ZAMBIA SOCIETY FOR THE
PREVENTION OF CHILD
ABUSE AND NEGLECT

(ZASPCAN)

INTERDISCIPLINARY TRAINING MANUAL
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACRONYMS</td>
<td>5</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>6</td>
</tr>
<tr>
<td>PREFACE</td>
<td>7</td>
</tr>
<tr>
<td><strong>CHAPTER ONE: DIAGNOSIS OF CHILD SEXUAL ABUSE</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 CHILD SEXUAL ABUSE- DEFINITION</td>
<td>11</td>
</tr>
<tr>
<td>1.2 RISK FACTORS IN CHILD SEXUAL ABUSE</td>
<td>11</td>
</tr>
<tr>
<td>1.3 PERPETRATORS OF SEXUAL ABUSE</td>
<td>11</td>
</tr>
<tr>
<td>1.4 OTHER DEFINITIONS OF SEXUAL ABUSE</td>
<td>12</td>
</tr>
<tr>
<td>1.5 MYTHS AND MISCONCEPTIONS PEOPLE HAVE ON CHILD SEXUAL ABUSE</td>
<td>12</td>
</tr>
<tr>
<td>1.6 PREVENTION OF CHILD SEXUAL ABUSE</td>
<td>13</td>
</tr>
<tr>
<td>1.7 MULTI-DISCIPLINARY MANAGEMENT OF CHILD SEXUAL ABUSE</td>
<td>13</td>
</tr>
<tr>
<td><strong>CHAPTER TWO: MEDICAL COMPONENT</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 GENERAL</td>
<td>16</td>
</tr>
<tr>
<td>2.2 IDENTIFICATION (MEDICAL HISTORY)</td>
<td>16</td>
</tr>
<tr>
<td>2.3 COMBINING A FORENSIC (INVESTIGATIVE) ELEMENT</td>
<td>16</td>
</tr>
<tr>
<td>2.4 DURING HISTORY TAKING</td>
<td>16</td>
</tr>
<tr>
<td>2.5 EVIDENCE COLLECTION</td>
<td>17</td>
</tr>
<tr>
<td>2.6 DOCUMENTING THE CASE</td>
<td>17</td>
</tr>
<tr>
<td>2.7 THE PHYSICAL EXAMINATION</td>
<td>17</td>
</tr>
<tr>
<td>2.8 GENITO-ANAL FINDINGS</td>
<td>19</td>
</tr>
<tr>
<td>2.9 SEXUALLY TRANSMITTED INFECTIONS</td>
<td>20</td>
</tr>
<tr>
<td>2.10 HIV AND POST-EXPOSURE PROPHYLAXIS (PEP)</td>
<td>21</td>
</tr>
<tr>
<td>2.11 PREGNANCY TESTING AND MANAGEMENT</td>
<td>23</td>
</tr>
<tr>
<td>2.12 DIAGNOSTIC CONCLUSIONS</td>
<td>23</td>
</tr>
<tr>
<td>2.13 FOLLOW-UP TREATMENT</td>
<td>23</td>
</tr>
<tr>
<td>2.14 DOCUMENTATION AND REPORTING</td>
<td>25</td>
</tr>
<tr>
<td>2.15. STORAGE AND ACCESS TO RECORDS</td>
<td>25</td>
</tr>
<tr>
<td><strong>CHAPTER THREE: PSYCHOSOCIAL COMPONENT</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 SAFETY/CONFIDENTIALITY</td>
<td>31</td>
</tr>
<tr>
<td>3.2 FEELINGS COMMONLY EXPERIENCED BY CHILDREN WHO HAVE BEEN SEXUALLY ABUSE</td>
<td>31</td>
</tr>
<tr>
<td>3.3 PSYCHOSOCIAL MANIFESTATION OF SEXUAL ABUSE</td>
<td>31</td>
</tr>
<tr>
<td>3.4 EFFECTS OF CHILD SEXUAL ABUSE: SHORT AND LONG TERM</td>
<td>31</td>
</tr>
<tr>
<td>3.5 POST TRAUMATIC STRESS DISORDER (PTSD)</td>
<td>32</td>
</tr>
<tr>
<td>3.6 COUNSELING</td>
<td>34</td>
</tr>
<tr>
<td>3.7 TALKING ABOUT SEXUAL ISSUES</td>
<td>35</td>
</tr>
<tr>
<td>3.8 DISCLOSURE/CONSEQUENCES OF DISCLOSURE</td>
<td>35</td>
</tr>
<tr>
<td>3.9 REASON FOR REFUSALS TO DISCLOSE THE SEXUAL ABUSE</td>
<td>36</td>
</tr>
<tr>
<td>3.10 CARE FOR THE CAREGIVERS</td>
<td>36</td>
</tr>
<tr>
<td>3.11 IS THE CHILD SCHOOL GOING?</td>
<td>36</td>
</tr>
<tr>
<td>3.12 RECOMMENDATIONS FOR PARENTS WITH CHILDREN SHOWING SEXUAL BEHAVIOR PROBLEMS</td>
<td>37</td>
</tr>
<tr>
<td>3.13 CHALLENGES IN CHILD COUNSELLING</td>
<td>37</td>
</tr>
</tbody>
</table>
CHAPTER FOUR: MEDIA COMPONENT ................................................. 38
4.1 ACCURATE REPORTING .................................................. 40
4.2 PUBLIC AWARENESS ..................................................... 40
4.3 PRINCIPLES FOR ETHICAL REPORTING ON CHILDREN .......... 40

CHAPTER FIVE: THE ROLE OF THE POLICE IN CHILD SEXUAL ABUSE .... 43
5.2 INVESTIGATING CHILD SEXUAL ABUSE .................................. 45
5.3 SEXUAL OFFENCES EXTRACTED FROM THE PENAL CODE CHAPTER 87
OF THE LAWS OF ZAMBIA .................................................. 46
5.4 THE FOLLOWING PROCEDURE MUST BE ADHERED TO IN THE OPENING
OF A CASE DOCKET ....................................................... 47
5.5 EVIDENCE .................................................................. 48
5.6 PROTECTING YOUR CASE ................................................. 48
5.7 CHILDREN'S FIRST DOCTRINE ....................................... 48
5.8 FORMAT OF A STATEMENT .............................................. 49
5.9 TAKE CONTROL OF SCENE OF CRIME ................................ 50

CHAPTER SIX: THE LEGAL COMPONENT ..................................... 51
6.1 WHO IS A CHILD IN ZAMBIAN LAWS? ............................... 53
6.2 THE REPUBLICAN CONSTITUTION AND CHILDREN'S RIGHTS ...... 53
6.3 AMENDMENTS IN THE LAWS ........................................... 54
6.4 HOW TO TREAT CHILDREN WHO ARE WITNESSES .............. 54
6.5 WHISTLE BLOWERS AND THEIR PROTECTION .................... 54
6.6 CHALLENGES ON CHILD SEXUAL ABUSE IN ZAMBIAN LAWS ..... 54
6.7 CHILD RELATED LAWS ................................................... 55
6.8 INTERNATIONAL LAW INSTRUMENTS AND CHILDREN .......... 55
6.9 RATIFICATION AND DOMESTICATION OF INTERNATIONAL LAW INSTRUMENTS ................................. 55
6.10 THE LAW OF EVIDENCE ................................................. 56
6.11 WHAT IS CORROBORATION? ............................................. 56
6.12 HOW TO DEAL WITH CHILD OFFENDERS ............................ 56
6.13 REPORTING CHILD SEXUAL ABUSE ................................... 56
6.14 HOW TO PRESERVE EVIDENCE ....................................... 56
6.15 WHAT IS A CONFESSION? ............................................... 57
6.16 STEPS TO THE ADMISSION OF EXHIBITS AND EVIDENCE ...... 57
6.17 THE SENSITISATION OF PEOPLE AND THEIR ROLES .......... 58
6.18 THE LAW AND DNA TESTS ............................................ 58
6.19 REPORTING ABOUT CHILDREN ....................................... 58
6.20 LACK OF ADVOCACY FOR CHILD FRIENDLY LAWS ............. 59

APPENDICES .................................................................................. 60
APPENDIX 1: PSYCHO-SOCIAL SEXUAL DEVELOPMENT .................. 63
APPENDIX 2: BEHAVIORS RELATED TO SEX AND SEXUALITY IN
PRE-SCHOOL CHILDREN .................................................... 64
APPENDIX 3: GUIDELINES FOR RESPONDING TO CHILDREN WHO ARE
ENGAGING IN SEXUAL BEHAVIOR ....................................... 64
APPENDIX 4: THE AMENDED PENAL CODE .................................. 64

REFERENCES ................................................................................. 66
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA</td>
<td>CHILD SEXUAL ABUSE</td>
</tr>
<tr>
<td>JHPIEGO</td>
<td>JOHNS HOPKINS PROGRAM FOR INTERNATIONAL EDUCATION IN</td>
</tr>
<tr>
<td></td>
<td>GYNECOLOGY AND OBSTETRICS</td>
</tr>
<tr>
<td>UTH</td>
<td>UNIVERSITY TEACHING HOSPITAL</td>
</tr>
<tr>
<td>VSU</td>
<td>VICTIM SUPPORT UNIT</td>
</tr>
<tr>
<td>ZASPCAN</td>
<td>ZAMBIA SOCIETY FOR THE PREVENTION OF CHILD ABUSE AND</td>
</tr>
<tr>
<td></td>
<td>NEGLECT</td>
</tr>
</tbody>
</table>
ACKNOWLEDGMENTS

ZASPCAN would like to thank the following people for their efforts in the collection and gathering of information that was used in the formulation of this manual:

Dr Mwaba Kaseke-Bota  
Dr. Thomas M. Kapakala  
UTH Paediatrics Unit  
Superintendent Trespord Kasale VSU  
Mr. Tutwa Ngulube LRF  
Mr. Augustine Mukuka  
MRS. Violet Bwalya  
UTH Family Support Unit  
Mr. Kabanda Sampa UTH One Stop Centre

Thanks are also extended to:

Dr. Chipepo Kankasa Clinical Director UTH Paediatrics  
Dr. Christine Kaseba-Sata Head of Department UTH Obstetrics/ Gynaecology Superintendent Peter Kanunka of the VSU  
Ms. Chimuka Hamudulu  
Ms. Theresa K. Kabeka  
Ms. Linda G. Malulu ZASPCAN  
Ms. Mafunase Mako

Special thanks are also extended to the former Director General of Central Board of Health, Dr. Ben Chirwa, for the enduring support during the Multidisciplinary training workshop.

We also wish to thank the General Membership of ZASPCAN for the enduring support and commitment.

Lastly, we wish to recognize the following ZASPCAN Board Members for their valuable input towards the development of the Manual:

Dr. Christopher Mazimba JHPIEGO.  
Mr. Scott Robertson CARE Zambia

For and behalf of ZASPCAN,

Dr. Elwyn Chomba  
BOARD CHAIRPERSON
PREFACE

The United Nations Convention of the Rights of the Child (U. N. Doc A/44/49/1989) in Article 34 states: "State Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse". This is not happening in most African countries, including Zambia. Child sexual abuse, in and out of the family, is increasing at an alarming rate. Child sexual abuse violates children's rights and causes immediate and long-term health problems for the child. With the advent of HIV, the risks become life-threatening.

This manual has been developed as a guide to all those who are tasked to protect and manage sexually abused children with a focus on the following disciplines:

- Medical
- Mental
- Child protective services
- Law enforcement
- Prosecution
- Victim advocacy

Zambia Society for Prevention of Child Abuse and Neglect (ZASPCAN) which is a society of professionals and individuals have undertaken the task for producing this manual to coordinate the prevention and management of child abuse and neglect in Zambia. ZASPCAN was formed and registered as an NGO in January 2004. Some of the information appears in more than one chapter to facilitate easier references for each of the professionals listed.

ZASPCAN welcomes feedback, comments, and suggestions for future editions. This manual will be subject to revision and editing as Zambia gains more insight to the dynamic field of managing child sexual abuse.
CHAPTER I

DIAGNOSIS OF CHILD SEXUAL ABUSE
1.1 CHILD SEXUAL ABUSE - DEFINITION

Child sexual abuse 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.

Child sexual abuse 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. The sexual act can be divided into penetrative and non-penetrative and this may include but not limited to:

- 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).

Child sexual abuse includes:

- Actual or attempted penetrative sexual
- Intercourse with a child; or oral sex with a child, i.e. mouth to sexual parts;
- 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;

Child Sexual Abuse has been in existence since time immemorial. Child sexual abuse occurs in all societies as well as all social structures. Given the high prevalence (16.3%) of HIV/AIDS in Zambia (Zambia Sentinel Survey 2003), child sexual abuse should be addressed seriously (according to a WHO statement 1 in 4 girls is likely to suffer some sexual abuse). It has been difficult to quantify the magnitude of child sexual abuse throughout the world including Zambia as most cases are unreported. This is because most child sexual abuse occurs within families and committed by people well known to the child.

1.2 RISK FACTORS IN CHILD SEXUAL ABUSE

There are a number of factors that make children vulnerable to sexual abuse. The key determinants are:

(i) Increased number of orphans:

Zambia has one of the highest 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 homes or orphanages where it is not uncommon to be sexually abused. Some are taken in by relatives or find themselves in child-headed homes where they are often forced to trade sex for money, food or abused their caretakers.

(ii) Female sex - The most common cases of child sexual abuse in Zambia are that of a girl child by an adult man accounting for over 95% (UTH One Stop Centre Statistics) with a few between adult woman with an under age boy.

(iii) HIV pandemic resulting in loss of parents has forced children into prostitution.

(iv) 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 increased reported cases of child abuse by stepfathers.

(v) The loss of control by the mother in homes where there is no father figure has increased number of reported cases of child sexual abuse.

(vi) Children whose parents suffer from mental illness or drug dependency have an increased risk of being sexually abused

(vii) War/ armed conflicts: Sexual abuse has been reported to be rampant in communities engaged in wars and armed conflicts.

(viii) Children who are mentally impaired are more likely to be sexually abused and the abuse may not be detected until the child presents with pregnancy

Child Sexual Abuse 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 literate people and the illiterates.

1.3 PERPETRATORS OF CHILD SEXUAL ABUSE

Perpetrators of child sexual abuse could be:

Family members (intra familial)
- Parents
- Uncles/Aunties
- Grandparents
- Cousins
- Brothers/Sisters
Community members (extra familial)
   Neighbors
   Teachers
   Clergymen
   Strangers

Sexual abuse can be perpetrated by anyone

1.4 OTHER DEFINITIONS OF SEXUAL ABUSE

RAPE happens when a person has sex that he or she didn't agree to. It includes intercourse in the vagina, anus or mouth. Sometimes it happens when one 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) without 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.

1.5 MYTHS AND MISCONCEPTIONS PEOPLE HAVE ON CHILD SEXUAL ABUSE

There are a number of myths and misconceptions about child sexual abuse. It is important to be aware of such myths and to educate people and society alike. Provided below are some of the commonly held myths and misconceptions:

"The abuser is usually a stranger"
False: Up to 90% of the time, the abuser is known to the victim.

"Incest is not common among civilized people. Drunks and deviants do it, but never families."
False: Incest happens in all types of families, irrespective of class, race, economic status, nationality and religion. The saddest thing about incest is that the child is not safe in the one place he or she should feel safe, and that is in the home.

"Sexual abuse never happened and the child is making it up."
False: Society generally does not want to accept that this happening to the children and prefers to pretend that children are making it up. The fact that adults do not believe them is the most difficult problem children face. Note that children often fantasize about positive events, but they rarely make up stories about severely traumatic events.

"Men molest children when their wives are not satisfying them sexually."
False: Sexual abuse is more often about power and control than simple sexual gratification. As such, 'satisfaction' is not the issue.

"Many children do not report sexual abuse because they are enjoying it."
False: Children do not report sexual abuse for a number of reasons that may include fear, shame, or anxiety. The child is also, very often, sworn to secrecy, threatened, bribed, or blamed.

"No damage is done by sexual abuse if the child is not physically harmed."
False: Pregnancy, sexually transmitted infections, and genital trauma may be physical results of sexual abuse. A child who has been abused may also suffer psychological trauma.

"Some children are seductive and cause adults to be sexually aroused."
False: Adults who are sexually aroused by children and who act on this arousal are confused about their own sexuality and are not able to exercise a socially acceptable level of control over their own sexual behavior.

"My child who was sexually abused seems fine and does not need counseling."
False: All sexually abused children need to be assessed and treated by professionals. If they are not attended to, there may be major problems later on in the child's life.

"All homosexual men molest and sexually abuse young boys."
False: The sexual attraction of men to other men is distinct from the attraction of men to young boys.

"HIV patients become negative after they have sex with a virgin."
False: Men who are positive when they have sex with a virgin will just infect them. The risk to transmit the virus to a virgin is much higher when she has sex for the first time.
1.6 PREVENTION OF CHILD SEXUAL ABUSE

It is the responsibility of individuals, families and the community to protect children against child sexual abuse. Prevention of child sexual abuse lies in minimizing and mitigating circumstances of potential risks. Parents and Caretakers should:

- Educate children on their rights, and child sexual abuse and its dangers
- Ensure that children are in the protection of adults especially at night
- Encourage same sex cleaning of children e.g. mothers or maids bathing or changing the girls clothes etc.
- Avoid having adults share sleeping rooms with children especially men sleeping in the same room with girl children
- Ensure that children watch developmentally appropriate Television programmes
- Monitor your children’s use of cell phones and internet
- Encourage free dialogue with children
- Parents to spend some time with their children as much as possible
- Provide a safe, caring environment

*Parents should talk to their children about the difference between good touch and bad touch. Tell the child that if someone tries to touch his or her body and do things that make the child feel uncomfortable, he or she should say NO to the person and tell you about it right away. Let children know that they have the right to forbid others to touch their bodies in a bad way. Alert your children that perpetrators may use the Internet, and monitor your children’s access to online websites.*

1.7 MULTI-DISCIPLINARY MANAGEMENT OF CHILD SEXUAL ABUSE

Abused children benefit when professionals coordinate their efforts to investigate cases and protect the children involved. A multi-disciplinary management approach does not require a formal center.

