

Risk Factors in Sexually Abused Children Reporting to the One Stop Centre at University Teaching Hospital in Zambia

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1. Introduction

1.1 Definition of Child Sexual Abuse

Child sexual abuse (CSA) is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society (Faller 1988, Kempe 1978, Sedlak & Broadhurst 1996, Sgroi 1988).

CSA is evidenced by an activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person (Kempe 1978, Sgroi 1988). The sexual act can be divided into penetrative and non-penetrative and this may include but is not limited to the following;

Child sexual abuse includes:

- Actual or attempted penetrative sexual intercourse or oral sex with a child.
- Non-penetrative sexual activity, e.g. rubbing the penis between the child's thighs or genitals;
- Fondling of a child's sexual parts, i.e. genitals, breasts, buttocks, etc.;
- Masturbation between adult and child;
- Displaying or exposing a person's genitals to a child (exhibitionism);
- The exploitative use of a child in prostitution or any other unlawful sexual practice;
- The exploitative use of children in pornography;
- Forced early marriages;
- Peeping on a child when he or she is bathing or undressed for the purpose of sexual gratification;
- The inducement or coercion of a child to engage in any unlawful sexual activity
- The exploitative use of a child in prostitution or other unlawful sexual practices
- The exploitative use of children in pornographic performances and materials (WHO 1999)

1.2 Other definition of sexual abuse

- RAPE happens when a person has sex that he or she did not agree to. It includes intercourse in the vagina, anus or mouth. Sometimes it happens when aone person forces another to have sex. Rape can happen to men and women.
- STATUTORY RAPE is sexual intercourse with a girl under the age set down by the law (16 years for girls and 14 for boys in Zambia) with his/her consent.
- INCEST means the performance of any sexual act between persons who are forbidden by law to marry because they are family members. It applies not only to biological family members, but also to sexual acts between stepparents and stepchildren or adopted children and their parents.
- FELATIO is penal satisfaction by licking or sucking with the mouth and tongue (oral sex).
- SODOMY is anal sexual intercourse
- INDECENT ASSAULT is assault involving the sexual organs. It includes such actions as forced oral or anal sex, fondling, and attempted rape such actions as forced oral or anal sex, fondling, and attempted rape.

1.3 Risk factors in Child Sexual Abuse

CSA has been in existence since time immemorial. CSA occurs in all societies as well as all social structures. It has been difficult to quantify the magnitude of CSA globally including Zambia as most cases go unreported. There are a number of factors that make children vulnerable to sexual abuse. The key determinants are:

- Increased number of orphans has a big impact on the increase of CSA.
 - Zambia has one of the largest numbers of AIDS orphans in the world. This is estimated to be a total of 1,100,000 orphan of which two thirds of these orphans are AIDS orphans (Central Statistics Office – Lusaka)
 - Orphans are taken into foster home or orphanages where it is not uncommon to be sexually abused. Some may be taken in by relatives or find themselves in child-headed homes and are often forced to trade sex for money, food or abused by their caretakers
- Female sex - The most common cases of CSA in Zambia are that of a girl child by an adult man or with a few between an adult woman with an under aged boy
- HIV pandemic resulting in loss of parent has children into prostitution
- Broken homes have been well documented in the United States as an important risk factor for child sexual victimization. In Zambia, loss of one parent has resulted in increase of repoted cases of CSA.
- Children whose parents suffer from mental illness or drug dependency have an increased risk of being sexually abused.
- War/ armed conflicts: Sexual abuse has been reported to be rampant communities engaged in wars and armed conflicts. Zambia is surrounded by neighbours who have had armed conflicts and resulting in setting up of these camps within the Zambian borders.
- Children who are mentally impaired are more likely to be sexually and the abuse not be detected until the child presents with pregnancy.

CSA is not limited to the categories itemized above. It happens in any forum or society. It exists amongst the rich and the poor, the highly educated people and the illiterates.

1.4 Definition of a child

There are multiple definitions of a child in the Zambian laws and these create disparities in interpretation. In the context of One Stop Centre (OSC) children are defined as those aged 16 years and below in keeping with the medical definition at the University Teaching Hospital (UTH).

