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Child sexual abuse in urban Tanzania: Possibilities and barriers for prevention

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Dedicated to my wife *Epiphania,* our children *Godbless, Viscar-Elianchopasia,* and *Gregory* for their moral support during my Ph.D. studies.

Abstract

Background: Child sexual abuse is a global public health and human rights concern. Despite being a crime in most countries, and with well-known physical and mental health consequences, the majority of sexual offences are not reported. Child sexual abuse is a maltreatment form characterized by contact or non-contact acts perpetrated by adults or older children toward younger children who have little power to resist. This thesis aims to understand the social context of child sexual abuse, and the perceived roles of parents, community, and key professionals in handling such incidents in urban Tanzania.

Methods: A combination of qualitative and quantitative research designs were applied to four sub-studies performed in Temeke district, Dar es Salaam. Qualitative content analysis was conducted on 23 in-depth interviews to describe the perceptions of key professionals and their experiences of handling cases of child sexual abuse, in addition, eight in-depth interviews with parents to capture their experiences of legal reporting of child sexual abuse incidents. Grounded theory was used to analyse 13 focus group discussions held with male and female community members to explore norm systems and community awareness related to child sexual abuse. Findings from these exploratory sub-studies paved the way for a school survey among 1359 students from 23 randomly selected secondary schools. Using descriptive statistics and multivariate regression analyses, prevalence, risk factors, and health consequences of child sexual abuse were estimated.

Results: Lack of working tools and financial support were perceived as major problems among the key professionals. Corruption at community and institutional levels was seen as jeopardizing justice. Community passivity and lack of knowledge about laws regulating sexual offences were identified as additional challenges for conducting fair investigations. The community perspective illustrated that children's rights were challenged by lack of agency. Community awareness about child sexual abuse was clear but there was also a lack of trust in that the healthcare and legal systems were capable of handling such cases. Myths and cultural beliefs justified abuse. Disclosure of abuse was threatened by fear of stigma and discrimination. Parental interviews identified four types of sexual abuse incidents. The type most strongly associated with a determination to seek justice was one with an innocent child. The youth who was forced into sex elicited feelings of parental betrayal. The consenting, curious youth created uncertainty in how to proceed, while the transactional sex youth evoked feelings of parental powerlessness. Shame and stigma, but also fear of perpetrator retaliation and breach of confidentiality, were seen as challenges for disclosure. The school survey showed that 28% (boys=30%, girls=26%) of the students were exposed to child sexual abuse, with boys more often affected than girls. Twenty-six per cent of boys and 19% of girls reported being forced to look at pornography.

Forced sexual intercourse was experienced by 9.8% of boys and 8.7% of girls. Abuse increased with age and diminished self-rated health. Perpetrators were most often neighbours, teachers and peers. In contrast, survivor confidants were most often teachers, family members and friends. Most survivors did not want any action taken for the abuse. Proportions of students who perceived having fair/poor health increased with severity of abuse comparing the none-abused (7.0% and 6.3% of boys and girls respectively) with the ever abused (26% and 41% of boys and girls respectively) and those reporting penetrative sex (35% and 53% of boys and girls respectively). Likewise, suicidal ideation and attempts increased with severity of abuse when compared with those not abused.

Conclusions and recommendations: Sexual abuse of children poses a devastating social, and public health challenge. In Tanzania neither the community nor the health or legal institutions are adequately prepared to handle these cases. Educating the community, economically empowering women and strengthening the medico-legal system are needed to increase the opportunity for human, legal and fair investigations and reactions. A national child protection system is needed to address the complexities of abuse at different levels and to safeguard the rights of children in Tanzania.

Key words: child sexual abuse, gender, socio-legal system, survivor experiences.

Original papers

This thesis is based on the following papers. They will be referred to by their Roman numerals:

I Kisanga F, Mbwambo J, Hogan N, Nyström L, Emmelin M, Lindmark G. (2010) Perceptions of child sexual abuse–a qualitative interview study with representatives of the socio-legal system in urban Tanzania. *Journal of Child Sexual Abuse*, 19(3), 290-309.

II Kisanga F, Hogan N, Nyström L, Emmelin M. (2011) Child sexual abuse—community concerns in urban Tanzania. *Journal of Child Sexual Abuse*, 20(2), 196-217.

III Kisanga F, Nyström L, Hogan N, Emmelin M. (2012) Parents' experiences of reporting child sexual abuse in urban Tanzania. *Journal of Child Sexual Abuse,* in press.

IV Kisanga F, Emmelin M, Urassa D, Nyström L. (2012) Child sexual abuse among secondary school students in urban Tanzania: Prevalence, risk factors and consequences, submitted.

Papers I, II and III are printed with the permission of the publisher.

Abbreviations

GBV	Gender-based violence
CHMT	Council Health Management Team
CSA	Child sexual abuse
FGD	Focus group discussion
FGM	Female genital mutilation
HIV	Human immune deficiency virus
MoCDGC	Ministry of Community Development, Gender and Children
MoNEVT	Ministry of National Education and Vocational Training
NGO	Non-governmental organization
PEP	Post exposure prophylaxis
PF3	Police Form 3
SAREC	Swedish Agency for Research Cooperation
SIDA	Swedish International Development Agency
SOSPA	Sexual Offence Special Provision Act
STD	Sexually transmitted disease
TAMWA	Tanzania Media Women's Association
TDHS	Tanzania Demographic Health Survey
URT	United Republic of Tanzania
WHO	World Health Organization
YRBS	Youth Risk Behavior Survey

Definition of terms

District	The largest sub-division of a *region* governed by District Commissioner
Ward	The largest sub-division of a *division* governed by a ward executive officer
Village	The largest sub-division of a *ward* in the rural setting whose leader is village executive officer
Ten-cell unit	The smallest rural-based administrative unit administered by a ten-cell leader and comprising 10 households
Kitongoji/ hamlet	An administrative unit having 50–200 households in peri-urban/rural setting led by street executive officer (Kitongoji leader)
Street	The smallest administrative unit in urban setting comprising 25-150 households and led by street executive officer

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BACKGROUND

Child sexual abuse

Child sexual abuse (CSA) is a serious worldwide public health concern that requires collective, as well as individual, pro-active measures for safeguarding children's rights.

Maltreatment of children takes many forms including physical, emotional, and sexual abuse, and neglect (Johnson, 2004; Ruiz-Casares et al., 2012; WHO, 2005).

CSA includes several sexual behaviours perpetrated by men, women or young people toward children and is defined as "*any activity with a child before the age of legal consent that is for sexual gratification of an adult or a substantially older child. The perpetrators take advantage of, violate, or deceive children or young people who have less power over elders*" (Johnson, 2004, p. 462). Despite having varying definitions, CSA broadly falls under contact and non-contact acts (Johnson, 2004; Senn et al., 2008). Contact acts include for example sexually touching of different areas of the child's body, (e.g., breasts and genitals) as well as penetrative oral, anal and vaginal sex. Non-contact CSA refers to acts such as a child being forced to pose naked, take part in or watch masturbation, take part in or view pornographic materials, or watch others having sex.

