ORIGINAL ARTICLE

Characteristics of Child Sexual Abuse in Zambia

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ABSTRACT

Child Sexual Abuse (CSA)is a problem in many countries in the world including Zambia. The effects of CSA are both physical (genital trauma, contraction of infections, pregnancy, etc) and psychosocial (emotional dysregulation, bed wetting, regression of milestones, relational problems, poor self-esteem and other psychiatric diagnosis such as depression, eating disorders, substance misuse disorders, dissociative anxiety disorders, anxiety disorders, posttraumatic stress disorder (PTSD), etc). As a result of its effects, CSA is a psychiatric emergency. However, little data exists in sub-saharan Africa). Knowing the characteristics of CSA in our setting, aids early identification and intervention.

Objective: To describe the characteristics of child sexual abuse (CSA) among sexually abused children from the CSA centre at University Teaching Hospital (UTH).

Design: Cross-sectional study based on information from CSA centre records of children aged 4 to 15 years.

Main Outcomes: There were 192 participants in the study with only 3 boys. Teenagers constituted almost 50% of the study population with median age = 13, mean age = 11. Ninety eight percent of the referrals were from the Police. All the abusers were maleswith neighbours, boyfriends and non-relative adults constituting over 50% of the abusers in the study. Penile penetration was the main feature of the abuse with only one in twenty abusers being reported to have used condoms. Physical Force was the main mode of engagement used on the children.

Conclusions*:* Most of the sexual abuse involves unprotected penetrative sex. The police should be included in planned care for CSA victims.

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INTRODUCTION

Background

Child sexual abuse (CSA) "involves forcing or encouraging a child to take part in sexual activity"[1] and may include penetration of the vagina, anus, mouth, by the penis, fingers or other objects and non-penetrative activities. Non-penetrative sexual activities may include attempts to do any of the above listed but also fondling with or without clothes on, exhibitionism, watching others engage in sexual acts and pornography. Of prime importance is the fact that child are unable to give informed consent for these activities.[2] A meta-analysis[3] (Barth, Bermetz, Heim, Trelle& Tonia 2013) from 24 different countries worldwide that looked at 55 studies over the period of 2002 to 2009 puts the prevalence at 3% to 17% for boys and 8% to 31% for girls. Lalor[4] noted that there is little information about CSA in sub-Saharan Africa (SSA) apart from information from South Africa. Lalor[4](p. 3) proposed that a "reason that the sexual abuse of children may not have received more attention in SSA is the range of competing social problems affecting children, such as war, disease, poverty, hunger and homelessness." In Zambia, national gender based violence (GBV) statistics of 2011 from the Victim Support Unit (VSU) of the Zambia Police (ZP) indicate that there were 1939

cases of defilement of children and 2396 cases of child defilement in 2012. ZP records from previous years also show that child sexual abuse reports increase annually. The Zambia Demographic Health Survey (ZDHS)[5] shows that 15% of girls aged 14 years and below have experienced sexual violence already at some point in their lives. It is evident from the above statistics that CSA is a global problem but it is also a Zambian problem.

Furthermore, the CSA problem is said to be under-estimated because few actually get official recording. ZDHS[5] data shows that of 47% of the women who were referred to the hospital actually got to the hospital. CSA studies are also a challenge because researchers have never quite defined CSA in uniform terms.[6,7,8]"CSA experiences vary greatly over multiple dimensions including, but not limited to: duration, frequency, intrusiveness of acts perpetrated, and relationship with the perpetrator (p. 1).[6] Some researchers have been broad and included even indecent exposure while some data like the Zambia Police statistics refer to only penetration (also called 'carnal knowledge') according to the law.[9] Also, the different ages of legal consent in the countries affect the results. These varying definitions make it difficult to compare among different studies.

