

# Responding to sexual violence against minors:

## What to consider, what to do?

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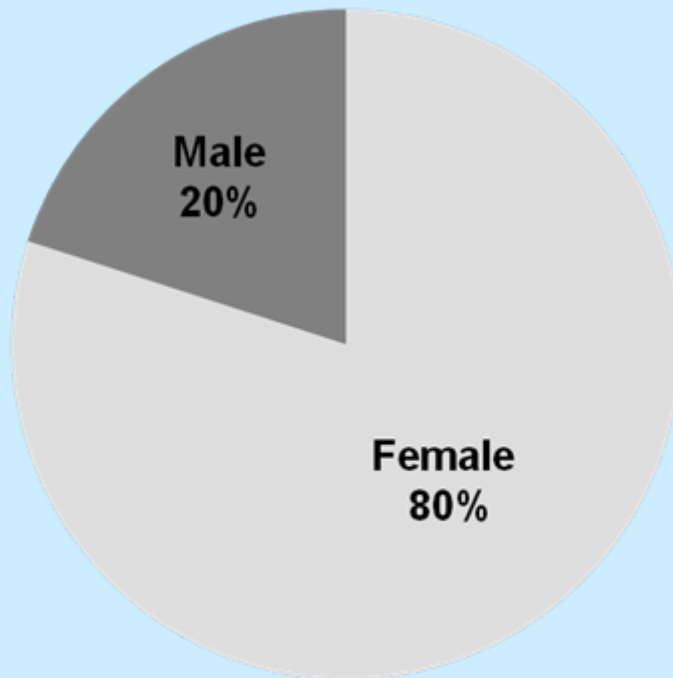
Director, Reproductive Health  
Services and Research

Population Council

# About half of all reported cases of sexual violence are for children (under 19 years)

- In Copperbelt, Zambia, of the 612 survivors reporting to the police, **49%** were under 14 and **85%** were under 19
- In Limpopo, South Africa, of 556 cases presenting at a trauma centre, **56%** were minors and **31%** pre-teens
- Of 284 survivors examined at a rural hospital in Limpopo, **44%** were children aged 17 years and younger
- In Malawi, a national study found that **50%** of child sexual assault cases were aged 2-13 yrs
- In South Africa, police records indicate that **41%** of all reported cases of rape are against children

# 77 percent of male survivors were children in Mombasa, Kenya (980 over period Aug 2007- May 2009)



6% were less than 10 years

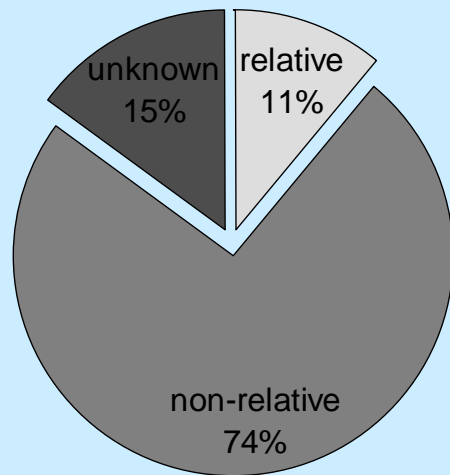
1% were aged 10 – 14 years

0% were aged 15 – 19 years

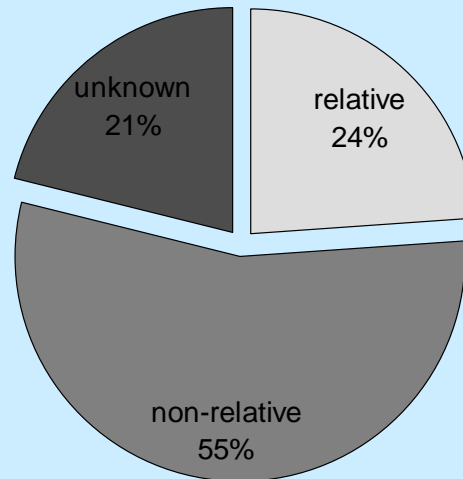
# Child survivors much more likely than adults to report knowing the perpetrator