1.5 Prevalence of Child Sexual Abuse in Zambia

Zambia is a country in sub-Saharan Africa where the problem of CSA is compounded by HIV prevalence of 19.7 % in urban adults compared 10.3% in rural adults ($p < 0.00001$) (ZHDS 2007). There are no studies on the prevalence of CSA in Zambia. The OSC was established specifically to offer post exposure HIV prophylaxis to children sexually abused.

Lusaka is the capital of Zambia with a population of close to 2 million (ZHDS 2007).

UTH houses the only medical school in the country and the schools of Registered Nurses and Midwifery. The paediatric department is the busiest department within the UTH catering mainly for management of the acutely ill. Most of the children before the establishment of the OSC were cared for at the department of obstetrics and gynaecology. Though there is significant emphasis on prevention of mother to child HIV transmission in Zambia, HIV transmission through CSA had been a neglected issue. The contribution of CSA to the HIV pandemic remains unknown. However, the impact of HIV on children has been evaluated.

Children have been much affected by the HIV/AIDS epidemic in Zambia, where over 30,000 children are HIV positive (UNAIDS Report 2007). Perinatal transmission accounts for the majority of pediatric HIV infections where HIV prevalence is high. However, sexual exposure remains an important risk factor in children in the post-weaning period. While HIV transmission rates attributable to sexual abuse are unknown, pediatric victims of sexual abuse are at a higher risk of HIV transmission due to physical trauma and due to the fact that multiple exposures often occur prior to discovery of the abuse (Lindgren ML et al 1998).

In a pilot study conducted at the UTH in 2003, 99% of sexually abused children reporting to the gynecology ward were female, which also placed them at a higher risk for HIV acquisition (Chomba et al 2006).

Although epidemiologic data for the prevalence of child sexual abuse (CSA) in Zambia is not available (Collings 2002), recent establishment of one stop centres will help in providing some information on factors associated with child sexual abuse thus help to unravel the extent of the problem.

Literature from countries surrounding Zambia documents the existence of a CSA epidemic in the region. Prevalence studies rely on cross-sectional study design, most often surveying school children about their experiences of sexual abuse. In a review article of child sexual abuse in sub-Saharan Africa, Lalor et.al. report that between 3.2 and 7.1% of all respondents

report unwanted or forced sexual intercourse before the age of 18 years (Lalor 2004). Jewkes et al. surveyed 11, 735 South African women between the ages of 15 and 49 years about their history of rape during childhood. Overall, 1.6% reported unwanted sexual intercourse before the age of 15 years of age. 85% of child rape occurred between the age of 10 and 14 years and 15% between the ages of 5 and 9 years (Jewkes, Levin et al. 2002). In a study in Zimbabwe, Birdthistle reports that among unmarried, sexual active adolescents, 52.2% had experienced forced intercourse at least one time. 37.4% of first sexual intercourse acts were forced (Birdthistle IJ 2008). In a study of 487 university students in Tanzania, 11.2% of women and 8.2% of men reported unwanted sexual intercourse. The average age at the time of abuse was 13.6 years (McCraan D 2006). Collings et al (Collings 2002) surveyed a sample of 640 female university students in South Africa and found that 34.8% had experienced contact sexual abuse before the age of 18 years. Another study among high school students in South Africa (Nadu 2002), found that almost 20% were victims of parental or guardian sexual abuse. Additional research suggests that the prevalence of child sexual abuse in sub-Saharan Africa is similar to other countries across the world (Lalor 2004).

2. Rationale

In the era of HIV infection with the highest mortalities in the sub-Saharan region documenting the characteristics of children who are at risk of being sexually abused is an important strategy to reduce horizontal transmission of HIV in children.

The current preventative strategies for children from acquiring HIV are enveloped in the Prevention of Mother to Child Transmission (PMTCT) and there are no studies in Zambia to characterise risk factors on children who may be sexually abused nor strategies to prevent HIV acquisition in these vulnerable children as far as we are aware.