In this study, sexual abuse is as defined in the introductory sentence and " "child" means a person below the age of sixteen years." (Definition of child - As amended by Act No. 15 of 2005).[9]

Effects of Child Sexual abuse (CSA)

Common physical complaints related to CSA include bleeding, rash, pain or discharge in the genital and/or anal area and dysuria,[10] pregnancy, sexually transmitted infections (STIs) and physical injuries resulting from violent attack by the assailant.[2] However, physical injuries usually heal with no future complications[2] unless there is contraction of a disease, profound secondary injury when forcibly trying to penetrate in very young children or use of force to overcome the victim. Psychosocial effects have longer lasting repercussions sometimes up to years.[1,11,12,13]These may include impulse control, affect regulation, relational problems with peers, attentional problems, delusions, hallucinations, delay in language development, self-injurious behaviour (scratching, hitting, self-laceration, biting, etc) and soiling or enuresis even after they had previously been continent.[1,6,14]Psychiatric disorders that can possibly result are borderline personality disorder, somatisation disorder, major depression (and dysthymia), substance misuse disorders, dissociative identity disorder and related dissociative conditions, bulimia nervosa (and other eating disorders) and post-traumatic disorder (PTSD).[1,15]

Several characteristics of sexual abuse that have been associated with a worse outcome on the psychological trauma such as:

- Multiple incidents (in terms of frequency or duration)
- Abuser being a father figure
- Multiple abusers
- Use of force
- Male sex offender
- Age of perpetrator is significantly older than victim
- Negative response to disclosure[2]

CSA is a major social and public health problem in Zambia. Of the 612 survivors who reported to the police facilities in a population council study that took place at police station, over 49 percent of them were aged 14 and below. However, research in CSA in peer reviewed journals is rare south of the Sahara and mainly from South Africa.[4] No such study has ever been done. This aim of this study is to describe characteristics of CSA among sexually abused children of the CSA Centre at the University Teaching Hospital (UTH), Zambia. In so doing, there is enhancement of knowledge in the area that can influence policy and practice.

METHODS

This was a cross-sectional study done at Zambia's only multidisciplinary CSA centre (as of 2014)

based at a major hospital (descriptive type). Participants were attendees coming for their one month follow up care aged 4 to 15 years old that consented to have their information used in the study (convenient sampling). Data collection was from the CSA centre routine records. Information in these records is collected by nurses that work full time at the centre and are trained in data collection and counselling children.

Data was processed and analysed using Excel windows version8

RESULTS

Study Population

The study population was 192. Figure 1 below shows the age distribution of the population. It can be seen that 49%of the population were teenagers with the highest age population contribution coming from those aged 15 (21%). There were only three boys (2%) in the study. The mean age was 11 years. The median age was 13 years of age with an interquartile range of 8 and 14.

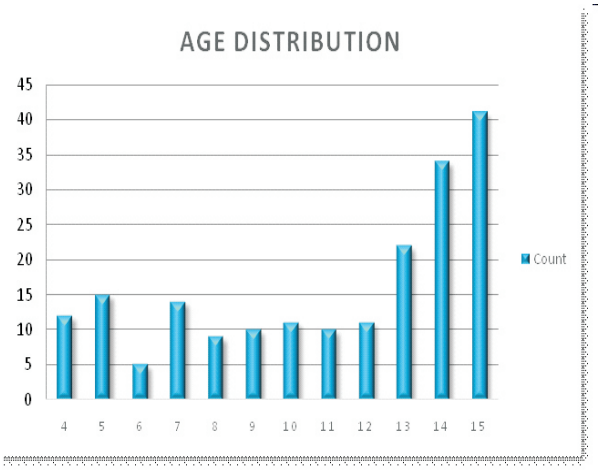

Figure 1: Age Distribution

Over half of the children were of primary level education (53%) and 28 children were of pre-school level (Table 1). Only 7% of the children were double orphaned while three quarters of them had both parents (Table 1). The mother accompanied the child in half the instances.Almost all the referrals were from the police station (98%).

Table 1: Demographic details and characteristics of sexual abuse

Variable		Frequency (n)	Percent (%)
Sex	Male	3	1.6
	Female	189	98.
Education	Secondary	42	21.9
	Primary	91	47.4
	Preschool	29	15.1
	Not in School	6	3.1
	Never been to School	24	12.5
Orphaned	Not orphaned	140	72.9
	Single	31	16.1
	Double	13	6.8
	Unspecified	8	4.1
Reported within 72 hours	Yes	111	57.8
	No	77	40.1
	Don't know	4	2.1
Mode of sexual abuse	Abuser seen naked	112	58.3
	Touching (clothed)	86	44.8
	Touching (naked)	72	37.5
	Kissing	44	22.9
	Simulated Intercourse	94	49.0
	Genital Penetration with object	44	22.9
	Oral intercourse	7	3.6
	Penile Penetration	134	69.8
	Condom used	8	4.2
Frequency of abuse	1	29	15.1
	2	95	49.5
	3	24	12.5
	4	9	4.7
	5	5	2.6
	6	1	0.5
Coercion Used	Don't know	29	15.1
	Playful Coaxing	46	24.0
	Verbal threats	12	6.3
	Physical Force	84	43.8
	Not used/Unspecified	50	26.0
Presenting Complaint	Genital Pain	59	30.7
	Abdominal pain	8	4.2
	Discharge	1	0.5
	Bleeding	3	1.6
	Bruising	1	0.5
	Behaviour changes	0	0
	Other	20	10.4
	None	99	51.6