Although many sexual offences are secretly committed and never disclosed (Johnson, 2004), those associated with severe health consequences, such as tissue injury (tears), manifest with bleeding and pain in small children and are often not possible to hide. These children suffer an increased risk of acquiring HIV and other sexually transmitted diseases, which are also difficult to hide (Menick & Ngoh, 2003; Ohene et al., 2005). An analysis of 1194 records of CSA cases in Zimbabwe from July 2004 to June 2005 showed that 94% experienced penetrative sex (Birdthistle et al., 2011). Amongst them, 520 (44%) were tested for HIV and (6.0%) were positive.

CSA is also associated with long-term physical and mental health effects. The physical consequences include vesico-vaginal and recto-vaginal fistulae (Nduati & Muita, 1992) and chronic pelvic pain (Glod, 1993). These outcomes are especially common in developing countries where survivors have poor access to health care. The mental health consequences of sexual abuse as a child involve psychological/behavioural disorders which may manifest in suicidal thoughts (Devries et al., 2011; Eskin et al., 2005; Valente, 2005), post-traumatic stress disorders, or depression (Johnson, 2004). Other behavioural disorders include bodily shame (Andrews, 1997), abuse-related fears (Singh et al., 1996), substance abuse, and discomfort during sex (Denov, 2004). Others may experience sleeping or eating disturbances, fears and phobias, depression, guilt, shame or anger (Menick & Ngoh, 2003). Externalized reactions are expressed by for example school absenteeism and running away from home (Valente, 2005). These effects are more or less similar for male and female survivors of CSA (Dube et al., 2005).

Challenges in measuring magnitude

Addressing CSA is a difficult and challenging undertaking. The complexity of sexually offensive behaviours arises from the fact that they are hidden in nature, involve a range of survivors and perpetrators, and often involve time-consuming disclosure trajectories (Johnson, 2004; Lalor, 2004). Depending on the circumstance, disclosure may take weeks, months or years (Hershkowitz et al., 2007). Disclosure of abuse may be hindered by children's lack of understanding of what constitutes sexual abuse, threats posed by the perpetrator, and lack of opportunities to tell someone about the abuse. Children may only tell about the abuse when directly asked or after having a reaction such as nightmares (Schaeffer et al., 2011).

Hébert and colleagues (Hébert et al., 2009) conducted a telephone survey with 804 adults in Quebec, Canada. Twenty one per cent of women and 9.5% of men disclosed childhood experiences of unwanted sexual activities by adults or older children. After their first exposure, only one in five survivors disclosed the abuse within a month; 58% delayed for over five years. Re-victimization was reported by 21% of men and 22% of women. A US national telephone survey of 3220 adult women revealed that 288 (8.9%) experienced rape before the age of 18 (Smith et al., 2000). Among them, 47% waited more than five years before disclosure, and 28% had not disclosed their rape experiences until the survey. Shorter delays occurred in stranger perpetrated rapes. The recurrence of rape was associated with young age and a close family relationship with the perpetrator.

Furthermore, survivors fall into a wide range of age groups; the extreme of which includes infants. Young children may have difficulty in narrating their stories coherently due to denial or language limitations. The risk of recall bias from survivors increases the importance of thorough investigations to collect medical evidence by skilled forensic experts (Lahoti et al., 2001). In this context, it becomes imperative to analyse victim information pertaining to *what*, *how*, and *where* it happened, and *who* was the perpetrator (Pillai, 2002). Since perpetrators are often family members, investigations are often complicated by the close relation and dependency involved (Allagia, 2010; Hershkowitz et al., 2007). This is specifically evident in male dominant societies such as sub-Saharan Africa (Jewkes, 2005; Meursing et al., 1995).

Challenges in estimating the true number of children who suffer sexual abuse indicate a need for eliciting information close to the time of the incident. In-depth interviews would be the best way to collect information from younger children. Surveys would only be feasible for older children. There are numerous ethical dilemmas in asking about sensitive and painful experiences and parental consent is needed for children younger than 18 years of age. Anonymous self-administered questionnaires are less emotional and suitable for a child over 15 years where parental consent may not be necessary (Helweg-Larsen & Bøving-Larsen, 2003).

Global estimates

The true estimates of children who are sexually abused are unlikely to be known. Comparisons are further complicated by differences in definitions and data collection methods (Johnson, 2004; Finkelhor et al., 2011). However, efforts are made to get reliable and comparable measures.

A meta-analysis based on 65 cross-sectional community and school surveys from 22 countries estimate the worldwide prevalence of exposure to sexual abuse before the age of 18 years as 7.4% among men 19% among women (Pereda et al., 2009). The highest prevalence rates are reported among men (61%) and women (44%) in South Africa. Among men, high prevalence rates are also reported from Jordan (27%) and Tanzania (25%) and rates ranging between 10-20% are reported from Israel (16%), Spain (16%), Australia (13%) and Costa Rica (13%). Among women, prevalence rates above 20% are reported from Australia (38%), Costa Rica (32%), Tanzania (31%), Israel (31%), Sweden (28%), the United States (26%) and Switzerland (24%). These prevalence estimates may suffer from retrospective collection (above 18 years of age) where recall bias could be expected to cause an underestimate of the true figures.

Sub-Saharan Africa

The 2000-2010 Demographic and Health Survey and AIDS Indicator data (DHS/AIS) from 24 countries show that 25% of 15-19 years olds had their first sexual experience before reaching 15 years of age (Doyle et al., 2012). Similar figures were found in cross-sectional surveys conducted in 2003 and 2007 among school children aged 11-16 years in ten Southern African countries. There, 25% of boys and 29% of girls reported experiences of forced or coerced sex (Andersson et al., 2012). Individual risk factors for forced sex were having insufficient food at home and being over 13 years of age. School factors include low knowledge of children's rights, a high proportion of students experiencing or perpetrating abuse, and alcohol abuse. Community factors include high rates of intimate partner violence, and adults involved in transactional sex.

Pooled data based on the Global School-based Student Health Survey of 13-17-year-old children in Namibia, Swaziland, Uganda, Zambia and Zimbabwe estimated the prevalence of sexual violence at 23% (Range 9-33%) (Brown et al., 2009). Children exposed to forced sexual violence had two times greater sleep problems compared to those not exposed. Suicidal ideation was reported by 24% whereas 29% planned suicide. Compared to the unexposed children, those reporting sexual violence had twice as high odds of suicidal ideation (OR=2.2; 95%CI: 1.9–2.5) and planned suicide (OR=2.0; 95%CI: 1.8–2.3).

Tanzania

For a long time, data on CSA in Tanzania depended on tertiary hospital statistics. A review of July 1995 to June 1997 hospital records from Muhimbili National Hospital identified 143 sexual offence cases involving children aged 6 months to 10 years. Half of the cases (49%) had narrated sexual abuse stories from survivors, and 11% of them were obtained from caretakers. Sodomy was the most frequent form of abuse, followed by vaginal sexual intercourse. For 69% of the children, this was reported to be their first incident of sexual abuse. Perpetrators were aged 9-60 years of whom 53% were teenagers. Half of the perpetrators were neighbours (52%) and 13% were close relatives (Ngiloi & Carneiro, 1999).

Population-based figures became available when Tanzania participated in the WHO Multi-country Study on Women's Health and Domestic Violence (WHO, 2005). The study took place in the capital (Dar es Salaam) and a rural province (Mbeya). Prevalence of CSA among women was estimated at 4.0% by face-to-face interviews and 11% by anonymous reporting in the urban area. In the rural area, using face-to-face interviews the prevalence was 4.9% and 9.0% by anonymous reporting (Figure 1). In 2009, CDC and UNICEF conducted a national survey of violence against children (URT, 2011) that revealed higher figures. Among individuals aged 13-24 years, 28% of females and 13% of males experienced sexual abuse perpetrated by an adult before reaching 18 years of age. The most common forms were sexual touching and attempted sexual intercourse.