In a survey by Mathews et al (Mathews et al, 2011) of girls aged between 13 -24 years, respondents who lived in a rural environment were significantly less likely than those in an urban environment to report having experienced sexual violence before the age of 18. Compared with respondents who had been close to their biological mothers as children, those who had not been close to her had higher odds of having experienced sexual violence, as did those who had had no relationship with her at all.

In the second quarter of 2003, Zambian police handled 300 cases of child rape and some experts believe that for every case reported another 10 go unreported. (Agence France-Presse 2003). The number of reported cases and the realization that these cases were likely to be the tip of iceberg, in combination with high HIV prevalence led to the identification of the need to establish a comprehensive multidisciplinary centre to train health workers in the recognition of CSA, to increase public awareness of CSA, to improve management of sexually abused children with an emphasis on preventing HIV acquisition and document the characteristics and risk factors of sexually abused children.

3. Objective

The aim is to identify risk factors of child sexual abuse in children reporting to the OSC and propose possible interventions. Currently the OSC is offering PEP to children who are at risk of contracting HIV through sexual abuse. Other services offered include;

- psychosocial counseling,
- treatment of sexually transmitted infections (STIs.)
- Emergency contraceptives
- Evaluation of Post Traumatic Stress Disorders
- Referral to HIV Clinic for HIV positive children (PTSD)

4. Methodology

In most western countries Child Advocacy Centers (CACs) are not located within medical institutions and offer a more comprehensive package to include physical abuse as well as child neglect (Downing 2002, Hansen 1998). We chose to establish the multidisciplinary centre within the pediatric department because most the sexually abused children came to the attention of the health workers because of medical complications (Chomba, Kasese-Bota Haworth, Fuller, Amaya, 2006) and in order to offer PEP to abused children, which was only available at the UTH. The centre would not provide services for isolated physical abuse cases nor neglected children.

The One Stop Centre was established in the pediatric department on 26th April 2006. A location was selected where there was minimal foot traffic, and there are no conspicuous notices indicating its function to help preserve the confidentiality of the children and their guardians attending the center. The Centre included a physical examination room and several interview rooms including one with a two way mirror, microphone and speakers which allows one person to interview (usually a medical person) whilst the police officers and counsellors take notes from another room. The centre is equipped with comfortable child-friendly waiting facilities (TV set, toys and educational materials).

The Centre has employed one medical doctor who oversees medical examinations and attends to court cases, one clinical officer who performs physical examinations; one police officer who documents on police medical forms and ensures that they are delivered to the prosecutors; one social worker who follows up children in the community and advises on rehabilitation; and three nurses who assist the physician and the clinical officer.

Intake interviews are conducted with the caregiver and child separately (if the child is able). Information on demographic characteristics and abuse history is collected. A medical/laboratory form includes the following tests: HIV, RPR, pregnancy, Hepatitis B and forensic specimens (High vaginal swab for wet prep, gram stain and culture to identify gonorrhoea, trichomonas, and spermatozoa).

Mental health assessments for the youth include the Post-traumatic stress disorder – Reaction Index, the Strengths and Difficulties Questionnaire, and My Feelings About the Abuse. This last measure specifically examines the construct of shame, which is considered to be critical in the Zambian culture. The mental health assessment administered to the caregivers about the abused child is the Child Behaviour Checklist.

A systematic flow has been designed to promote excellence in the care of sexually abused youth.

1. Family register at UTH main desk and receives a treatment form
2. Once the family has both forms, they are directed to the centre where they are greeted by the social worker and/or nurses. Youth and their care-givers are immediately asked if the abuse happened within the last 72 hours.