- Kenya:
  - <18 years: 64%
  - Children are 4.8 times more likely than adults
- South Africa:
  - >18 years: 33%
  - <18 years: 76%
  - <14 years: 86%

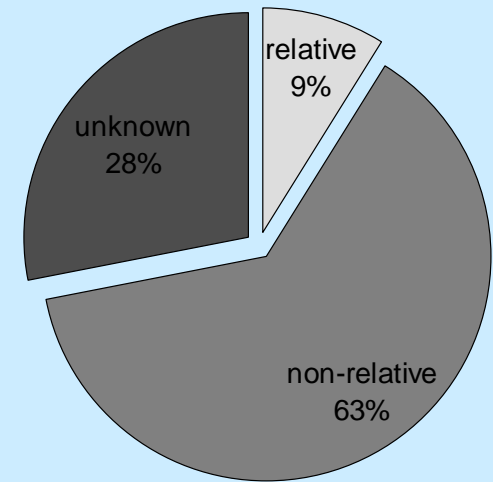
# But although known, most were not related



Zambia police records (n=2203)



South Africa hospital records (n=294)



Malawi hospital records (n=64)

# After decision to report for services has been made.....

- Most report to police before health facility because:
  - Health or social services don't exist, are inaccessible, or are not known
  - Guardian sees incident as a legal rather than health issue
  - May not present with any medical symptoms
- Most do report to police / hospital within 72 hours
  - Kenya: 91%
  - South Africa: 54%, 84%
  - Zambia: 80%
- Delayed reporting may be due to:
  - Repeated occurrence
  - Family member
  - No symptoms
  - Inaccessibility

# Timeliness important because:

## Medical treatment:

- Eligible for PEP
- Eligible for STI prophylaxis
- Eligible for EC

## Evidence collection:

- More likely to be able to provide forensic evidence
- Perpetrator may still be present

# PEP for child sexual assault (CSA)

## Studies in Malawi, Kenya, South Africa

- Exclusion criteria for eligibility:
  - Time delay; previous assault; physical evidence(??)
- To test or not to test? Stat vs. full dose?
- One month compliance rates:
  - Malawi: 65%, n=17
  - Kenya: 45%, n=48
  - South Africa: 56%, n=120
- Pediatric dosage – dedicated vs. adapted
- Follow-up repeat testing variable

***Guidelines are evolving with experience***



# Evidence collection from minors: Some critical issues

- Consent to provide evidence
  - Consent and assent
  - If guardian is suspect
- Collecting verbal evidence
  - Language
  - Processes
- Medical exam: is an internal exam necessary?
- Medico-legal exam:
  - Collecting forensic evidence for police investigation
  - Interpreting evidence during prosecutions
- A 'normal' condition can **not** exclude sexual assault
  - The dynamic around childhood sexual abuse
  - The dynamics of disclosure
  - The dynamic ♀ genital tract

# Distinguishing sexual abuse from other conditions



# What needs should a strengthened response address?

- **Medical:**
  - Physical damage
    - Perineal
    - Other body places
  - STI risk
  - HIV risk
  - (Pregnancy)
- **Justice**
  - Legal
  - Protection
- **Trauma:**
  - Traumatic sexualization
  - Stigmatization
  - Betrayal
  - Powerlessness
- **Other psychological effects**
  - PTSD
  - Depression
  - Substance abuse

# What could constitute a services package for child sexual assault?

## **Immediate response:**

1. Physical and genital exam
2. Treatment of physical injuries
3. Preventive medical management
  - a. STI prophylaxis
  - b. HIV testing and prophylaxis
  - c. Tetanus, Hep B prevention
  - d. (Pregnancy prevention)
4. Immediate psychological trauma counselling
5. Forensic evidence collection
6. Legal advice and opening police case

## **Longer-term response:**

1. Access to and legal aid to support through justice process
2. Sustained protection of child's safety
3. Sustained post-traumatic psychological and sexuality development support
4. Family reconstruction