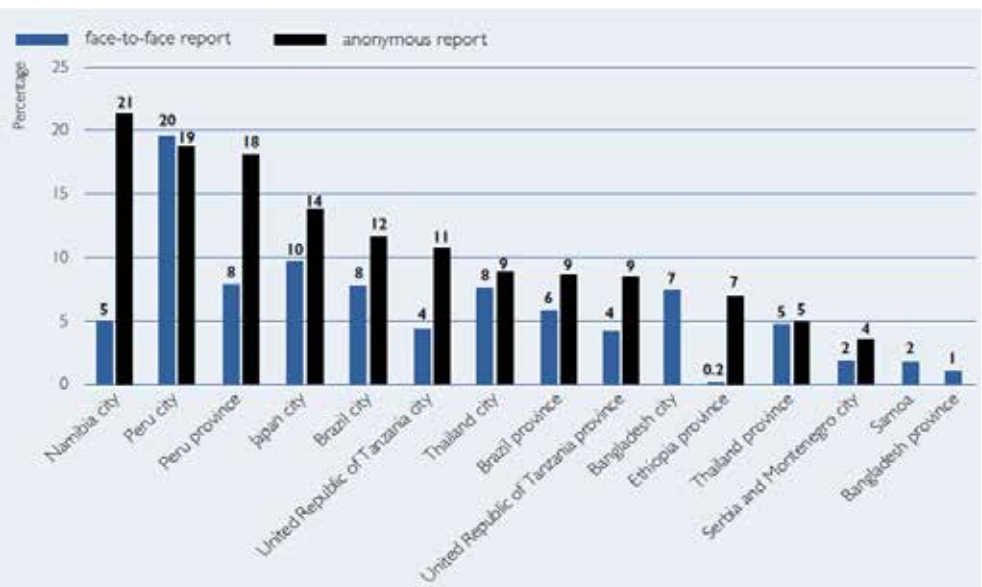


Figure 1. Prevalence of child sexual abuse before 15 years of age using face-to-face interviews and anonymous reporting. Source: WHO, 2005.

Understanding child sexual abuse

Several factors are suggested to explain the high prevalence of sexual abuse in sub-Saharan Africa. Traditional practices such as early marriage, forced marriage and beliefs that early sex can give magical power, wealth or cure HIV may be partial explanations. On the other hand, the number of sexual abuse incidents may have increased because of rapid social change and male dominant cultures that interfere with efforts to prevent or limit CSA within the society (Jewkes et al., 2005).

Rapid social change

Many countries in sub-Saharan Africa are experiencing an increased rural-urban migration with people seeking employment opportunities and better living conditions. This migration not only increased the spread of HIV from the urban to rural populations, but also predisposed girls aged 10-19 years to have sex with adults (Abdool Karim et al., 1992). Connections to the extended family and village elders have weakened. In many settings, cultural taboos make open discussions on sexual matters difficult (Ecker, 1994). Young generations are thus left to sort out traditional African values from emerging Western concepts that may shelter practices such as CSA (Lalor, 2004). Poverty is an important risk factor that puts women at higher risk of early sexual debut, transactional sex, and unwanted pregnancies (Rogan et al., 2010). The risk of pregnancy is even higher in conflict zones such as the Democratic Republic of Congo (Nelson et al., 2011). In a meta-analysis of 21 studies, Noll et al (2009) found that experience of CSA doubled the likelihood of adolescent pregnancy (OR=2.2; 95%CI: 1.9-2.5). Furthermore, Young et al (2011) showed that in comparison with women with no history of abuse, risk of pregnancy was increased by 20% among survivors of childhood sexual abuse, 30% among survivors of adolescent sexual abuse, and 80% for those who are survivors of both. This means that young female survivors of abuse may have reduced economic and social potential, increased dependency, or other social problems (Jewkes et al., 2002).

Male dominated social structures

Male patriarchy is defined as *"the systematic organization of male supremacy and female subordination"* (Asiyanbola, 2005, p2). In many sub-Saharan societies, men tend to dominate and control the economic and social environment. They are in charge of the decision-making process and leave women with no power to control their own lives (Asiyanbola, 2005; Jewkes et al., 2005; Mugweni et al., 2012; Thomas, 2007).

A qualitative study from Zimbabwe, based on focus group discussions with adult men and women, illustrates how within a family men are considered "providers" and wives are "dependants". The community is characterized by hegemonic masculinity with regard to sex. Forced sex or marital sex among couples is

used as a way for men to exert control over women; men want women to accept submissive femininity. Women are not expected to discuss sexual abuse matters with outsiders or to report problems to the police. A woman who reports maltreatment to the police is often sent back to settle the matter with her family (Mugweni et al., 2012). Similar gendered expectations are described in Namibia and South Africa (Jewkes et al., 2005). Such social norms affect children. A study, using record reviews, in-depth interviews, and focus group discussions of child rape cases from Zimbabwe, described a majority (40-60%) of the cases had to be brought to the attention of police, hospitals and the justice system since the prevailing culture had no provision for discussing or solving sexual matters (Meursing et al, 1995).

Myths

Myths about CSA are defined as *"prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists—creating a climate hostile to rape survivors"* (Burt, 1980, p217).

In sub-Saharan Africa, harmful myths include a belief that HIV-infected adults may be cured by having sexual intercourse with a child. This myth has been reported from several countries since the 1990s (UN, 1996) and shown to prevail in Botswana (Seloilwe & Thupayagale-Tshweneage, 2009) and South Africa (Jewkes & Abrahams, 2002; Meel, 2003). This type of myth, not only inflicts harm on innocent children and adolescents, but violates human rights, and nurtures other forms of interpersonal violence.

Transactional sex

Access to sexual and reproductive health information among adolescents often remains an individual struggle (Masatu et al., 2003). Mother to daughter/son communication is mainly coded with warning messages, and children express their sexual desires secretly and without parental knowledge (Wamoyi et al., 2010a). An ethnographic study in north western Tanzania that describes young women's motivations and negotiations for sex found that 54% of 14 year old boys and 16% of 14 years old girls have had sex (Wamoyi et al., 2010b). Three of four girls reported receiving some form of gift from their sexual partners; 43% of sexually active boys reported rewarding their partners. Money motivates young girls to have prolonged sexual relationships. School girls over 14 years of age, from poor families, secretly practice transactional sex to get money for food while at school and buying clothes and cosmetics for themselves. In rare circumstances in this setting, mothers or grandmothers allow their daughters to embark on transactional sex to obtain money for similar reasons (Wamoyi et al., 2010a).

THEORETICAL FRAMEWORK

A human rights issue

A child is a human being under 18 years of age. Article 1 of the United Nations Universal Declaration of Human Rights (UNUDHR, 1989) stipulates:

> *"All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood".*

Furthermore, article 3 stipulates that "Everyone has the right to life, liberty and security of person". These articles do not exclude children from such rights. In order to develop and attain their full potential, children deserve full human rights similar to adults. Furthermore, by virtue of their vulnerability they need to be protected. Article 19 (1) of the Convention on the Right of the Child (CRC, 1989) states that;

> *"States' parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child".*

The protection carries legal and social dimensions. The legal aspect is well-defined under the convention. This internationally recognised convention is the most endorsed treaty in the world. All but two countries ratified it as adopted by the United Nations Assembly declaration (UNUDHR, 1989).