- a. If abuse occurred within 72 hours, the child is immediately brought to a nurse to take the necessary blood tests, and administer PEP if appropriate. After blood tests and PEP administration, the intake forms and the questionnaire for assessment of level of trauma are completed by the nurse or social worker. A physical exam is completed and the UTH treatment form and police medical forms are completed.
- b. If abuse did NOT occur within 72 hours, the child/care-giver is interviewed by one of the staff , blood tests are performed, a physical exam of the child is conducted and the forms are completed as well as the police medical form are completed (The police officer stationed at the centre completes the relevant portion of the form.
- c. If a child is HIV positive, they are referred to the Paediatric Antiretroviral Therapy (ART) Clinic for further management and follow up.
- d. If a child is found to be pregnant, she is referred to the Antenatal and/or Prevention of Mother to Child HIV Transmission (PMTCT) clinic.
- e. If abuse did NOT occur within 72 hours, the child/care-giver is interviewed by one of the staff, blood tests are performed.

Drugs used for PEP were Zidovudine 240mgs/m² in combination with Lamivudine 4mg/kg (Combivir) twice daily for 28 days. No syrups were available initially leaving the very young children without any PEP options until later when syrup formulations were made available. Initially, a two drug regimen was recommended as effective (WHO, Geneva Report 2006) though currently a 3 drug regimen is in place in accordance with current guidelines

5. Results

For the purposes of this chapter, data for 2010 was analysed. A total of 1068 children were seen during this period.

Of the total 1068 children , most of the abused children were girls 1042 (97.6%), boys 46 (2.4%) were boys. Those most likely to be abused were aged between 0-5 years 246 (23%), 6-10 years 223 (20.9%) and 11 and 16 599 (56.1%) (Table 1).

	Frequency	Percent
Age		
0-5 Years	246	23.0
6-10 Years	223	20.9
11-16 Years	599	56.1
Total	1068	100.0
Sex		
F	1042	97.6
M	26	2.4
	1068	100.0

Table 1. Age and Sex Distribution

Of the 1068 children who reported to the centre only 628 (59%) had complete data consistent with the analysis.

Most of the abusers are non relative adults known to the child (66.4%). Strangers accounted for only 7% (Table 2) (Figure 1)

	Frequency	Percent
Father	18	2.9
Known Adult (Neighbor, teacher)	417	66.4
Stranger	44	7.0
Multiple people at the same time	5	.8
Grandfather	4	.6
Auntie	1	.2
Uncle	33	5.3
Cousin	13	2.1
Sibling	11	1.8
Don't know	82	13.1
Total	628	100.0

Table 2. Who is the Abuser?

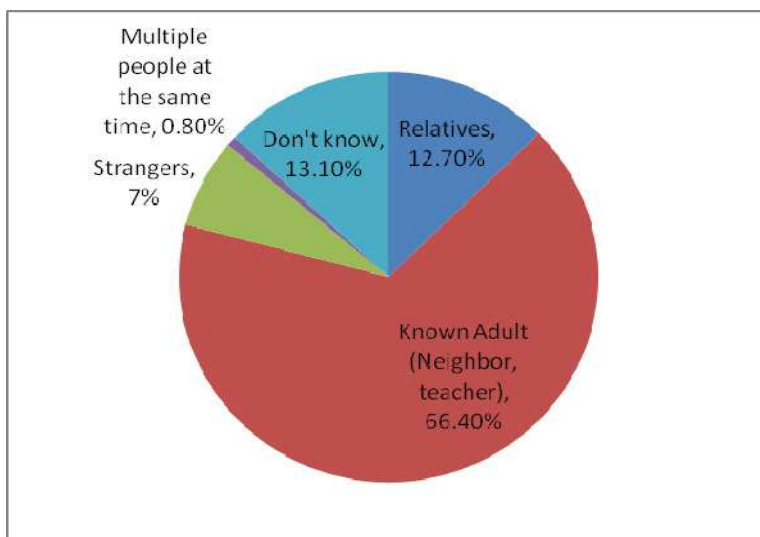


Fig. 1. Summary of Abuser Information

26.6% of these children were reported to be orphans (Table 3)

Is this child an Orphan	Frequency	Percent
No	461	73.4
Yes	167	26.6
Total	628	100

Table 3. Number of Orphans

15.6% reported that they were living in the same household as the abuser during the time of the abuse. About 24% of the children in contact with the abuser (Table 4).