Characteristics of Sexual Abuse

All the abusers were males, and it was noted that neighbours (24%) and boyfriends (20%) were the common persons identified (Fig.2). However, cases of incest (14%) were reported in which uncles were the commonest perpetrators. Penile penetration was commonly reported at 69% of the cases (Table 1.) and only 5% of the victims reported condom use. Apart from penile penetration, the next two commonest features of the abuse was that they allowed the victim to see them naked (58%) and that object or finger penetration was also done (49%). Most of the clients were abused at least twice.

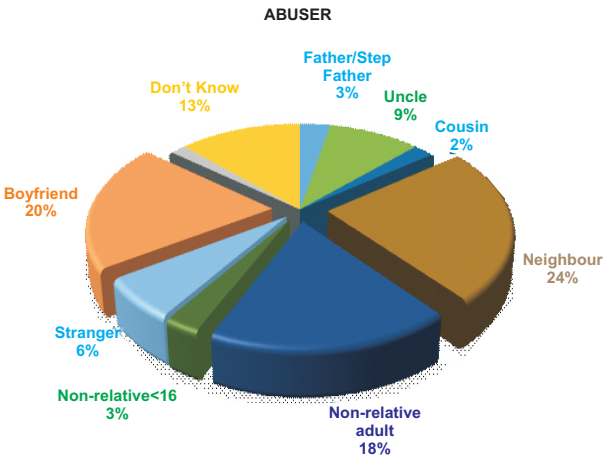

Figure 2: Abuser Statistics

Findings further show that 58% of the children presented within 72 hours since the last abuse. In 84 of the cases, physical force was used to achieve submission followed by gentle coaxing. The most frequently given complaint at the time of first presentation is genital pain although half children did not have any presenting complaint.

DISCUSSION

Summary of Key Findings

Almost half of the study population consisted of teenagers with a median age of 13. Ninety-eight percent of the cases referred to the CSA centre were referred by the police. All abusers were males with the most frequent abusers being neighbours, boyfriends and non-relative adults. Most of the abuse involved penile penetration and unfortunately, condom use was only reported once in every 20 cases. Physical Force was the main mode used to engage the children in sexual intercourse.

Participants

The study population was characterised by female children (boys made up only 2%). This is significantly low compared to other studies.[3,16,17] The assumption for this low representation could be that Zambia is a male dominant heterosexual society and as such sodomy maybe rare since it is also an offence liable to imprisonment according to the laws of the country.[9]

About half of the study population consisted of teenagers. This finding relates very well with results that showed that the 20% of the abusers were boyfriends. In a number of cases, the teenagers were unwilling to give detailed information about their abusers because they had consensual sexual intercourse and feared legal implications on their boyfriends. This was in instances were the caregiver is the one that reported the abuse and took the child to the centre.

Only 6% of the study population were double orphans. This finding is contrary to literature that states that the absence of one or both parents comes with an increased risk of sexual abuse.[16] The proposed explanation for this picture in our study is that only the children with good social support such as both parents made it to this point in the journey. Since almost all the referrals were from the police (98%), the basic process that a child went through is illustrated in Fig 3. below:

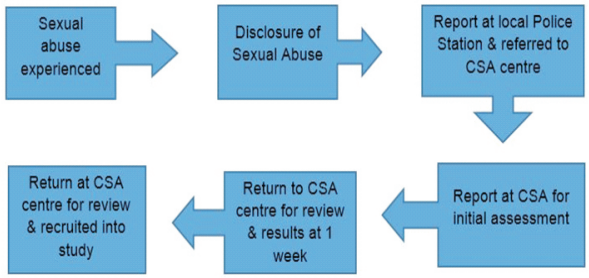

Figure 3: Basic Process Before Recruitment in Study

In the figure (3) above, each of those five points after the sexual abuse were potential drop out points for the victim. The assumption is that only a child with good social support could go through with this process, i.e. end up at the CSA centre and return for their one month reviews up to the point of recruitment into the study. Good social support helps to both cushion the trauma (probably less PTSD) and complete the process of follow up at the CSA centre thus increasing likelihood of recruitment in the study. Capturing a wider diversity of clients would perhaps have entailed recruitment at community centres, community health centres or school counsellor offices.