# Management guidelines being developed for health workers

Example:  
KZN Province, SA

1. Suspect abuse
2. Investigate
3. Validate evidence
4. Manage the child
5. Ensure on-going safety of the child
6. Family reconstruction

[http://www.kznhealth.gov.za/chrp/guidelines\\_kzn.htm](http://www.kznhealth.gov.za/chrp/guidelines_kzn.htm)



## Management of Childhood Sexual Abuse



**Six easy steps**

**What you hear**

- Allegation of abuse by the child, a co-abused, the perpetrator or a 3rd party witness
- Urinary tract symptoms, lower abd pain, vaginal discharge

**What you see:**

- Behavioural problems, sleep disturbance, sexualised language or behaviour

**What you find:**

- Genital/anal injuries, infections, structural changes

**Suspect**

- The involvement of a child in sexual activity based on an imbalance of power
- Requires confirmation by the child
- Comprises 4 categories:
  - Unconfirmed suspicion
  - Mild / non-contact (verbal, exhibitionism, pornography)
  - Moderate / contact abuse (fondling)
  - Severe / penetrative (anal, oral or vaginal)

**Who can suspect abuse**

- Anyone may suspect abuse – a family member, friend, health care worker, teacher, concerned citizen
- Refer every case of suspected abuse to the SAAPS (PSC unit) &/or a social worker

**Social workers:**

- Risk assessment to evaluate the social circumstances of the child & his/her vulnerability to abuse
- Ideal party to coordinate holistic management of abused children

**Investigate**

- All cases of suspected child abuse require 5 investigations:
  - Risk assessment
  - Criminal investigation
  - Medical examination
- These should ideally be done by a specialised multidisciplinary team

**Healthcare workers**

- Clinical examination of presenting complaint based on history, examination & special investigations
- Forensic examination:
  - Sexual assault evidence collection kit (SAECK) within 48 – 72 hr of assault
  - JOB

**SA Police services**

- Investigation of a suspected criminal offence

**Validate**

- Must not influence medical management

**Legal process**

- Prosecutor reviews input from all role-players in investigative step to assess chances of a successful prosecution
- Interest of the child must come first

**Role of healthcare worker**

- JOB
  - complete at time of examination
  - must be completed regardless of interval between assault & examination
- Sexual Assault Evidence Collection Kit (SAECK)

**Mental:**

- Prevent post-traumatic stress disorder (PTSD) by “debriefing”. The earlier the better.
- Look for PTSD – development of 5, following incident:
  - Sleep disturbance
  - Change in appetite
  - Development of separation anxiety
  - Deterioration in school performance
  - General behavioural change
- Treat PTSD if suspected – refer to counselor / psychologist

**Treat**

- Consent is required for both examination & management
- Examination:
  - Parental consent ideal but not essential
  - If not available use SAP 308 consent (permission to examine in the event of a suspected criminal offence – available from police)
  - NEVER examine without the consent of the child
- Management:
  - HIV test – consent from child, if >10yrs, plus guardian or commissioner
  - PEP treatment – consent from child, if >10yrs, plus guardian or commissioner

**Prevent physical sequelae:**

- Pregnancy:
  - Exclude pre-existing pregnancy
  - All girls with 1 stage 2 contraceptive (Tanner staging)
  - Up to 7 days after the abuse
  - Oral 20 2 stat & 2 after 12 hours
  - Misoprol 10 mg po tds for 24 hours
- Infections:
  - ATT 1% or Mili stat - if skin/mucous membrane broken
- Sexually transmitted infections:
  - Roxithrom 120 mg / 250 mg IM stat
  - Flagyl 7mg/kg/dose qid for 7 days
  - Erythromycin 30mg/kg/day qid for 14 days
- HIV:
  - Must have – see HIV test (rapid test is adequate)
  - Baseline bloods
  - AZT & 3TC according to weight
  - Add protease inhibitor if serious injury present