It does require that the professionals make efforts to communicate from the earliest opportunity, coordinate investigations, limit repeat interviews by different agencies and by multiple interviewers, and continue to share information throughout the duration of the case.

All agencies involved in the investigation of child abuse are encouraged to use a multi-disciplinary case management approach whenever possible.

The goal of this approach is to reduce trauma to the child, improve coordination of service delivery, ensure forensic defensibility of services [i.e. medical and interview components], and enhance the courts’ ability to protect communities.

Multi-disciplinary team (MDT) professionals should view their function as part of a team. The team must consist of three or more people and usually includes, but is not limited to, a police officer, social worker (Ministry of Community Development) and a medical professional. While the individual effort of each professional is crucial, the child benefits most when all professionals coordinate with each other.

The team should identify one member to conduct the primary forensic interview with the child. Preference should be given to a trained professional. Thereafter, one member should be identified and act as “primary case manager” who in most cases is the social worker. This promotes efficiency and ensures quality case management.

In areas where its not possible to have a multi disciplinary team meet at the same time, or a multidisciplinary team approach is not feasible, all agencies should try to keep the number of interviews to the minimum possible so as reduce trauma to the child victim to the extent possible.

Social Workers (Social Welfare Staff)

Social workers assume responsibility for child protective services. Social workers are vested with the responsibility of investigating (with the police) allegations of child abuse, neglect, abandonment, exploitation, and caretaker incapacity.

In addition, the social worker has responsibility for determining whether a child should be separated from his or her parents or guardians. In places where MDT is established, the social worker may take the leading role of case manager and coordinating all the other disciplines involved in case management.

Law Enforcement

Law enforcement services are provided by the Victim Support Unit (VSU) of the Police Service. The VSU is mandated by law to receive reports of child abuse and to take action when they learn that a child under age 16 is the victim of suspected child abuse or neglect. To fulfill their investigatory role, they are required to work with the social welfare (social worker) and the health worker to ascertain the possibility of abuse, ensure continued safety from the time the abuse is discovered or reported and to pursue successful prosecution of the abuse cases.

Medical Professionals

Medical professionals are responsible for providing a comprehensive examination of a child and to treat any physical illness or injury the child may suffer. They also collect critical forensic evidence, both visually and physically, to help corroborate the child’s account of the abuse or neglect.

Moreover, medical professionals who provide services to abused children must perform additional tasks mandated by the state, and they must be available to testify to their findings in court.
CHAPTER II

MEDICAL COMPONENT
2.1 GENERAL

The healthcare providers are in a unique position to identify and respond to child sexual abuse.

For most abused children the healthcare facility is their first and frequently only contact with the system that provides intervention and support.

A child may present to the facility alleging sexual abuse or for other ailments not obviously related to sexual abuse. It is therefore important to recognize that children may present with a variety of medical ailments some of which may or may not be related to sexual abuse. Medical management should therefore be tailored to immediate treatment of life threatening conditions and any other medical complications which maybe present. For treatment of such conditions, follow standard national treatment guidelines.

The medical professional must establish a comfortable, reassuring and a trusting atmosphere for the child. Providing you are at ease in carrying out the interview and physical examination, and you do not display emotions such as shock or disgust, the child is likely to accept this as yet one more medical examination which s/he may even find to be an interesting experience.

The medical interview will normally take place in a medical setting which most children will recognize as such. Many who have been recently physically hurt by the abuse will recognize it as not unnatural to be brought to a medical facility. Previous experience of health care may well determine whether this will lead to added fear or distress from what has happened. It will be best to complete the medical component (including physical examination of the child) before proceeding with a more detailed forensic interview, if this is indicated.

2.2 IDENTIFICATION (MEDICAL HISTORY)

The function of the medical or health history is to find out why the child is being brought for health care at the present time and to obtain information about the child’s physical or emotional symptoms. It also provides the basis for developing a medical diagnostic impression before a physical examination is conducted. The medical history may involve information about the alleged abuse, but only in so far as it relates to health problems or symptoms that have resulted there from, such as bleeding at the time of the assault, or constipation or insomnia since that time. The medical history should be taken by a health professional.

It is important for the health worker to create a safe and trusting environment for the interview and examination.

All children should be approached with extreme sensitivity and their vulnerability recognized and understood.

Older children will expect to be asked about their symptoms but it will be important to try to establish a neutral environment and rapport with the child before beginning the interview.

Try to establish the child’s developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time and that they may use terminology differently to adults making interpretation of questions and answers a sensitive matter.

When planning investigative strategies, consider other children (boys as well as girls) that may have had contact with the alleged perpetrator. For example, there may be an indication to examine the child’s siblings. Also consider interviewing the caretaker of the child, without the child being present.

The highest priority for the examiners should be:

- Patients safety
- Patients comfort
- Quality of care

2.3 COMBINING A FORENSIC (INVESTIGATIVE) ELEMENT

The medical interview is a critical component of the diagnostic, legal and remedial aspects of child sexual abuse. Because specific medical evidence of sexual abuse is often lacking and there are no eye witnesses, the child’s verbal statements describing abuse and the questions used to elicit these statements will be carefully scrutinized during any judicial process.

1. The medical interview in our environment often serves as the forensic interview.

2. The medical interview should provide specific details from the children in regard to what happened to their bodies.

3. Medical Interviews for abuse are conducted in a variety of circumstances:
   - When a preliminary finding of sexual abuse has been established and greater substantiation is required
   - Child’s behaviour or physical symptoms raise suspicion of CSA
   - When reports of sexual abuse arise unanticipated during an examination for another presenting complaint

2.4 DURING HISTORY TAKING

1. Begin the interview by asking open-ended questions, such as “Why are you here today?” or “What were you told about coming here?”

2. Assure the child it is okay to respond to any questions with “I don’t know”.

16
Be patient, go at the child’s pace; don’t interrupt his/her train of thought.

4. Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details.

5. The dynamics of sexual abuse in children is generally different from adult abuse.

For example, there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- The home situation (has the child a secure place to return to?)
- How the abuse was discovered?
- The number of incidents and the date of the last incident.
- Was there any bleeding, did (s)he have difficulty walking?

### 2.5 EVIDENCE COLLECTION

Evidence is collected at the same time as when performing the examination. The purpose of gathering evidence is:

1. To confirm recent sexual contact
2. To show that force or coercion was used
3. To possibly identify the assailant (if DNA testing is done)
4. To corroborate the victim’s story

*The evidence should be collected as soon as possible after the incident, optimal within 72 hours (Refer to forensic collection in Chapter 5)*

Documenting injuries and collecting samples of different materials such as blood, hair, sperm, etc. within 72 hours of the incident may help to corroborate the victim’s story and might help to identify the aggressor(s). If the victim presents more than 72 hours after the sexual abuse, the amount and type of evidence that can be collected will depend on the situation.

### 2.6 DOCUMENTING THE CASE

The interview and the findings of the examination should be recorded in a clear, complete, objective and non-judgmental way.

A complete assessment together with the physical and emotional state of the victim should be documented. Important statements made by the victim such as threats made by the assailant should also be documented. The medical officer should not be afraid to include the name of the assailant, as long as qualifying statements such as “the patient states” or “the patient reports” are used. Use of the term “alleged” should be avoided as the victim can interpret it as meaning the victim is exaggerating or lying. All the medical and forensic samples taken should be noted down.

### 2.7 THE PHYSICAL EXAMINATION

Physical examination goes hand in hand with evidence collection.

A young child should normally be examined in the presence of the parent or guardian who will be able to help in reassuring the child, especially if any examination needs to be conducted which involved discomfort. With an older child, s/he may prefer a nurse to be present, rather than the parent. Ensure there is a support person or trained health worker in the examining room who is the same sex as the victim. Before proceeding, ensure that you explain to the child and the caregiver on what you are going to do. Ask whether the child would mind to be touched by the Clinician. If the child minds, find out why he/she doesn’t want to be touched. It may be possible to address some of the child’s fears and anxieties (e.g. a fear of needles) or potential sources of unease (e.g. the sex of the examining health worker). Many health workers have a tendency to give instructions rather than eliciting the cooperation of their patients during the physical examination. Instead of saying “May I now look at where it hurts” they say “just take off your panties so that I can see what is wrong” – the exaggeration makes the point.

Encourage the child to ask questions about anything he/she may be concerned about or does not understand at any time during the examination.

If the child has pain and cannot relax for that reason during examination, give paracetamol or other simple painkillers to relieve pain and wait for the drugs to take effect.

*In rare cases when the child is highly agitated and examination is vital ONLY if the child cannot be calmed down, AND ONLY IF within 72 hours of an abuse, AND evidence collection or treatment is vital should the examination be performed under sedation, using Diazepam, tablet 2mg or 5mg by mouth. Diazepam does not provide pain relief. If you think the child is in pain, give simple pain relief first, such as paracetamol; 1–5 years: 120 – 250mg, 6-12 years: 250 – 500mg, and wait for this to take effect. Oral sedation will take 1 to 2 hours to take full effect – in the meantime allow the children to rest in a quiet environment.*

The physical examination of children should consist of a head-to-toe review plus a detailed inspection of the whole body including the genito-anal area. Examine the victim’s clothing with a good light source before she/he undresses.
Collect any foreign debris on clothes, skin or in the hair (e.g. soil, leaves, grass, and foreign hairs). The child can be asked to undress while standing on a paper sheet (provide a gown). Collect torn and stained items of clothing, but only do so if you can give her replacement clothes or if she has some other clothes.

When performing the head-to-toe examination of children it will be important to include all the following:

- Record the height and weight of the child (neglect may co-exist with sexual abuse).
- Note any bruises, burns, scars or rashes on the skin. Carefully describe the size, location, pattern and colour of any such injuries.
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum.
- Check for any signs that force and/or restraints were used, particularly around the neck and in the extremities.
- Record the child's sexual development (Tanner) stage and check the breasts or signs of injury.
- Collect samples from all places where there could be semen on the skin, with the aid of a cotton bud swab, lightly moistened with sterile water, the victim's pubic hair may be combed for foreign hairs.
- Take samples and swab the oral cavity if ejaculation took place in the mouth, for direct examination for sperm, and acid phosphatase analysis. Take blood, for Syphilis, Hepatitis B and HIV test urine sample in case of bladder bleeds etc if indicated.

2.7.1 Inspection of the anus, perineum and vulva

Inspect and swab the skin around the anus, the perineum and vulva (in that order) with cotton-tipped swabs moistened with sterile water

2.7.2 Maintaining the chain-of-evidence

It is very important to maintain the chain-of-evidence at all times, so the evidence will be admissible in court. Maintaining the chain-of-evidence requires that the evidence is collected, labeled, stored and transported properly.

Documentation must include a signature of everyone who had possession of the evidence, from the individual who collected it to the individual bringing the evidence to the courtroom, to prevent any possibility of tampering.

If it is not possible to bring the samples immediately to a laboratory, precautions must be taken.

All samples should be clearly labeled with an identifier, date, time, and type of sample (e.g. what it is, from which location it was taken) and put in a container.

Seal the bag or container with paper tape cross the closure of the container – again write the identifiers and the date and sign your initials across the tape.

2.7.3 Genito-Anal examination

In order to conduct the genital examination in girls, it is helpful to ask the child to lie supine in the frog-leg position, and/or, if comfortable, in the knee chest position. A good light source is essential.

Look for any sign of infections, such as ulcers, vaginal discharge or warts. In the prepubertal girl, vaginal specimens can be collected with a dry cotton sterile swab.

Examinations of most children with substantiated abuse are normal, in which case the definite diagnosis of sexual abuse will rely on good history taking.

THE MEDICAL EXAMINATION

In girls, the external genital structures to be examined are the:

- mons pubis;
- labia majora and labia minora;
- clitoris;
- urethra;
- vaginal vestibule;
- hymen;
- fossa navicularis;
- posterior fourchette.

Digital examination (assessing the size of the vaginal orifice by the number of digits inserted) is NOT recommended.

The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.

In most cases, the hymen and surrounding structures will be easily identified. If not, the following technique may be useful for assisting in the visualizing of the hymen and surrounding structures to check for signs of injury:
Separate the labia with gentle lateral movement or with anterior traction (i.e. by pulling labia slightly towards examiner);

After forewarning the child, gently drop a small amount of warm water on the structures; this may cause the structures to “unstick” and become more visible;

Ask the child to push or bear down.

Describe the location of any injuries using the face of a superimposed clock, paying close attention to the area between 4 and 8 o’clock, the most probable location of a penetrating injury.

Most examinations in pre-pubertal children are non-invasive and should not be painful. Speculums or proctoscopes and digital or bimanual examinations do not need to be used in child sexual abuse examinations unless medically indicated. If a speculum examination is needed, sedation or anaesthesia should be strongly considered.

If indicated by the history and the rest of the examination, do a bimanual examination and palpate cervix, uterus, and adnexae, looking for signs of abdominal trauma, pregnancy and infection.

Record the position of anal fissures or tears on the pictogram.

Digital examination to assess anal sphincter tone is NOT recommended

2.8 GENITAL ANAL FINDINGS

In practice, clear physical findings of sexual abuse are seldom seen in children because child sexual abuse rarely involves physical trauma. Many studies have found that normal and non-specific findings are common in sexually abused prepubertal girls. A genital examination with normal findings does not, therefore, preclude the possibility of sexual abuse; moreover, in the vast majority of cases the medical examination will neither confirm nor refute an allegation of sexual assault.

Physical genito-anal findings are listed below, grouped according to their strength of evidence for sexual abuse and ranging from normal to definitive.

Normal And Non-Specific Vaginal Findings Include:

- hymeneal bumps, ridges and tags;
- v-shaped notches located superior and lateral to the hymen, not extending to base of the hymen;
- vulvovaginitis;
- labial agglutination.

Normal And Non-Specific Anal Changes Include:

- erythema;
- fissures;
- midline skin tags or folds;
- venous congestion;
- minor anal dilatation;
- Lichen sclerosis.

Anatomical variations or physical conditions that may be misinterpreted or often mistaken for sexual abuse include:

- Lichen sclerosis;
- vaginal and/or anal streptococcal infections;
- failure of midline fusion;
- non-specific vulva ulcerations;
- urethral prolapse;
- unintentional trauma (e.g. straddle injuries)
- labial fusion (adhesions or agglutination)
Findings Suggestive Of Abuse Include:

- acute abrasions, lacerations or bruising of the labia, perihymenal tissues, penis, scrotum or perineum;
- hymenaeal notch/cleft extending through more than 50% of the width of the hymenal rim;
- scarring or fresh laceration of the posterior fourchette not involving the hymen (but unintentional trauma must be ruled out);
- condyloma in children over the age of 2 years;
- Significant anal dilatation or scarring.

Findings That Are Definitive Evidence Of Abuse Or Sexual Contact Include:

- sperm or seminal fluid in, or on, the child's body;
- positive culture for N. gonorrhoea or serologic confirmation of acquired syphilis (when perinatal and atrogenic transmission can be ruled out);
- Intentional, blunt penetrating injury to the vaginal or anal orifice.
- Pregnancy

Note: Straddle injuries are the most common type of unintentional injury involving the genitalia and arise when soft tissues of the external genitalia are compressed between an object and the pubic bone resulting in a haematoma of the external structures with visible swelling and some pain in the anterior portion of the external genitalia.

Sometimes small linear abrasions are seen on the labia majora and minora, as well as at the posterior fourchette. It is extremely unlikely that a straddle injury will cause damage to the hymenial membrane. Straddle injuries are typically asymmetric or unilateral.

2.8.1 Labial Fusion

Labial fusion is a reasonably common condition and is caused by minor chronic inflammation. It may be caused by sexual abuse, but the finding is not diagnostic of abuse. In most cases, no treatment is necessary but if the adhesions are extensive, treatment with estrogen cream is usually successful. Surgical treatment for labial fusion is rarely indicated.

Female adolescent victims of sexual assault are less likely to show signs of acute trauma or evidence of old injuries than pre-pubertal girls. During puberty, the female genital tissues, especially in the hymenal area, become increasingly thick, moist and elastic due to the presence of estrogen and therefore stretch during penetration. Furthermore, tears in the hymen may heal as partial clefs or notches that will be very difficult to distinguish in an estrogenized, redundant or fimbriated hymen. Even minor injuries, such as abrasions in the posterior fourchette, will heal almost immediately.

Signs of major trauma, i.e. lacerations, to the anal orifice are very rarely observed. Minor injuries may sometimes be seen and typically include anal erythema, abrasions or fissures. In the vast majority of cases, there are no visible signs of trauma to the anal area.

Treatment

The child should be treated according to the findings. Life threatening emergencies should be attended to as a matter of urgency.

2.9 SEXUALLY TRANSMITTED INFECTIONS

The epidemiology, diagnosis and transmission modes of STIs in children differ from those in adults; age-appropriate diagnostic tests are thus required and treatment prescribed.

There are a number of ways in which children and adolescents can become infected by sexually transmitted organisms, including:

- In utero (vertical) transmission (e.g. HIV, syphilis);
- perinatal acquisition via cervical secretions (e.g. gonorrhoea, Chlamydia);
- Human papilloma virus (HPV), herpes simplex virus (HSV);
- Direct contact with infected secretions as a result of sexual abuse, consensual sexual abuse (adolescents), non sexual contact or forensic transmission (extremely rare).