Since adoption of the declaration, and due to an increase in sexual offences involving both adults and children, the Tanzanian parliament enacted the Sexual Offence Special Provision Act (SOSPA) in 1998 (URT, 2002). The intention is to curb such offences in the country. The act clearly states that the age of legal consent to sex is 18 years. Severe punishment was proposed for anyone charged and incriminated for a sexual offence against a child. To be more explicit in protecting children, the government of Tanzania enacted 'Law of the Child Act 2009' (URT, 2009) which further reiterates that any person under the age of 18 years is considered a child. The law regards "child abuse" as

> *"Contravention of the rights of the child by causing physical, moral or emotional harm, including beatings, insults, discrimination, neglect, sexual abuse and exploitative labour"* (URT, 2009; p663).

Whoever is charged with committing such acts on a child is liable for an offence subject to the court of law, and punishment if incriminated for the offence. In

this thesis, the human rights perspective will form the basis for discussing CSA in the Tanzanian setting and how CSA is handled at individual, family, community and societal levels.

Justification of the thesis

In abiding by the Convention on the Rights of the Child (CRC, 1989) high-income countries made efforts to improve the handling of CSA cases; a promising decline has been observed over the past two decades. In a population based study from Finland, less emotional neglect and abuse were reported by younger cohorts (Laaksonen et al., 2011). Similar findings are reported from an Australian study of unwanted sexual experiences before 16 years of age. There, twice as many women (34%) compared to men (16%) reported non-penetrative CSA; penetrative CSA was reported by 12% of women compared to 4.0% of men. Abuse incidents were less frequently reported by the younger cohorts compared to the older ones (Dunne et al., 2003). A national decline of 40% of substantiated cases of CSA was observed in the US from 1990–2000, which may partly be explained to result from increased prevention efforts (Finkelhor and Jones, 2004). Little is known about what is needed to improve the situation of children in the Tanzanian context or see that internationally recognised Convention on the Right of the Child (CRC, 1989) applies here.

This thesis aims to understand the challenges of decreasing the number of CSA cases in Tanzania by highlighting the social context of CSA, as well as the experiences and challenges faced by professionals, the community and parents who handle CSA incidents. The findings are expected to contribute to better handling of cases as well as improved control measures.

STUDY AIMS

The aim of the thesis is to contribute to a better understanding of barriers and potential for prevention of CSA in urban Tanzania. The specific aims are:

- to explore the social, medical and legal context of CSA from the perspectives of key professionals, community members and parents of children exposed to sexual violence (Papers I, II, III),
- to estimate the prevalence and health consequences, and identify risk factors for CSA among secondary school students (Paper IV).

METHODS

Study design

This thesis consists of four sub-studies that are based on triangulation of qualitative and quantitative research methods. The sub-studies were performed during 2006-2010. An overview of the aims, designs, data sources and analytical approaches is given in Table 1.

Table 1: Thesis aims, study designs, data sources, study periods, and analytical approaches.

Aim	Study design	Data sources	Study period	Analytical approach	Paper
To explore the social, medical and legal context of CSA from the perspectives of key professionals, community members and parents of children exposed to sexual violence	Qualitative	In-depth interviews • 24 professionals • 14 police investigators • 5 magistrates • 4 legal officers • 1 key informant at ministry level	June-Aug 2006	Content analysis	I
	Qualitative	Focus group discussions • 13 homogenous FGDs with 74 18-55 year old community members	Jan-April 2007	Grounded theory	II
	Qualitative	In-depth interviews • 8 parents • 4 CSA14-16 year-old survivors	July-Nov 2008	Content analysis	III
To estimate the prevalence and health consequences, and identify risk factors for CSA among secondary school students.	Cross-sectional survey	Self-administered questionnaires • 1359 form I & II students from 23 secondary schools	April 2010	Multivariate logistic regression analysis	IV

Triangulation of research methods

In order to have a deep understanding of different aspects of CSA, a combination of qualitative and quantitative methods is required. The research questions guided the choice of methodologies, which then complemented each other (Dahlgren et al, 2007). In-depth interviews are regarded as most suitable for exploring individual experiences of handling and reporting sexual abuse incidents. Focus group discussions (FGDs) are better for capturing norms and attitudes on the community level. FGDs are preferably used for eliciting sensitive subjects on the group level without necessarily touching on individual experiences (Barbour & Kitzinger, 1998).

To be able to estimate the magnitude of CSA, statistically representative data is needed. A questionnaire-based school survey was chosen that contained mostly pre-determined response alternatives. This mixed method approach is increasingly recognized for its ability to capture several aspects of a phenomenon and used in the field of CSA (Johnson & Onwuegbuzie, 2004; Schönbucher et al., 2012; Wright et al, 2012).

Study setting

Country profile

Tanzania is one of the five countries that form the new East African Community. Tanzania is bordered on the west by Zambia, Democratic Republic of Congo Rwanda, and Burundi, on the north by Uganda and Kenya, on the east by the Indian Ocean, and on the south by Mozambique and Malawi (Figure 2).

Figure 2. Map of Tanzania showing the Dar es Salaam region. (Encircled area). Source: TDHS, 2010.

Great Britain granted independence to Tanganyika in 1961 and Zanzibar in 1963. The union government, Tanzania, was inaugurated in 1964 and Zanzibar was granted autonomy for a separate government.

The mainland population is primarily African (99%) of Bantu descent (95%), with about 130 ethnic tribes. Asian, European, and Arab races constitute 1% of the population. The national language, Kiswahili, is spoken by almost all tribes although each has its own dialect. The Dar es Salaam region is on the eastern side of the country and harbours the capital city along the Indian Ocean. Some national indicators are presented in Table 2.

Table 2: Demographic indicators for Tanzania, 2010.

Indicator	**Estimate**
Total population	43 million
14 years and younger	47%
15-64 years	49%
65 years and older	4.4%
Under-five mortality rate/1000	81
Maternal mortality rate/100,000 live births	454
Life expectancy (years):	
Women	54
Men	51
Population growth rate	2.9%
Fertility (children born/woman)	5.4
Literacy rate (%):	
Women	62%
Men	78%

Source: URT-TDHS, 2010.

Temeke District

This thesis sub-studies were conducted in Temeke, one of the three districts in the Dar es Salaam region, as shown on the map of Tanzania. The region consists of three districts: Kinondoni in the north, Ilala in the west, and Temeke in the south. While Kinondoni and Ilala are mainly urban, a large part of Temeke is rural.

Temeke district (Figure 3) was chosen as the field site for the overall research programme on Violence against Women and Children because of the possibility of relating the results to a study on rape against women (Muganyizi et al., 2004) and relating the results of several PhD projects to a well-defined socio-cultural

context. The other PhD projects were entitled "*Prevention of intimate partner violence—Community and healthcare workers' perceptions in urban Tanzania*" (Laisser, 2011) and "*Rape against women in Tanzania: studies of social reactions and barriers to disclosure*" (Muganyizi, 2010). Together, the three projects are expected to contribute to a deeper understanding about violence against women and children in the district.

