and HIV/AIDS and condom acquisition. Almost none of the child respondents in the present study reported calling on the law enforcement for assistance regarding violence they experienced in prostitution. Hounmenou (2016b) found that, for issues of violence, children in prostitution in the West African region rarely counted on the police because of experiences of harassment and abuse by law enforcement.

Based on the study findings, one of the most important long-term services needed by almost all the child respondents in this study was education and job training, but none of these respondents reported being provided services for that need. Other long-term-service needs identified in the literature as highly important for CSEC victims (i.e., life skills, language skills, permanent housing, and family reunification) could not be considered major concerns for children in the study. For instance, family reunification was reported by very few child respondents as a major need. Overall, basic social and economic assistance, health care, and education and job training were found to be the major services needed by the majority of the children in this study. The findings do not appear to indicate a need for mental health care among the 709 child respondents.

The findings on the activities and interventions of the support service structures in each of the three countries show that most of these structures had various organizational capacities in the field of child protection. First, it was found that most public agencies in the three countries had implemented programs about street children and prostituted children in three ways: awareness

campaigns about CSEC, education of child victims, and capacity building of NGOs, especially in Burkina Faso. Second, most of the criminal justice and law enforcement structures reported providing services for issues of child maltreatment, sexual abuse, and child prostitution. Third, the substantial representation of NGOs among the structures in this study (i.e., 26 out of 64 structures) appears to reflect the literature showing that, contrary to public institutions and agencies, NGOs have the vanguard role in support service provision to victims of CSEC (ECPAT International, 2014; IOM & NRC, 2013; M'jid, 2008; Tompkins, 2014). The 26 NGOs worked with various categories of vulnerable children, including CSEC victims, providing various care services, especially related to prevention and interventions about STIs and HIV/AIDS, and education and reinsertion of child victims. Most services to child victims of sexual abuse and exploitation in countries in West Africa are provided by NGOs, very often supported with external funding from international partners (M'jid, 2008). According to this author, "regarding the provision of specialized psycho-social care, reintegration and monitoring children victims of sexual abuse and exploitation, numerous actions have been carried out, most often by NGOs" (p. 6).

Finally, the two main services provided by health-care structures in the three countries were awareness about primary health care, STIs and HIV/AIDS, and family planning and sexual health. The literature establishes that almost victims of CSEC need trauma-informed or trauma-focused care (IOM & NRC, 2013; Macias-Konstantopoulos et al., 2015; Okech et al., 2012; Reid, 2010; Walker, 2013). Likewise, research shows that a lack of specialized training for health care providers and NGOs (i.e., mental-health services, trauma-sensitive care for CSEC victims) can impact the service provision to CSEC victims (IOM & NRC, 2013; Macias-Konstantopoulos et al., 2015; Okech et al., 2012; Reid, 2010; Walker, 2013). Yet, none of the 64 structures, especially among the health care agencies and NGOs in any of the three countries, reported providing any mental-health-related services to CSEC victims. Representatives from four law enforcement agencies in the study acknowledged taking into custody many children in prostitution for help in criminal investigations. Nevertheless, being in police custody can cause further, extensive harm to individuals such as victims of CSEC, who are already traumatized through sexual exploitation. While trauma is well established in the mainstream literature as a predictable consequence of sex trafficking on victims, there are almost no studies on trauma-focused services for CSEC victims in the West African region. Overall, it can be argued that the support structures that provided services for CSEC victims in the target countries lacked adequate resources and the ability to provide specialized care to victims.

Considering the findings from the structures indicating that substantial resources were available, it can be argued that the limited access to services among the child victims could be related to the characteristics of this population and challenges they face on the one hand and/or to issues in the support service systems on the other hand. First, the limited access of children to services could be due to many issues including their perception or experience of stigmatization in service settings and their lack of awareness about the existing resources and sociocultural issues. The literature on CSEC shows that victims rarely seek help by themselves for various reasons including shame, refusal to consider themselves victims of sexual exploitation, and high control by pimps over the victims to prevent them from accessing help they need (Clawson & Dutch, 2008b, 2008c). Yet, the child respondents were not afraid of admitting being in the sex trade and were relatively accessible for the study and eager to have their voices heard, hoping for a solution to their problems.

Second, some child respondents might feel helpless about their victimization through sexual exploitation or were not aware that they could seek help to leave the sex trade because of cultural obstacles. According to Lalor (2004), in sub-Saharan Africa, the sexual abuse and exploitation of children appears to be facilitated by a widespread belief and cultural acceptance of a certain tolerance or expectancy of the use of physical coercion against girls and women in sexual relations. There is an emphasis on children's obedience to adults and male supremacy over females, which allows men to have a sense of a double authority over girls and women. Finally, research shows that CSEC victims in West Africa tended to avoid health clinics because of stigmatizing experiences in such settings

(Hounmenou, 2016b). Issues of stigmatization might explain why some of the respondents did not try to contact any service providers for STI issues. Respondents from health care agencies reported that CSEC victims were often reluctant to seek help in health centers. Research shows that CSEC victims who experienced STIs in the West African region preferred self-treatment than go to a health-care center (Hounmenou, 2016b). Most CSEC victims do not often seek medical assistance in health-care settings because of humiliation and shame medical staff put them through when providing services to them (Hounmenou, 2016b; McClure, Chandler, & Bissell, 2015; Silverman, 2011).