2.9.1 STI Testing

The child should be tested for HIV, Syphilis and Hepatitis B (Hepatitis B is optional) at presentation. HIV testing should be treated with urgency as it is a determinant in PEP administration if child is HIV negative. A vaginal swab is also taken to check for gonococcal and trichomonas vaginalis infections.

When evaluating a child and the need for STI screening, it is important to bear in mind that if the sexual abuse occurred recently, STI cultures are likely to be negative, unless the child had a pre-existing STI. A follow-up visit 1 week after the last sexual exposure may be necessary in order to repeat the physical examination and to collect appropriate specimens for STI testing.

In pre-pubertal children, swabs for STIs are only indicated where symptoms (e.g. vaginal discharge, pain) are present.

Genital swabs in pre-pubertal children should be taken from the vaginal orifice or canal; cervical specimens are only required in adolescents (i.e. those at Tanner stage II of puberty or later), as adolescents may have asymptomatic infections.
2.9.2 Treatment of STIs

Presumptive treatment of children who have been sexually abused is not recommended. Children and adolescents who test positive for a sexually transmitted infection should be treated as shown in Table 2.2.

TABLE 2.1 Children and Sexually Transmitted Infections: Diagnostic Infections

<table>
<thead>
<tr>
<th>STI</th>
<th>NOTES AND COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>Chlamydia can be acquired perinatally, but if diagnosed in the second year of life, it is most likely to be sexually acquired. Nucleic acid amplification (NAA) examination by two separate test methods targeting different parts of the genome should be employed and repeated as necessary according to jurisdictional requirements. If this is not possible, enzymeimmuno-assays tests should be used.</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Gonorrhea infections outside the immediate neonatal period can be attributed to sexual abuse. Cultures of Gonorrhea are rarely positive in prepubertal children without signs or symptoms of vaginitis. Culture via direct inoculation, under optimal conditions, is the gold standard for diagnosis.</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Serologic testing should be completed if child has not received the HBV vaccine.</td>
</tr>
<tr>
<td>HIV</td>
<td>There are some documented cases of HIV and AIDS transmission via sexual abuse in children. HIV screening for all sexual abuse victims should be offered in high prevalence areas. Screening should be done at 3, 6 and 12 months following the abuse.</td>
</tr>
<tr>
<td>HPV</td>
<td>Perinatal exposure is common. Many cases of genital warts have been shown to be sexually acquired. Non-sexual transmission has been postulated. Many unanswered questions regarding HPV epidemiology in children remain and therefore, although sexual abuse should be considered as possible etiology, caution is advised during investigation. Detection is by cellular morphology or direct detection of HPV DNA.</td>
</tr>
<tr>
<td>HSV Type I</td>
<td>Type I is a common universal infection transmitted by close bodily contact such as kissing. It causes sores in the mouth and lips. Type I is rarely causes genital infections.</td>
</tr>
</tbody>
</table>

STI       NOTES AND COMMENTS

HSV Type II Type II is transmitted predominantly through sexually contact with an infected individual shedding virus. Vertical transmission occurs if delivery takes place concurrently with the presence of sores in the mother's genital tract. Standard laboratory diagnosis alone is by inoculation of cells in the tissue culture with infected secretions. Clinical diagnosis alone is not sufficient.

Syphilis Considered being proof of sexual abuse unless shown to be acquired congenitally.

Syphilis Considered being proof of sexual abuse unless shown to be acquired congenitally.

Diagnosis is by dark field microscopy from Diagnosis is by dark field microscopy from a primary chancre or secondary lesion, or by serological tests on serum Trichomoniasis found rarely in prepubertal girls. In adults and adolescents it is almost always sexually transmitted.

HIV= human immunodeficiency virus; HPV= human papilloma virus; HSV= herpes simplex virus.

SEE TABLE 2.2 ON THE NEXT PAGE

2.10 HIV AND POST-EXPOSURE PROPHYLAXYS

All children who to the health centre within 72 hours of the sexual abuse should be offered the HIV test as urgently as possible. The children found to be HIV negative offered post exposure prophylaxis of HIV. PEP has been found to be effective when started within 2 hours to 72 hours of the sexual abuse. Table 2.3 below shows the regimen and the doses for PEP.

Table 2.3

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>ADMINISTRATION &amp; DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (AZT)</td>
<td>240 mg/m² Bd 28/7</td>
</tr>
<tr>
<td>Lamivudine (3TC)</td>
<td>4mg/kg Bd 28/7</td>
</tr>
<tr>
<td>Nelfinavir</td>
<td>2-13 years 30 mg/kg per dose twice a day</td>
</tr>
<tr>
<td></td>
<td>&gt;13 years 60 mg/kg per dose twice a day</td>
</tr>
</tbody>
</table>

Source: University Teaching Hospital (UTH) Paediatrics Unit
<table>
<thead>
<tr>
<th>STI</th>
<th>MEDICATION</th>
<th>ADMINISTRATION &amp; DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td>Cefixime</td>
<td>&gt;12 years 400 mg</td>
</tr>
<tr>
<td>orally per dose</td>
<td></td>
<td>&lt;12 years 8 mg/kg</td>
</tr>
<tr>
<td>body weight orally per dose</td>
<td>Ciprofloxacin</td>
<td>&lt;12 years 5mg/kg</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Azithromycin</td>
<td>&lt;3 years 10 mg/kg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Taken once daily for 3 days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3-7 years 5 iu/stat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8-11 years 7.5 iu/s</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12-14 years 10 iu/s</td>
</tr>
<tr>
<td></td>
<td>Erythromycin</td>
<td>40mg/kg/day</td>
</tr>
<tr>
<td>Trichomoniasis and Bacterial vaginosis</td>
<td>Metronidazole</td>
<td>1-3 years 50 mg tds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3-7 years 100 mg Bd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7-10 years 100mg tds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>over 10 yrs adult dose</td>
</tr>
<tr>
<td>Note: Metronidazole is not recommended for children less than 1 year. Also not recommended as a single dose.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>Benzathine Penicillin</td>
<td>Newly born – 2 years 50,000 iu/kg/dose</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2-5 years - 600,000 iu/stat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6-12 years 1.2 million iu/stat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>=13 years 2.4 million iu/stat</td>
</tr>
</tbody>
</table>
Children on PEP should be reviewed after 1 week of taking PEP and at 28 days. It is important to have these children followed up to 6 months so as to allow the determination of HIV status at 6 months.

2.11 PREGNANCY TESTING AND MANAGEMENT

Any child over 12 years and any post menarche children should be offered the pregnancy test at presentation and after 28 days. Children found to be pregnant should be referred to the Obstetrician with the relevant information highlighted.

Those that are negative should be given emergency contraception also known as the morning after pill if the abuse took place within 72 hrs as per table 2.4.

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Pills to swallow</th>
<th>Number of pills to swallow 12 hours later</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postinor Levonorgestrel 750 microgram</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PC4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Oral Combined Pills (e.g Microgynon, Safe Plan etc)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Oral Progesterone only pills (e.g Microlut)</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

This process is greatly assisted by the use of a classification system for the range of physical, laboratory and historical information that is obtained in cases of alleged child sexual abuse. Table 2.5 on the next page illustrates the use of one such a system, developed by Adams in which both physical examination findings and other data (i.e. statements from the child, observed behavioural changes and laboratory findings) are used collectively in order to make an overall assessment of the likelihood or otherwise of sexual abuse.

In some cases, physical findings alone will confirm abuse; for example, penetrating trauma to the hymen without an explanation. In others, forensic findings, such as sperm on a child’s body will be sufficient to make the diagnosis. Alternatively, in the absence of physical findings (i.e. negative or non-specific findings) the diagnosis of abuse can be made on the basis of the child’s statement or that of an eye-witness to the abuse.

2.13 FOLLOW-UP TREATMENT

Because physical findings are rare in cases of child sexual abuse, a follow-up examination may not be necessary especially if there were no findings in the initial evaluation. If, however, findings were present at the time of the initial examination, a follow-up examination should be scheduled.

The timing of follow-up examinations sometimes may dependent on the nature of the injuries and the conditions being treated and health care workers are advised to use their own judgement when determining how soon after the initial visit a follow-up examination should be done. Otherwise the victims should be seen as per guidelines specified below:

2.13.1 Follow-up care of the victim

7 day follow-up visit

Evaluate for STIs, treat as appropriate, counsel on HIV testing.

Check for any side effects of PEP if started. Do adherence counseling.

Evaluate mental and emotional status; refer or treat as needed.

In a post menarche girl child, evaluate for pregnancy and provide counselling

One month follow up visit

Check for STIs, treat as appropriate.

Evaluate mental and emotional status; refer or treat as needed.

Evaluate for pregnancy.

NOTE: If a vaginal infection does not clear, consider the presence of a foreign body or continued sexual abuse.
<table>
<thead>
<tr>
<th>DIAGNOSTIC CONCLUSION</th>
<th>EVIDENCE</th>
</tr>
</thead>
</table>
| Definite abuse or sexual contact body. | Finding sperm or seminal fluid in, or on, a child’s body.  
Pregnancy  
Positive cultures for Neisseria gonorrhoeae  
Evidence of syphilis or HIV infection (outside perinatal products or trauma to the)  
contaminated needles)  
Clear evidence of blunt force or penetrating  
hymenal area (without history)  
Clear videotape or photograph of abuse or eye-witness of Abuse |
| Probable abuse | Positive cultures for Chlamydia trachomatis  
Positive cultures for HSV Type II  
Trichomoniasis infection (absence of perinatal transmission)  
Child has given spontaneous, clear, consistent and detailed description of abuse, with or abnormal or physical findings |
| Possible abuse combination | Normal or non specific physical findings in sufficiently with significant behavioural changes, especially sexualized behaviours  
HSV type 1  
Condylomata accuminata with otherwise normal examination  
Child made a statement but statement is not sufficiently detailed |
| No indication of abuse | No history, no behavioural changes, no witnessed abuse.  
Normal examination  
Non specific findings with the same as above  
Physical findings or injury consistent with history of unintentional injury that is clear and believable |
Three month follow-up visit
Evaluate for STIs, treat as appropriate.

Perform an HIV test if victim had earlier tested negative. If positive refer to ART centers.

Evaluate mental and emotional status; refer as needed.

Evaluate for pregnancy. (Pregnancy may be the result of a sexual abuse. All options available, e.g. keeping the child, adoption and abortion, should be discussed with the caretaker and the victim.

Six month follow-up visit
Evaluate for STIs, treat as appropriate. Possible voluntary counselling and testing for HIV if victim had tested negative. Reaffirm HIV negative status if negative and give further HIV prevention messages. If positive refer to ART centres. Evaluate mental and emotional status; refer as needed

Further follow-up examination is more as a psychosocial follow-up measure to ensure that the appropriate counseling referrals have been made and that there is adequate support for the child and family.

2.14 DOCUMENTATION AND REPORTING

SUMMARY

All consultations with patients must be documented in the form of hand-written notes, diagrams or body charts and, if appropriate, photography. Use of standard examination forms can greatly assist the process of documentation, and ensure that important details are not omitted.

All aspects of the consultation should be documented, including consents given; medical history; account of the abuse; outcome of the physical examination; samples taken; tests and their results; treatments and medications prescribed; and schedule of follow-up care and referrals.

In the interests of accuracy, notes should be made during the course of the consultation, rather than after.

Patient records are strictly confidential and should be stored securely.

Health workers may be required to comment on their findings in a written report and/or give evidence in court. If so required, health workers must ensure that their evidence is impartial and represents a balanced interpretation of their findings.

If not trained in medico-legal matters, health workers should confine their service to health care provision and documentation of findings, and leave the interpretation of physical and other observations to a suitably qualified expert.

In sexual abuse cases, documentation should include the following:

- Demographic information (i.e. name, age, sex);
- Consents obtained;
- History (i.e. general medical and gynaecological history);
- An account of the assault;
- Results of the physical examination;
- Tests and their results;
- Treatment plan;
- Medications given or prescribed;
- Patient education;
- Referrals given.

2.5 STORAGE AND ACCESS RECORDS

Patient records and information are strictly confidential. All healthcare providers have a professional, legal and ethical duty to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case or as required by local and national statutes.

All patient records (and any specimens) should be stored in a safe place. Biological evidence usually needs to be refrigerated or frozen; check with your laboratory regarding the specific storage requirements for biological specimens.

The Health Provider and Law Enforcement

It is beyond the scope of this document to deal with the specific obligations of health care practitioners in meeting the needs of the justice system. Generally speaking, however, the health worker would be expected to:

Be readily available;

Be familiar with the basic principles and practice of the policing and legal systems and obligations of those within the system, especially their own and those of the police, as it applies to their jurisdiction;

Make sound clinical observations (these will form the basis of reasonable assessment and measured expert opinion);

Reliably collect samples from victims of crime (the proper analysis of forensic samples will provide results which may be used as evidence in an investigation and prosecution).

Health workers may be called upon to give evidence, either in the form of a written report or as a witness in a court of law. When charged with this task, health care practitioners should be aware of the following pitfalls and potential problem areas:

Providing opinions which are at the edge of, or beyond, the expertise of the witness;

Providing opinions that are based on false assumptions or incomplete facts;
Providing opinions based on incomplete or inadequate scientific or medical analysis;

Providing opinions which are biased, consciously or unconsciously, in favour of one side or the other in proceedings.

Health workers should aim to convey the truth of what they saw and concluded, be it in a written report or to the court, in an impartial way, and ensure that a balanced interpretation of the findings is given should the court require this.

Health care workers providing medico-legal services to victims of sexual violence, in particular the more experienced practitioners, should be given training in this field.

### TABLE 2.1 PEP Flowchart

#### POST EXPOSURE PROPHYLAXIS (PEP) FLOWCHART

**Sexually abused child**

- **HIV +**
  - -72 hours Urgent PEP Treatment medical conditions
  - Give 7 day Course of PEP
  - Refer to HIV Clinic for further evaluation

- **HIV -**
  - +72 hours Treatment medical conditions

**Visit 1 (Day 14)**
- Assess side effects and PEP compliance. Give remaining 14 days of PEP

**Visit 2 (Week 1)**
- Assess side effects and PEP compliance

**Visit 3 (3 Months)**
- Repeat HIV test
Figure 2.2  Tanner's Development Stages

**The Adolescent Examination**

Tanner Stages of Secondary Sexual Development:

**Breast:**
- I: None
- II: Bud
- III: No contour
- IV: Secondary mound
- V: Mature breast

**Puberty: Male genital development**

**Stage 1**

**Stage 2**

**Stage 2**

**Stage 4**

**Stage 5**

**Tanner Stages of Secondary Sexual Development:**

- Pubic hair:
  - I: None
  - II: Sparse
  - III: Curly
  - IV: Abundant
  - V: Thigh
Notes on completing the Consent Form

Consent for an examination is a central issue in medico-legal practice. Consent is often called "informed consent" because it is expected that the patient (or his/her parent(s) or guardian) will be "informed" of all the relevant issues to help the patient make a decision about what is best for him/her at the time.

The patient needs to understand:

- What the history-taking process will involve.
- The type of questions that will be asked and the reason those questions will be asked.

For example:

"I will need to ask you for details of the assault. I will need to know where your attacker's body touched yours so I will need to look on your body for signs of injury or for traces of evidence from your attacker."

- That the examination will be done in circumstances of privacy and dignity. The patient will lie on an examination couch and an extensive examination will be required.
- That a genito-anal examination will require the patient to be in a position where this area can be adequately seen with the correct lighting.

For example:

"I will ask you to lie on your back on the examination couch with a sheet draped over your knees. I will ask you to draw your knees up, keep your ankles together and fray your legs apart so that I can look carefully at your pelvic area with the help of this light."

- That the genito-anal area will be touched by the examiner's gloved hands to allow internal structures to be better seen. A device designed for looking inside the vagina or the female birth canal, called a speculum, may be used. A device for looking inside the anus, an anoscope, may be used.
- That specimen collection involves touching the body and body openings with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva. Clothing may be collected. Not all of the results of the forensic analysis may be made available to the patient.

It is crucial to inform the patient that the information told to the health worker and found on examination will be conveyed to investigators for use in the pursuit of criminal justice if the patient decides to pursue legal action or in jurisdictions with mandatory reporting requirements. This means that anything told to the health worker may not be kept private between patient and health worker, but may be discussed in an open court at some time in the future.

The patient should also be given an explanation as to how photographs may be used. Photography is useful for court purposes and should NOT include images of genital areas.

All of the above information should be provided in a language that is readily understood by the patient or his/her parent/guardian.
CHAPTER III

PSYCHOSOCIAL COMPONENT
The role social workers and any other workers providing psychosocial support is to identify and assess children who have been sexually abused for psychological symptoms which may need further management. These will vary from minor to severe (suicide) which may require urgent referral to a psychiatric unit.

Such symptoms will depend on the circumstances surrounding the abuse and the level of comprehension of the abuse.

3.1 SAFETY CONFIDENTIALITY

It is more important that the counselor makes the child feel safe and comfortable. The following are some steps that may make a child feel at ease.

See to it that the child is in an appropriate and comfortable setting = children may feel threatened by an unfamiliar or threatening environment. Counselors may decorate their surroundings with bright child friendly pictures and have simple play material to have the child relax.

Dress Code counselors should dress more modestly or appropriately e.g., Uniforms may be a barrier to communication between the child and the counselor.