Similar to the Kinondoni and Ilala districts of Dar es Salaam region, Temeke represents cultural pluralism since it harbours many tribes from up-country. Three per cent of the population is employed in the public sector, while 96% is self-employed, with the majority being farmers (URT, 2007). The Ndengereko, Makonde and Zaramo tribes are primarily peasants who occupy rural Temeke and cultivate staple foods (cassava, potatoes, and coconuts) and cash crops (oranges, tangerines, paw paws, pineapples and cashew nuts). Most of the population lives in the peri-urban setting and is self-employed in micro-entrepreneurship. A small proportion represents employees in various sectors. Male dominant structures and cultures prevail. Studying attitudes and perceptions of CSA in this community was expected to allow the interpretation of the results in relation to a well-defined socio-cultural context.

The district has three hospitals. One is the district hospital and the other two are private. Primary care health facilities consist of five health centres and 108 dispensaries. There are nine autonomous laboratories, 23 pharmacies, and about 220 drugstores. Most of the population (70-90%) live within a five kilometre catchment of a government health facility (Haram, 2008). One district police station provides back-up support to police sub-stations located in each of the 24 wards. The district court is within proximity to the district headquarters, and supports primary court in each ward. Sexual offence cases are referred to the district court by the ward courts.

Administratively, the district has several sub-divisions including "tarafa" (divisions) and "kata" (wards) in descending order. In the peri-urban area, further subdivisions include "kitongojis (hamlets) and streets comprising clusters of houses. Usually there are 10-30 households lead by a 'mjumbe' (ten cell leader).

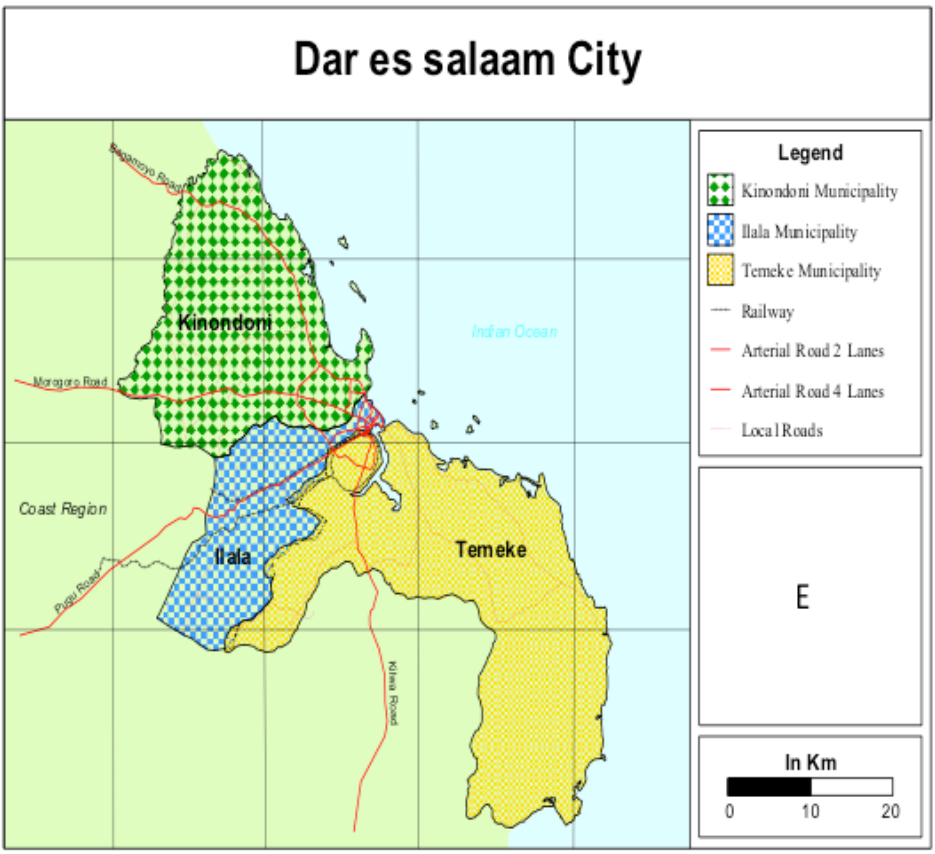


Figure 3. Map of Dar es Salaam region with Temeke district in the south.

Medical and legal procedures for handling sexual abuse

The Sexual Offense Special Protection Act (SOSPA) (URT, 2002) stresses mandatory reporting of CSA. Even so, sexual offences are most often committed secretly and the majority remain hidden. This is especially true when familiar perpetrators are involved. Few cases are reported to the police for legal action. A large number may seek health care even if the history of abuse is hidden. Reported cases meet personnel who may include the police, a qualified medical officer, a registered nurse, the court prosecutor, and the magistrate/judge. Health personnel assist the police in carrying out forensic evaluation of survivors of the alleged offences. They describe the physical findings including bruises, bleeding, and tears, along with their location, discharges and presence of body fluids such as semen or blood. They also collect specimens for various other laboratory investigations intended to rule out STDs such as syphilis, chlamydia, gonorrhoea and HIV. HIV infection is ruled out at reporting and subsequent three, six and twelve month follow-ups. Apart from continuous psychological support, survivors are given post exposure prophylaxis (PEP), to decrease the risk of contracting

HIV infection. A broad-spectrum antibiotic is prescribed to treat sexually transmitted infections (STIs). Reproductive age survivors undergo a urine pregnancy test and are given a high-dose oestrogen emergency contraception pill ("morning after pill") to avert the risk of conception.

In some circumstances, people may report sexual abuse incidents at the hospital without notifying the police. These persons are normally advised to get a police form three (PF3) and to go through the described procedures. If they do not, they are managed and discharged through a social worker who investigates and advises the respective family as appropriate.

Normally, the attending medical doctor completes PF3 and submits the form, through the responsible police, to the attending prosecutors at the court. This should be done prior to the dates allocated for case-mentioning or deliberation. Occasionally, the survivor or caretaker must collect the report at the hospital and submit the form.

Prosecutors prepare the cases and present them before the magistrates for court judgment. Under the Tanzania National Constitution, all judges are magistrates, but not all magistrates are judges since judges must be appointed. Judges are responsible for referral to high courts, while magistrates take care of the cases at lower levels.

The judiciary involves a hierarchy of courts that ranges from the national to the ward level. The High Court of Tanzania is essentially the highest referral court. The lower levels include the regional, district and ward courts. Sexual offence cases are usually handled at the district level and above.

There are non-governmental organizations (NGOs) that focus on supporting survivors of violence. These have legal officers and social workers who provide services to victims who are unable to handle their cases in court. In cases of false accusations, they may also provide assistance to the accused.

Since survivors may delay reporting sexual abuse incidents, there is often a loss of forensic evidence. For those who report promptly, it is not easy to follow all the required steps and instructions at the time they have experienced a traumatic event. Some may not be conversant with the police and hospital examination protocols that follow sexual offence incidents. Consequently, many cases are not followed up at the medical or legal institutions unless they are supported, guided and treated confidentially. An overview of the prescribed procedures for handling sexual offences is given in Figure 4.