	FREQUENCY	PERCENT
Did abuser live in the child's household during the abuse?		
No	508	80.9
Yes	98	15.6
Don't Know	22	3.5
Total	628	100.0
Since the abuse had been disclosed, does the child have any contact with the abuser?		
No	480	76.4
Yes, seen around	140	22.3
Yes, unsupervised contact	3	.5
Yes, in court, VSU, police	4	.6
Total	627	99.8
999	1	.2
Total	628	100.0

Table 4. Abuser location and Contact with child

Of the 628 children reporting to the centre 86% were referred by the police. Most of the children reporting within 72hrs of abuse at the OSC were given PEP (Table 5).

	Frequency	Percent
Who referred you to the clinic?		
Medical facility/doctor	55	8.8
Police	540	86.0
Parent/caregiver/relative	20	3.2
Friend	3	.5
VSU	7	1.1
Total	625	99.5
Other	3	.5
Abuse Reporting Time		
No	245	39.0
Yes	353	56.2
Don't know	30	4.8
Total	628	100.0
PEP Administration		
No	6	1.7
Yes	347	98.3
Total	353	100.0

Table 5. Referral, Reporting Time and PEP Administration of CSA victims

At the OSC physical force was used in about 20% of the victims of CSA, 23.7% playful/gentle coaxing was applied. 52% had no presenting complaints and 28.2% had genital pain. (Table 6)

	Frequency	Percent
How Did The Abuser Engage The Child?		
Don't know	122	19.4
Playful/gentle coaxing	149	23.7
Bribes	91	14.5
Commands/instructions	8	1.3
Verbal threats	21	3.3
Physical threats	98	15.6
Physical force	125	19.9
offering alcohol	4	.6
Other	10	1.6
What is the presenting complaint?		
None	329	52.4
Genital Pain	177	28.2
Abdominal Pain	48	7.6
Discharge	9	1.4
Bleeding	5	.8
Genital itching	5	.8
Bruising	1	.2
Behavior change	8	1.3
Other	46	7.3

Table 6. Methods used to engage the child and presenting signs and symptoms

6. Discussion

Child sexual abuse in the sub-saharan region is a risk factor to the acquisition of HIV infection (Dunkle 2006, UNICEF 2001, WHO 2006). Risk factors to child sexual abuse are evaluated in this chapter to help guide health workers, psychosocial counsellors, organisations and other professionals tasked in the protection of children to help manage sexually abused children. Planning strategies to mitigate against child sexual abuse requires understanding risk factors associated with CSA.

The female child was by far more likely to be abused. Other studies in the sub-Saharan region have reported similar findings (Birdthistle et al2009, Mathew et al 2011). Zambia has one of the highest HIV prevalence rates 14% (Zambia NAC 2009) and females aged between 15-19 are more likely to be HIV infected 16% as compared to their male counterparts 10%

(Zambia NAC 2009). These high rates amongst females may suggest that CSA may be putting females at higher risk of HIV acquisition.

There is a high proportion of children aged below 10 reporting to the OSC and 23% of these are aged below 5 years. In Zambia, the school enrolment is between 6 to 7 years for the first grade suggesting that about 20% of the children are being abused right in the home. The statistics also show that 66% of the abusers were non-relative adults (neighbours, teachers, etc). Only 7% was attributed to strangers. This finding explains the absence of clinical presenting complaints and lack of pathological findings on examination in spite of the history of physical force having been used in 20% of those who were sexually abused. This could be attributed to delayed in reporting to the OSC allowing for healing which occurs rapidly in children. However in a review of CSA literature done by Pitche (Pitche 2005), though 30-60% abusers were known to the child, 97% of cases had penetrative sex resulting in injuries. However this study was retrospective.

Among the 628 children seen, 56.2% reported within the 72hrs required leaving a large number of children who did not qualify for PEP. This also has been shown in several studies (Birdthistle et al, Bablet al 2000, Chesshyre et al 2009, Speight et al 2006) that PEP as a strategy for preventing HIV acquisition has not been very successful. This may be due to the fact that the very nature of the abuse being committed by some trusted adult or on who the child depends on for upkeep becomes the abuser. This may lead to delays in reporting to health authorities as opposed to when the abuser is a stranger.