Get to know the child not just the problem. Counselors should ask children about their daily activities and interests (school, social, life, family activities). Counselors need a range of approaches to encourage communication with children, for example, drawing, play, storytelling, drama, singing

You cannot protect the rights and safety of the child while keeping abuse secret. Tell the child this. At the same time protect the child’s privacy and confidentiality by only informing those who need to know

Create an atmosphere for safety and trust for the child. Accept that it may have taken the child time to be able to talk to you and that they may choose to tell some things and not to tell others.

Below are some feelings that are commonly associated with sexually abused victims which will help in the evaluation process

3.2 FEELINGS COMMONLY EXPERIENCED BY CHILDREN WHO HAVE BEEN SEXUALLY ABUSED

I have to accept bad situations because they are part of life and I can do thing to make them better.

I don’t expect much good to happen in my life

Nobody could ever love me.

I am always going to feel sad, angry, depressed, and confused.

There are situations at work and at home that I could do something about, but I don’t have the motivation to do so.

Life overwhelms me, so I prefer to be alone whenever possible.

You can’t trust anyone except a very few people.

I feel I have to be extra good, competent, and attractive in order to compensate for my many defects.

I feel guilty for many things; even things that I know are not my fault.

I’m often afraid to do something new for fear I will make a mistake.

Children exhibiting the above symptoms will need prolonged support and referral to a psychiatric unit.

3.3 PHYSCHOSOCIAL MANIFESTATION OF SEXUAL ABUSE

3.3.1 Emotional

- Excessive crying
- An increase in irritability or temper tantrums
- Aggression towards others

3.3.2 Behavioral

- Poor school performance
- Bedwetting or soiling of pants (enuresis or encopresis)
- Knowing more of sexual behavior than what is expected of a child of that age
- Sexualized play (e.g. trying to have sex with other children)
- Unexplained change in child’s behavior (e.g. a lively outgoing child becomes withdrawn.
- Hypersensitivity and hypervigilance

3.4 EFFECTS OF CHILD SEXUAL ABUSE: SHORT AND LONG TERM

It is important for counselors to understand that the effects of abuse on children are both long and short term.

3.4.1 Short-Term Effects

- Feelings of powerlessness;
- Fear;
- Increased anxiety;
- Phobias (fears of specific objects, places or people); or nightmares;
- Difficulty concentrating;
- Flashbacks of the event;
- Frequent vigilance of one’s environment for fear of confronting the perpetrator;
- Acute Stress Disorder (ASD);
- Sleep disturbances and nightmares;
- Sudden weight change
3.4.2 Long-Term Effects

- Psychological problems (depression and anxiety);
- Psychosomatic problems (continual unexplained illnesses); or difficulties with trust and intimacy in relationships;
- Re-victimization (e.g. becoming a victim of domestic violence or further sexual abuse as a child or adult);
- Suicide or suicide attempts;
- Substance abuse (alcohol/drugs);
- Delinquency (stealing, breaking the law, etc);
- Post traumatic Stress disorder (PTSD).

3.5 POST TRAUMATIC STRESS DISORDER (PTSD)

PTSD describes the response to a traumatic event that involves threat to death or actual injury, or a threat to ones physical integrity (e.g. rape, or assault, military combat, destruction of ones community due to natural disasters such as floods bombing, torture, airplane crashes, armed robbery, earthquake, victims of animal attacks, etc).

Symptoms of PTSD include repeated thoughts of the assault; memories and nightmares; avoidance of thoughts, feelings, and situations related to the assault; and increased arousal (e.g., difficulty sleeping and concentrating, juminess, irritability).

If the presenting symptoms are related to re-experiencing, a traumatic event persistent for at least four weeks then PTSD is confirmed. However, if presenting symptoms that are related to re-experiencing highly traumatic event last at least for two weeks and no more than four weeks, PTSD IS NOT indicated.

3.5.1 Counseling as a way of Treating PTSD

"Counseling denotes a professional relationship between a trained counselor and a client designed to help the client to understand and clarify their views of their life space, and to learn to reach their self-determined goals through meaningful, well informed choices and through resolution of problems of an emotional or interpersonal nature" (Burks & Steffire, 1979:14).

"Counseling is a process by which a troubled person (the client) is helped to feel and behave in a more personally satisfying manner through interaction with an unbiased/external person (the counselor) who provides information and reactions which stimulate the client to develop behaviors which enable him to deal more effectively with himself and his environment" (Lewis, 1970:10).

3.5.2 PTSD Symptoms in Children

Very young children may present with few PTSD symptoms. This may be because eight of the PTSD symptoms require a verbal description of one's feelings and experiences. Instead, young children may report more generalized fears such as stranger or separation anxiety, avoidance of situations that may or may not be related to the trauma, sleep disturbances, and a preoccupation with words or symbols that may or may not be related to the trauma. These children may also display post-traumatic play in which they repeat themes of the trauma. In addition, children may lose an acquired developmental skill (such as toilet training) as a result of experiencing a traumatic event, or have difficulties with acquiring new skills.

Researchers and clinicians are beginning to recognize that PTSD may not present itself in children the same way it does in adults (see what is PTSD below). The criteria for PTSD now include age-specific features for some symptoms.

3.5.3 Elementary School Aged Children

Clinical reports suggest that elementary school-aged children may not experience visual flashbacks or amnesia for aspects of the trauma. However, they do experience "time skew" and "omen formation," which are not typically seen in adults. Time skew refers to a child mis-sequencing trauma related events when recalling the memory. Omen formation is a belief that there were warning signs that predicted the trauma. As a result, children often believe that if they are alert enough, they will recognize warning signs and avoid future traumas. School-aged children also reportedly exhibit post-traumatic play or re-enactment of the trauma in play, drawings, or verbalizations. Post-traumatic play is different from re-enactment in that posttraumatic play is a literal representation of the trauma which involves compulsively repeating of some aspect of the trauma, and does not tend to relieve anxiety.

EXAMPLES

Post traumatic play is an increase in shooting games after exposure to a school shooting.

Posttraumatic reenactment, on the other hand, is more flexible and involves behaviorally recreating aspects of the trauma (e.g., carrying a weapon after exposure to violence).

3.5.4 PTSD in Adolescents

PTSD in adolescents may begin to be more closely resemble PTSD in adults. However, there are a few features that have been shown to differ. As discussed above, children may engage in traumatic play following a trauma. Adolescents are more likely to engage in traumatic reenactment, in which they incorporate aspects of the trauma into their daily lives. In addition, adolescents are more likely than younger children or adults to exhibit impulsive and aggressive behaviors.
3.5.5 Treatment of PTSD in Children and Adolescents

Although some children show a natural remission in PTSD symptoms over a period of a few months, a significant number of children continue to exhibit symptoms for years if untreated. Few treatment studies have examined which treatments are most effective for children and adolescents.

3.5.6 Cognitive-Behavioral Therapy

A review of the adult treatment studies of PTSD shows that Cognitive-Behavioral Therapy (CBT[1]) is the most effective approach. CBT for children generally includes the child directly discussing the traumatic event (exposure), anxiety management techniques such as relaxation and assertiveness training, and correction of inaccurate or distorted trauma related thoughts.

CBT also involves challenging children’s false beliefs such as, “the world is totally unsafe.” The majority of studies have found that it is safe and effective to use CBT for children with PTSD.

CBT is often accompanied by psycho-education and parental involvement. Psycho-education is education about PTSD symptoms and their effects. It is as important for parents and care-givers to understand the effects of PTSD as it is for children.

Research shows that the better parents cope with the trauma, and the more they support their children, the better their children will function. Therefore, it is important for parents to seek treatment for themselves in order to develop the necessary coping skills that will help their children.

Several other types of therapy have been suggested for PTSD in children and adolescents. Play therapy can be used to treat young children with PTSD who are not able to deal with the trauma more directly. The therapist uses games, drawings, and other techniques to help the children process their traumatic memories.

3.5.7 Psychological First Aid

Psychological first aid has been prescribed for children exposed to community violence and can be used in schools and traditional settings. Psychological first aid involves clarifying trauma related facts, normalizing the children’s PTSD reactions, encouraging the expression of feelings, teaching problem solving skills, and referring the most symptomatic children for additional treatment. Twelve Step approaches have been prescribed for adolescents with substance abuse problems and PTSD.

3.5.8 Eye Movement Desensitization and Reprocessing

Another therapy, Eye Movement Desensitization and Reprocessing (EMDR), combines cognitive therapy with directed eye movements. While EMDR has been shown to be effective in treating both children and adults with PTSD, studies indicate that it is the cognitive intervention rather than the eye movements that accounts for the change.

There is some controversy regarding exposing children to the events that scare them, exposure-based treatments seem to be most relevant when memories or reminders of the trauma distress the child. Children can be exposed gradually and taught relaxation so that they can learn to relax while recalling their experiences. Through this procedure, they learn that they do not have to be afraid of their memories.

3.5.9 Specialized Interventions

Finally, specialized interventions may be necessary for children exhibiting particularly problematic behaviors or PTSD symptoms. For example, a specialized intervention might be required for inappropriate sexual behavior or extreme behavioral problems.

What should be done to help the child?

Reading this fact sheet is a first step toward helping your child. Gather information on PTSD and pay attention to how the child is functioning. Watch for warning signs such as:

- sleep problems,
- irritability,
- avoidance,
- changes in school performance,
- and problems with peers.

3.5.10 Medical Attention

It is very important that the child be given urgent and immediate medical attention. This is because the medical treatment will be evidence that the child was abused. This is simply because it is not necessary to delve into technicalities for this particular instance. If the evidence is mismanaged, there will be no need to go to court because it will be a sheer waste of time since there is no evidence. If a child is sexually abused for example, the child must be immediately taken to be seen and examined by a qualified medical practitioner.

3.5.11 Some Symptoms Related to Sexual Trauma in Boys

Particularly when the assailant is a woman, the impact of sexual assault upon men may be downplayed by professionals and the public. However, men who have early sexual experiences with adults report problems in various areas at a much higher rate than those who did not (e.g. depression, anxiety, alcohol and drug use).

Men and boys who have been sexually assaulted are more likely to suffer from PTSD, other anxiety disorders, and depression than those who have never been abused sexually.

3.5.12 Substance Abuse

Men who have been sexually assaulted have a high incidence of alcohol and drug use. For example, the probability for alcohol problems in adulthood is about 80% for men who have experienced sexual abuse, as compared to 11% for men who have never been sexually abused.

Encopresis - One study revealed that a percentage of boys who suffer from encopresis (bowel incontinence) had been sexually abused.
3.5.13 Risk-Taking Behavior

Exposure to sexual trauma can lead to risk-taking behavior during adolescence, such as running away and other delinquent behaviors. Having been sexually assaulted also makes boys more likely to engage in behaviors that put them at risk for contracting HIV (such as having sex without using condoms).

3.5.14 Other Effects of Trauma on Children

Besides PTSD, children and adolescents who have experienced traumatic events often exhibit different types of problems. Perhaps the best information available on the effects of traumas on children comes from a review of the literature on the effects of child sexual abuse. In this review, it was shown that sexually abused children often have problems with:

- Fear
- Anxiety
- Depression
- Anger and hostility
- Aggression
- Sexually inappropriate behavior
- Self-destructive behavior
- Feelings of isolation and stigma
- Poor self-esteem
- Difficulty in trusting others
- Substance abuse

These problems are often seen in children and adolescents who have experienced other types of traumas as well. Children who have experienced traumas also often have relationship problems with peers and family members, problems with acting out, and problems with school performance.

Along with associated symptoms, there are a number of psychiatric disorders that are commonly found in children and adolescents who have been traumatized. One commonly co-occurring disorder is major depression. Other disorders include substance abuse; other anxiety disorders such as separation anxiety, panic disorder, and generalized anxiety disorder; and externalizing disorders such as attention-deficit/hyperactivity disorder, oppositional defiant disorder, and conduct disorder.

3.5.15 Age of the Child

This question is not just a formality but important for ascertaining whether the child really understands what happened.

Children of tender years may have to depend on the testimony of a next friend, parent or guardian. They may not even describe the perpetrator with precision. Identification of the accused or suspect is paramount for every offense hence the need for the people dealing with the child abuse cases to pay extra attention to the age of the victim for all purposes. This is because certain offences are defined in relation to the age of the victim for example defamation – as having carnal knowledge of a girl below the age of 16 years. Before the child is sixteen it will be child defamation and after the age of sixteen it will not be defamation but rape. Where the age of the child is not ascertained the court will not convict, the suspect will walk to freedom for insufficient evidence.

3.6 COUNSELING

Counseling is a basic ingredient in the abused child’s healing process. The counselor becomes a trusted person to the abuse victim and helps the child revert back to normal day to day living and activities. For example, there is need for the child to go ahead with school and other types of development. Restrictions should be made on the number of people that the child deals with. If possible, the child should deal with the same psycho-social counselor throughout his/her healing process.

3.6.1 Child Counseling Techniques

**Body Language**

Read the language from the child, is he happy, sad, e.t.c in /or from the way they sit, stand e.t.c. It is the 1st language of communication.

**Play Language**

Shows you what happen than tell you; Shows you how they are living in and in turn you refer to what they feel by their action.

**Spoken Language**

With their limited vocabulary, children can communicate what happened to them.

**Things That Block Communication**

- Fear;
- using language not understood by child;
- if child has strong feeling about;
- interventions address child’s fear;
- don’t use adult language/communication;
- don’t become upset about certain topics.

3.6.2 Important Skills in Counseling

(a) Attending skills:
These are a group of counseling skills that enable a counselor to establish rapport with a client.

(b) Reception skills:
  greeting, offering a sit etc,

(c.) Active listening skill:
  paying attention to psychological detail such as verbal and non-verbal Communication.

(e) Empathy:
  the ability to enter into a client’s world of experiencing, the ability to place oneself in another person’s shoes without taking over.
  Empathy involves understanding analyzing, interpreting and giving feedback.

(f) Paraphrasing:
  to clarify understanding. Involves repeat what the client says in the counselor’s own words.

(g) Reflecting feelings:
  to ‘move’ with the client. It is important to use empathic understanding to pick and reflect feelings accurately.
(h) Probing:
this is important to address some critical issues such as challenges and insinuations.

(i) Challenging:
used in immediacy situations or distractions such as misplaced love feelings, emotions and disruptions.

(j) Confidentiality:
assurance given to the client that whatever is mentioned in the session cannot be discussed elsewhere by the counselor, though the client at will can tell somebody of their own choice.

3.6.3 Important Things to Remember

- Let the examination and questioning take place in a confidential place.

- If the offender is on bail he should not be allowed to talk to the child.

- The child should be prepared psychologically for the trial days well in advance. The child should be made aware that she will testify and give evidence against the perpetrator in court.

- Familiarization tour- prior to the day of the trial the support person intermediary, public prosecutor or police officer should take the child on a familiarization tour of the courtroom. Usually, the Social Worker will explain to the child what will take place in court so as to prepare him/her.

<table>
<thead>
<tr>
<th>The ARENA</th>
<th>The BLIND SPOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known to self</td>
<td>Hidden to self but</td>
</tr>
<tr>
<td>and to others</td>
<td>known to others</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The FACADE</th>
<th>The UNCONSCIOUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known to self</td>
<td>Hidden to self</td>
</tr>
<tr>
<td>but hidden to</td>
<td>and to others</td>
</tr>
<tr>
<td>others</td>
<td></td>
</tr>
</tbody>
</table>

(a) The ARENA

The arena by implication is an open ground. It means that the individual is awareness of his/her behavior as it relates to other people and the environment.

(b) The BLIND SPOT

The blind spot is the part where a person may not be aware of his behavior so that it takes other people to tell her/him about the effect of his behavior.

Therefore her/his good or bad characteristics are hidden to self but known to others.

(c) The FACADE

This is the part where an individual takes a deliberate action to disguise himself/herself for a known reason.

This may be useful to the person although it becomes a danger if s/he forms a pattern or habit.

Counselors should be real or genuine so that their behavior both out and inside the session they remain trustworthy.

(d) The UNCONSCIOUS

The unconscious is the hidden part of a person.

This means that the person may exhibit some behaviors without being aware and there will be no one to warn her/him of adverse effects of his behavior.

Most painful past experiences, such as rape and childhood abuse lie in the unconscious mind.

Counselors should have a free mind that will enable them to be genuine, stable or congruent during their work, by reducing or dealing with hidden material.

3.7 TALKING ABOUT SEXUAL ISSUES

It is difficult for children to put their experience of sexual abuse into words. Children may lack the vocabulary to describe sexual acts or events: they may feel very embarrassed or shameful about discussing sexual issues with an adult; or there may be strong cultural taboos against discussion of sexual matters.

It is important for a counselor to be aware of the child's sensitivities and difficulties when talking about sexual issues.

Counselors need to be aware that children may use their personal words to describe genital organs. They may talk about a stick or a snake when referring to penis. Many children do not know the common terms for genital organs. The person caring for the child should know the meanings of the words used by the child. In addition to a child's awkwardness in talking about sexual issues or abuse, children may be overwhelmed by their feelings, especially in front of people whom they do not know.

3.8 DISCLOSURE / CONSEQUENCES OF DISCLOSURE

DISCLOSURE is the word used when it is revealed that the child sexual abuse has occurred. Voluntary disclosure is when the child reveals this information. Involuntary is when someone other than the child reveals the abuse. When counseling sexually abused children, disclosure is a process. Children may not disclose all the details at first. As they start feeling more comfortable with the disclosure they will begin to tell more details.
Encourage the child to tell more but do not force or coerce to disclose what happened. Sometimes a child will not talk. Acknowledge the child’s fears then take action to answer the reasons for fearing. For example, if the child is fearful of punishment, the counselor should discuss this fear with parents and obtain the assurance that there will be no punishment.

