A STUDY TO FIND OUT THE PERCEPTION OF FACTORS THAT HAVE LED TO THE OCCURRENCE OF CHILD SEXUAL ABUSE IN LUSAKA URBAN DISTRICT

BY

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DECLARATION

I, **Namwaka Mooto** do hereby declare that this dissertation is my own original work. It has been presented in accordance with the guidelines for MPH dissertation of the University of Zambia. It has not been submitted before for any degree or examination in any other University.

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I, Dr. C. Michelo, having submitted and read this dissertation, I am satisfied that this is the original work of the author under whose name it is being presented. I confirm that the work has been completed satisfactorily and is hereby ready for presentation to the examiners.

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CERTIFICATE OF APPROVAL

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ABSTRACT

Background

Child Sexual Abuse (CSA) is a growing public health issue of international concern that requires immediate attention. A total of 45.3% of Zambia's population are children. This study was looking at the perception of factors that have led to the occurrence of Child Sexual Abuse in Lusaka Urban district. The study estimated the burden of Child Sexual Abuse occurring and illustrated the findings according to age range, sex and the number of prosecuted cases.

Methods

This was a cross-sectional study that utilized both qualitative and quantitative methods of data collection and analysis to assess the extent of Child Sexual Abuse cases in Lusaka Urban district and the perception of factors that have led to the occurrence of Child Sexual Abuse. The study population comprised of programme officers from organisations that are working in the area of Child Sexual Abuse and residents of Chilenje community. The data was collected by means of a Focussed Group discussion guide and an Interview schedule. A total of six (6) FGDs were conducted with seven (7) participants in each group. In addition ten (10) KI interviews were conducted with participants from various organisations working on CSA programmes.

Results

A total of 1079 Child Sexual Abuse cases were reported in 2008 and out of these 1049 victims were females. In addition a total of 628 children aged between 11 – 15 years were abused in 2008. In 2009, a total of 1676 Child Sexual Abuse cases were reported to the police, of which there have only been 277 convictions.

Some key factors such as culture, HIV, myths, poor parenting practices and socio-economic factors were identified as key factors that have contributed to the occurrence of CSA.

Conclusion

We conclude that a national task force on Child sexual Abuse should be established. Furthermore, there is need for standardised reporting and data management systems. In addition there is need to formulate policies across health, psychosocial and legal sectors. There is also need to coordinate with communities in order to formulate adequate Child Sexual Abuse prevention programmes.

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ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
AMA:	American Medical Association
CSA:	Child Sexual Abuse
CRC:	Convention on the Rights of a Child
CSO:	Central Statistical Office
CASE:	Community Agency for Social Enquiry
FGD:	Focus Group Discussion
GBV:	Gender Based Violence
GFP:	Gender Focal Point
GIDD:	Ministry of Gender in Development Division
GNP:	Gross National Product
HIV:	Human Immuno Virus
ILO:	International Labour Organization
IOM:	International Organization for Migration
KI:	Key Informant
MOE:	Ministry of Education
MSYCD:	Ministry of Sport, Youth and Child Development
NCCR:	Non Governmental Organizations' Coalition on Child Rights
NGO:	Non-governmental Organisation
NGP:	National Gender Policy
PTSD:	Post Traumatic Stress Disorder
REC:	Research Ethics Committee
SCT:	Social Cognitive Theory
SGBV:	Sexual and Gender Based Violence
STD/STI:	Sexually Transmitted Disease/ Sexually Transmitted Infection
UN:	United Nations
UNICEF:	United Nations Children's Fund
UNZA:	University of Zambia
UTH:	University Teaching Hospital
VSU:	Victim Support Unit
WILDAF:	Women in Law and Development
WILSA:	Women in Law in Southern Africa
WHA:	World Health Assembly
WHO:	World Health Organization
YWCA:	Young Women Christian Association
ZDHS:	Zambia Demographic Health Survey

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1. INTRODUCTION

1.1 Background Information

The HIV/AIDS epidemic has had drastic consequences on families worldwide especially in Africa. With the number of deaths due to AIDS still very high in Zambia, children have not been spared from its effects. Children have lost their caregivers to AIDS or ended up infected themselves. Children aged between 0 – 14 years make up 45.3% of Zambia's population (CSO, 2009) and out of these 42.6% live in urban areas. Several HIV prevention programmes which include PMTCT, condom use and sex education have been implemented. However an important area which is child sexual abuse (CSA) has been overlooked in the fight against HIV/AIDS. The HIV/AIDS pandemic has given rise to more careful examination of levels of sexual violence worldwide (Coombe, 2002). CSA is one of the missing gaps to the effective HIV/AIDS prevention, treatment and care worldwide (Olufemi, 2004).

The problem of CSA in Southern Africa is a mental health problem that is growing at an escalating rate (Mathoma et al., 2006). In Zambia CSA is very common and is closely linked with a high risk of HIV transmission (Bota, 2003). In Zambia, the HIV prevalence rate is at 14% in people aged 15 – 49 years and Lusaka Province has the highest HIV prevalence rate which is at 21% (CSO, 2009). There is however no information on how much of this proportion is as a result of CSA. The fact that most abusers do not use protection puts children at a high risk of contracting HIV. Therefore CSA is not only a risk factor for HIV transmission but is also a major hindrance in the prevention of HIV.

With poverty on the increase in Africa, there has been a rise in the commercial sexual exploitation of children which is a form of human trafficking. Children have been used as a source of livelihood. As a result children have become vulnerable to unwanted pregnancies and HIV infection.

Many pregnant adolescent girls give birth without access to professional mid-wives or antenatal services and an alarming 60,000 die yearly due to complications of childbirth and unsafe abortions (UNICEF, 2002).

CSA is a profound social and growing public health problem that cuts across class, religious, ethnic, national boundaries and occurs in many if not all parts of the world (Krug et al, 2002). It is a multifaceted problem, extraordinarily complex in its characteristics, dynamics, causes and consequences. CSA is a public health problem due to trauma and damage to a victim's

health (Price et al, 2001). The risk and consequences of HIV infection, unwanted pregnancies, physical and psychological trauma, draw international attention to this silent emergency (WHO, 2004).

Hence WHO has declared violence prevention including CSA as a public health priority requiring urgent attention (Finkelhor, 1994; WHA, 1996). Although CSA has been documented throughout history, what has varied considerably as a result of cultural diversity and norms has been society's willingness to recognize it as a problem.

The CRC defines a child as every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier (WHO, 2004). WHO defines a child as any person between the ages of 0-19 years (WHA, 1996). In Zambia a child is any person under the age of 16years (Bota, 2003). Perception is the interpretation of information provided by the sensory system (Darley et al, 1984). It is the reality to the perceiver and gives insight to community beliefs and attitudes that influence individual behaviour.

The AMA defines CSA as the engagement of a child in sexual activities for which the child is developmentally unprepared and can not give informed consent (Conte, 1986). Kempe (1978) defines CSA as the involvement of dependent, developmentally immature children and vulnerable adolescents in sexual activities which they do not fully comprehend, can not give informed consent to and violate social taboos of family roles. Sexual activities are imposed on a child and represent an abuse of a caregiver's power over a child (Giardino, 2006). It consists of both contact and non-contact activities. These include behaviour involving sexual penetration, fondling, exposing to adult sexuality, pornography, early marriage, defilement, incest, sexual exploitation, molestation and forced prostitution (Mathoma et al, 2006).

1.2 Statement of the problem

Despite CSA being a recurring event, surprisingly little information exists on CSA in Sub-Saharan Africa (Cambanis, 2007; Murray&Burnha, 2009). The fact that CSA is a relatively common experience for children implies a lack of protection and care for these vulnerable members of society (Glaser&Frosh, 2002). CSA is on the increase and the girl child is more at risk (Ikechebelu et al, 2008; Melesse&Kessie, 2005). It is exacerbated by the growing poverty coupled with inadequate legislation that protect children against neglect, abuse, molestation and other traumatic experiences (Mathoma et al, 2006).

Determining the scale of CSA worldwide is complicated, not only because it is difficult to define the abuse cross-culturally, but also because of its hidden nature. More than a half-million children are abused sexually each year (Renk et al, 2002). WHO estimates that approximately 25% of girls and 8% of boys around the globe based on available data have been subjected to some form of CSA (WHO, 2007). WHO estimates that at least one in five of the world's female population has been physically or sexually abused (WHO, 2007). However these numbers are likely to under represent the true scope of the problem given the hidden nature of this abuse.

Statistics on the magnitude of CSA in Zambia are very scarce and only the VSU and UTH have CSA databases based on reported cases. According to VSU records, there were no CSA cases reported before 1999. However overtime cases began to be reported and increased yearly from 84 cases reported in 1999 to 1079 cases reported in 2009 (VSU, 2010). In 2008, UTH reported having received 1079 cases of which 1049 victims were females and 30 were males (UTH, 2009). Although significant figures of CSA cases have been reported to the VSU, UTH and NGOs, there is still limited research documenting this problem (Mathoma et al., 2006). In addition there has been little research into the social and cultural factors that contribute to its existence (Jones&Jemmet, 2009). Research on CSA has been characterized by non-representative sampling, deficient controls and limited statistical power resulting in most of them remaining unpublished (Bassani et al, 2009).

An extremely serious concern is the increased incidence of rape involving very young children and babies due to the misconception that sex with a virgin is a cure for HIV/AIDS (WHO, 2004). This misconception has dramatically increased the number of CSA cases. In addition CSA persists because of various social and cultural beliefs, weak law enforcement, inadequate health systems and inadequate legal systems that have failed to criminalize CSA.

In recent years there has been an alarming growth in the commercial sexual exploitation (CSE) of children worldwide. More than 1.8 million children are trapped in the commercial sex trade (UNICEF, 2008). CSE is on the increase in Zambia and is done for the financial benefit of the exploiter making children vulnerable to the sex trade (Ward et al, 1998; IOM, 2003). Children in Zambia are exploited for sexual and labour purposes (ILO, 2008). Children are therefore more vulnerable to sexual exploitation due to high poverty levels, burden of HIV/AIDS, gender inequalities, cultural factors, migration, wars and conflict (ILO, 2007).

Most abused children hide the abuse, preventing them from receiving the necessary preventive treatment such as Prophylaxis. A study in Cameroon found that 18% of sexually abused children who tested for HIV became seropositive as a result of penetration (Menick&Ngoh, 2003). A Zambian study by Bota (2003) reported that 7% of reported CSA cases later developed STIs. However since there is no follow up system, it is not known whether the children may have contracted HIV. Therefore if CSA levels are high there is a likelihood of an increase in HIV prevalence.

2. LITERATURE REVIEW

A study by Pereda et al (2007) compared prevalence rates obtained from 38 independent studies from 21 countries and concluded that CSA remains an international problem (Jones&Jemmott, 2009). WHO (2007) estimated that the lifetime impact of CSA accounts for approximately 6% of depression cases, 6% of alcohol and drug abuse/dependence, 8% of suicide attempts, 10% of panic disorders and 27% of PTSDs. A study conducted on violence and PTSD in five (5) countries found that 83% of the respondents in the study who were engaging in prostitution in Zambia had indicated a history of CSA (Farley et al, 1998).