The biggest challenge for any of the support service structures in the study, exception of the five international organizations, was found to be financial. For instance, even though the public structures in the study reported having enough human resources to deal with CSEC, they lacked financial resources to coordinate their awareness and intervention programs. Issues of funding for public structures, especially ministerial departments, could limit their capacity to coordinate and monitor efforts of NGOs because the latter were in a greater number and more engaged in services to victims of CSEC. Thus, due to a lack of financial capacity of public institutions, states in West Africa do not have any centralized information system, which makes it very difficult to monitor and evaluate the impact of national efforts to assist CSEC victims in the region (M'jid, 2008).

The finding that almost all the structures had experiences of interagency collaboration could imply substantial information sharing among the service-provider systems. Yet, this did not appear to translate into information sharing and communication or coordination and consensus on service delivery in any of the three target countries, which contrasts with the literature indicating the importance of having a central case manager or care coordinator to ensure coordination of services across multiple systems of stakeholders (Burke et al., 2015; Clawson & Dutch, 2008a; Clawson et al., 2009; Hom & Woods, 2013; Ijadi-Maghsoodi et al., 2016; Walker, 2013).

Another challenge that prevents support service-provider systems to appropriately gauge and respond to the actual needs of CSEC victims was the lack of research to inform the service delivery. Thus, very few support services reported by the 64 structures were known or accessible to most of the victims of CSEC in this study, possibly for many reasons including difficulty to identify and find victims, a lack of understanding of the actual needs of victims, a lack of training opportunities for service providers, lack of mapping of child prostitution sites, and a lack of outreach to child victims. In fact, the study findings indicate that there were limited outreach activities targeting CSEC victims in any of the three countries. While none of the structures in Benin reported doing outreach to CSEC population, only one NGO in Burkina Faso as well as in Niger reported conducting outreach services for girl victims of CSEC, using peer educators. According to ECPAT International (2014), basic support services for CSEC victims in Sub-Saharan Africa were inadequate because the assistance often reaches only a small proportion of those indeed in need.

Yet, outreach methodology is shown to be an effective approach for work with vulnerable populations in general, and particularly CSEC victims. Holger-Ambrose, Langmade, Edinburgh, and Saewyc (2013), the only one study of its kind to explore CSEC victims' perspectives of how street-outreach workers could appropriately provide outreach and connections to services, showed that street outreach is an excellent method to find and connect homeless, sexually exploited youth to service providers. Outreach is a form of approach rooted in harm reduction, which helps identify, approach and engage sexually exploited children where they are. Street outreach workers are likely to be the first people that CSEC victims may contact for help. Thus, they should pay attention to the understated disclosures and requests by CSEC victims to whom they reach out. Holger-Ambrose et al. (2013) found that CSEC victims wanted outreach workers to use "soft words" (p. 71) when referring to child prostitution. By "soft words," victims meant "euphemistic terms for exploitation as well as respectful, non-judgmental and caring interactions with street outreach workers" (p. 7).

An issue highlighted by the findings was the limited opportunities for CSEC-related training for service providers. Thus, even though law-enforcement agencies have an important role in the protection of victims of CSEC, the lack of appropriate training can seriously impact their assessment

of cases of sexual exploitation and creates delays in police and justice actions in resolving cases of CSEC (Farrell et al., 2012; Hammond & McGlone, 2014). Awareness raising through training for law enforcement officers is an important step to facilitate a change in perception and response by law enforcement to sex trafficking (Farrell et al., 2012). Only three law-enforcement structures in this study indicated that their staff received specific training on CSEC in the last 5 years prior to the study. Interestingly, none of the law-enforcement agencies reported having experience of providing assistance to boys in prostitution, or being contacted by boys in prostitution, which contrasts with the presence of 13 prostituted boys among the 205 child respondents in Niger. Research shows that boys in prostitution in that country often experienced violence and harassment by law enforcement (Hounmenou, 2017).

Overall, as arguably the first study that explored the services needed by and provided to CSEC victims in the sub-Saharan African region, this three-country research highlights three important service aspects as related to the extant literature indicating that support services for CSEC victims should be based on three related care approaches: trauma-informed care, case management, and survivor-led and survivor-informed models (Clawson & Dutch, 2008a; Clawson et al., 2009; IOM & NRC, 2013). First, mental health services in general, and trauma-informed/focused care in particular, do not appear to be a key service need for CSEC victims in any of the three countries in this study and in the region. The findings from neither the CSEC victims nor the representatives of support service structures in this study indicate any important concern of mental health issues among the CSEC population. As explained above, conditions that usually create trauma in sex-trafficking victims were not present in the situation of sexual exploitation of the majority of the 709 prostituted children in this study (e.g., presence of pimps, living environment of the children, agency over sexual transactions, etc.). Second, most research calls for a central case manager for services to CSEC victims, especially because of the latter's complex needs as related to trauma they experienced in sexual exploitation. The study points to the need of a national coordinator for service provision regarding CSEC victims, instead of any central case management requested for victims of trafficking who experienced trauma. Third, survivor-informed services are important in the context of this study, because, as the findings show, CSEC victims' input and voice are missing in almost all the support services most structures had available.