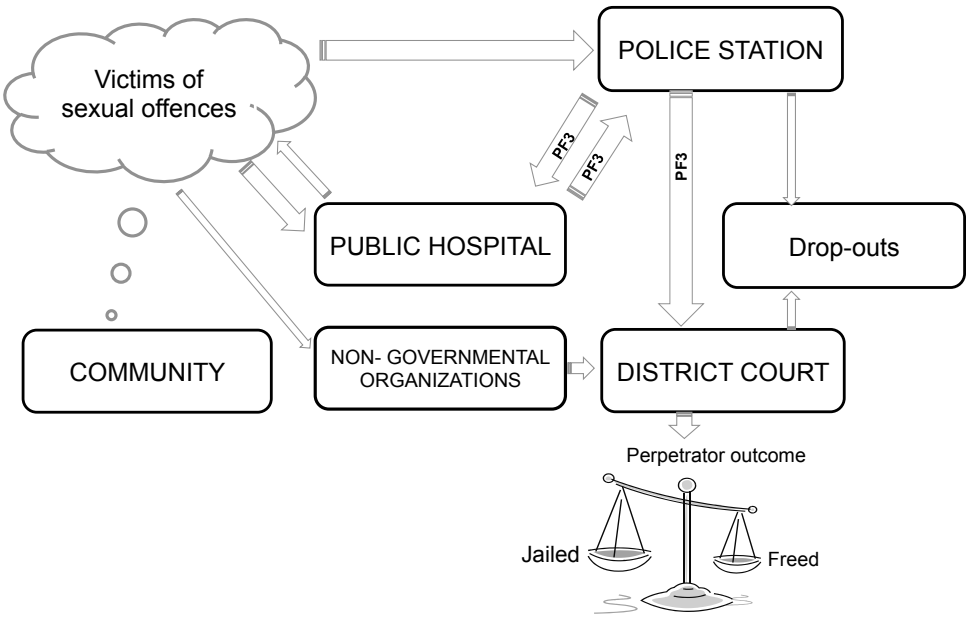


Figure 4. Handling sexual offence cases in Tanzania. (PF3=Police Form 3)

Study populations

The study populations included professionals (police investigators, magistrates, social workers and legal officers), 18-55 year-old male and female community representatives, parents of 14-16 year-old CSA survivors and 13-25 year-old form I and II children from Temeke secondary schools.

Sampling strategies

Qualitative in-depth studies

Purposive sampling was applied for the qualitative sub-studies with an aim of capturing variation in experiences and handling cases of CSA. The actual number of interviews and focus groups was dependent on an effort to reach saturation, i.e., when little new information emerged (Dahlgren et al, 2007).

The interviews with key professionals (Paper I) aimed to involve persons with different professional perspectives. The researchers approached police officers, magistrates, NGO representatives, and technical staff. The sampling of police investigators was facilitated by a list made available by police officers in charge at selected police stations. In total, 14 police investigators (4 women and 10 men) with varying durations of work experience were selected. The seven magistrates who work with district court were invited for interviews but only five were able to be interviewed (three women and two men) during the study period. Four legal officers and a social worker from different NGOs were personally approached at their workplaces. One representative at the

ministry level was included in order to contribute experiences at the national level.

For the interviews with parents of survivors (Paper III), the researchers approached parents who were completing a district course process. The court prosecutors agreed to assist in identifying parents and introducing them to the researcher. Ten cases were identified during the study period. Eight parents accepted an invitation to participate and share their experiences of reporting a sexual offence case to the community (village government, women groups), health care, and legal systems.

Sampling of community representatives for the 13 focus group discussions (Paper II) was done in collaboration with local leaders. The selection process was based on census lists from 2008 that could be used for selecting men and women from different age groups, marital status, and professions. Participants were purposively selected among non-professionals and professionals from the public and private sectors. People working within the medical and legal systems were deliberately excluded. Individuals were contacted by their respective local leaders before being approached by the researcher.

Quantitative school survey

The cross-sectional survey (Paper IV) was performed among secondary school children. Of the 24 wards in Temeke district, three did not have secondary schools during the survey. Two schools in the southern and southeast part were excluded due to inaccessibility caused by heavy rains. Of the remaining 68 schools, 16 boarding schools were excluded because of difficulties in obtaining informed consent from the parents in a timely manner. Of the remaining 52 day schools, one school was randomly selected in each of the remaining 19 wards and a second school was selected in the four largest wards. Thus, the sample consists of eight private and 15 public schools (Figure 5).

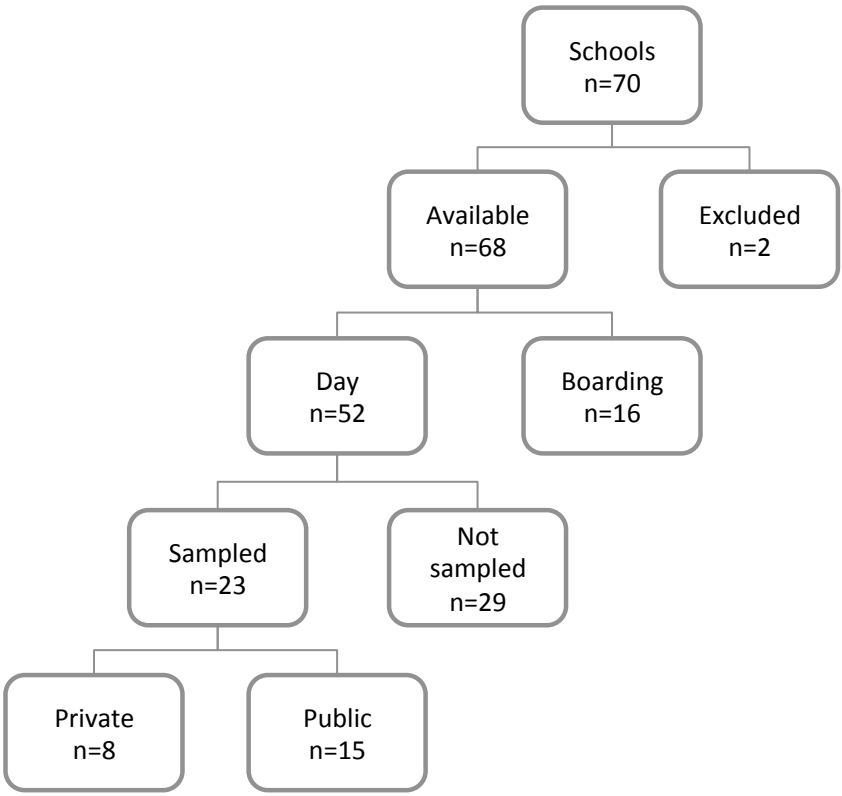


Figure 5. Flowchart illustrating the selection of secondary schools from 24 wards in Temeke District.

Data collection

Qualitative in-depth studies

Qualitative sub-studies were based on prolonged engagement of the thesis author. He spent a great deal of time in the field learning to understand the local context (Dahlgren et al, 2007). He conducted all of the in-depth interviews and moderated the focus group discussions with some assistance of co-researchers. Regular field notes were taken as part of the data collection and used to inform the emergent data analysis. Verbal and written informed consent was obtained prior to interviews and focus group discussions. The language used was Kiswahili, the national language in Tanzania, which is spoken by the majority of the population.