In the past, CSA was perceived to only occur in the streets, rather than in the home and the perpetrator was thought to be a male stranger (Miller-Perrin, 1993). However literature has shown that CSA occurs everywhere including the home. In addition the perpetrators include both male and female strangers, and family members. A GBV Survey conducted in 2006 in Zambia reported that the most common place of first sexual abuse was the abuser's home 27%, relative's home 22%, school 15% and 11% in the respondent's home (CSO, 2006). This shows that abuse occurs everywhere.

UNICEF (2001) conducted a study in Zambia and found that female children are more at risk of sexual abuse, with 72% of female children experiencing this form of abuse compared with 28% of males. More than one quarter of the children who had been sexually abused reported that most of their time was spent around the home. The implication is that a considerable amount of sexual abuse takes place in the vicinity of the home, and sometimes within the home itself. The findings suggested that about one in every five cases of sexual abuse is likely to occur around market and trading areas and another fifth in or near to the home (UNICEF, 2001[2]).

Mathoma et al (2006) conducted a study in Botswana and Swaziland on knowledge and perception of parents regarding CSA and reported that CSA was a devastating problem that posed a serious threat to the emotional and mental well-being of the victims. In addition CSA has been linked with the development of various problems affecting the physical and mental health of victims. The study also found that CSA was a cause of family disruptions especially when the perpetrator was a family member (Mathoma et al., 2006).

Several studies have been conducted on CSA worldwide and the findings documented. However the occurrence of CSA has not declined. Moreover, the secretive nature of CSA and the fact that it is largely under-reported make it difficult to pinpoint the extent of the problem (CASE, 2005).

The UTH reported having had 1079 cases in 2008 as compared to 955 cases that were reported in 2007 (UTH, 2009). Out of these cases, 1049 victims were females and 30 were males. In addition 233 victims were aged between 0-5years, 218 victims were aged between 6-10years, and 628 victims were aged between 11-15 years. However these statistics are only limited to cases that have been reported. As a result the figures above are but a small percentage of the actual number of CSA cases occurring around Lusaka district.

Some families opt not to report the cases to the police and settle the matter within the community. It is not known on whether this is as a result of the sensitive nature of the issue, due to fear of stigmatization within the community, witchcraft activities, taboos or monetary settlements. Therefore the true extent of CSA in Zambia is unknown. Fear of bringing dishonour to the family and shame at what has occurred prevent parents, especially fathers, from pursuing reported cases (UNICEF, 2001[2]).

CSA is seen to be as a result of multiple causes that are political, socio-economic, cultural and environmental. This is can be explained by the Social cognitive theory (SCT) that describes a dynamic on-going process in which personal factors, environmental factors and human behaviour exert influence upon each other (Glanz&Rimer, 2005). SCT explores the reciprocal interactions of people and their environments and the psychosocial determinants of health behaviour. These factors are illustrated using the Ecological framework (Annex II) and the Precede-proceed model (Annex III). The Precede-proceed model assumes that health and health risks are caused by multiple factors (Glanz&Rimer, 2005). This model views health

behaviour as being influenced by individual and environmental forces. Different factors from the societal level down to the individual level influence the occurrence of CSA as illustrated in the Ecological framework (Annex II).

Non-governmental organizations (NGOs) have partnered with the Zambian government to try to address the problem of child sexual abuse in the country. However there have been challenges with the success of such programmes. Most of these programmes have been implemented in selected urban areas, thus limiting the number of people who can access the services. As a result denying people that live far away from the line-of rail access to these services. In addition programmes have been planned and implemented without the input of the community. Hence community resistance leading to the failure to achieve the programmes' intended goals and objectives.

The government can be commended on the establishment of the gender based violence bill and the National Gender Plan 2010 – 2014. However, the government has not done enough to fight CSA in the country. There are deficiencies in government's social support systems and infrastructure resulting in the need to conduct this study. For example there is a breakdown with the social welfare system in the country which has since been commercialised and only seems to be operational in major towns and even then inefficiently. There is also a lack of political will to institute the legal will and implement the legal instruments.

In addition there is a direct correlation of CSA to the macro-economic performance of the country and development. Therefore from an economic point of view, the occurrence of CSA affects the micro behaviour of an individual. However, very little funds if any have been allocated to CSA programmes and social systems by government hence the breakdown and inefficiency of such programmes and systems. There is limited man power and a lack of a capacity building plan in most of these social protection institutions. CSA is a major problem that can not be fought one institution or government ministry but needs a collaborated effort by all government ministries and various stakeholders as it affects every sector of society.

Most of the CSA programmes are donor funded and tend to have a limited operational timeframe. In addition problems arise when the donor funded programmes are handed over to the government as these programmes are usually phased out due to unavailability of funds to continue running the programmes.

Research has shown that CSA also occurs in the church. The church is an area that has not been widely investigated due to the spiritual role that it plays in peoples' lives. A study on CSA in the Anglican Church found that significant numbers of clergy who are in charge of parishes have abused children (Parkinson,Oates&Jayakody, 2009). In addition in the Catholic Church priests made a vow of celibacy and did not view having sexual relations with boys as representing a breach of that vow.

A study in the United States found that from the years 1950-2002, 4392 priests and deacons had CSA allegations against 10,667 children (Terry&Tallon, 2004). Some of this abuse occurs in the orphanages run by the priests and also in the church grounds. Boys are much more at risk of abuse in church communities than girls because boys are more often given assignments with priests for example altar boys.

The role that traditional healers play in the occurrence of CSA has not been widely researched. Ritual abuse which is the abuse of children to fulfil supernatural or divine rites has since development. Ritual abuse is associated with symbols or group activities that have a magical or supernatural connotation (Tomison, 1995). This is a very common issue in Zambia where people sleep with children for the purpose of fulfilling a divine or witchcraft ritual. For example there is a belief that sex with children can bring about success to an individual's business.

The widely held African belief that an infected male can be "cleansed" of HIV through sexual intercourse with a virgin puts younger girls at particular risk in communities with a high prevalence of HIV (Coombe, 2002; Murray&Burnha, 2009). This myth is also held by some Zambians who believe that children are safe HIV-free sexual partners. This is a common belief primarily held by men (Coombe, 2002). In several countries CSA may be increasing as a result of adults with AIDS trying to 'cleanse' themselves from infection (Lalor, 2004[1]; Meel, 2003). A study estimated that 0.6 –1.8% of children in high HIV incidence countries experience penetrative sexual abuse by an HIV-infected perpetrator before the age of 18 years (Lalor, 2004[2]).

With the world becoming a global village, there has been a lot of migration and cross cultural pollination. This has seen the fusion and adoption of different cultures. For example the Afro-Euro centrism which has seen Africans developing western ideology. In some cases these

western ideologies contradict the African culture and the societal norms in some communities. Due to the influence of the internet and pornographic movies, many young people have changed their behaviour and dressing (Stanley, 2001). This has resulted in children adopting different forms of dressing and trying out actions or behaviour that they see in movies.

Globalization has seen the introduction of new technology in the world. The use of the Internet knows no boundaries and has become a necessity in schools and in everyday life. However it is almost without regulation and today it is being used to exploit children (UNICEF, 2001[1]). Advents of child pornographic images on the internet, volume of such images and numbers of persons accessing them, have since reached epidemic proportions (Jones&Jemmott, 2009). A study by Gallagher (2007) found evidence of another insidious and virulent form of internet abuse where offenders initiate contact with other individuals over the internet to incite, or conspire with them to commit CSA (Jones&Jemmott, 2009).

Current social, political and economic situations in the Southern Africa including the high rates of HIV-AIDS appear to further aggravate the problem of CSA, rendering the girl child particularly vulnerable to sexual abuse (Childline, 2005). With HIV-AIDS being a worldwide problem, there is need to explore its relationship to CSA. HIV and AIDS are the biggest contributors of CSA. As the fight against HIV and AIDS has intensified, different factors that facilitate the transmission of HIV have been identified. There is a growing recognition that HIV is linked to violence. Coupled with violence the HIV transmission is through a wide range of methods that include CSA, rape and gender inequality. A study in Zimbabwe found a frequency of sexually abused children who had HIV and other STIs, with a 40–60% of rape cases reported to hospitals as a result of CSA (Meursing et al, 1995).

Physical and sexual abuse of adolescents in Zambia is significantly related to HIV risk behaviours. The findings from a KAP study on AIDS and behaviour indicated that past abuse was a key factor predicting participation in high-risk behaviours associated with HIV infection (Slonim- Nevo & Mukuka, 2007). CSA victims tend to indulge more in risky sexual behaviours that are likely to increase their likelihood of HIV infections (Murray et al, 2006). A study by Murray et al (2006) found that a higher proportion of CSA was found in HIV positive women than in the general population.

Poverty, gender inequality and the increasing number of AIDS orphans are rapidly expanding the number of children at risk of sexual abuse (Bota, 2003). The death of parents from AIDS leaves children vulnerable to abuse as a result of not having someone to look after them due to a breakdown in extended family systems and poverty.

Poverty has been identified as one of the most common factors that have contributed to the occurrence of abuse and violence against women and children (NCCR, 1997). This is as a result of the economic decline, high unemployment levels and the burden of HIV/AIDS that have characterised communities. Zambia is characterised by high unemployment levels and three-quarters of the citizens are living below the poverty datum line. A study in Botswana reported that indices of poverty such as low income and poor housing are important factors associated with CSA (Childline, 2005). The high prevalence of poverty has fostered social isolation leading to families tending to use their children as sex workers in order to realize their basic needs. Children are forced to engage in sexual activities in order to support their families.

Culture affects how society functions or operates. Cultural practices provide members of society with guidelines about what behaviours are deemed appropriate within a community (Glaser&Frosh, 2002; CASE, 2005). Culture creates norms for sexual relations and their violations. Culture is a major contributing factor to the occurrence of CSA. This has been as a result of weakening cultural values, norms, practices, biased gender roles and inequalities.

A study that was conducted in Pakistan found that there was a high prevalence of male CSA including commercial sexual exploitation of children in the North-western frontier (NCCR, 1997). The study showed that societal norms had a large influence on the behaviour of the people and it was reported that one-third of the respondents did not consider CSA to be bad, a crime or sin. Keeping young boys for sexual services by adults was tolerated and accepted by this Society and many people viewed CSA as a matter of pride, a symbol of power and status. In addition there was a belief in this society that if people did not see what you were doing then your behaviour was accepted. These findings correlated with the feminist theorists who stated that sexual assault is as a result of societal norms (O'Hagan 1989).

Some cultural practices that are being carried out, such as early marriages and child sexual cleansing, have adverse effects on the health of the children. Child sexual cleansing is where

a widow or widower has sex with a child to prevent the ghost of the deceased spouse from causing trouble or reappearing. The Zambia GBV Survey reported that sexual cleansing is practiced in Zambia (CSO, 2006).

In addition some cultural practices conflict with the laws in some countries. Although the legal age of marriage has risen steadily in countries around the world, tradition often takes precedence over new laws. For example, in Nepal the average age at first marriage is 19 years, however, 7 % of girls are married off before they are 10 years old and 40% before they are 15 years. Early marriage which is a harmful practice to children has continued to be practiced in communities around the world (UNICEF, 2001[1]). Most families marry off their daughters early for economic reasons and receive a 'bride price' for their daughters. Some communities that prize virginity before marriage feel that marrying girls early 'protects' them from out-of-wedlock pregnancies.