**Create a protective environment:**

- Ensure child safe from ongoing abuse
- If possible separate child & perpetrator
- Implement adequate supervision:
  - Female
  - Safety in numbers

**Ensure safety**

- Understand process of abuse (Finkelhor):
  - Denial
  - Overcome internal inhibitions
  - Overcome external inhibitions
  - Overcome child – rejection or force

**Hospital as a place of safety:**

- Only admit children for medical reasons
- In rural areas one may have to use hospital as a place of safety but only as a last resort
- Need to consider admission on a Form 4, available from social worker or SAAPS

**Family reconstruction**

The family is the child's support system.  
Keep the family intact & functional to minimize sequelae for the child.

Department of Paediatric, Paediatric/Child Protection Hospitals Complex, 2007

# What's happening in East and Southern Africa?

- ✓ Rapid increase development of medical management guidelines and policies that include managing CSA
- ✓ Sporadic services strengthening, with little strategic planning
  - Piloting primarily in tertiary hospitals
  - Some decentralization to district hospitals
  - One Stop Crisis Centre (OCSS) model popular
- ✓ Massive need for training in medical exams and treatment
- ✓ Confusion around using forensic evidence in prosecutions
- ✓ Lack of engagement with, and strengthening of, police
- ✓ Lack of attention to trauma and family support

# In summary, CSA is characterized by.....

- Usually a known perpetrator instigating a process of abuse culminating in single or repeated assault – different than adults
- Police often first point of contact, but most also present for medical management
- Children are the majority of those presenting for services, **BUT....** protocols / policies oriented towards adult (female) survivors
- Poor understanding of which evidence to collect, how medical evidence can be interpreted, and what is legally convincing
- Medical management is relatively well understood
- Little response available beyond health and police
  - Legal aid?
  - Trauma counselling?
  - Social services support for family?
- Limited availability and lack of coordination for funding, planning and programming

# WHAT ACTIONS SHOULD BE SUPPORTED IMMEDIATELY?



# 1. Develop, pilot and evaluate models that strengthen and link existing services

- i. Identify existing services to strengthen that could serve as national / regional models
  - South Africa, Malawi, Kenya....?
- ii. Focus on strengthening services at FPCs
  - Police: attitudes; evidence collection; referral
  - Health: attitudes; exam skills; services organization; forensic evidence collection
  - Trauma counselling – specialist vs. Generalist
- iii. Develop referral linkages between services
  - Police to medical; medical to police
  - Police to legal aid
  - Medical to counselling

## 2. Improve and synthesize understanding through research

### i. Child survivors' service-seeking behaviours

- Role of guardian
- Grooming process vs. spontaneous act
- Relationship with perpetrator and seeking justice
- Awareness, desire and ability to access quality services

### ii. Services availability

- Mapping type, distribution and access
- Clientele accessing services
- Quality of services available
  - Provider competencies
  - System readiness
  - Service settings

### 3. Advocate for national / international attention and support for strengthening CSA services

- i. Review and strengthening of national laws, policies and service delivery protocols
- ii. Support development of regional norms and standards
- iii. Develop standardized training curricula and skills for health, police, counsellors, legal staff
- iv. Strengthen and standardize national record-keeping and reporting
- v. Support existing regional and national organizations and advocacy networks

# And over the longer-term?

- ✓ Longitudinal evaluation of services' effectiveness on survivors' well-being and behaviors
- ✓ Role of OSCCs in high density populations
- ✓ Establishing linkages between FPCs and SecondPCs
- ✓ Screening for CSA by health providers
- ✓ Strengthen government services for counselling and protection
- ✓ Integrate CSA with wider child abuse services
- ✓ Link response services with prevention efforts

# Concluding messages

- Increased realization that CSA is highly prevalent in general populations
- Minimal services available
- Current and desired service responses poorly understood
- Limited funding sources and lack of coordination, by governments and donors
- Need for strategic and coherent programme of action to stimulate national and regional responses to CSA