The interviews with professionals for Paper I were held in a time sequence starting with the police, and followed by magistrates, NGOs and ministry representatives. Since CSA is a sensitive issue time was required to motivate informants to share their experiences and to gain their trust that the information would be treated confidentially. Interviews were centred on perceptions of causes of CSA, their roles and responsibilities, strengths and weaknesses in fulfilling their re-

spective duties, factors that influenced justice, and envisaged changes needed. The interviews were held in places where the informants were comfortable talking. This meant interview locations were away from workplaces. The interviews lasted 45-60 minutes. Data were captured by audio-taping. Verbatim transcriptions were made within two days after the date of collection. Transcriptions were used to explore issues for further probing in the following interviews.

Interviews with parents for Paper III were based on semi-structured interviews using an interview guide to facilitate the process. The aim was to get a phenomenological description related to the case event, the actions taken, reactions they had encountered from the community, and experiences with the police, health care, and court system staff. Again, much time was spent creating trust and rapport with the informants. To facilitate openness in sharing their stories, the interviews took place in a convenient setting away from the court and informant homes. The researcher was also invited to seven of the informants' homes to understand better their living conditions and the circumstances in which the offences took place. These interviews lasted 40–60 minutes each. Four of the survivors volunteered on their own for shorter informal discussions that focused on their experiences of abuse.

The focus group discussions for Paper II were all conducted with the assistance of a co-researcher. The discussions were homogenous in terms of gender and age to minimize potential barriers relating to known power relations and influence of sexual taboos (Mwambete & Mtaturu, 2006). For these reasons, the women groups were moderated by the female co-researcher. Discussions were held in a small rented conference hall to maintain privacy and allow for uninterrupted discussions.

Newspaper articles portraying CSA cases that had occurred in the study area were brought to the groups and used as discussion starters. Participants were asked to choose one or two articles to read aloud for the group. This procedure encouraged participants to share their experiences of similar events in their locality. A thematic guide helped the moderator to focus the discussion on three main themes: 1) moral issues involved in CSA, 2) awareness of health consequences and perceptions about their own roles in controlling or preventing CSA in the community, and 3) their knowledge and perceptions of the Sexual Offence Special Provision Act. Focus group discussions require moderators to be skilled and allow for an open discussion on the subject matter (Reventlow & Tulinius, 2005). This was a challenge since initially professionals tended to dominate, and the moderator had to encourage the quiet participants to join the discussion. However, once they felt included, the unemployed participants and housewives were very active and seemed to be more aware of events in their neighbourhoods than the professionals. The tape-recorded discussions lasted between 1.5 to 2 hours. After 13 discussions, it was felt that no new ideas were being brought up that contributed to the emerging interpretation.

A focus group discussion with male community members.

Form 1 students filling in the questionnaire

Quantitative school survey

The thesis author (FK) supervised data collection in the secondary schools (Paper IV) with assistance of four well-trained research assistants who were conversant with the research tool. Conducting a survey among secondary school children (15-18 years) was regarded as appropriate since they are mature enough to be able to make an informed choice to participate and to answer sensitive questions. This is also the age during which most abuse or sexual exposures take place. Anonymous self-administered questionnaires were seen as less embarrassing compared to face-to-face interviews (Plummer et al., 2004; Tang, 2002). Use of anonymous questionnaires could have ethically warranted avoidance of parental consent. This has been found to compromise the participation rate of respondents who may have been abused by parents or relatives (Helweg-Larsen & Bøving-Larsen, 2003). Parental consent was requested for this study as per regulation of the Ministry of National Education and Vocational Training (MoNEVT) for research involving students. To minimize the influence of parental consent on the response rate, the survey was presented to the school authority, the students and the parents/guardians from whom consent was sought as '*A study of health and life experiences of secondary school children*'.

Data collection took three days at each school. The first day was used to introduce the study to the school administration and ask for permission to conduct it in one class attending form I and one class attending form II. A random selection of the classes was done in the headmaster's office. A secret ballot was used that listed eligible classes on pieces of papers. The teachers responsible for the selected classes were assigned by the headmaster/headmistress to assist the research team. The class teacher was asked to tell the students about the study aims and then request for their consent to participate. All students agreed to participate and were provided with parent/guardian consent forms. The second day returned consent forms were collected. The third day was used for data collection. Students who did not consent and students who were not given parental consent were asked to leave the class before data collection began. In each participating class, students were spread apart to ensure confidentiality. Students were instructed to answer the first part that reflected their demographic profile. Then one student was appointed to read a newspaper scenario of CSA case to the class. After hearing the scenario, students were asked to respond to the rest of the questionnaire.

The questionnaire included a demographic profile, a few socio-economic indicators, prior knowledge of abuse, history of CSA, information about responsible perpetrators, and action(s) taken. Questions were partly adopted from a questionnaire used in a survey on CSA among 13-17 year old secondary school students from 17 schools in Geneva, Switzerland (Halperin et al., 1996). Questions on psycho-social factors were added from the CDC and UNICEF national survey on violence against children conducted in Tanzania (URT, 2011). Efforts were made to make an understandable and concise questionnaire. This is im-

portant for the validity of responses (Plummer et al., 2004). Students needed 45-60 minutes to complete the questionnaire. The questionnaire is included in the Appendix.

The scenarios of sexual abuse cases from local newspapers, which were read out to the students, were chosen to help the students recognize abuse incidents and remind them of cases they may have encountered.

> **Example I**. "*Mbaroni kwa kubaka watoto wa mitaani*" (Held responsible for raping street children…)
>
> (*Source*: 'Mwananchi Ijumaa April/23/2010; [Local newspaper])

The first example refers to local newspaper report on rape of street children aged 10-12 years by night watch security guards. These children were preyed upon by the guards as they looked for night shelter in the guard's area of jurisdiction. In addition, one woman was found selling such children to perpetrators for sex at TZS 3000-5000 (equivalent of USD 2-3.5).

> **Example II**. "*Kikongwe mbaroni kwa kubaka mtoto*" (An old man held responsible for sexually abusing a child).
>
> (*Source*: Mwananchi Jumatano April/28/2010; [Local newspaper]).

The second example was also taken from a local newspaper. A landlord sexually abused a 13 year old daughter of one of his tenants. The landlord's wife and the tenant suspected the landlord of abusing the girl. One evening, the two women trapped the landlord when he was having sexual intercourse with the daughter and reported the incident.

Data analyses

The data sets were subjected to different analytical frameworks depending on the research questions. Data from in-depth interviews with professionals (Paper I) and parents of CSA survivors (Paper III) were analysed using content analysis. Data from focus group discussions with community representatives (Paper II) were analysed using grounded theory. The quantitative data from school surveys (Paper IV) were analysed with descriptive statistics and multivariate regression using SPSS.

Qualitative approaches

The data from in-depth interviews with professionals (Paper I) and interviews of parents reporting incidents of CSA (Paper III) were analysed using qualitative content analysis. The analysis followed the steps described by Graneheim and Lundman (2003). Reading through the transcribed text enabled extraction of meaning units which were shortened into condensed meaning units. The Open-

Code sofware (Umea University, 2007) facilitated the coding process and was used to assign conceptual codes to the condensed meaning units. Sub-categories were then developed and used to summarize codes. Finally, categories were developed focusing on the manifest messages in the sub-categories. Through constant comparison, going back and forth between the text, meaning units, codes, sub-categories and categories, a theme(s) was/were generated interpreting the latent content to answer specific research question(s). The final interpretations closely adhered to the accounts of the participants.