Implications

Implications for practice

First, this research has an interdisciplinary character because it has explored the capacities and input of professionals from four major categories (i.e., public institutions, law enforcement/criminal-justice system, health care agencies, and NGOs) in efforts to effectively assist CSEC victims. The findings should appeal to teachers, physicians and other health care providers, child-welfare professionals, leaders of community and faith-based organizations, law enforcement personnel, judges in juvenile and criminal courts, social workers, and mental health professionals. Second, training of professionals of various sectors about support to CSEC victims should build on the core capacities of each key sector dealing with CSEC. Training activities should be designed to engage service providers to act for the welfare of victims without doing further harm. Consequently, it is important that professionals in each sector be consulted to determine the best methods for providing the training and recognizing that service providers' needs may vary, for instance, between law-enforcement personnel and health care providers. Third, professionals in the four core sectors should develop new perspectives on victim service needs, by giving substantial consideration to victims' perceptions in interventions to assist them. Thus, any effective CSEC-related services or interventions should be victim-informed, gender-based, and culturally responsive service delivery. Fourth, professionals working in the West African region and in other developing countries need also to consider the social and economic situation of CSEC victims, instead of just replicating care

approaches from the mainstream literature. Trauma-focused services may not be applicable to the situation of most victims in sub-Saharan Africa. Yet, there is a need to address the issue of dire scarcity of mental-health service professionals in general and for cases of sexual abuse and assault in countries in the region. Multisector interventions should be designed with the clear aim to prevent children from becoming victims and to assist those who have been exploited. Special efforts should be done to increase the awareness of children to help them avoid becoming victims and to help them access needed assistance by disseminating information about the services available for child victims. Schools can play a key role in preventing CSEC by inserting in curricula programs effective and evidence-based programs for preventing, identifying, and addressing CSEC. Peer education may be suitable strategies for raising awareness about CSEC among children in schools.

The accessibility to the population of CSEC victims in West Africa for research purposes provides a unique opportunity to develop mapping of sites where victims could be found for outreach services. Most child respondents complained about not being aware of services. As Holger-Ambrose et al. (2013) showed, street outreach interventions are one of the first approaches every service provider should consider when trying to identify, to learn about the needs of CSEC victims, and to develop services that address their actual needs. Other strategies to protect CSEC victims can include the following: (a) creating in each city a comprehensive list of all service providers with their locations for referral purposes, (b) setting up in every major city drop-in centers for psychosocial care to CSEC victims, and (c) integrating into the training of law-enforcement modules on how to identify and interview CSEC victims without viewing them as criminals. It is also important that proper protocols to prevent any arrests of children (if their life is not in danger) be developed and related training be provided to law enforcement.

Implications for policy

It is important to strengthen the existing legislation on human trafficking in every country in West Africa and other regions in Africa by including a specific law that focuses on CSEC. The law must provide maximum of penalties for exploiters and prevent the arrest and prosecution of CSEC victims. There is a need to create or strengthen special child protection divisions in the police by providing them sufficient resources to accomplish their mission of rescuing and assisting children. The study has shown that the National Plans of Action (NPA) about CSEC in the three target countries are not effective due to many issues. Thus, it will be necessary to appoint a national coordinator of the existing NPAs for a better monitoring of the implementation of the plan based on well-defined indicators. Based on the study findings, it is recommended that all policies related to CSEC be extensively disseminated. It is important for every government to provide substantial financial assistance to all major structures, especially NGOs with a proven track record of support services to CSEC, for better inclusion of the issue of CSEC in their traditional programs of activities. Consequenlty, a centralized coordination of the support services should be developed and standards to monitor the child protection mechanisms and the indicator-based performance of the structures should be used to evaluate progress made in the policy responses to CSEC.

Implications for research

As an initial exploratory study on service provision to CSEC victims in West Africa, this research calls for a comparative evaluation of NPAs on CSEC that most countries in the region have been implementing for the last 5 years or so. Such an evaluation will provide governments and international funding organizations a measure of the progress being made on both national and regional plans regarding service provision to CSEC victims. This study also provides an opportunity to initiate a comparative study on service provision to CSEC victims in developing countries and developed ones. Longitudinal and multidisciplinary research is also needed to understand the recovery process of rescued CSEC victims in countries in sub-Saharan Africa. Finally, this calls for

further research to advance understanding and support the development of prevention and intervention strategies regarding CSEC in sub-Saharan Africa.

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