Early sexual debut is known to predispose young people to early pregnancy, HIV-AIDS and other STIs (Jones&Jemmett, 2009). The immature genital tract and lack of power against adult sexual aggressors place children at risk of HIV infection from sexual abuse and child prostitution (WHO, 2007). In addition young girls are expected to reproduce soon after marriage and are often denied access to contraception and lack the power to negotiate safe-sex practices, putting them at risk for contracting STIs and HIV/AIDS (UNICEF, 2001[1]). An early marriage usually means the end of a girl's education if she is in school and the end of her autonomy to make important decisions about work, her health and her well-being. Abuse is common in child marriages. A study in Jordan found that 26% of reported cases of domestic violence were committed against wives less than 18 years (UNICEF, 2001[1]).

Gender inequality and norms also contribute to the occurrence of CSA. Research with men and boys demonstrates how gender norms related to masculinity influence not only how men interact with women and girls, but also with other males, such that inequitable gender norms may increase men's own vulnerability to violence, injury, and death (WHO, 2008). Men feel more superior to women and hence treat them as inferior individuals. This is most prominent in Moslem countries where a woman is regarded as being inferior to a man.

Social relations are very important for the healthy development of a child. Some children live in environments that are characterized by violence, overcrowding and social isolation. These all prevent children from developing normally and may also cause them to be vulnerable to

abuse. For example children not having any friends or recreational facilities may encourage them to go to other communities in search of friends. Parental factors have been recognised as being prominent determinants of abuse (Patz, 1996). However in some instances parents go to work living their children to fend for themselves and might lead to them roaming the streets making them vulnerable to attacks.

Domestic violence and dysfunctional family system also contribute to the occurrence of CSA. A study conducted in Brazil found that physical abuse was strongly associated with CSA (Bassan et al, 2009). Case studies have linked family breakdown to the incidence of sexual abuse (UNICEF, 2001[2]). Many indigenous communities suffer from a 'toxic' environment which together with geographical and social isolation is associated with the break-up of families (Garbarino, 1992; Tomison, 1995).

A study by Trangkasombat (2008) found that dysfunctional family systems contributed to CSA and reported that growing up in broken families increased the chances of neglect. The study identified that neglect, lack of supervision and parental unavailability contributed to most of the abuse. This was as a result of many families living in severe poverty which was characterized by crowded living space and inappropriate sleeping arrangements.

A study on violent deaths and maternal mortality found that CSA was strongly associated with a lifetime history of domestic violence and high risk behaviours (Granja, Zacarias, & Bergstrom, 2002). Unwanted pregnancies as a consequence of sexual abuse may lead to suicide under social circumstances stigmatising women who have a pregnancy out of wedlock. It was reported that induced abortion was clearly a contributing factor in almost one-fifth of violence-related maternal deaths in this study (Granja, Zacarias, & Bergstrom, 2002). Victim's of CSA engaged in behaviours that included the use of drugs, having more than 10 male sexual partners, having male partners at risk of HIV infection, and exchanging sex for drugs, money or shelter.

A study conducted by Tabachinick (1995) in Vermont found that CSA was a problem. 74% of the respondents in the study described CSA as either a "major problem" or "somewhat of a problem". The study concluded that prevention programs for child sexual abuse may be effective if the public views CSA as a problem relevant in their communities.

A study to investigate Chinese parents' knowledge, attitudes, and communication practices with their children about CSA found that more than 95% of respondents agreed that

elementary schools should provide programs to prevent CSA (Chen, Dunne, & Han, 2007). Although nearly all parents talked with their children about the dangers associated with talking to strangers, they were much less likely to talk specifically about sexual abuse. Many of the parents personally lacked basic knowledge about characteristics of perpetrators, the sexual abuse of boys, and non-physical consequences of CSA. About 46.8% of the parents expressed some concern that CSA preventive education could cause their children to know "too much about sex". The study concluded that future CSA prevention programs should include community-wide efforts to educate adults to ensure that parental advice is accurate and hopefully effective.

Most of these factors discussed above contribute to the occurrence of CSA but also affect and influence one another.

3. RESEARCH QUESTION

What practices, beliefs and attitudes do people in communities have regarding CSA and what measures can be put in place to reduce it?

4. OBJECTIVES

4.1 Key Objective

To explore factors associated with the burden of Child Sexual Abuse in Lusaka District

4.2 Specific Objectives

i. To establish an indication of the burden of CSA in Lusaka

ii. To identify community attitudes and beliefs towards CSA

iii. To identify social systems available to fight CSA

iv. To determine CSA prevention programmes that might be socially desirable and acceptable in the community

5. METHODOLOGY

5.1 Study setting

The study was conducted in Chilenje Community in Lusaka Urban district of Zambia. Chilenje community is home to people of diverse cultures, norms, beliefs, tribes, races, religion and nationalities.

5.2 Study design

The study was both qualitative and quantitative. The quantitative study design was used to determine the incidence of CSA in Lusaka Urban District by conducting an audit of CSA cases that had been reported to VSU and UTH between 2005 and 2009. The qualitative design (as adapted from Kitzinger 1994) utilized key informant interviews and focus group discussions. A qualitative study method was chosen because of its usefulness in the exploration of people's knowledge, views and experiences (Kitzinger 1994). The qualitative method helps to reveal patterns of feelings and emotions that underlie community perceptions and knowledge about child sexual abuse through discussions and responses to certain situations (psychometrically). This may result in the development of new perspectives and attitudes that are health promoting (Kitzinger 1995).

The Key Informant interviews were conducted with respondents from various organizations that include the government ministries, police, legal, health, NGOs and the church. Several CSA sensitisation and awareness campaigns have been conducted in Lusaka District. The FGDs were conducted with respondents from Chilenje community. Chilenje community was selected because of its location in the city of Lusaka and also because it is home to people of diverse cultures. It is a densely populated community with people of various nationalities, races, religious and cultural background. The main objective of holding FGDs was to get beneath the surface of CSA. It was presumed that respondents would reveal more when they were stimulated by the camaraderie and comments of others in FGDs (Kaplowitz &Hohn, 1998). Both FGD participants and KI interview participants were guided by an interview schedule and a FGD guide.

The selection criteria included the inclusion and exclusion criteria. The inclusion criteria for participants in the FGDs were both men and women aged 16 years to 49 years, sex and age matched and residents of Chilenje community. The legal age of consent in Zambia is 16 years. The inclusion criteria for KI interviews included men and women from the health,

police, legal, church, government ministries and NGOs who have been working in the area of CSA. The exclusion criterion for both FGDs and KI interviews was every one who did not meet the criteria set in the inclusion criteria.

5.3 Sampling Method and Sample Size Consideration

Purposive sampling was used to select respondents for both FGDs and Key informant interviews. The inclusion and exclusion criteria, and design criteria were used.

6 FGDs consisting of 7 participants in each FGD = **42 participants**

Key Informant Interviews = **10 participants**

Total sample size = **52 participants**

5.4 Data Collection Techniques and Tools

An interview schedule and FGD guide was developed using themes built from the research objectives.

5.5 Data Management and Analysis

The data that was collected from the discussions and interviews was recorded on tapes. The tapes were then marked with a number that represented the date and time of the interview/ discussion. To ensure anonymity participants names were not put on the tapes. The tapes were then locked up for storage.

The Qualitative data that was collected from the KI interviews and FGDs was transcribed and categorised into common themes as illustrates in Table 5. The common themes were derived from the interview guide and FGD schedule. Content analysis was done and a qualitative research package NVivo 9 was used.

The quantitative data that was collected which consisted of statistics on CSA cases was analysed using the Statistical Package for Social Sciences (SPSS). Percentages and differences were calculated as illustrated in Tables 1-4 below.

6. FINDINGS

This section of the paper begins with an introduction to the findings with reference to the research objectives that have been outlined above. It gives a brief description including the sex and age distributions of the respondents that participated in this study. It also gives information on the research methods (FGD and KI) that were used in this study. It further gives a summary of the core findings with a brief illustration of the key findings.

The participants in the KI interviews were people who had previous knowledge and expertise on CSA. These were people who had experience from working in the area of CSA and came from various organisations and government departments. The information obtained from participants of the Key informant interviews was very vital to this study as it describes the current CSA programmes and social support systems that are in place to fight CSA.

The participants in the FGDs were both males and females aged between 18 – 45 years. These participants were sex matched in the FGDs in order to avoid biasness, discomfort and the dominance of one sex over the other. In addition the participants were placed in groups according to their age from 18 – 26 years, 27 – 34 years and 35 – 45 years.

A total of six (6) FGDs were conducted with seven (7) participants in each group. The number of participants was reduced from eight (8) to seven (7) to accord each participant enough time to share their views on CSA. In addition ten (10) KI interviews were conducted with participants from various organisations working on CSA programmes. The interviews conducted were only limited to ten (10) due to time constraints and also because some of the people with expertise on CSA were unavailable at the time of this research.

The findings from this study were guided by a Key informant interview schedule and a FGD guide. The findings are summarised in tables and graphs as follows:
Table 1and Graph I: Total Number of CSA cases reported from 2005-2009, Table 2 and Graph II: Total number of CSA cases reported in 2009 – Prosecutions/ not prosecuted cases, Table 3 and Graph III: Total number of CSA cases reported in 2009 – Prosecutions, Table 4 and Graph IV: Total number of CSA cases reported in 2008 – Sex specific, Table 5: Summary of core findings, Table 6: Summary of key findings and Annex I below.

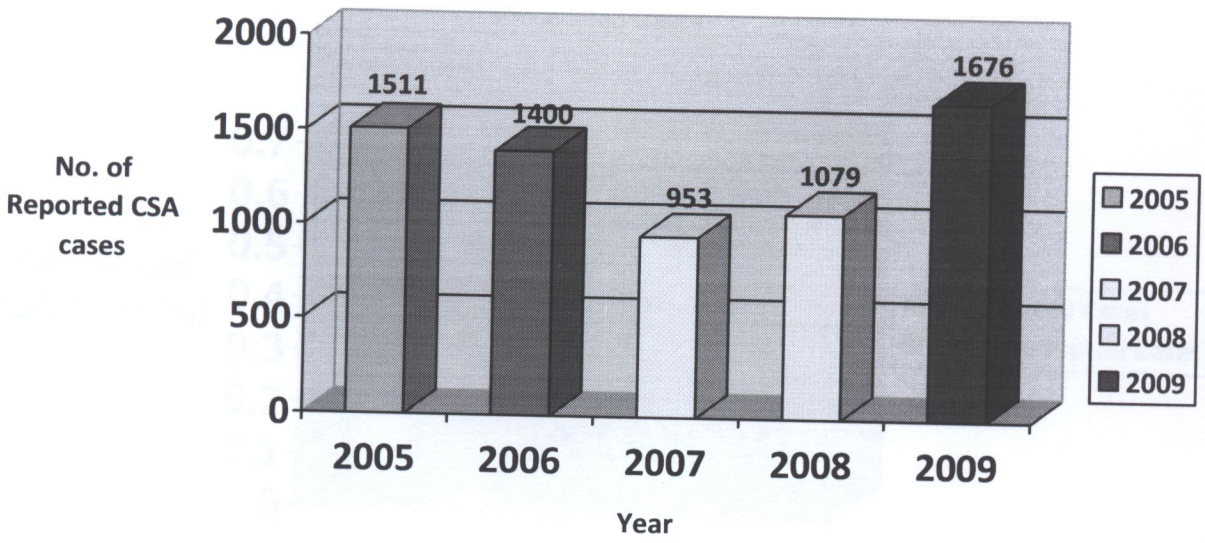
The findings begin with an estimation of the burden of CSA. These findings are however only limited to the cases that were reported to VSU and UTH over a period of 2005 - 2009.