3.9 REASONS FOR REFUSAL TO DISCLOSE THE SEXUAL ABUSE

There are a number of reasons that may prevent children from disclosing sexual abuse. These may include:

- Feeling that they will not be believed
- Thinking that the abuse was their fault
- Fear of punishment
- Fear of hurting their parents
- Not wanting the police involved
- Worries about what people will say
- Being too young to know what is going on
- Thinking that it would not make any difference if they did tell
- Being threatened, bribed or coerced by the offender

3.6.4 Counselor Self-Awareness

Self-awareness deals with personal development and growth, which is dynamic and runs from childhood through adulthood.

The counselor should be fully grown at a personal level to be able to take care of other people’s stress and problems.

It is important that the counselor remains in good relationship with other people either as individuals or groups.

S/he should also be in good relationship with the environment in the general context.

Self-awareness is about learning about oneself. It involves looking at oneself as if you were outside yourself.

Knowing about self may not always be pleasant, as some new discoveries may be terrifying, especially when the hidden self and the unknown self start to be evident or revealed.

Two psychologists: Joe Luft and Harry Ingham invented a model of self-awareness known as the JOHARI WINDOW. This model argues that most human being fall under the four categories as described below:

- Being too young to know what is going on
- Thinking that it would not make any difference if they did tell
- Being threatened, bribed or coerced by the offender

Questions To Keep In Mind

- What will be disclosed to the child?
- How much information should be given?
- What is the best way for the child to understand and cope with a positive HIV test result?

Advantages of HIV Testing

Knowledge of HIV test status helps children cooperate with their medical schedules and other health care services that may prolong their life.

3.10 CARE FOR THE CAREGIVERS

A) CARE FOR COUNSELORS

Counselors by nature are subject to stress. Stress is an event that produces tension or worry (Robert Stahl, 1994). Normal stress is the kind that drives us towards achieving goals. Stress may come by the amount of work and the nature of cases counselors see. Stress is said to be part and parcel of life. Selye (1974) notes that whether we like it or not stress is inescapable, as complete freedom from stress implies death. We might struggle to reduce stress in our efforts but others will create it for us. Counselors themselves therefore, need counseling from time to time to ensure quality counseling services and to prevent “burn out”.

B) CARE FOR PARENTS

Parents can also experience stress especially when the abuse has just taken place. It is thus equally important to take care of their emotional needs at that point because they have an important role to play in the healing process of the child. These care-givers should also be cared for.

3.11 IS THE CHILD SCHOOL GOING?

There must be a deliberate policy put in place that should strictly prohibit teachers from disclosing the same to the other children or the other teachers because children are very sensitive and have a bigger role to play in the development of other children especially when they meet in groups as peers.

In the event of the teachers being involved, no one should be permitted to discuss anything with the child directly because not all teachers are experts at dealing with children. If possible better change the school for the child so that in case any children from the abused child’s neighborhood go to the same school as the child.
3.12 RECOMMENDATIONS FOR PARENTS WITH CHILDREN SHOWING SEXUAL BEHAVIOR PROBLEMS

Close supervision is important when the child is playing with other children. Check on them frequently to make sure you know where they are and what they are doing. Do not allow them to play in a room with the door closed. It is preferable that the child does not bathe or sleep in the same bed with other children. Also, if possible, the child should sleep in a room alone.

The child should not be given any opportunities for assuming a role of authority over younger or more vulnerable children. Sexually explicit materials should not be available in the home. With easy accessibility to sexually explicit materials on the Internet, parents need to be mindful of and monitor their child's Internet use.

Adults should enforce privacy in their bedroom and in the bathrooms. There should be established rules about entering the adults' bedroom (e.g., knock before entering). If engaging in sexual activity, adults should take steps to ensure that children cannot come in and observe.

The adults should use appropriate modesty in the child's presence. There should be no nudity, partial nudity, or explicit displays of sexual behavior by either parent or other adults in front of the child. It is, however, appropriate for adults to show normal affection to each other and the children.

The child should not be permitted to sleep or bathe with the parent.

Adults should communicate clear rules and expectations about privacy and appropriate sexual behavior to the child. It is important that all members of the family know and observe the rules. Adapted From Bonner, Walker & Berliner.

3.12.1 When a Child Discloses Abuse

Stay calm and just listen. It is important that the child not be "interviewed" at this time. The child needs to know that you are available to help them. Shock, outrage, or fear may inhibit the child and make them feel more anxious or ashamed.

Reassure them that they have not done anything wrong. Be supportive. Let the child know that they are safe with you and you're glad that they chose to tell you about this.

Reassure them that you will do everything you can to be sure they are not hurt again and you know others who can be trusted to help solve their problem.

Tell the child what will happen next. You will take them to see someone who knows just what to do.

Reported disclosure immediately report to Victim Support Unit and to a health facility.

Make notes of all comments made by the child using their exact words were possible. Save all drawings and artworks.

3.13 CHALLENGES IN CHILD COUNSELING

A) Disabled Children (Deaf)

The victim may not be able to communicate on account of mental illness or retardation. In this case medical examination may provide the necessary information. The suspect too may require medical examination to adduce any evidence related to the alleged sexual abuse on or in the suspect's body.

B) Child Offender/ Sexual Activity between Children

The situation must be carefully analysed to establish:

- Age difference between the involved children e.g. sexual contact between children who have not yet reached puberty may have less serious repercussions than the contact between older child (one with secondary sexual characteristics) and a younger child (pre-puberty).
- The sexual activity that has occurred.
- The context of abuse e.g. use of coercion, number of children involved, the presence of adult supervision.
- The occurrence of normal sexual activity
- Culture as a Barrier

Culture may be a barrier to communication especially when it comes to parents talking to their children about sexuality. This is because this is considered to be a taboo in the African culture.

Working in families can also be a challenging issue when dealing with child sexual abuse. This is challenging especially when the perpetrator is a close member of the family. Such cases may not be reported due to fear of persecution and also for the sake of family solidarity.

It is however important to mention that action should be taken in the interest of the child. Children also have the right to a decent and innocent childhood.
CHAPTER IV

MEDIA COMPONENT
The media's key roles in the management of sexually abused children involve the following:

- Accurate reporting
- Public Awareness
- Strict adherence to ethical principles on reporting on cases of child sexual abuse.

It is therefore vital for the media to work closely with professionals dealing with child sexual abuse if they are to fulfill their role in mitigating against child sexual abuse.

4.1 ACCURATE REPORTING

INTERNATIONAL FEDERATION OF JOURNALISTS
DECLARATION OF PRINCIPLES ON THE CONDUCT
OF JOURNALISTS

1. This international Declaration is proclaimed as a standard of professional conduct for journalists engaged in gathering, transmitting, disseminating and commenting on news and information and in describing events.

2. Respect for truth and for the right of the public to truth is the first duty of the journalist.

3. In pursuance of this duty, the journalist shall at all times defend the principles of freedom in the honest collection and publication of news, and of the right of fair comment and criticism.

4. The journalist shall report only in accordance with facts of which he/she knows the origin. The journalist shall not suppress essential information or falsify documents.

5. The journalist shall do the utmost to rectify any published information which is found to be harmfully inaccurate.

6. The journalist shall observe profession secrecy regarding the source of information obtained in confidence.

7. The journalist shall be aware of the danger of discrimination being furthered by the media, and shall do the utmost to avoid facilitating such discrimination based on, among other things, race, sex, sexual orientation, language, religion, political or other opinions and national or social origins.

8. The journalist shall regard as grave professional offences the following:

- Plagiarism
- Malicious misrepresentation
- Slander, libel, unfounded accusations
- The acceptance of a bribe in any form in consideration of either publication or suppression.

Journalists worthy of that name shall deem in their duty to observe faithfully the principles stated above.

These principles must be closely adhered to when reporting cases of CSA.

4.2 PUBLIC AWARENESS

The media can play a vital role in raising public awareness on child sexual abuse. They have tools which are capable of informing a wide range of people from different walks of life. To do this effectively there is need to consult professionals and the communities on appropriate messages for the prevention of CSA.

There is also need for the media to use appropriate messages which are helpful to children as they adjust to physical and psychological development.

4.2.1 Radio, Television and Print Media

This is a powerful tool which media should use in informing the public in matters of CSA because of it wide coverage. Different professionals, community elders, influential networks, NGOs should work and participate in the production of programs which adequately deal with concerns about CSA.

Television and print media though powerful tools in dissemination of information are expensive and therefore limited in their use within the Zambian context.

4.2.2 Media and Technology

Exposing children to different technological devices such as the Internet, DVD and mobile phones poses many challenges to parents, as children can’t set limits in terms of use of such devices hence the reason for the parents to be watchful, as such any exposure of a child to pornographic materials such as pornographic films and "Digital Versatile Disc" or "Digital Video Disc") which is an optical disc storage media format that can be used for data storage can lead to serious abusive sexual activity.

4.3 PRINCIPLE FOR ETHICAL REPORTING ON CHILDREN

UNICEF has developed principles to assist journalists as they report on issues affecting children. They are offered, as guidelines that UNICEF believes will help the media to cover children in an appropriate age and a sensitive manner. The guidelines are meant to support the best intentions of ethical reporters: serving the public interest without compromising the rights of children.

4.3.1 Ethical Theory

Journalists asking themselves ethical questions could best answer the issue of ethics, and the following are some of the questions*

- What do I know?
- What do I need to know?
- What is my journalistic purpose?
- What are my ethical concerns?
- What organizational policies and professional guidelines should I consider?
- How can I include the voices of other people, with different perspective and diverse ideas, in the decision making process?
- Who are the stakeholders - those affected by my decision?
• What if the roles were reversed? How would I feel if I were in the shoes of one of the stakeholders?
• What are the possible consequences of my actions? Short term? Long term?
• Are we sacrificing truth telling for technical quality?
• What are my alternatives to maximize my truth telling, responsibility and minimize harm?
• Can I clearly and fully justify my thinking and my decision? To my colleagues? To the stakeholders? To the public? To myself?
• Is the photograph being presented as editorial reporting telling or illustration?

4.3.2 Principles

1. The dignity and rights of every child are to be respected in every circumstance.

2. In interviewing and reporting on children, special attention is to be paid to each child’s right to privacy and confidentiality, to have their opinions heard, to participate in decision affecting them and to be protected from harm and retribution, including the potential of harm and retribution.

3. The best interest of each child is to be protected over any other consideration, including over advocacy for children’s issues and the promotion of child rights.

4. When trying to determine the best interest of a child, the child’s right to have their views taken into account are to be given due weight in accordance with their age and maturity. Those closest to the child’s situation and best able assess it are to be consulted about the political, social and cultural ramifications of any reportage.

5. Do not publish a story or image, which might put the child, siblings or peers at risk even when identities are changed, obscured or not used. Ensure that the child is comfortable. The reporter should be able to develop a good rapport with the child to build trust. Do not intimidate the child with gadgets like a camera, a recorder, and notebooks and so on.

6. Let the child speak for him or herself. While interviewing the child, a reporter should avoid using leading questions; otherwise the child would be willing to tell you what you expect to hear.

7. Proper orientation of the reason of your visit, mentioning where you work would only create jitters within the child, which is a possible reason for getting wrong information from the child.

8. The reporter should take care while interpreting from a second language because it might lead to misquoting or misrepresentation. Editors should mind the gender of reporters who cover certain stones. For example, if a girl child has been defiled, the best person to cover the story would be a female reporter.

This is because the child will be more open to the lady journalist than to the male journalist. The reporter should find a conducive environment safe for the child.

Interpret the law of the land regarding the particular act of violation and the rights of the child. Journalists should have a thorough knowledge of the UNCRC; children’s laws in their respective countries. A journalist should use different information sources by talking to several people; experts like the police, doctors and so on. Before publishing or broadcasting the story, the journalist should think of the effect of the child and those around him.

The children’s views, feelings and ideas should be respected and taken into account. Objectivity – the story should be presented in a balanced manner by giving the pros and cons; the audience should be left to decide on its own.

The journalist should consider the child’s cultural background if certain issues are discussed. Protocol and culture of society should be observed, involving a third party would be advisable, perhaps a person who is close to the child.

Background research and study of the story being reported should be done. Facts and figures should be verified to avoid misreporting.

In reporting, hide the identities of the child’s relatives, school and home area. In electronic reporting, the face of the child should be censored. Do not betray the confidence of the child in case it reveals some information that may excite the reporter.

Do no harm any child, avoid questions, attitudes or comments that are judgmental, insensitive to cultural values, that place a child in danger or expose a child to humiliation, or that reactivate a child’s pain and grief from traumatic events. Do not discriminate in choosing children to interview because of sex, race, age, religion, status, educational background or physical abilities.

No staging: Do not ask children to tell a story or take an action that is not part of their own history. Ensure that the child or guardian knows that they are talking with a reporter. Explain the purpose of the interview and its intended use.

Obtain permission from the child and his or her guardian for all interviews, video taping and, when possible, for documentary photographs. When possible and appropriate, this permission should be in writing. Permission must be obtained in circumstances that ensure that the child and guardian are not coerced in any way and that they understand that they are part of a story that might be disseminated locally and globally.
17. Pay attention to where and how the child is interviewed. Limit the number of interviewers and photographers. Try to make certain that children are comfortable and able to tell their story without outside pressure, including from interviewer. Ensure that the child would not be endangered or adversely affected by showing their home, community or general whereabouts.

18. Do not further stigmatize any child; avoid categorizations or descriptions that expose a child to negative reprisals – including additional physical or psychological harm, or to lifelong abuse, discrimination or rejection by their local communities.

Always provide an accurate context for the child’s story or image. Change the name and obscure the visual identity of any child who is identified as:

A) A victim of sexual abuse
B) A perpetrator of physical or sexual abuse
C) HIV positive, living with AIDS or has died from AIDS, unless the child, a parent or a guardian gives fully informed consent.
D) Charged or convicted of a crime

In certain circumstances of risk or potential risk of harm or retribution, change the name and obscure the visual identity of any child who is identified as:

- A current or former child combatant
- An asylum seeker, a refugee or an internal displaced person

In certain cases, using a child’s identity – their name and or recognizable - image is in the child’s best interest. However, when the child’s identity is used, they must still be protected against harm and supported through any stigmatization or reprisals.
CHAPTER V

THE ROLE OF THE POLICE IN CHILD SEXUAL ABUSE
This chapter is designed to help police service providers, develop the knowledge and fundamental skills for supportive role in child sexual cases, especially in collection and processing of evidence. It is designed to assist service providers with relevant skills in the investigations of cases of child sexual abuse as well as in the preparation of witnesses when cases are brought before the courts of law.

As with any kind of abuse, people who abuse children may be upstanding members of their community, and may be respected for their work with and mentorship of children. They will go to great length to discredit a child’s complaint, but it is important to remember that even people with good reputations can be abusers, and to take a child’s complaint seriously. The involvement of a children sexual activities by a relative, parent, caretaker or any other person, including fondling, touching, intercourse, exposing the child to adult sexuality in other forms like telling dirty stories, and commercial exploitation through prostitution or pornography.

Sexual abuse does not exist as a specific offence under the Zambian law, but it consists of various omissions and acts which are defined as offences under the law. These acts and omissions depending on the nature may be categorized as follows;

5.2 INVESTIGATING CHILD SEXUAL ABUSE

5.2.1 The First 24 Hours

The first 24 hours of child abuse investigations is a critical window of opportunity. This is a window before the suspect has had a chance to hide evidence, threaten witnesses not to talk, make up an alibi, realize implications or reflect and think, disturb or alter crime scenes (get a lawyer), or sleep. This is also the window of time before the child has been told that the consequences of the disclosure are his or her fault. He or she hasn’t yet found that some of the consequences impact on him or her negatively or been affected by multiple exposures to the justice system or had a chance recant.

5.2.2 Investigations and Gathering of Evidence

Crime investigations can be defined as a systematic search for the truth with respect to a crime or alleged crime. The purpose of crime investigations is the collection of evidence, in strict accordance with the provisions governing the process. This evidence can serve in a court of law, through which the involvement of the accused in the commission of a crime can be proven. The collection of such evidence involves a search for exhibits, clues and witness in an attempt to establish the identity of the offender and prove the commission of the crime in court. To establish the facts about a crime, the crime investigator must solve the crime situation by means of two sources of information namely, people and objects that can be respectively referred to as objective and subjective clues.

Objective Clues

(i) By objective clues means physical proof and the objective explanation thereof, i.e. ‘mute’ indirect of circumstantial evidence or exhibit.

Subjective Clues

(ii) Subjective clues refer to the evidence of persons (victims, eyewitnesses, and suspects) directly or indirectly connected with the crime.

Identification forms an integral part of crime investigation. A series of identification leads to our primary goal in respect of crime investigation, namely, individualization.

Individualization

Individualization simply means that crime is individualized to be the act of a particular person.

Identify the Situation

The first step is to find out whether a crime has been committed, or whether a social problem or issue is being raised. If the only issue is substance abuse, for example, then it is appropriate to refer the parties to an organization that can help with counseling and other information. If the complainant is unsafe or has been violated, however, the officer has an obligation to open a case.

As with any kind of abuse, people who abuse children may be upstanding members of their community, and may be respected for their work with and mentorship of children. They will go to great length to discredit a child’s complaint, but it is important to remember that even people with good reputations can be abusers, and to take a child’s complaint seriously. The involvement of a children sexual activities by a relative, parent, caretaker or any other person, including fondling, touching, intercourse, exposing the child to adult sexuality in other forms like telling dirty stories, and commercial exploitation through prostitution or pornography.