The results of this study seem to suggest that the Police are the first responders in cases of CSA. This finding is consistent with a Zambian study done in Ndola[18] where 91% of the sexual abuse victims first reported to the police. The findings are vital in planning integrated care as was demonstrated by the Keesbury, et al[18] study. The study[18] further showed that less than half of those that reported to the police followed through and later reported at a health facility. It would be worthwhile to investigate whether a police station is indeed a primary reporting site following disclosure in a home (or otherwise). Considering that Zambia is a religious community, the Church may also be a first respondent in CSA. If the Police station is not the primary reporting site, it would be important to bridge the gap between the community centres, community health centres, school counsellor offices and churches and whatever other primary sites that would be identified and the CSA centre at the hospital in order to minimise the dropout rate. The police station may not be a very child friendly place for reporting of sexual abuse in certain circumstances but perhaps those that end up at the police station may be those that are motivated by litigation. Community awareness of services that can be obtained from the hospital such as post exposure prophylaxis (PEP) and emergency contraception (EC) may be lacking. In view of this, it is essential that community centres are available where children can report abuse of any kind and families can get support. Integrated care will be vital at the first point of contact.

Characteristics of Sexual Abuse

This study highlights the fact that penile penetration is the main characteristic among the children studied although in most instances, the care givers were unaware of the specifics of the abuse going on such as in the form of kissing, oral sex, etc. or the type of coercion used to engage the child in sexual activity. One striking feature was that the care givers did not often know who the abuser was, perhaps because the child was unable to disclose at home. Some adolescents did not give the details of the abuse or abusers perhaps due to discomfort because of the nature of the abuse, fear of litigation of their boyfriends or other unknown reasons. Similar to other studies, all the perpetrators in the study were male.[16,19] Furthermore, four out of five children knew their abuser which was slightly higher than the Keesbury, et al[18] study from the Copperbelt in Zambia (74%). Many studies show the majority of perpetrators to be known to the victim.[5,15,17,19,20] The neighbour was the most frequent perpetrator in our study. This impacts on community awareness and intervention on child sexual abuse and community approaches would have to be implored. Awareness and intervention packages will have to include family packages as well because incest accounted for about 14% of the cases. The boyfriend was the second most frequent perpetrator (20%). The ZDHS[5], however, reported quite a different picture with boyfriend making up 6% of the perpetrators and the most frequent abuser being a stranger.

Almost two thirds of the clients that came to the CSA centre had been abused within 72 hours. It is possible that the reason there are more of those that followed through is because of PEP and EC interventions that can be done if abuse occurs within the said period of time. This may further be supported by the fact that the majority of the participants (69%) reported penile penetration. Most sexual abuse victims will go to the hospital when they feel that there is evidence that can be reported or there is an intervention that can be done. It was unusual though, that almost half the children did not have a presenting complaint. There is need to explore how this question was presented to the respondents. About a quarter of them complained of genital pain and this was the most frequent complaint. This was less than the expected number because penile penetration was reported in about double the number. However, some of this discrepancy may be accounted for by the fact that the study was unable to tease out those that considered the abuse as playful exploration or loving acts.

A limitation of the study is that it was done in a clinical population which may focus on a certain type of people that already have major problems in one area or another.[2] It was also done at an urban centre providing specialised and integrated care for CSA victims in Zambia. Therefore, the results may not necessarily be representative of therest of the Zambian population. Another consideration to factor in is that not all teenagers may perceive sexual intercourse as abuse even if they may be below consenting age because of the prevalence of early marriages in Zambia. The fact that the Zambian law (as earlier discusses) only considers sexual abuse when penetration is involved, it is likely that it is mainly those that experience penetrative sexual abuse presented at the CSA which could have affected the results.

CONCLUSION

Most of the abuse involves unprotected penetrative sex. It is, therefore, imperative that any claim of CSA be followed up by relevant medical examination and prophylaxis to protect children from STIs and other consequences of unplanned sex. Also, since the Police play a vital role in the process cycle of these children, they should be equipped with mental health first aid skills and they should be taught child friendly approaches to minimise drop outs in the service delivery system.

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