In Zambia a large number of children are orphans. One estimate is that 1.656 million children, or more than one-third of those under the age of 15, are orphans who have lost one or both parents (Kelly 2000). Of the 628 children who had complete data 26.6% were orphans. In another study (Birdthistle 2009) 30.1% reporting to a the facility were orphans. This puts this group of children at high risk of sexual abuse. They more likely to be greatly economically disadvantaged and lack adult protection from abuse.

Though the OSC set-out to screen for syphilis which is known to increase HIV acquisition (Dunkle et al 2006, Pitche 2005) most children did not have this laboratory test done due to the shortage of re-agents. Hepatitis B similarly was not performed consistently for us to evaluate the prevalence of this in these children.

7. Conclusion

Child sexual abuse is prevalent in Lusaka. The female child is by far the most vulnerable and there needs to urgent policy and support for prevention of CSA for this vulnerable group. Communities need to be sensitised on the dangers of CSA as numbers reporting to the OSC are the tip of the iceberg. The 23% of children abused aged 0-5 years pose a great challenge as this is a helpless vulnerable group when abuse is occurring within the home. Understanding family dynamic should be part of the prevention strategy of CSA. There needs to be more resources and better tools for collection of data to better unravel risk factors associated with sexual abuse.

8. Limitations

The data was not obtained in a research setting but in a clinic setting where the workers are busy with managing acute cases. Lack of adequate human and material resources led to

incomplete data collection. The results cannot be extrapolated to the rest country as they were collected from children living in Lusaka an urban area where about 20% of the population lives.

9. Acknowledgment

We acknowledge the courage of the young children and their caregivers who came to University Teaching Hospital One Stop Centre.

I would like to thank the Centre for Disease Control and Prevention (CDC) Zambia for funding the establishment of the One Stop Centre at UTH. Also I would like to thank the following people for their efforts in the collection and gathering of information that was used for this chapter:

Mr. Elson Chama
Mr. Katai Chola
Ms. Mafunase Mako

Special thanks are also extended to:

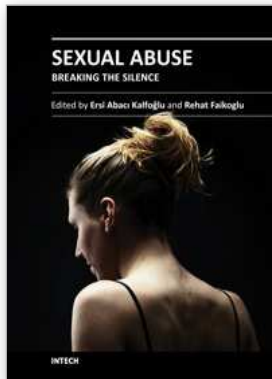
Dr. Lackson Kasonka Managing Director UTH, Dr. Chipepo Kankasa Director Paediatric Centre of Excellence, Dr. Jonathan Mwansa Paediatrician, Mr. Kabanda Sampa OSC Clinic Coordinator and all the OSC Staff.

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Zambia Health Demographics Survey 2007



Sexual Abuse - Breaking the Silence

Edited by Dr. Ersi Abaci Kalsoğlu

ISBN 978-953-51-0425-4

Hard cover, 238 pages

Publisher InTech

Published online 23, March, 2012

Published in print edition March, 2012

Sexual assault can be considered as expression of aggression through sex. This, in turn, can have serious negative effects on a survivor's social and occupational functioning. This book has been organized towards that specific approach, by compiling the scientific work of very well-known scientists from all over the world. The psychological victimization of sexual assault, the physiological aspect of sexual abuse and the different attitudes in coping with sexual assault based on different cultural backgrounds are analyzed. Having in mind that one solution may not necessarily be suitable for all cases, we hope that this book will open a debate on sexual assault for future practice and policy and that it will be a step forward to 'break the silence'.

How to reference

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Elwyn Chomba (2012). Risk Factors in Sexually Abused Children Reporting to the One Stop Centre at University Teaching Hospital in Zambia, *Sexual Abuse - Breaking the Silence*, Dr. Ersi Abaci Kalsoğlu (Ed.), ISBN: 978-953-51-0425-4, InTech, Available from: <http://www.intechopen.com/books/sexual-abuse-breaking-the-silence/risk-factors-in-sexually-abused-children-reporting-to-the-one-stop-centre-at-university-teaching-hos>

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