Sexual abuse does not exist as a specific offence under the Zambian law, but it consists of various omissions and acts which are defined as offences under the law. These acts and omissions depending on the nature may be categorized as Identify a Crime

What type of crime was committed? What time? Was it recent, or some time ago? Was it one incident, or did it occur over a period of time?

Does the abuse constitute a crime?

Perhaps this could be the most difficult question to ask oneself if you do not even know the elements of a crime. There is a very simple criterion to be employed in determining what a crime is and what is a mere wrong. It should be born in mind that not every wrong is a crime. The law is not concerned with the moral fiber of the society but with the security of the individuals in a society, thus only those wrongs that offend the whole society are crimes.
On a balance of common sense it would offend society to allow abuse of innocent children. Society would not even allow any member of society to take any undue advantage over children because they are not only weak in body and in mind but also they lack the capacity to defend themselves. The net effect of this is that all cases of abuse affect the whole society and should be reported to the police as crimes.

5.2.3 Crime Scene(s)

Especially in cases of rape and sexual abuse, the crime scene is not just the geographical location. It is also where the crime was committed; the victim's body is also the scene of crime. The woman or the child's body must be treated with respect not only out of empathy, but also with regard to the evidence located there.

The crime scene is also anywhere the victim and offender traveled, for example the offender's house, a third location, any stops along the way. It can be indoors or outdoors or both; even inside a vehicle. If the crime was committed outdoors and recently, the weather will be a factor to consider. Don't wait until the rain washes away valuable evidence before you go to the scene.

5.2.4 Reports

Who reported the crime? When? What time? Where? Was it over a telephone, at a police station, through an emergency service or a specialized unit? Many crimes against women and children such as rape and domestic violence are reported person to person in a confidential environment because the victim may feel shame and stigma associated with the event. Sensitivity to the needs of the victim when creating private spaces in a station can make a huge difference in whether women and children choose to report.

5.3 SEXUAL OFFENCES EXTRACTED FROM THE PENAL CODE CHAPTER 87 OF THE LAWS OF ZAMBIA

5.3.1 Rape Contrary to Section 132

Any person who has unlawful carnal knowledge of a girl or woman without her consent or with her consent. If the consent is obtained by force or means of threats or intimidation of any kind by force or fear of bodily harm or by means of false representation as to the nature of the act or in case of married woman, by personalizing her husband. Is guilty of a felony termed "rape" and liable to imprisonment for life.

5.3.2 Attempted rape contrary to section 134

Any who attempt who attempts to commit rape is guilty of a felony and liable to imprisonment for life.

5.3.3 Indecent assault on females contrary to Section 137

(1) Any person who unlawfully and indecently assaults any woman or girl is guilty of a felony and is liable to imprisonment for fourteen years.

(2) It shall be no defense to a charge for indecent assault on a girl under the age of twelve years to prove that she consented to the act of indecency;

Provided that it shall be a sufficient defense to any charge under this subsection if it shall be made be to appear to the court before whom the charge shall be brought that the person so charged had reasonable cause to believe, and in fact believe that the girl was of or above the age of twelve years.

5.3.4 Defilement of girls under sixteen Contrary to Section 138

(1) Any person who unlawfully and carnally knows any girl under the age of sixteen is guilty of the felony is liable to imprisonment for life.

(2) Attempt- Any person who attempts to have unlawful carnal knowledge of any girl under the age of sixteen years is guilty of a felony and is liable to imprisonment for fourteen years.

5.3.5 Defilement of idiots or imbeciles Contrary to Section 139

Any person who, knowing a woman or girl to be an idiot or imbecile, has or attempts to have unlawful carnal knowledge of her in circumstances not amounting to rape but which prove that the offender knew at the time of the commission of the offence that the woman or girl was an idiot or imbecile, is guilty of a felony and is liable to imprisonment for fourteen years.

5.3.6 Unnatural offences (Sodomy) Contrary to Section 155

(a) Has carnal knowledge of any person against the order of nature; or
(b) has carnal knowledge of an animal;
(c ) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of a felony and liable to imprisonment for fourteen years.

5.3.7 Indecent assault of boys under fourteen Contrary to Section 157

Any person who unlawfully and indecently assaults a boy under the age of fourteen years is guilty of a felony and is liable to imprisonment for seven years.

5.3.8 Incest by males Contrary to Section 159

(1) Any male person who has carnal knowledge of a female person, who is to his knowledge his granddaughter, sister, or mother, is guilty of a felony and liable to imprisonment for five years:

Provided that if it is alleged in the information or charge and proved that the female person is under the age of twelve, the offender shall be liable to imprisonment for life.
5.3.9 Incest by females Contrary to Section 161
Any female person of or above the age of sixteen years who with consent permits her grandfather, father, brother or son to have carnal knowledge of her (knowing him to be her grandfather, father, brother or son as the case may be) is guilty of a felony and liable to imprisonment for five years.

5.3.10 Negligent acts likely to spread infection Contrary to Section 183
Any person, who unlawfully or negligently does any act which is, and which he knows or has reasons to believe to be likely to spread the infection of any disease dangerous to life, is guilty of a misdemeanor. (Infecting a child with Sexually Transmitted Disease).

5.4 THE FOLLOWING PROCEDURE MUST BE ADHERED TO IN THE OPENING OF A CASE DOCKET
The Accused person number 1 statement must be completed. The preamble must meet the prescribed requirement and must be completed. If firearms and vehicles are involved it must be mentioned. The A1 statement must contain all the elements of the crime. The affidavit must be completed and signed. The A1 statement must be filed and properly marked. Station number, case number and index number on top of every page.

5.4.1 Case or Docket Preparation
A docket is an official document in which a record is kept of a reported crime and its investigations. The process flow for dockets is;

a. The report of a complainant
b. The opening of a case docket
c. The inspection of the case docket
d. Registration of the docket
e. The transfer of the case docket to crime unit, to detective unit, or to station level.

5.4.2 The Following Must Be Performed (If Applicable) and Completed

• The full description of the scene of crime
• The full description of possible suspects must be given
• The CR and the OB number must be written
• Details must be given of person (s) from whom statements have been taken (names of other witnesses)
• The number from the APPB must be obtained if an arrest has been made
• The suspect must be charged, the warning statement indexed and all other relevant information must be given for example fingerprint form) taken
• Statements / particulars where applicable must be given regarding arrest being made.
• Statements must be field regarding exhibits that have been confiscated.
• The property register number must be indicated on the top page of the case docket if exhibits have been confiscated in RED ink.

• The full description of the scene of crime
• Notice for the arrest of juveniles must be obtained as well as the place where the juvenile is detained.
• Medical examination of a person to determine physical condition, sobriety
• Psychological condition (report of district surgeon)
• Requested arrest or information must be completed and the circulation number must be given.
• Proof of report of complain by complainant must be handled over to the complainant.

After the case docket has been opened and the above requirements have been met, it is the responsibility of the shift officer (Criminal Investigating Officer) to perform the first information on crime inspection.

5.4.3 Identify Potential Witnesses
Are there people who might have seen the crime, or what happened just before or after the crime took place? Eye witness’s accounts are the most used identification media where the offender has been identified. This evidence is subjective, however, and not always reliable due to factors such as;

• Human fallibility
• Defective perception
• Defective reporting
• Suggestion
• Faulty association
• Fear of involvement
• Fear of retaliation
• Ignorance

5.4.4 The Initial Response
(a) The first question to ask on arriving at a scene of crime are;
Is it safe for the officers?
Is it safe for the victim?
Are there witnesses?
Who is the suspect and where is s/he?
Is there a protocol?

(b) If the initial response is by patrol, priorities are;

• Is the child in need of medical attention?
• Identify and control the crime scene
• Collect and properly preserve all evidence (forensic evidence from the child can include his or her clothes or possession)
• If the suspect has been arrested at the scene, collect forensic evidence from him
• Document all excited utterances and statements by the suspect, victim, and witnesses
5.4.5 Interviewees

Interviewees to consider are:

The Accused
Victim
Household members and relatives
Other children in the home
Other children at risk or exposed to abuse
Neighbors and friends
School personnel/ activity leader
Medical professionals
Child or Protective Service workers
Character witnesses

Obtain the child's caretaker explanation for any injuries and
Collect a social history of a suspect; prior girlfriends / boyfriends, co-workers and sex partners.

5.4.6 Crime Scene(s)

In case of child sexual abuse:

- Clothing of victim
- Clothing of suspect
- Beddings, carpet, towels
- Car mats, seats
- Weapons
- Suspect's belongings
- Lubricants / Condoms
- Sexual devices
- Pornography
- Forensic evidence from both suspect and victim's bodies
- Collect grooming materials (i.e. hair brush)
- Gifts given
- Photographs or videos of victim
- Computer disks / hard drives / emails / letters

5.5 EVIDENCE

Collect medical records of the victim, both present and past. Have there been any sexually transmitted diseases (STD), either in the victim's medical history, and / or the suspects or family? Get prior social welfare reports, school records, and work records of the suspect if applicable. Obtain phone records for suspect, Identify if there have been any prior calls to emergency police numbers. Does the suspect have criminal history or prison records? All of this evidence will help to corroborate the victim's statement.

5.6 PROTECTING YOUR CASE

- Protect the victim by making a safety plan and following up
- Guard against recantation by making sure the child is in a comfortable environment and away from the suspect or suspect's family
- Involve child protective services if necessary
- Find out if the child needs therapy and assist in finding referral
- Above all, be prepared to testify and defend your investigation

5.7 CHILDREN'S FIRST DOCTRINE

No matter what is happening in the course of investigation, the governing principle must be that the needs of the child come first. You must do whatever is in the best interest of the child.

5.7.1 Taking and Recording of Statements

(A) The Principles of a Good Statement

- Accuracy
- Completeness
- Conciseness
- Objectivity
- Intelligibility / comprehensibility
- Honest
- Simplicity and directness
- Clear definition of words and terms

Accuracy

The information that is provided in a statement must be as accurate as possible, enabling the reader to establish the facts. Think, for example, if it is stated as hearsay. Many deduction or opinions of the deponent may eventually be included in his/ her statement. To ensure accuracy a distinction must be drawn between the following:

- Facts and opinions
- Facts and supposition
- Different meaning of words

Accuracy of a statement can be established by asking the following questions:

Who?
Who committed the offence?
Who is the witness?
Who is the victim?(Complainant)?
Who reported the case?
Who searched the scene of crime?
Who found, marked and dispatched evidence?
Who might have had a motive to commit the offence?
Who discovered the scene of crime?

What?
What precisely took place?
(Describe the events in accurate detail)
What object (or body part) was used to commit the crime?
What was done to protect the scene of crime?
What was done to obtain information?
Was anything stolen?

Where?
Provide a complete description of the place, including the name of the building the street name and number, and the name of the area

Where was the complainant?
Where the body of the deceased, if any was found?
Where were the clues found?
Where was the witness when the crime took place?
When?
Note date and the time of the incident.

When was it reported?
When did the Police arrive at the scene of crime?
When was the crime discovered?

How?
Describe in detail the actions that constitute the offence.

How was the crime committed?
How did the person who discovered the scene of crime approach the scene of crime?

Conciseness
All the facts that the witness knows must be included in the statement. This must be done in complete sentences without using a 'telegram style' but should also strive for concise readability to prevent reader from having to work hard to 'get to the point'. Without losing any of the nuances or meaning of what the witness is saying, try not to include extraneous language that obscures the main points and facts.

Objectivity
State those facts that relates to the case in question. The officer who takes statement must not allow his / her emotions to affect the content of the statement. Emphasize with the witness to help understand the point of view, but don't get 'down in'. The officer should place him or herself on an imaginary platform and should stay removed from the person making the statement so as not to inject personal bias in to the process.

Comprehensibility
The contents of the statement should such that whoever reads it would not find it necessary to request that certain aspects be explained. The statement must be neat and presentable. The prosecutor, the attorney and the judicial officer may attempt during the presentation of evidence to form an opinion of the police official e.g. if he/ she is a reliable witness. What do you think the court will think of a police whose statement is full of mistakes and dirty marks? This type of statement creates an unprofessional and untidy image.

Honesty
The deponent (person testifying under oath) as well as the member of the service who takes the statement, must be absolutely honest at all times, even if some one else would be incriminated in the process.

Simplicity and Directness
Avoid argue and meaningless word in a statement. Write simple language and short sentences; cut away the deadwood from sentences (do not beat about the bush)

Clear Definition of Words and Terms
Does not use ambiguous words, be aware if a person is giving a statement in his or her second or third language and make sure to clarify words or phrases that have dual meanings in different languages. Instead of using vague language like 'he moved up and down' encourage the witness to be specific and use words like penis and vagina to be absolutely clear about what happened. Do not, under any circumstances, insert your own language in brackets to explain a witness statement. That means there is no longer 'owned' by the actual speaker and is not admissible.

5.8 FORMAT OF A STATEMENT
Every statement should start with an introduction or heading. The first paragraph should give personal details of the person speaking or writing, so that he or she will be traceable in the event of needing their testimony in court. The second paragraph should give the day, date, and time. Use paragraphs, leaving no open spaces or lines. Open space leaves the possibility open of letter tampering

5.8.1 First/Initial Statements
From the victim:
Getting a statement from a victim can be difficult. The victim may be suffering from post Traumatic Stress or Rape Trauma Syndrome, may be in denial, in pain, or unable to speak clearly.

Do not discredit or judge the validity of a statement because of the way in which it is made. Keep in mind that symptoms of trauma can make it appear that a person is joking (nervous laughter), uncaring (blank expression), or unsure (inability to remember detail because of mental block).

From the report witness
With rape and other sexual assault cases, a, 'first report Witness' is the person the victim first told about the event. This is a very important statement because it can be used in court to verify a victim's emotional state and initial recounting of the event.

5.8.2 Other Statements
Take statements form all possible witnesses. "Paper collectors" are detectives that do the minimum amount of work for a case; filtering names from the victim's statement and ignoring some that seem "unimportant". Good detectives record every single name mentioned and track those people down to give statements. The victim and first report witness statements are just beginning of a chain of witnesses that can help in the investigation. Experts can also be interviewed and the investigating officer must file signed reports every time he or she visits the scene of crime.
5.9 TAKE CONTROL OF SCENE OF CRIME

The first step in crime scene management is to control access to the scene. Prevent bystanders and non official observers from trampling on the evidence and moving things around. There are people at most of scenes of crime. Some are merely inquisitive, but they may be shocked family. Always explain to those present that the conservation of the scene is vitally important and for that reason the public must be kept away. Treat all people with respect, yet firmly.

5.9.1 Preserve and Protect the Scene of Crime

Conservation at the scene of crime is an important responsibility of the first member who arrives. Anything that does not require emergency action must be left until the scene is sufficiently protected. This process depends largely on the location of the scene. Excluding the victim's body, these can be roughly divided in three categories: indoors, outdoors and vehicles. To conserve a scene of crime sometimes simply entail locking a door to a building or room or cordoning off an area outside.

Any suitable article like furniture or boxes may be used indoors and screen off a certain area (as long as none of them is part of the crime scene). Officers should carry rope for cordoning off the crime scene area. Using a guard to ensure security is the option.

5.9.2 Be Observant and Pay Attention to Everything

A situation report should note anything that can / will change (smells, doors that are open or closed). A police official who first arrives must evaluate the situation, make deduction, and identify potential collection points for important evidence. Remember that details in writing are subject to a child “tall” is different than for an adult. Try to be an objective.

(a) Date and times: arrival at and departure from the scene, observation made, objects found, person traced and arrested and executed.

(b) Condition of doors: is it locked, closed, open, damaged? Is the key in the lock? Is the key on the inside or outside of the door? What type of lock is fitted to the door?

(c) Condition of windows: is the window catch secured in position? Is the window open or shut? Are the windowpanes intact? If broken, are the pieces of glass lying on the inside and outside of the wall? What type of window is it?

(d) Barriers at windows: are there blinds, curtains, and / or burglar proofing intact or damaged?

(e) Odors: is any particular smell at the scene (tobacco smoke, gun powder, perfume, petrol, paraffin, oil, methylated spirits, etc.)

(f) Weather condition: is there rain, snow, fog, fine weather

5.9.3 Searches

The Locard principle, also known a 'contact theory' states that there is a reciprocal transfer of traces whenever two objects or persons come in to contact with each other. This scientific fact implies that clues in some form must be left at every scene of crime. However these traces are often so concealed at the scene of crime that they cannot be detected with the existing techniques. It is the duty of the investigating officer to discover them by means of the techniques at his or her disposal. When searching is necessary, it is important it be done in an effective and organized manner. While no two crime scenes are alike and no single method can be applied universally, certain physical methods of searching have been internationally recognized and are and are good options:

It should be emphasised here that a search must be lawful for the evidence collected to be legally accepted as genuine and cogent.

5.9.4 Spiral method

This method is conducted in a circular fashion from any point outside the scene, moving slowly inwards towards the centre. One may also start at the central point and move slowly outwards in circular fashion. This method is especially suitable if one investigator has to conduct the search.

5.9.5 Sector searching (segmentation)

The scene is divided into segments, and each is searched individually. This method is especially suitable when a number of investigators are available, and large premises or a vast has to be searched.

5.9.6 Grid Method

The scene of the crime is crisis-crossed in the form of a grid. This method offers the opportunity to search the scene systematically and thoroughly. It is suitable for any number of searchers.
CHAPTER VI

THE LEGAL COMPONENT
This component is an outline of basic legal guidelines based on a practical approach of dealing with children's rights and Child abuse cases. When working with these guidelines address your mind to the most critical areas in Child abuse cases. One other thing one needs to note is that Child abuse cases are very serious criminal cases today and are not an exception to the strict rules of evidence. When it comes to sexual offences the rules are very strict for child victims as well as for adult victims. We need to state that although most of these cases are handled in police stations, police stations and courts are not a good place for addressing abuse cases because of the trauma that children go through in such places and child victims should if possible be kept away unless circumstances are really compelling.