A total of 1511 CSA cases were reported in 2005 as illustrated in Table 1 and Graph I. Statistics compiled for 2006 and 2007 showed a steady decline in the number of reported CSA cases. However, there has been a steady increase in the number of CSA cases that were reported in 2008 and 2009. A total of 1676 CSA cases were reported in 2009 as compared to 1079 CSA cases that were reported in 2008. It should be noted that the CSA statistics are the actual values (crude) as reported to VSU and UTH, and are illustrated in Table 1 and Graph I below.

Table 1: Total Number of CSA cases reported from 2005 – 2009

Year		***2005***	***2006***	***2007***	***2008***	***2009***
Total No. of CSA Cases (actual values)		1511	1400	953	1079	1676
Approximate Population of Zambian children under 14years	Percentage (%)	45.3% of 13.5 million				
	Actual Figure	6, 115, 500				

Graph I: Total number of CSA cases reported in 2005-2009



- The highest numbers of CSA cases were reported in 2009.

In 2009 a total of 1676 CSA cases were reported. Statistics show that only 37.78% of these reported CSA cases were prosecuted and 62.22% of the CSA cases were not prosecuted as illustrated in Table 2and Graph II below.

Table 2: Total Number of CSA cases reported in 2009 – Prosecutions/ Not Prosecuted Cases

Type of Cases

		Prosecuted Cases	***Not Prosecuted Cases***	***Reported CSA Cases***
Total No. of Cases	***%***	37.78%	62.22%	**100%**
	Actual Values	633	1043	**1676**

Total No. of: Prosecuted Cases $\frac{633}{1676} \times 100 = 37.78\%$

Total No. of Cases Not Prosecuted $\frac{1043}{1676} \times 100 = 62.22\%$

Graph II: Total number of CSA cases reported in 2009 - Prosecutions/ Not Prosecuted Cases

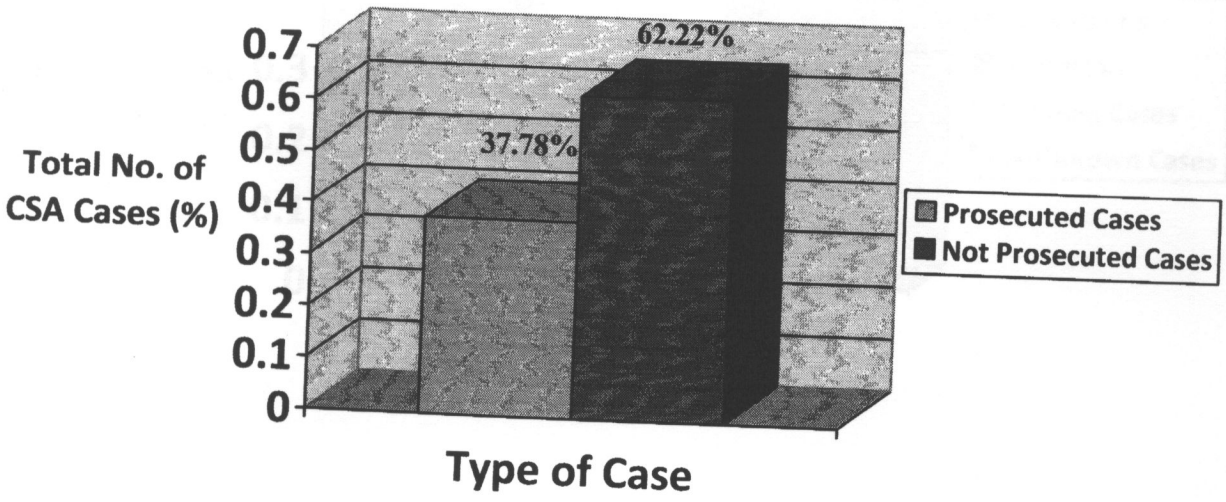


Table (3) and Graph (III) show the distribution of prosecuted CSA cases in 2009. There have been 16.53% convictions, 15.57% pending cases, 9.95% acquittals and 5.06% cases were withdrawn as illustrated below.

Table 3: Total Number of CSA cases reported in 2009 – Prosecutions

No of Cases

	Convictions	*Acquittals*	*Pending Cases*	*Withdrawn Cases*	*Total No. of Prosecutions*
Total No. of Cases (%) (Actual Values)	43.76% 277	9.95% 63	41.23% 261	5.06% 32	**100%** **633**

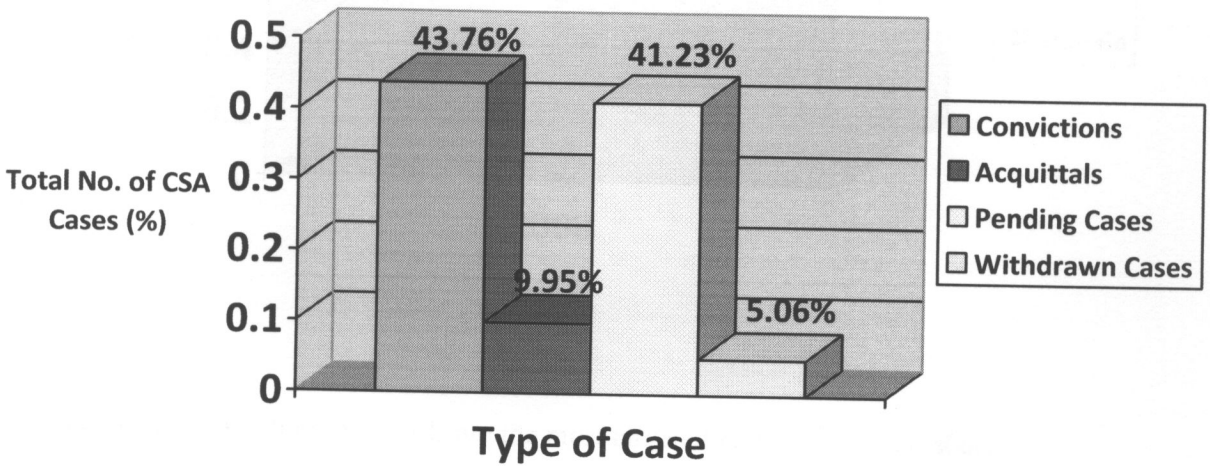
Convictions: $\frac{277}{633} \times 100 = 43.76\%$

Acquittals: $\frac{63}{633} \times 100 = 9.95\%$

Pending Cases: $\frac{261}{633} \times 100 = 41.23\%$

Withdrawn Cases: $\frac{32}{633} \times 100 = 5.06\%$

Graph III: Total Number of CSA cases reported in 2009 - Prosecutions



- Inspite of the existence of laws to fight CSA, the conviction rate is still fairly low at 16.53%.

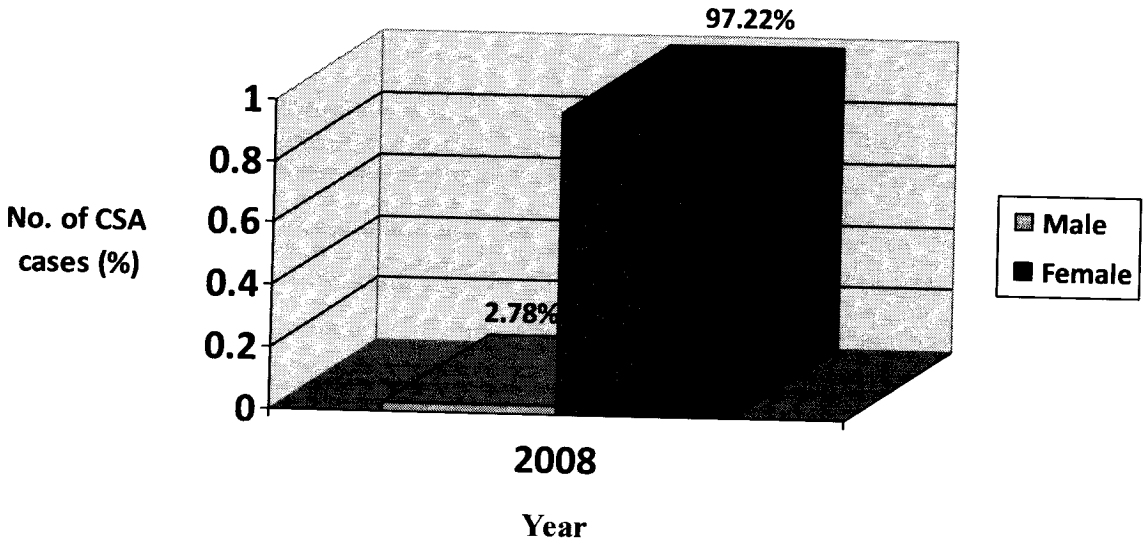
Table 4 and Graph IV below show CSA statistics for 2008 distributed according to sex. Statistics show that more than 97% of the victims of CSA in 2008 were girls. Most of the victims of CSA in 2008 were girls as can be seen in below.

Table 4: Total number of CSA cases reported in 2008 – Sex specific

No. of cases

Year/ Sex	***Females***	***Males***	***Total No. of Cases***
No. of CSA cases (%)	97.22%	2.78%	
Actual Values	1049	30	**1079**

Graph IV: Total Number of CSA Cases reported in 2008 - Sex specific



- The graph above shows that girls are the most targeted victims of sexual abuse. However this does not mean that boys are not sexually abused but that the number of such reported cases is lower than that of girls. From statistics shown above it can therefore be concluded that in 2008 girls were more vulnerable to abuse than boys.

From this study some key issues were raised. From the findings it can be noted that CSA is due to many different factors that are interrelated. However some of these factors have a greater influence on the occurrence of CSA than others. These factors include myths, HIV-AIDS, laws, socio-economic factors, media, poor parenting practices and culture as illustrated in Table 6 below.

Socio-economic factors including poverty were highlighted as a major contributor to the increase in CSA cases occurring. These factors have to a large extent resulted in people becoming vulnerable to abuse. Furthermore with the advent of HIV, there has been a rise in deaths compounded by high poverty levels. This has left a lot of children destitute and susceptible to abuse. In addition with the many misconceptions that have come with HIV, there have been increased cases of CSA due to HIV myths. People believe that a person can be cured of HIV by having sex with a child who is a virgin and is perceived to be pure.

Negative cultural practices and beliefs have also contributed to CSA. Culture not only shapes society but also people's attitudes, perceptions and behaviour. In additions there tends to be a conflict between customary and statutory laws when it comes to the issue of early marriages. Furthermore although laws to fight CSA are in place there are problems with the implementation of such laws.

The media in modern times plays a major role in peoples' daily lives as it is viewed as a tool to inform, educate and entertain. This has resulted in the media being used as a tool of communication and contributing largely to the increase in the number of CSA cases occurring. With the liberalisation of various sectors that include communication, more private service providers have established agencies. As a result of competitiveness and a need for profit, some of the programmes that are broadcasted by the media are not suitable for children's viewing. In addition the internet has been viewed as the new way to communicate. The internet is unregulated and is accessible everywhere including cell phones, at home and in schools. However most of the material on the internet is not suitable for children. As children now spend most of the time on the internet or television, the media has a great influence on them.