People dealing with children need also to distinguish between child offenders and child victims. This is because in most cases both the victims and the offenders undergo the same kind of treatment. Because of this most Legal Practitioners and children's rights advocates think there should be a distinction between the treatment of perpetrators and victims. They contend that it would be wrong both in law and common sense to subject victims to the same treatment as offenders and it is this that forms the foundation of my opinion.

6.1 WHO IS A CHILD IN ZAMBIAN LAWS?

Zambia follows a common law system of the laws and as such has in addition to its own customary laws, a dual legal system. This means that we follow both the common law principles of the laws as received from our English colonial master (Britain) together with certain statutes passed in England but applicable and binding to Zambia and Zambia's own indigenous laws which are derived from customary law set ups of all the estimated 72 tribes.

From the indigenous laws, a child may have very few rights as he or she is considered to be no more than a mere dependent of his adult guardians.

However customary is unwritten and varies from place to place. Where the rights of a child have been violated, the child may no remedy against the aggressors and as such making the Zambian child more vulnerable to abuse and in most cases neglect.

The laws applicable to Zambia by way of English common law and statute do allow a child to sue but through an adult known as a next friend who must consent to sue on behalf of the child and to be next friend, while our local customary laws are silent on whether a child can sue. However, damages may be payable to the child's parents or guardians when a child is wrong in most customary law systems. This is because children lack the capacity to sue until they have attained the age of majority which is believed to be around 18 and 21 years.

The result is that the child is only assisted to sue for serious violations that border on criminality only such as assault, battery and personal injuries while he is not at liberty to maintain an action in other instances such as the right to education, health or life.

This is because our Republican Constitution does not guarantee social and economic rights. They are Non-Justifiable meaning a person cannot enforce these rights using the judicial process. Even if the State does not provide for its citizens, it cannot be compelled to do so using the courts of law.

The failure of our legislation to make provisions that allow children to sue and claim their social and economic rights has for a number of decades been the source of concern as it defeats the purpose for claiming children's rights and eventually reduces children's rights to a mere secondary right of preference. As the law books stand today a child in Zambia is legally incapacitated and has little or no rights to sue and enforce the law against perpetrators. A child can only depend on others for such rights.

6.2 THE REPUBLICAN CONSTITUTION AND CHILDREN'S RIGHTS

The protection of the child must be placed in a grand norm like the Republican Constitution, but a close examination of the last four constitutions shows very little mention of the child. It needs to be stressed here that if the Republican constitution which in its Article 1 (3) states that:

“This constitution is the supreme law of the land and that if any law is inconsistent with the provisions of the constitution, that law shall to the extent of the inconsistency be void”

This clause gives the constitution the greatest place in all the laws of the land such that should there be an inconsistency in the application or administration of the law, the republican constitution shall always prevail. All the Four constitution review commissions have failed to include in their drafts and final copies guarantees for the rights of the child.

6.2.1 Children and the Bill of Rights

The Bill of Rights which is Part Three of the Republican Constitution which enshrines the fundamental rights of the individual has also failed to guarantee children's rights against child sexual abuse. The Bill of Rights has a constitutional protection against amendment and that is the more reason why all the children's rights for instance the United Nations Convention on the Rights of the Child should be transplanted there. The Republican constitution demands that before any amendment to the Bill of Rights can be made or done, there is need, before the first reading of the Bill in Parliament making such proposed amendments, to have a National referendum with at least 50% of the people eligible to vote at the General election casting their votes on the propose amendment.

Just this procedure alone prevents the touching of the people's rights. The republican constitution can be amended in any way but the bill of Rights will not be touched. The amendments need not be positive or negative meaning you cannot even add to the Bill of Rights before you hold a national referendum.
A good example is the 1996 amendments to the Constitution where there entire constitution was amended but the Bill of Rights (see appendix) survived because of the national referendum clause. The amendments were thus said to be annexed as an appendix to the constitution since it was not a new constitution. That was even the more reason why that constitution was adopted in parliament by parliament itself.

6.3 AMENDMENTS IN THE LAWS

One may wish to note that these concepts were never envisaged at the time we received our laws from Britain and this is the reason why we have no simple definition of Child abuse. From the time I became associated with the law, I have noted the serious gaps in the law. But I also need to stress the role of law in society. The law is there to regulate society and can only change when the same society it regulates demand for new regulations. Most laws dealing with children are either International instruments or Treaties which, although are persuasive have no binding effect on our courts.

6.4 HOW TO TREAT CHILDREN WHO ARE WITNESSES

Children are not allowed to testify in court because of several factors such as their age, ability to remember and ability to tell the truth. These are some of the factors that have to be ascertained by a Court before a child witness is allowed to testify. This is done through a process called a Voire Dire. In the event that a case of child sexual abuse is taken to court before the child has to testify the special rules of evidence will have to be addressed. For example, if the child is likely to be traumatized or suffer long term consequences, the court may be compelled to receive the evidence of the child in camera (privacy).

In this case, the child will not be allowed to testify in open court (Public Court). The courtroom will be cleared so that the child can testify. The Criminal Procedure Code states that evidence in criminal matters shall be received in open court and in the presence of the accused person. This is another factor that has to be considered when deciding to receive the evidence of a child. When the courtroom is cleared only those people directly concerned with the case will be allowed to be present. These may be the parents and guardians, court officials and the accused person.

It should be emphasized that the evidence and testimony of a child will be treated in the same way as the evidence of an adult. This is because other than just the offence being tried, the liberty of an adult suspect is at stake and secondly, the suspect must receive a fair trial regardless of the circumstances in which he finds himself and furthermore because of the presumption of innocence which the accused person enjoys throughout trial. This presumption states that "no one is guilty until he has confessed or has been proven so." The safeguards are meant to protect the accused person because the child may be mistaken about the abuser's identity or may be used to implicate an innocent person names.

For these reasons, courts are always impartial or neutral. Regardless of the age of the child, the criminal justice system requires the child to prove her allegations beyond reasonable doubt.

6.5 WHISTLE BLOWERS AND THEIR PROTECTION

People that report or raise alarm of children sexual violence, neglect and abuse must be protected if the battle is to be won. Anybody can report a matter to the police and his or her name will be kept confidential as such a person is a state witness. The basic principle should be that in so far as it is reasonable to suspect that there is child sexual violence, neglect or abuse, such people should enjoy some form of immunity and freedom from disclosure of their

Zambia seems to have just started moving in the protection of children and their rights and even then the pace is too slow for us to catch up with the rest of the world. We do not seem to have a form of protection for our informants thereby creating a sense of insecurity in the public. This may perhaps even be the more reason why even police officers do not get the right information on time. This protection may be by way of a statutory instruments or the amendment to the Defamation Act. Although a person cannot be sued for whatever he said in Court, the situation on the ground is that that person can be harassed and the police will ignorantly say and as they usually do, that it is a civil case we cannot move in.

6.6 CHALLENGES ON CHILDSexual ABUSE IN ZAMBIAN LAWS

The greatest challenges we face as a country are that the laws we have are not child related. We face a serious challenge in the area of child protection because our laws do not, strictly speaking, have mechanisms for ensuring child protection. When a child has been defiled for example, the child has top be treated in the same away as adults and as a result the whole process becomes very difficult to cope with. The child has to be exposed to the same type of facilities for not only health treatment but also law enforcement mechanism.

As already stated above the greatest challenge is how to ensure that our laws focus on children in the strict sense. The British have a Children's Act that looks into the affairs of the Child. In Zambia laws relating to children are so fragmented and have to be dealt with in various aspects depending on the circumstances surrounding each piece of legislation. One of the major challenges lies in the duality of our laws whereas sex with a girl aged below 16 is defilement; it is not if the girl marries the assailant. In addition, the Juveniles Act is not sufficient in that it does not provide for all the offences. It only supplements the Criminal procedure Code and the Penal Code. Other pieces of legislation such as the Maintenance and Affiliation of Children's Act are so inclined to and biased towards Civil matters such as such cannot be used as instruments for the protection of sexually abused children.

54
6.7 CHILD RELATED LAWS

What Zambia needs is a piece of legislation that will not only deal with the Child but also with sexually abused children per se. There is also need to have the laws synchronized to localize the rules of proof for children because at the moment and as far as the laws are concerned; child witnesses are not spared from the grueling means of proof in court. The position of the law is that all sexual offences need corroboration before the court can convict otherwise the whole process will just result in a mistrial and will even see the accused perpetrator walk to freedom.

6.8 INTERNATIONAL LAW INSTRUMENTS AND CHILDREN

The other reason is that there is no harmony of international law and its instruments and our local laws. Our laws need to be harmonized in such a way as to create a minimum age for the child or the ascertaining of the age of majority. The United Nations Convention of the Rights of the Child and other instruments such as the Worst Forms of Labour Convention do point to the Fact that Sexual abuse is one of the Worst forms of Exploitation a Child can be subjected to.

The most difficult part of the whole topic is that most of these international instruments have not been domesticated and as a result they have no binding force on the Republic. They are just like declarations which cannot be used as a weapon for the combating of the child sexual abuse in Zambia.

6.8.1 African Charter on the Rights and Welfare of the Child

There is need to have the penal code and the criminal procedure codes harmonized with the other international pieces of legislation such as African Charter on the Rights and Welfare of the Child, 1990 that was adopted by the 26th Ordinary Session of the Assembly of the Heads of States and Governments in Addis Ababa in July 1990. In its preamble this Charter emphasizes the fact that:

"The Child occupies a unique and privileged position in the African Society and that for the full and harmonious development of his personality, the child should grow up in a family environment in an atmosphere of happiness, love and understanding,

"Recognizing that the Child due to the needs of his physical and mental development requires particular care with regard to health, physical mental, moral and social development, and requires legal protection in conditions of freedom dignity and security."

It is noticed from this the great need for having these international law domesticated as part of our own local laws.

6.8.2 Definition of the Child in International Law

Definition of the Child in the International law set up is 18 years. Both the African Charter on the Rights and Welfare of the Child and the United Nations Convention on the Rights of the Child has set 18 years as the age of the child.

All sexually abused children must be given preferential treatment in the case of medical attention and it should be made very clear that whatever is done should be done in the best interest of the Child. Article 4 of the African Charter states that:

"In all actions concerning the child undertaken by any person or authority the best interest of the child shall be primarily consideration".

What this infers is that in all judicial or administrative proceedings affecting the child the best interest of the child must be paramount.

Article 27 of the African Charter on the Rights and Welfare of the Child expressly prohibits sexual exploitation and sexual abuse; State parties to the present Charter shall undertake to protect the Child from all forms of sexual exploitation and sexual abuse and shall in particular take measures to prevent:

a. The inducement, coercion or encouragement of the child to engage in any sexual activity,
b. The use of children in prostitution or sexual practices,
c. The use of children in pornographic activities, performances and materials.

6.8.3 Worst Forms of Labour Convention 1999

Several International instruments such as the Worst forms of Labour Convention of 1999 state in its Article 3 (b) and (c) that,

"For the Purposes of this Convention, the term the worst forms of labour comprises:

(b) The use, procuring or offering of a Child for prostitution, for the production of pornography or for pornographic performances;

(c) The use, procuring or offering of a Child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international Instruments."

6.9 RATIFICATION AND DOMESTICATION OF INTERNATIONAL LAW INSTRUMENTS

The Zambian Government does on most occasions ratify International Law instruments but do not move a step further by domesticating these laws. This creates a lacuna in the law as most of these instruments are not part of the local legislation.
The advantage of domestication of these instruments is that Zambia will move with the rest of the World at the same pace in combating the scourge of child sexual abuse. In cases where certain particular acts constitute crimes in the international scenario, but not yet crimes in Zambia, the laws in our country are silent and as such the same offence cannot be punishable in our laws.

This is because the Rule of Law states that you cannot punish a person for an act that was or is not a crime and our Republican Constitution in Article 18 (4) states that there can be retrospective application of the law in such a way that even if Zambia decided to make certain acts criminal, those acts cannot be regarded as criminal if at the time they were committed they did not constitute crimes.

The jurisprudence behind this reasoning is strongly supported by propositions that if the law was like that, then we would all be criminals in a way and would have to be punished.

6.10 THE LAW OF EVIDENCE

Where the evidence collected is not properly stored and preserved the defence team will take advantage and form a very strong defence from the mistakes of the prosecution. It should be remembered that a good case can be lost on a technicality. We need to stress that when it comes to court it is not a question of truth of the statements made but the strength of the evidence presented.

6.11 WHAT IS CORROBORATION?

Corroborated is a legal requirement that requires that to all sexual offences there must be independence evidence. Corroborated takes many forms. It may be by an exhibit, and odd coincidence or something other than a mere testimony. Corroborated is always needed where the witness is a child or where the offence being tried is a sexual offence. Where his prosecution fails to corroborate statements, the accused persons may be acquitted. Corroborated means independent evidence from the one the witness wishes to rely upon. For example the testimony on a Child must be supported either by a torn dress or blood samples pointing to the identity of the accused. At times it could even be the testimony of an adult.

6.11.1 How to Corroborate Child Statements

As stated above, sinceCorroborated is a legal requirement, there may not be enough physical evidence to make a strong case based on statements alone. It is thus important to prepare very good Medical and Police Reports for use in court. These may help to strengthen the child's veracity and abilities as an 'accurate historian' of what happened. It is important to keep the exhibits in good order. It is also important to document each and every finding in the investigations so as to be remembered when serious cross examination of the investigator or Medical Officer is called in place.

6.12 HOW TO DEAL WITH CHILD OFFENDERS

The rules of evidence may remain the same in an instance where both the Victim and the Offender are children. But it has to be remembered that where the offender is a child, special rules do apply to help the child who has committed the offence to have a second chance. Children in conflict with the law are dealt with in compliance with the Juveniles Act. Juveniles may not be incarcerated but sent to approved community service schools. Corporal punishment has been outlawed.

6.12.1 Age of Criminal Responsibility for Boys

It should also be remembered that boys children below the age of 12 years are deemed not to be capable of having the capacity to commit criminal offences of a sexual nature. His is a legal principle called Doli Incapax and varies from country to country subject to the criminal laws governing a particular state.

6.12.2 Basic Rules for Child Questioning

People tasked with the questioning of the child in the course of investigations of an abuse should have some expertise because once the child realizes the gravity of the matter, he becomes apprehensive and most children prefer not to tell the truth to please the investigator.

It is advisable that an officer from social welfare or child welfare departments is available or present during the taking of a statement. It is also advisable that the child is removed from the abusive situation and kept in a place of safety. There is no need to expose the child to the public because the child becomes apprehensive and traumatic. It is also prudent to find out exactly how long the abuse has been going on. This is very important where the abuse might have been going on for a long time and the police might want to know how to charge the accused.

If the police draft a defective charge, the accused person or his lawyer might object to the charge and the abuser might just end up being acquitted even if he committed a crime.

6.13 REPORTING CHILD SEXUAL ABUSE

Whereas it is against the law for anyone to sexually abuse a child. And where as it is important to report all sexual abuse to the police so the abuser can be arrested and taken to court. It is better to report to police as soon as the incidence of abuse happens. In this way the police can ask the child important questions about the sexual abuse while child remembers clearly and assist the police gather the necessary evidence.

6.14 HOW TO PRESERVE EVIDENCE

Where possible keep the evidence as it has been gathered from wherever it has come from, for example, do not wash the child or change clothes if the sexual abuse has just taken place. Underwear with blood or semen on them should not be washed but put in paper bag rather than a plastic bag.
The police officers should even take photos of the exhibits if they believe that preservation might be difficult or that the exhibit might transform into another state the time the case goes to court. Injuries can also be photographed and photos kept in a secure place. This is because criminal cases in Zambia and in many parts of the world take long to be concluded.

6.16 STEPS TO THE ADMISSION OF EXHIBITS AND EVIDENCE

The presentation, production and admission into evidence of exhibits is a very time consuming and heavily technical area basically for the trained prosecutors and lawyers. To non lawyers anything is evidence; to lawyers nothing is evidence until accepted by the court. How the courts will accept the items of evidence is a question of both facts and law. The following are the major steps to be followed:

A. The Source of the Exhibit Must Be Competent

The source of the item of evidence must be competent and reliable. For example if the rape or defilement took place at a school and there was a torn dress with blood stains and semen at the scene of the crime. That particular dress with the same blood stains and semen must be presented before the court. There can be no substitute for another dress of another rape. Neither can there be a substitute from another stranger. The police officer investigating the case will be competent to produce the dress to be exhibited and the school where the rape took place will be a competent source for this dress. Anything outside this will be rejected.

B. Admissibility of the item of evidence

The item to be exhibited must be admissible as evidence at law. If it is an intangible item such as computer software and program the steps for securing its admission must be followed. Computer generated evidence might be problematic if the steps to its admission are not followed. This is also the case for VCD's and DVD's containing pornographic materials. The accused person might allege that the video was edited to incriminate him.

C. Relevance to the case in question

The item must be both legally and logically relevant to the case in question. For example if there have been defilements in a particular area or district, the other evidence of defilements from other cases has nothing to do with a particular case in question.

Most good cases are lost on this technicality especially if all the evidence is confused with that which has no relevance to the case because once the evidence is thrown out it cannot be brought back to be presented.