Table 5: Summary of core findings

Factors	Findings
i.Culture	• Negative cultures such as early marriages, sexual cleansing and initiation ceremonies all contribute to the occurrence of CSA • In the olden days parents would get married early and parents want to continue with this trend on their children
ii. HIV-AIDS	• Large number of orphans due to HIV • One of the effects of CSA
iii. Myths	• Myths related to HIV that sleeping with a child cures HIV • When you sleep with a young girl you will have money
iv. Poor parenting practices	• Parental negligence • Poor parenting skills • A parent who is away from home from 06:00 – 22:00hrs does not know what the child does during the day and it would be more difficult to notice changes in behaviour.
v. Socioeconomic factors	• High poverty levels • When someone who has money approaches an orphan who is selling ground nuts, the child will be enticed. • High levels of unemployment • Lack of social safety nets • Breakdown of extended family system
vi. Media	• When you are continuously exposed to obscene material, you start doing what you have seen.
vii. Laws	• Poor implementation of laws • Deficiencies in the current laws • Conflicts between customary and statutory laws

The table below gives summaries of key findings from both the KIs and FGDs.

Table 6: Summary of Key Findings

1. What is CSA?	• It is the violation of children's rights and is the involvement or subjecting of a child below the age of 16 years according to the law, to sexual knowledge, sexual activities and sexual exploitation which involves fondling, penetration, exposure of a child to pornographic material and obscene activities by an adult or another child.
2. Why does CSA occur?	• Due to alcohol and drug abuse and perversity of adults. • Children watch television uncontrolled and unsupervised. • Economic deprivation of homes including financial pressure. • Negative cultural practices, traditional beliefs and myths that people hold. • Lack of social safety nets for children.
3. Why are CSA cases on the increase? What factors increase the likelihood of CSA?	• There has been increased sensitisation and awareness HIV-AIDS. • Myths including those related to HIV-AIDS. • Poverty issues. • Lack of sensitisation. • Negative cultural practices. • Parental negligence.
4. How has culture contributed to the occurrence of CSA?	• Some bad cultural practices such as sexual cleansing contributed to CSA. • Culturally girls are not taught to be assertive. • Most cultures teach girls not to speak back to people older than they are or even refuse to be sent by an older person. • Zambia practices a dual-legal system which has created problems in the fight against CSA due to their being contradictions in the customary and statutory laws. • Customary law often overrides statutory law. • We have a culture of silence in Zambia. Our societies and culture are not proactive but reactive.

	• In some cultures having sex with a child is not seen (viewed) as abuse.
5. What social support systems and structures are in place to prevent or reduce CSA?	• Availability of an operational National Gender Policy and implementation NPA-GBV and a draft bill on domestic violence. • The amendment of the Penal Code Act No. 15 of 2005. • Department of Social welfare provides shelter for vulnerable children. • There is a "One Stop Centre" in Lusaka which offers free services that include counselling, medical care, administration of PEP and legal advice. • Physical Education has become compulsory in government schools to help children to be healthy and also as a means to keep the children busy. • MYSCD has created activities for children in both the community and government run schools such as competitions and community soccer.
6. What deficiencies are in the current social support system?	• Social safety measures and facilities are inadequate. • There is no task force on CSA. • There is a deficiency in the case reporting system and a lack of a GBV data collection and management system to collect data and monitor GBV incidents. • There are no specific statistics on CSA occurring in schools at MOE headquarters. • There are no policies across health, psychosocial or legal sectors mandating coordinated, prompt and supportive services to victims. • Inadequate technical, logistic, financial and human resource capacity to adequately monitor and respond to preventive as well as the management of GBV. • Counselling services are not widely available. • Health sector does not have a policy or guideline on its response to GBV.

	• There is no standard medical response outside of the "One Stop Centres" nor is PEP (Post-exposure Prophylaxis) routinely available to CSA victims. • Funding to the department of Social Welfare is very low. • Need to open more "One Stop Centres" and decentralise the programme around the country.
7. Is the current Law adequate to fight CSA?	• The current law is inadequate. • The statutory law doesn't override customary law and in some cases there tends to be a conflict between the two. • Civil society has been calling for an amendment of the Gender Based Violence and Sexual Offences Act. • The law does not include compensation when a child has been infected by HIV and does not give health workers mandate to investigate CSA cases. • Some parents opt for compensation than take cases to court. • There is no specific legislation on GBV including CSA. • There are problems in implementing the Law.
8. Why are conviction rates very low?	• The standard set by the law is high in terms of securing a conviction and technicalities in the administration of justice are hard to prove. • There is no common definition of various GBV offences including CSA, this has resulted in judges making their own interpretation of the law. • Cases take too long to be disposed off in court. • Sometimes there is un-collaborated evidence or inadequate evidence.

7. DISCUSSION OF FINDINGS

There has been a steady increase in the number of CSA cases reported between 2008 and 2009 as shown in Table 1. This increase may be attributed to different factors that include the increased sensitisation and awareness of CSA related issues in communities. Hence people have more knowledgeable about CSA. In addition with increased awareness, people are now knowledgeable on how and where to report CSA cases.

The statistics in the tables above are only limited to CSA cases that have been reported to VSU and UTH. As a result these statistics under represent the true scope of CSA occurring in communities. This is as due to most people choosing not to report cases of CSA to the police or the hospital. This is because some people opt to settle the matter outside the court. In some cases people are paid off by the perpetrator so that the cases should not be reported to the police or in other cases the perpetrator is the breadwinner of the family. Moreover people are mindful of the attitudes and perceptions that people and society hold concerning CSA and are thus conscious of how people would look at them and the stigma they will receive once they report CSA cases.

There were 97.22% female and 2.78% male victims of CSA in 2008 as illustrated in Table 4 above. The statistics show that girls were more vulnerable to abuse than boys in 2008. However this does not mean that boys are not sexually abused but that there is a lower rate of reporting of the sexual abuse of boys. In addition the highest numbers of CSA victims were in the age group of 11- 15 years and this was consistent in both 2007 and 2008. Hence children who are in this particular age group were more vulnerable to sexual abuse.

A total of 1676 CSA cases were reported to VSU in 2009. However there have only been 37.78% prosecuted cases and 62.22% of the CSA cases have not been prosecuted as illustrated in Table 2 above. From the prosecuted cases there have been 16.53% convictions, 9.95% acquittals, 15.57% cases are still pending in courts and 5.06% of CSA cases have been withdrawn as illustrated in Table 3 above. This shows a fairly low conviction rate inspite of some laws on CSA being in place.

The low conviction rate can be attributed to different factors. Technicalities in the administration of justice in the area of sexual offences are very difficult to prove. The standard set by the law is high in terms of securing a conviction. Evidence of the occurrence of CSA is very difficult to find and relies more on narrations from the victim or witnesses. In addition, CSA cases are usually reported to the police long after the abuse has occurred and at

such a time it is very difficult to find evidence of abuse and to ascertain the period or time of the abuse through a medical examination. Hence in most cases there is un-collaborated or inadequate evidence that would be administered in a court of law.

Furthermore there is no common definition of various GBV offences including CSA which in turn allows judges to make wide interpretation of the law. Moreover prosecutions are low because cases take too long to be disposed off in court. It should be noted that CSA cases that are reported and taken to court can not be withdrawn whether a victim wants to withdraw the case or not. At the local court level (customary court) victims' families more often opt for compensation rather than pursuing criminal proceedings through the penal system due to long procedures and costs involved.

Most of the participants in this study already had some knowledge about CSA. According to the findings in the Table 6 above, CSA is the violation of children's rights. It is defined as the involvement or subjecting of a child below the age of 16 years according the laws of Zambia to sexual knowledge, sexual activities, sexual exploitation or/ and sexual advances of any form that involve fondling, sexual penetration, subjecting a child to have sexual knowledge with other people, exposure of a child to pornographic material and obscene activities by an adult or another child be it by force, bribery or coercion. It is the exploited use of an underage child by an adult or another older child for the purpose of sexual satisfaction. CSA is also the use of a child who is unable to defend or speak for himself for ritual purposes.

The occurrence of CSA can be identified by various signs that include a change of behaviour that may be unusual to that child, a notable change in the disposition of the child or physical signs. For example some children would become withdrawn or isolated from their friends. In addition there could be unexplained pain, swelling, bleeding or irritation of the genital or anal area or mouth, chronic urinary tract infections, virginal infections, soreness of the genitals or discharge from the genitals and constant bodily discomforts. Furthermore, the other signs that would be observed include an unusual behaviour for example sexual gestures that are inappropriate for the child's age, compulsive masturbation, fear of being bathed, acquiring an STI that did not originate from the mother at birth, sexual withdrawal and talking about vivid details of sexual activity. Furthermore, there could be other physical signs observed that include upon examination the health provider will notice the absence of the hymn or in other cases the victim might fall pregnant.

CSA can occur in any environment whether at school, home, streets (roads), relative's house or even at markets. CSA occurs to both the rich and the poor and is due to various factors. Various factors that are social, economic, cultural and political have all contributed to the occurrence of CSA. According to the Social cognitive theory, behaviour is as a result of the inter relation of various factors that result in the occurrence of such behaviour. This is illustrated in the Ecological framework (Annexes I and II) and the Precede – proceed model (Annex III).

The media has contributed to the occurrence of CSA in terms of some of the material that have been broadcasted or televised to the public. Some of the programmes, for example, movies that have been televised have not been suitable for children. These movies have a lasting effect in the minds of the children. A child's mind becomes adapted to watching obscene material and in-turn a child will want to go and experiment what they have seen.

The numbers of deaths due to AIDS have left a lot of children as orphans and making them vulnerable to sexual abuse. Myths that people in communities hold have contributed to the occurrence of CSA. The HIV myth that sleeping with a young girl will cure HIV has also largely contributed to the increase in the number of sexual abuse cases. There is also a myth that when a person sleeps with a young, he/she will become rich.

Poor parental care has contributed to the occurrence of CSA. Parents are not free with their children and when sexual abuse occurs children have difficulty reporting the abuse to their parents. Parents do not talk to their children about sexuality. When parents are asked about sexuality they usually change the subject or tell their children to shut up. Children will in turn go out to find out from other sources.

There is a lack of social safety nets for children in communities. There has been a breakdown of the extended family system where a child is an orphan and the relatives, for example uncles and aunties, refuse or do not support the child. This child will engage in sexual activities as a means of survival. In addition some parents do not know what their children are doing and do not even notice a change in the behaviour of their children. This could be as a result of parents being away from home for long hours. Some parents are also so too busy with their work that they leave their children to be looked after by other people such as maids, caretakers, neighbours and other family members. As a result not knowing what is occurring in their absence and what their children are being taught. Moreover most grand

parents contribute to increased CSA cases by giving their grand children wrong advice and information.

There is a new trend where children are being raised by television. With the advent of modern technology children are seen to watch more uncontrolled and unsupervised television as a means to keep themselves occupied. This has raised a problem because what the children are watching is not regulated. As a result children are being exposed to obscene or sexual material from these television programmes too early and hence want to go out and experiment. So instead of parents training their children, they leave them to learn on their own. Some children acquire bad morals from the kindergarten schools they are sent to and from bad friends who have a negative influence on the children.

Another area of much concern is the new primary education curriculum in schools also known as the "New Break Through to Literacy". The new integrated education curriculum entails that children as early as grade two (2) learn about sexuality. For example these children are exposed to information on condom use and sex in the class room and will tend to want to experiment.