D. Marking of the exhibit

The proponent of the piece of evidence must ensure that as soon as an item is introduced into court, the item must be Marked and given an Identification number e.g. the dress be marked ID 1, the medical report be marked ID 2 e.t.c. When the items are admitted into evidence, the same IDs will become exhibits the dress P 1, the Medical Report P 2. The court will only take into account the exhibits when passing judgment if the same were identified, produced, marked, exhibited and admitted.
6.16.1 Laying the Foundation for Admission of Exhibits

If no proper foundation is laid for the admission of the exhibit the Defence team might object to the inclusion of the exhibit into the evidence upon which the court should write its judgment. The Defence lawyer may object to the production of and admission of an item of evidence into court if no sufficient foundation was laid.

What is called sufficient foundation is where the Prosecutor in court or during trial is calling the witness to come and testify about a defilement he witnessed. The witness must make mention of the torn dress in his testimony and must portray enough understanding of what was happening when the dress was being torn. If spontaneously the witness produces the torn dress when he did not mention the same in his testimony, the Defence will object and the objection if sustained removes the item of evidence from being used in court, thereby the evidence is lost.

6.16.2 The Probative Value of the Exhibit

The item of evidence presented in court must have a tendency to incriminate or to vindicate the accused person. There must be a connection between the item introduced and the accused in the case in question. For example it saves no purpose to introduce an item of evidence with semen and blood stains when you cannot satisfy the court whose blood, semen or stains it is. If it was a murder no murder weapon is produced and the prosecutions seek to introduce another item whose value cannot be established, the court will not allow it and the evidence is lost.

6.17 THE SENSITISATION OF PEOPLE AND THEIR ROLES

Sensitization has a bigger role to play. If organizations dealing with children partnered it would be easy for the government not only to make promises but to domesticate instruments dealing with children. The more people get aware of these things the more pressure will government face and see the need for legislating in favour of the child.

6.18 THE LAW AND DNA TESTS

Our laws are very sketchy and at the moment we have no laws dealing with the admission of DNA evidence.

None of our laws even clarify the confusion surrounding the use of DNA Laboratories abroad or outside Zambia. Ordinarily the law states that the person that had conducted the Laboratory examination on the DNA samples must testify in person and must be cross examined in court. Where he is not cross examined, the law is strict; the samples of evidence may not be accepted as evidence in court. Perhaps there may be no law directly addressing the administration of DNA evidence. But it remains to be seen by all key role players that, without abridging the law, there must not be any problem with the admission into evidence of DNA samples provided the person presenting these samples into court is competent in the area of DNA.

6.19 REPORTING ABOUT CHILDREN

It is incumbent upon every media professional to avoid sensationalizing children reporting for the purpose of making the story flowery and injuring the child or children involved. As much as the role of a journalist is not that of an activist, the media professionals could positively transmit facts and figures regarding child rights to the general public. This expectation should drive the journalist to perform his or her duties with a high degree of professionalism and judgment in their daily work.

While working as a reporter, a journalist should strive for accuracy and try to reach the hearts of the people by not evoking pity but making sure that they help to bring about change. This means it is not how well acquainted with the UNCRC that matters but how they treat the story, which is a rather difficult task as it involves more of sound judgment. Looking at the UNCRC in journalistic terms, two broad categories are drawn and these are: Participation and Protection. In talking about participation, the UNCRC says that children have the right to have views and express them, which means that they can be seen and heard as good sources of information.

They can be useful in doing stories and providing information for stories that concern children as they are very often creative and intelligent enough to give a fresh angle to a story.

Most importantly concerning sexual abuse is the protection aspect of the UNCRC. Most of the guidelines provided by the UNCRC stress more on the protection of the child looking at issues such as sexual abuse, illegal trafficking of children, child soldier and so on.

Our local statutes the Penal and the Criminal Procedure Codes do not lay down the procedure relating to children who fall victims of the sexual violence and abuse. Even for the sexual offences, our laws are as old as they have been and need to be amended. The rules of natural justice as they stand mostly make the fight against child sexual abuse very difficult to handle. It would be prudent if most of these laws are softened in the best interest of the child.

The authorities dealing with children need understand the unique position the child occupies in society coupled with the vulnerability to all forms of abuse and exploitation. It is for this that the children should be protected by both legal and administrative mechanisms. The reporting mechanism should have enforcement mechanisms. As the laws stand they do not compel members of the public to report such cases to the authorities and as a result there are so many cases that go unnoticed. The law should actually make it mandatory for members of the public especially those directly linked or involved with the child to report such cases as soon as they happen. The problem is that very few people are aware of the implications of not reporting cases in good time.
6.20 LACK OF ADVOCACY FOR CHILD FRIENDLY LAWS

There is need for ZASPCAN to critically advocate for laws to address the issue of child sexual abuse. This is because of the fact that justice for children in this area cannot be handled in the absence of swift legal and administrative channels.

6.20.1 Lack of Children’s Policy

The majority of these problems can be ironed out as soon as the country develops a Children’s Policy to act as a guiding tool for all children’s rights and laws. Currently, there seems to be duplicity of laws and activities and perhaps there is lack of seriousness in the administration of children’s rights in the light of increasing abuses and sexual violence.

6.20.2 Lack of Children Specialists

All the little efforts made, in the fight for a better world for all the children to live in, are lost because we seem as a country to lack child specialists. If professionals like doctors, lawyers, economists, psychologists, and many more came together and advocated for the specialization in children’s welfare and activities, there would be tremendous improvements in the fight against all wrongs against children. Currently government departments exists which are3 supposed to champion the interests of the child but they are hampered by the lack of government and policy makers’ implementation of programmes and activities.

Only committed professionals have taken out a few of their busy schedules to take part in activities that promote children. Such organizations as ZASPCAN, Child Justice Forum, and many more. There is need to double the efforts to ensure that even the Laws governing Town and Country Planning should make special mention of the child when planners desire to put up infrastructure. Harmful structures to children such as uncovered drainages and so on should be addressed.

6.20.3 Environmental Safety for the Child

The present infrastructure countrywide, be it schools hospitals and others have very few facilities to improve or better the child’s growing and learning environment. It is because of such lack of concentration that certain public officers such as teachers, policemen e.t.c have taken advantage of the absence of safety for the children in public institutions that they have instead of protecting, ended up violating the children themselves.

Administrative rules and regulations need to be strengthened to deter any future sexual abuses in schools. For example if a teacher or any personnel sexually abused a child, other should be a life long sentence on him so that the rest may learn from other people’s mistakes.
APPENDICES
APPENDIX 1:

PSYCHO-SOCIAL SEXUAL DEVELOPMENT

Five phases were described by Sigmund Freud (from infancy to adulthood) to reflect the stages of sexual development.

0-2 years: Oral Mouth, Tongue phase

The infant (child) is preoccupied with sucking at mother's breasts. Children at this stage get some gratification of sexual nature. Therefore, with the same lips child fulfils needs for food and sexual pleasure. Infant needs to get basic nurturing or later it may develop feelings of greediness and acquisitiveness. Oral fixations result from deprivation of oral gratification in infancy.

2-3 years: Anal (anus) phase

Anal stage becomes of major significance Stage in formation of personality. In the second and third years life child shifts its pleasures to the anus and the pleasure of holding in and pushing out stools. These pleasures are barely established, however before the child encounters the social demands of toilet training. Freudian theorists regard toilet training as a crucial event, a systematic attempt to impose social requirements on the child's natural impulses just as she or he has begun to gain some bodily control.

3-4 years: Phallic (genitalia) phase

Basic conflicts on unconscious incestuous Stage desires that child develops include for parents of the opposite sex and that because of their threatening nature are repressed. Male Phallic stage known as Oedipus complex involves mother as love object for the boy.

Female phallic stage known as Electra Complex involves girls striving for the father's love and approval. It is believed that how parents respond verbally to a child's emerging sexuality has an impact on sexual attitudes and feelings that the child develops. Phallic stage fixation may result in self-centeredness. Male seeks for substitute of mother, female tends to have aggressive attempts to dominate men.

4-5 years: Latency phase

After the torment of sexual impulses of the stage preceding years, this period is relatively calm. Sexual interests are replaced by interest in school, playmates sports and a range of new activities. This is time of socialization as child turns outwards and forms relationship with others.

6-12 Genital phase

The focus in the final stage of psycho-Stage sexual development is on the pleasures of sexual intercourse. However some aspects of Freud's thoughts, such as his belief that early childhood experiences have a crucial impact on adult personality and his notion that different stages of an individual's life present different predictable problems in social and personality growth, have been widely accepted even by some psychologists who adhere to differing developmental perspectives.
## APPENDIX 2:

### BEHAVIORS RELATED TO SEX AND SEXUALITY IN PRE-SCHOOL CHILDREN

<table>
<thead>
<tr>
<th>NORMAL</th>
<th>OF CONCERN</th>
<th>SEEK PROFESSIONAL HELP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Touches/rubs own genitals when diapers are being changed,</td>
<td>Continues to touch/rub genitals in public after being told many times not to do so.</td>
<td>Touches/rubs genitals in public or in privacy to the exclusion of normal childhood activities.</td>
</tr>
<tr>
<td>Explores differences between Males and females, boys and girls</td>
<td>Continuous questions about genital difference after all questions have been answered.</td>
<td>Plays male or female roles in an angry sad or aggressive manner</td>
</tr>
<tr>
<td>Touches genitals, breasts of familiar adults and children</td>
<td>Touches the genitals, breasts of adults not in the family. Asks to be touched himself or herself.</td>
<td>Sneakily touches adults. Demands touching of self</td>
</tr>
<tr>
<td>Takes advantage of opportunity to look at a nude person</td>
<td>Stares at nude persons even after having seen many persons nude</td>
<td>As above</td>
</tr>
<tr>
<td>Asks about genitals, breasts, intercourse, and babies</td>
<td>Keeps asking people even after parents have answered questions</td>
<td>Asks strangers after parent has answered. Sexual knowledge too great for age</td>
</tr>
<tr>
<td>Erections</td>
<td>Continuous erections</td>
<td>Painful erections</td>
</tr>
<tr>
<td>Likes to be nude. May show others their genitals</td>
<td>Wants to be nude in public after parents say no</td>
<td>Refuses to put on clothes; secretly shows self in public after many scoldings</td>
</tr>
<tr>
<td>Interested in watching people doing bathroom activities</td>
<td>does not wane in days or weeks</td>
<td>Refuses to leave people alone in bathroom. Forces way into bathroom</td>
</tr>
<tr>
<td>Plays doctor, inspecting other bodies</td>
<td>Frequently plays doctor after being told to stop</td>
<td>Forces child to play doctor, to undress other</td>
</tr>
<tr>
<td>Puts something in the genitals or rectum of self or others due to curiosity or exploration</td>
<td>Puts something in genitals or rectum of self or other child after being told to stop</td>
<td>Use coercion or force in putting something in the genitals or rectum of other children</td>
</tr>
<tr>
<td>Plays house, acts out roles of mummy and daddy</td>
<td>Humping other children with clothes on</td>
<td>Simulated or real intercourse without clothes</td>
</tr>
<tr>
<td>Interested in having/birthing babies</td>
<td>Boy's interest does not wane after several week and days of play about babies</td>
<td>Displays fear or anger about babies, birthing or intercourse</td>
</tr>
<tr>
<td>Uses &quot;dirty&quot; words for bathroom and sexual functions</td>
<td>Continues to use &quot;dirty&quot; words at home after parent says no</td>
<td>Uses &quot;dirty&quot; words in public and at home after many scoldings</td>
</tr>
</tbody>
</table>
APPENDIX 3:

GUIDELINES FOR RESPONDING TO CHILDREN WHO ARE ENGAGING IN SEXUAL BEHAVIOR

Remain calm, voice even. Count to ten if needed. Remaining calm helps your child to understand it's the behavior you don't approve of, not them.

Provide a reminder of the specific privacy rule that they are breaking, (e.g. "Remember, no touching of others' private parts.) Children do forget. In addition, we may be trying to change a behavior that has become a habit, so it will take time.

Clarify for the child: "If you choose to continue doing what will happen".

If a consequence is necessary, provide it immediately in a firm but calm manner (e.g. "Because you touched Tommy's private parts, you chose to go to time out.")

After the consequence, help them to think of things they could have done instead of the sexual behavior (e.g., talk to an adult, play with a toy, draw a picture).

Let them know that you believe in their ability for self-control and that they can try something different the next time. "Next time you feel like touching Susie's private parts, you can play instead, or you can come and ask me for help. You could tell me, 'I need help to not touch.'" Talk with the child and practice with them.

If you determine that consequences are not necessary, redirect them to another activity. If the behavior is okay to be done in private (e.g., masturbation), remind your child that the behavior is okay but must not be done in public.

Praise your child during times when s/he is engaged in positive behaviors.


APPENDIX 4:

THE AMENDED PENAL CODE

Due to the amendment of the penal cap 87, which was done on the 28th of Sept. 2005 and enacted by the parliament of Zambia 7th of October 2005, the following offences against morality were amended;

Section 136 and 137 of the principal act was amended as follows;

1.1 ABDUCTION OF CHILDREN C/SECTION 136

Any person who unlawfully takes a child out of the custody of or protection of the child's father, mother or other persons having lawful care or charge of the child and against the will of such father, mother, or other persons, commits a felony and is liable, upon conviction to imprisonment for a term of less than ten years and not exceeding ten years.

1.2 INDECENT ASSAULT C/SECTION 137

(1) Any person who unlawfully and indecently assaults any child or other person commits a felony and liable, upon conviction to imprisonment for a term of not less than fifteen years and not exceeding twenty years.

(2) It shall not be a defense to a charge of an indecent assault on a child to prove that child consented to the act of indecency.

(3) Any person who is found in any building or dwelling house or in any verandah or passage attached thereto or in any yard, garden or other land adjacent to or within the cartilage of such building or dwelling house not being a public place—

(a) For the purpose of and from motives of indecent curiosity gazing at or observing any other person or child who may be within in a state of undress or semi-undress; or

(b) With intent to annoy or indecently to assault any child or person who may be Therein;

commits an offence and is liable, upon conviction, to imprisonment for a term of not less than two years and exceeding not five years.

1.3 SEXUAL HARASMENT C/SECTION 137A

(1) Any person who practices sexual harassment in workplace, institution of learning or elsewhere on a child, commits a felony and is liable upon conviction, to imprisonment for a term of not less than three years and not exceeding five years.

A child who commits an offence under subsection (1) is liable to such community service or counseling as the court may determine in the best interest of the child.

In this section, sexual harassment means:

(a) a seductive sexual advance being an unsolicited sexual comment, physical contact or other gesture of sexual nature one finds objectionable or offensive or which causes discomfort in one's studies or job and interferes with academic performance or work performance or conducive working or study environment.

(b) sexual bribery in the form of soliciting or attempting to solicit sexual activity by promise of reward;

(c) sexual threat or coercion which includes procuring or attempting to procure sexual activity by threat of violence or victimization; or

(d) sexual imposition using forceful behavior or assault in an attempt to gain physical sexual contact.
1.4 DEFILMENT OF CHILD C/SECTION 138

(1) Any person who unlawfully and carnally knows any child commits a felony and is liable, upon conviction, to a term of imprisonment of not less than fifteen years and may be liable to imprisonment for life.

(2) Any person who attempts to have unlawful carnal knowledge of any child commits a felony and is liable, upon conviction, to imprisonment for a term of not less than fourteen years and not exceeding twenty years.

(3) Any person who prescribes the defilement of a child as a cure for an ailment commits a felony and liable, upon conviction, to imprisonment for a term of not less than fifteen years and may be liable to imprisonment for life.

(4) A child above the age of twelve years who commits an offence under subsection (1) or (2) is liable, to such community service or counseling as the court may determine, in the best interest of both children.

1.5 PROCURING CHILD OR OTHER PERSON FOR PROSTITUTION, etc C/SECTION 140

Any person who —

(a) procures or attempts to procure any child or other person to have unlawful carnal knowledge either in Zambia or elsewhere, with any person or other persons for pornography, bestiality or any other purpose;

(b) procures or attempts to procure any child or other person to become, either in Zambia or elsewhere, a common prostitute;

(c) procures or attempts to procure any child or person to leave Zambia, with the intent that the child or person may become an inmate of or frequent a brothel elsewhere; or

(d) procures or attempts to procure any child or person to leave that child's or other person's usual place of abode in Zambia with intent that the child or other person may, for the purpose of prostitution, become an inmate of or frequent a brothel either in Zambia or elsewhere;

commits a felony and liable, upon conviction, to imprisonment for a term of not less than twenty years and may be liable to imprisonment for life.

Provided that no person shall be convicted of an offence under this section upon the evidence of one witness only, unless such witness be corroborated in some material particular by evidence implicating the accused.

1.6 HARMFUL CULTURAL PRACTICES C/SECTION 157

(1) Any person who conducts or causes to be conducted a harmful cultural practice on a child commits a felony and is liable, upon conviction, to imprisonment for a term of not less that fifteen years and may be liable to imprisonment for life.

1.7 CHILD PONOGRAPHY C/ SECTION 177A

(1) Any person who engages a child or other person —

in a pornographic performance;

in the production of a pornographic film or other material; or

in a pornographic activity of any nature;

Commits an offence and is liable, upon conviction, to a term of imprisonment of not less than fifteen years and may be liable to imprisonment for life.

1.8 ASSAULT OR BATTERING OF CHILD C/SECTION 248A

Any person who commits an assault or battery on a child occasioning actual bodily harm commits an offence and is liable, upon conviction, to a term of imprisonment of not less than five years and not exceeding ten years.
REFERENCES


WHO- Clinical Management of Sexual abuse Survivors by World Health Organisation, Geneva, - Reproductive Health and Research and UNHCR - Health and Community Development Section