The introduction of Structural Adjustment Programmes (SAPs) in Zambia resulted in a lot of people having to lose their jobs retrenchments and downsizing. This increased financial pressure for families to survive. Some parents have resorted to encouraging their children to get married early so that they may benefit from the marriage financially.

In addition there are high levels of unemployment in the country resulting in most people of the productive age being idol and having nothing productive to do with their time. As a result theses people resort to engage in alcohol and drug abuse which affects their judgement. Some children as young as 10 years old are seen patronising bars making them vulnerable to sexual abuse.

Furthermore some negative cultural practices such as early marriages, sexual cleansing and initiation ceremonies which have continued to occur in communities have contributed largely to the number of CSA cases occurring. In some cultures having sex with a child is not viewed or classified as abuse. There are some traditional beliefs that view a girl as being sexually mature upon attaining puberty. In the olden days people got married at a very early age. However some of these parents have tried to pass the tradition down to their children by encouraging early marriages. In addition there are some cultural practices which permit the

abduction of girls for marriage. Hence children having unwanted pregnancies and contracting HIV/AIDS. Some parents have adopted western cultures as a way to raise their children and as such encourage their children to start dating and being sexually active at an early age.

In Zambia, there is a culture of silence and societies are not proactive but rather reactive. Most cultures teach girls not to speak back to people older than they are or even refuse to be sent by an older person. Therefore culturally girls are not taught to be assertive.

In addition, Zambia practices a dual legal system that has created problems in the fight against CSA. This is due to the contradictions raised by the statutory and customary laws that very often conflict. Customary law over rides statutory law such that even when statutory law provisions might protect a survivor or victim of CSA, customary law and practice prevail. According to customary law anyone who is seen to be mature can be married off while statutory law states that a marriage to any person below the age of 16 years is classified as sexual abuse or defilement.

There is a lack of adequate recreational facilities for children in communities such as parks. In urban areas social amenities (recreational facilities) are available but are very few. This has contributed to children going to the streets to look for entertainment making them vulnerable to bad company and abuse.

There has been increased sensitisation and awareness on issues related to CSA hence people are aware of CSA and have come out to disclose sexual abuse. However there are still people who are ignorant of subjecting children to CSA and are unaware of the consequences of CSA to a child.

Several programmes have been implemented to fight CSA. Most of these programmes are run by civil society or NGOs. There have been collaborations in the fight against CSA which led to the creation of the "One Stop Centre" in Lusaka. The "One Stop Centre" offers free services that include counselling, medical care including administration of PEP and legal advice to victims of CSA.

Furthermore Government under GIDD has formulated an operational National Gender Policy and implementation Plan of Action 2010 - 2014. This is aimed to act as a framework or reference point for the creation of effective consolidated CSA and GBV programmes. Amendments have been made to the Penal Code Act No. 15 of 2005. In addition a draft bill

on domestic violence has been formulated. The Government under the Department of Social welfare provides shelter for vulnerable children and victims of CSA.

In addition MYSCD, MOE and MCDSS have tried to create programmes for children in both communities and schools. Physical Education has become compulsory in government schools to help children to be healthy and also as a means to keep the children occupied or busy. In addition, MYSCD has created activities for children in both community and government run schools. In schools MOE and MCDSS have created a programme called NATAZ where cultural activities are performed through arts and is done at district and provincial levels.

Inspite of all the positive activities outlined above, there are some deficiencies in the current social support system. There are laws already in place to fight CSA. These include laws and legal provisions or instruments such as the amendment of the Penal code Act no. 15 of 2005 which states that any sexual activity with anyone who is below the age of 16 years even where the child has given consent is defilement/ CSA. Consent from a child is immaterial.

However problems arise in the implementation of these laws. The implementation is affected by social factors. Certain social factors cause people to do certain things for example conflict or poverty. This law does not include compensation to a victim of CSA when a child has been infected by HIV. In addition the law does not give health workers mandate to follow up or investigate cases when they suspect abuse. Moreover the law does not give the MOE the mandate to monitor the education system and what is happening in schools.

Although the penal Code provides for definitions and penal sanctions for offences against morality such as defilement in section 138,139 and 158, there is however no specific legislation on GBV including CSA. The penal code was amended to include issues of children's rights however there are still deficiencies in this instrument. An example is that CSA is still not clearly defined. Hence the current law is said to be inadequate and needs be strengthened.

The statutory law doesn't override customary laws and in some cases there tends to be a conflict between customary and statutory laws. Some customary laws increase the likelihood of abuse to occur this is due to some societal expectations and norms.

Some CSA cases pass through local courts and parents decide to be compensated instead of the perpetrator serving his time in prison. Furthermore civil society has been calling for an amendment of the Gender Based Violence and Sexual Offences Act.

Government has not been adequately responding to CSA. Government has an obligation to protect children, ensure that CSA does not occur or if it occurs there is need to have accountability. In addition there is no task force on CSA and as such CSA prevention programmes are replicated and ineffective. There are no policies across health, psychosocial or legal sectors mandating coordinated, prompt and supportive services to victims. The health sector does not have a policy or guideline on health sector response to GBV nor do health professionals have adequate capacity to routinely identify and manage cases of GBV.

There is inadequate technical, logistic, financial and human resource capacity to adequately monitor and respond to preventive as well as the management of GBV. Counselling services are not widely available and most social workers from relevant institutions are inadequately trained to address CSA cases and have little institutional support. In addition social workers have large case loads and extremely limited resources resulting in difficulties in providing adequate services to victims of GBV. The social safety measures and facilities in place are inadequate. Funding to the department of Social Welfare is very low. The department of Social welfare does not have adequate resources to provide the service that it are mandated to provide. There are limited safety homes and homes of safety for victims of CSA.

There is also a deficiency in the case reporting system. People do not know where to report CSA cases and what steps to take in reporting such cases. There is a lack of a GBV data collection and management systems that define the kind of data to be collected and how this data will be managed. There is a lack of standardized data collection tools to monitor GBV incidents and/ or adequacy of response. There are no specific statistics on CSA occurring in schools at MOE headquarters. However statistics on cases that have occurred can be found in the schools where the abuse occurred.

Community mobilization information on GBV is not properly accessed by the communities.

There are more CSA cases occurring in communities but not reported due to the distance of the "One Stop Centre". There is only 1 "One Stop Centre" in Lusaka located at UTH. There is need to decentralise this programme taking it to the community and to open more centres around the country. There is no standard medical response outside of the One Stop Centres nor is PEP (Post-exposure Prophylaxis) routinely available to victims of CSA.

The church in Zambia has not played a big role in the fight against CSA and hence there has not been much sensitisation on CSA by the church.

8. Conclusion

Therefore CSA is a growing problem which needs consented efforts and cooperation from various stakeholders in order to prevent and reduce it. In order to effectively fight CSA, there is need to change the mindset of people for the them to view CSA as a problem and also have community participation in the creation of effective preventive programmes.

In conclusion it is therefore the resonsibility of every person to look after and ensure the safety of children as they are precious and are vulnerable citizens of our communities.

9. Recommendations

There is need to/ for:

- Create adequate technical, logistic, financial and human resource capacity to adequately monitor and respond to the prevention as well as the management of CSA and GBV.
- Formulate policies across the health, psychosocial and legal sectors mandating coordinated, prompt supportive services to victims of CSA.
- Formulate policies on the health sector's response to GBV and guidelines on the proper identification and management of cases of GBV.
- Offer wide spread Post Traumatic Counselling services with adequately trained personnel and institutional support to address CSA.
- Acquire DNA Analysis kits that are currently not available in Zambia.
- Government should be more committed to the fight against CSA.
- Increase safe homes/ shelters for victims of CSA and also increase the funding that is allocated to the Department of Social Welfare.
- The creation of more activities for children in communities by MYCDSS and MYSCD.
- Improve and increase recreational facilities for children in communities and also introduce activities for children in community schools.
- The government to consider the security of pupils before setting up schools in particular environments.
- Intensify life skills training for teachers and pupils.

- Increase school places and to also increase on the budget allocation to the bursary schemes to give more people access to education.
- More sensitization campaigns on the education policies.
- Government to the Civil service Terms and Conditions of service to emphasize CSA.
- Improve the commitment to implement the law.
- Hence there is need to address factors that impede/ prevent the proper implementation of the Law.
- Government to address the social factors such as conflict and poverty that force children to go to the streets and cause people to be susceptible or vulnerable to CSA.
- Government to come up with more poverty reduction programmes and create more empowerment programmes for people.
- To amend the Law to be more specific on CSA and to address issues of compensation to victims of CSA, to mandate health workers to investigate and report CSA cases.
- Address the conflict that arises between Statutory Law and Customary Law when it comes to addressing the issue of early marriages which has since been identified as one of the major causes of CSA.
- Pass the GBV bill as an act.
- Have stiffer punishments that will serve as a deterrent to the other would be Child Sexual Abusers/ offenders.
- Talk to and sensitize would be offenders and to bring all perpetrators to book.
- Creation of a National task force on CSA.
- All stakeholders to use the NPA-GBV 2010-2014 as a framework in the creation of major activities related to the prevention and response to CSA
- All stakeholders to use the NPA-GBV 2010-2014 as a resource mobilization tool for the implementation of focused and coordinated action to eliminate GBV in Zambia.
- Have collaborations among various stakeholders and coordination in programmes related to CSA.
- More interactions between communities, NGOs, government and co-operating partners to find effective solutions to the prevention and reduction of CSA.

- Creation of a national data base on CSA that includes information on CSA in schools.
- Create GBV data collection and management systems that will define the type of data to be collected and how this data will be managed.
- Create and circulate standardized data collection forms and tools to be used to monitor GBV incidents especially CSA and the adequacy of the response
- Formulate a simple clearly defined and standardized case reporting systems.
- Decentralize CSA response programmes and services, and to also open more "One Stop Centres" in communities countrywide.
- Standard medical response to CSA in clinics country wide instead of only having it at the "One Stop Centres".
- Offer free medical services to all victims of CSA with access to PEP and follow-ups should be carried out by health personnel country-wide.
- Create and implement National advocacy and media campaigns.

Conduct massive awareness campaigns on CSA in order to change the mindsets of people and to give them a better understanding of what CSA is.

Communities to have free access to community mobilization information on GBV.

Communities to take responsibility and be accountable.

Communities to form community crime prevention zones and they should report CSA cases to the relevant authority.

Consider Community drama mobilization as one of the means of educating communities on issues of CSA through drama.

More research on issues related to CSA, why CSA occurs and its effects on victims and families.

Conduct more research on CSA and its relationship to HIV-AIDS. There is emerging evidence on the relationship between violence and women's and girls' risk of HIV, which indicates that this is a critical area for more focused research.

Address the various gaps that have been cited and raised above and in various studies

Find ways to create and effectively implement effective CSA preventive programmes.

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Annexes (Data collection tools, Models and Tables)

Annex I: Summary of findings

2. What is CSA?	• It is the violation of children's rights and includes sexual advances in any form. • It is the involvement of a child in sexual activities that involve fondling, penetration, exposure of a child to pornographic material and obscene activities by an adult or another child. • CSA is subjecting children below the age of 16 years, according to the law, to sexual knowledge or sexual exploitation. This includes having sex with a child or subjecting a child to have sexual knowledge with other people. • It is the exploited use of an underage child by an adult or another older child for sexual satisfaction, be it by force, bribe or coercion.
9. Why does CSA occur?	• Due to abusers being idol (idol minds) and having nothing to do. • Due to alcohol and drug abuse • Children watch television uncontrolled and unsupervised. • Due to the myths that people have/hold • Some children are orphans and have no one to look after them • Perversity of adults • Economic deprivation of homes including financial pressure • Traditional beliefs that a girl is sexually mature upon attaining puberty • Cultural practices which permit the abduction of girls for marriage • Lack of social safety nets for children
3. How can you identify that CSA has occurred?	• Withdrawal and isolation from friends • Behaviour changes which may be unusual for that child • Physical signs that include pregnancy, limping steps, absence of the hymn, acquiring an STI that did not originate from the mother at birth. • Unexplained pain, swelling, bleeding or irritation of the genital or anal area or mouth, chronic urinary tract infections, virginal infections, STIs, Soreness of the genitals or discharge from the genitals, fear of being

	bathed, constant bodily discomforts, unusual sexual play inappropriate for the child's age, compulsive masturbation, sexual withdrawal, talking about vivid details of sexual activity
4. Why are CSA cases on the increase? **What factors increase the likelihood of CSA?**	• There has been increased sensitisation and awareness on CSA hence people are aware of CSA and have come out to disclose abuse. • Un-conducive environments. • HIV-AIDS • Myths including those related to HIV-AIDS • Poverty issues • Age of the children • lack of sensitisation • People are ignorant about subjecting children to CSA • Some cultural practices such as early marriages, have also increased the cases of CSA occurring • Parental negligence
5. How has culture contributed to the occurrence of CSA?	• Some bad cultural practices such as sexual cleansing &initiation ceremonies have contributed to the occurrence of CSA. • Culturally girls are not taught to be assertive. • Most cultures teach girls not to speak back to people older than they are or even refuse to be sent by an older person • Zambia practices a dual-legal system which has created problems in the fight against CSA due to their being contradictions in the customary and statutory laws. • Customary law often overrides statutory law such that even where statutory law provisions might protect a survivor or victim, Customary law and practice prevail. • We have a culture of silence in Zambia. Our societies and culture are not proactive but reactive. • In some cultures having sex with a child is not seen as being a form of abuse.

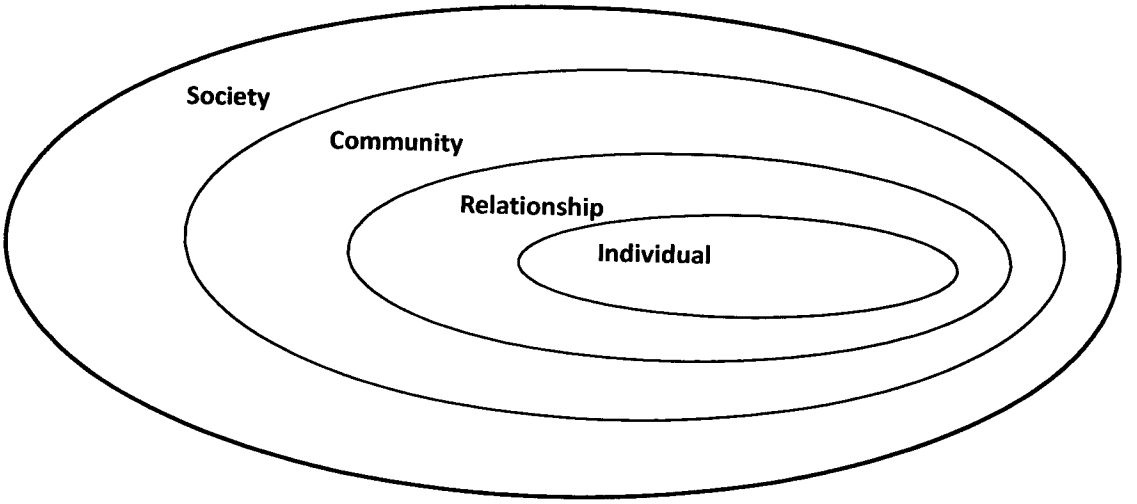
6. What social amenities are in place for children in communities?	• In urban areas social amenities (recreational facilities) are available but are very few and a lot more has to be done
7. What social support systems and structures are in place to prevent or reduce CSA?	• Social welfare provides shelter for vulnerable • Availability of an operational National Gender Policy and implementation Plan of Action. • The amendment of the Penal Code Act No. 15 of 2005 • A draft bill on domestic violence • Department of Social welfare provides shelter for vulnerable • There is a "One Stop Centre" in Lusaka which offers free services that include counselling, medical care including administration of PEP and legal advice to victims of CSA. • Physical Education has become compulsory in government schools to help children to be healthy and also as a means to keep the children occupied/busy. • MYSCD has created activities for children in both community and government run schools. • In schools there is NATAZ which is a programme where cultural activities are performed through arts. This programme is done in schools, district and provincial. MOE works with MCDSS in this programme.
8. What deficiencies are in the current social support system?	• There is no task force on CSA • Social safety measures and facilities are inadequate. There are limited safety homes and homes of safety are not enough. • Government has not been adequately responding to CSA. Government has an obligation to protect children, ensure that CSA does not occur or if it occurs there is need to have accountability. • There is a deficiency in the case reporting system. People do not know where to report cases where they begin with the police or go to the hospital. • There are no specific statistics on CSA occurring in schools at MOE

	headquarters. However statistics on cases that have occurred can be found in the schools where the abuse occurred. • There is a lack of a GBV data collection and management systems that define the kind of data to be collected and how this data will be managed. • There is a lack of standardized data collection tools to monitor GBV incidents and/ or adequacy of response • There are no policies across health, psychosocial or legal sectors mandating coordinated, prompt and supportive services to victims. • There is inadequate technical, logistic, financial and human resource capacity to adequately monitor and respond to preventive as well as the management of GBV. • Counselling services are not widely available and most social workers from relevant institutions are inadequately trained to address CSA cases and have little institutional support. In addition social workers have large case loads and extremely limited resources resulting in difficulties in providing adequate services to victims of GBV. • The health sector does not have a policy or guideline on health sector response to GBV nor do health professionals have adequate capacity to routinely identify and manage cases of GBV. • Victims have to pay for medical forensic examination where the service is available. • There is no standard medical response outside of the "One Stop Centres" nor is PEP (Post-exposure Prophylaxis) routinely available to victims of CSA. • Community mobilization information on GBV is not properly accessed by the communities. • Funding to the department of Social Welfare is very low. The department of Social welfare does not have adequate resources to provide the service that it are mandated to provide. • There is only 1 "One Stop Centre" in Lusaka located at UTH. There is need to open more centres around the country. • There are more CSA cases occurring in communities but not reported

	due to the distance of the "One Stop Centre". There is need to decentralise this programme and take it the community. • There is a shortage of man power.
9. Is the current Law adequate to fight CSA?	• The current law is inadequate. The current Law needs to be strengthened • The current law doesn't override traditional laws and in some cases there tends to be a conflict between traditional laws and the current law. Some traditional laws increase the likelihood of abuse to occur this is due to some societal expectations and norms. • The penal code was amended to include issues of children's rights however there are still deficiencies • Civil society has been calling for an amendment of the Gender Based Violence and Sexual Offences Act. • The law does not include compensation when a child has been infected by HIV. • The law does not give health workers mandate to follow up or investigate cases when they suspect abuse • The law does not give the Ministry of Education mandate to monitor the education system. The Ministry of Education does not have provision to monitor what is happening in schools • Some CSA cases pass through local courts and parents decide to be compensated instead of the perpetrator serving his time in prison. • Although the penal Code provides for definitions and penal sanctions for offences against morality such as defilement in section 138,139 and 158. There is however no specific legislation on GBV including CSA. • There is a Law in place to fight CSA, however there are problems with the implementation of this law. • We have enough laws in place to fight CSA. These include laws and legal provisions/ instruments such as the amendment of the Penal code Act no. 15 of 2005 which states that any sexual activity with anyone who is below the age of 16 years even where the child has given consent is defilement/ CSA. Consent from a child is immaterial. • The implementation of these laws is the problem. The implementation is

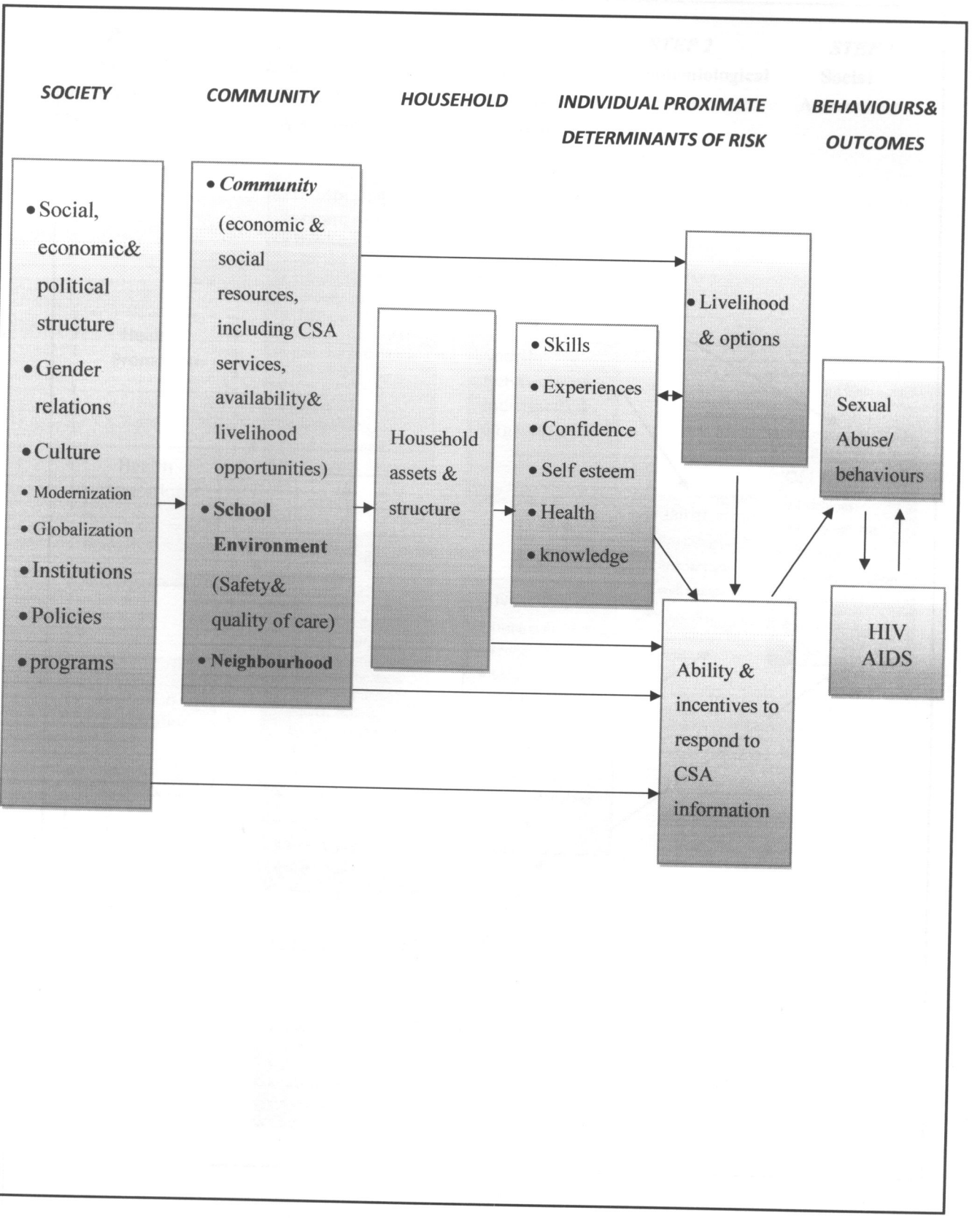
	affected by social factors. Certain social factors cause people to do certain things for example conflict or poverty.
10. Why are conviction rates very low?	• The standard set by the law is high in terms of securing a conviction • There is no common definition of various GBV offences including CSA , allowing judges to make wide interpretation • Persecutions are low because cases take too long to be disposed off in court. In addition courts still go ahead with cases whether a victim wants to withdraw the case or not. • At local court level victims' families more often opt for compensation through customary courts rather than pursuing criminal proceedings through the penal system due to long procedures and costs involved. • Technicalities in the administration of justice in the area of sexual offences are very difficult to prove. • Sometimes there is un-collaborated evidence or inadequate evidence. For example when a child is abused and the abuse is discovered 2weeks later it will be very difficult for the medical examination to show evidence of abuse.
11. Why don't people report CSA cases?	• People do not report cases because they are paid off or the perpetrator is the breadwinner. • People are mindful of the attitudes and perceptions of people and society, and are very mindful of how people would look at them once they report cases

Annex II: Heise Model

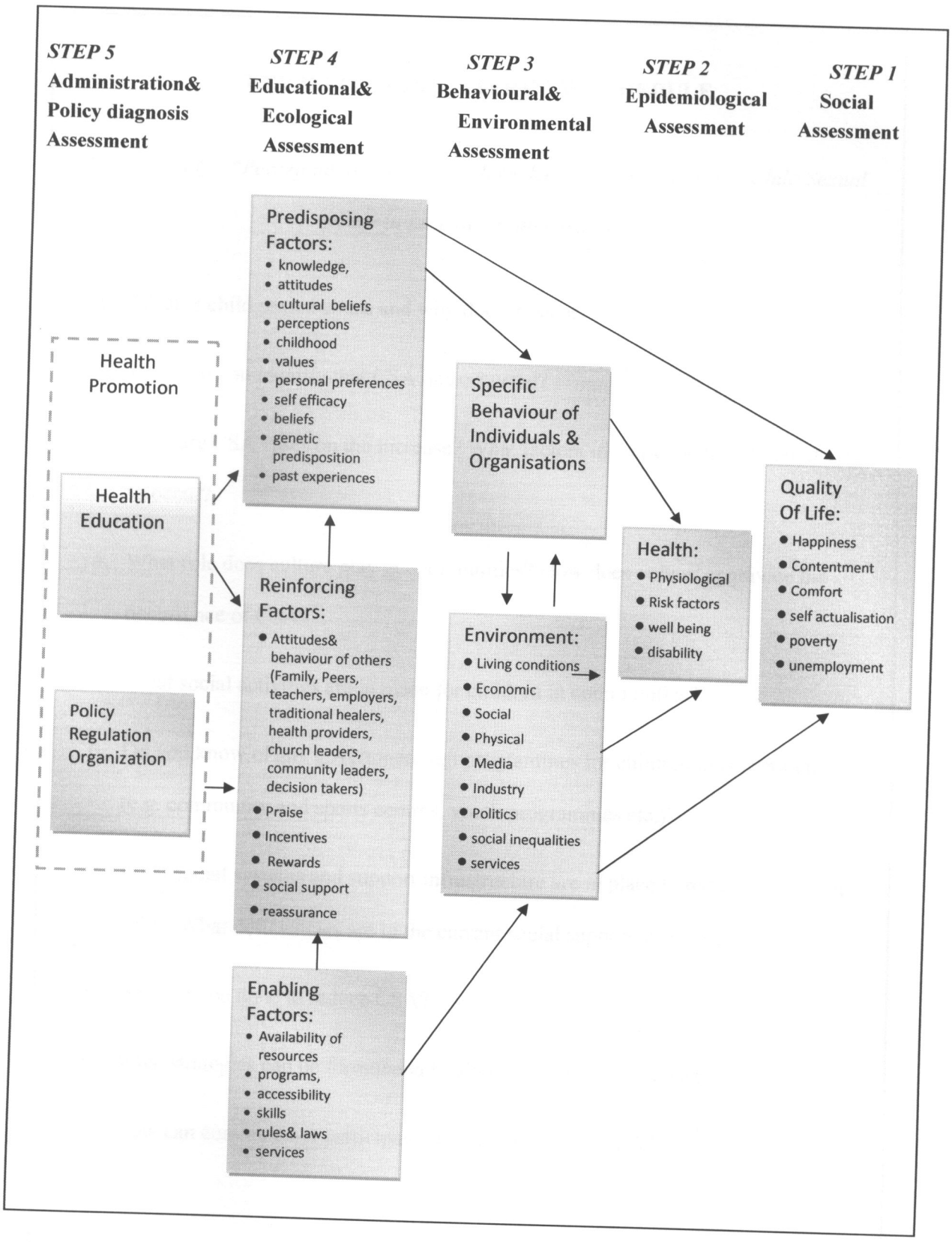


Ecological Framework – Heise Model (1998) WHO 2004

Annex III: Ecological Framework



Annex IV: The Precede-Proceed Model



Annex V: Key Informant Interview Schedule

KEY INFORMANT INTERVIEW SCHEDULE

Title of study: *"Perception of factors that have led to the occurrence of Child Sexual Abuse in Lusaka Urban District".*

1. What is child sexual abuse and why does it occur?
2. How can you identify that CSA has occurred?
3. Why are CSA cases on the increase? What factors increase the likelihood of CSA to occur?
4. What role does culture play in communities? How does culture aggravate the occurrence of CSA?
5. What social activities are in place for children in communities?
6. Do you know of any government run programmes for children in communities (e.g. community and sports centres, youth programmes etc.)?
7. What social systems and support infrastructure are in place to reduce or prevent CSA? What deficiencies are in the current social support systems?
8. What can be done to reduce CSA?
9. What strategies can be formulated to alleviate child sexual abuse?
10. How can communities participate in the fight against CSA?

Annex VI: Key Informant Interview Consent Form

KEY INFORMANT INTERVIEW CONSENT FORM

Instructions

This Informed Consent Form has two parts:

- Information sheet (to share information about the study with you)
- Certification of Consent (for signatures if you choose to participate in the study)

Part I: Information Sheet

Introduction

My name is Namwaka Mooto and I am a student at the University of Zambia pursuing a Masters degree in Public Health.

My research team and I are conducting a research on Child Sexual Abuse in Lusaka Urban District. My study is looking at the "Perception of factors that have led to the occurrence of Child Sexual Abuse in Lusaka Urban District". We invite you to be part of this research.

This consent form may contain words that you do not understand. Please feel free to ask questions as we go through the information and we will take time to explain.

Purpose of the research

Child Sexual Abuse cases still occur in Lusaka Urban District. The aim of the study is to find out ways to reduce and prevent the occurrence of Child Sexual Abuse in Lusaka Urban District. We believe that you can help us by sharing information with us about Child Sexual Abuse and its causes. This knowledge might help us learn how to better control CSA in Lusaka Urban District.

Type of Research Intervention

This research will involve your participation in an interview

Participation selection

You are being invited to take part in this research because we feel that your experience working in the area of CSA can contribute much to our understanding and knowledge of CSA.

Voluntary participation

Your participation in this research is entirely voluntary. It is your choice whether to participate in the study or not.

Risks

There is a risk that you may share some personal or confidential information by chance or that may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

Benefits

There will be no direct benefit to you, but your participation is likely to help us find out more about how to prevent and reduce CSA in Lusaka Urban District.

Reimbursements

You will not be provided with any incentive for your participation in this research.

Confidentiality

We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research will be kept private. Confidentiality and anonymity will be ensured and any information about you will have a number on it instead of your name. Only the researchers will know what your number is and the information will be locked up. We will ask you not to talk to people outside the study about what was said in the interview. We will not be responsible for any information about the study that may be shared by participants outside the study environment.

Sharing the results

The information collected will only be shared among the research team, faculty and will be included as findings in the final report.

Right to refuse or withdraw

You have the right to refuse to participate or withdraw from the study at any time.

Who to contact

If you have any questions, you can ask me now or later. If you wish to ask questions later, you may contact the principal investigator on the following:

Namwaka Mooto,
University of Zambia
School of Medicine
Department of Public Health,
P. O. Box 50110,
Lusaka, Zambia
Email:namwakam@gamil.com

Part II: Certificate of Consent

I have been invited to participate in a research on the "Perception of factors that have led to the occurrence of Child sexual abuse in Lusaka Urban District".

(This section is mandatory)

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Participant's No. ___

Signature of Participant _____

Date _____

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

- ❖ Notes from the discussion will be written down

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and their consent has been given freely and voluntarily.

Print Name of Researcher/person taking the consent _____

Signature of Researcher /person taking the consent _____

Date _____

Day/month/year

Annex VII: Focus Group Discussion Guide

FOCUS GROUP DISCUSSION GUIDE

Title of study: *Perception of factors that have led to the occurrence of Child Sexual Abuse in Lusaka Urban District*

1. What is child sexual abuse and why does it occur?
2. How can you identify that CSA has occurred?
3. What factors increase the likelihood of CSA to occur?
4. What role does culture play in communities and what cultural practices do you have in your communities?
5. How does culture contribute to the occurrence of CSA?
6. What do children do for entertainment in your communities?
7. Do you have any government run programmes for children in your communities (e.g. community and sports centres, youth programmes etc.)?

- What activities are in place for children in your communities?

8. What social systems are in place to reduce CSA?
9. What can be done to reduce CSA?

- What would you do if you found out that CSA has occurred?
- What would you do if you found out that your husband/wife sexually abused your daughter/son?

10. How can communities participate in the fight against CSA?

THE UNIVERSITY OF ZAMBIA

BIOMEDICAL RESEARCH ETHICS COMMITTEE

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5 November, 2010
Our Ref: 005-11-10

Ms Namwaka Mooto
C/O Mrs M. Mooto
UNZA School of Medicine
Department of Pharmacy
LUSAKA

Dear Ms Mooto,

RE: SUBMITTED RESEARCH PROPOSAL: **"PERCEPTION OF FACTORS THAT HAVE LED TO THE OCCURRENCE OF CHILD SEXUAL ABUSE IN LUSA DISTRICT"**

The above-mentioned research proposal was presented to the Biomedical Research Ethics Committee on 26 August, 2010 where changes/clarifications were recommended. We would like to acknowledge receipt of the corrected version with clarifications. The proposal is approved.

CONDITIONS:

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this Committee every six months and a final copy of your report at the end of the study.
- Any serious adverse events must be reported at once to this Committee.
- Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a Progress Report (Progress Report Forms can be obtained from the Secretariat).
- **Ensure that a final copy of the results is submitted to this Committee.**

Yours sincerely,

Dr E. M. Nkandu
CHAIRPERSON

Date of approval: 5 November, 2010

Date of expiry: 4 November, 2011