The transcribed text from focus group discussions was analysed using grounded theory. The process is very similar to the first steps of qualitative content analysis, focuses more on saturating a core category and the associated categories to construct a conceptual model of processes influencing the phenomena under study. Also the OpenCode software (Umea University, 2007) was used to facilitate the analysis, moving from open and selective coding to sub-categories and categories (Dahlgren et al., 2007; Glaser, 2001). By making constant comparison, going back and forth through the text, codes, sub-categories and categories, the team derived one core category. A model was constructed to depict linkages between the core category, categories and sub-categories in describing community perceptions and processes that surround CSA and what constitutes barriers for joint actions (Paper II). Figure 6 depicts the differences and similarities in the analytical processes of qualitative content analysis and grounded theory.

Quantitative data

Data from the school survey were analysed using SPSS. The prevalence of sexual abuse and distribution of socio-demographic characteristics of participants were obtained using frequency distribution tables. Cross-tabulations were made to analyse the association between sexual abuse and socio-demographic/economic characteristics. Chi-square test was used to test for significant associations between the outcome and dependent variables. P-values <0.05 were considered significant. In bivariate analysis, crude odds ratios were reported with 95% confident intervals. Variables that showed statistical significance in the bivariate analysis were added to a multiple logistic regression model while controlling for confounding. Adjusted odds ratios were computed and the variables were considered significant risk factors of sexual abuse if the 95% CI did not include 1.

Ethical considerations

The study received ethical approval from Muhimbili University of Health and Allied Sciences (MUHAS) that was renewable on a yearly basis for studies taking more than a year.

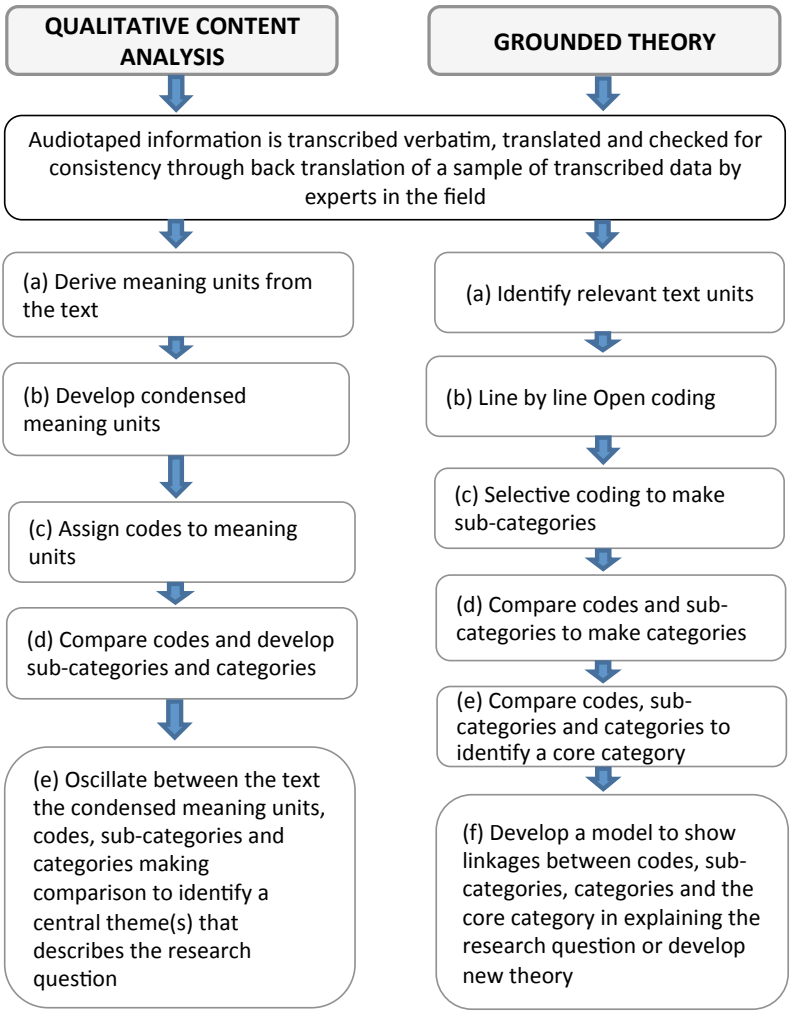


Figure 6. Comparison of the analytical processes used in qualitative content analysis and grounded theory.

Renewals for ethical clearance were from June 2006 (first sub-study), July 2007 (second sub-study), July 2008 (third sub-study) and January 2010 (fourth sub-study). The work adhered to the WHO ethical guidelines for biomedical research involving human subjects (WHO/CIOMS, 2002).

There was also need to get permission to approach the respective authorities involved in the study. The responsible ministries were contacted through letters and informed of the study, its objectives and the required participants in order to get permission to conduct the study. Professionals were selected from the Ministry of Justice and Constitutional Affairs (MoJCA) to which magistrates are

answerable, Ministry of Home Affairs (MoHA) to which police are answerable, Ministry of Community Development and Gender and Children (MoCDGC) from where one key informant was obtained. The Ministry of Education and Vocational Training (MoNEVT) was approached since secondary schools were part of the study. Permission was also solicited from the Regional, District and Local Authorities in which the study took place, and police stations, district courts, schools and communities from which the participants were selected.

In addition all informants/participants were asked for individual informed consent. This implies that prior to the data collection they were well-informed of the study objectives and the modalities for capturing information. Free participation was encouraged to participants in the different sub-studies. Participants were well-informed that the obtained information would be kept confidential and used only for research purposes.

Both interviews and focus group discussions were conducted in settings where privacy could be maintained. The moderators made efforts to adhere to gender norms and sensitivity. Focus group participants were informed about the limitations of confidentiality in a group discussion and urged to treat the information they heard with care.

The secondary school questionnaire was labelled 'A study on children's health and social problems'. A parent/guardian was also required to give consent. This was a way to decrease the risk of the parents declining to allow their children to participate in cases of sexual abuse exposure within the family.

Moral and psychological support by medically trained persons was organized and offered to participants in need. This is recommended by the WHO/CIOMS (2002) for studies that may evoke emotional reactions (Helweg-Larsen & Bøving-Larsen, 2003).

RESULTS

First, a summary of how professionals and the community perceive CSA will be presented. This will be followed by professional and community perceptions of the legal system and their experiences of handling cases of CSA. The next section mirrors parent experiences of seeking support and assistance from the community and official authorities when faced with a case of abuse in their family. The next section summarises community perceptions and feelings about CSA and the factors that influence their way of handling situations where CSA is involved. The final part summarises the results of the survey about sexual abuse among secondary school students.

Perceptions about child sexual abuse (Papers I and II)

The professionals interviewed for Paper I had long working experiences with cases of CSA. They identified an increase in abuse incidents that is reflected in the theme *a change in social dynamics*. The community members interviewed for Paper II also acknowledged being aware and worried about the situation as illustrated in the category *aware but distressed*. They knew both the short- and long-term consequences of abuse.

Small children were perceived as vulnerable to sexual abuse due to unawareness of the imminent dangers in their environment, for example un-monitored peer activities that expose young children to abuse. The community attributed a *decrease in respect for children's rights* to lack of parental guidance and legal protection mechanisms, and therefore an increased risk of being exposed to sexual abuse. The professionals perceived poverty as contributing to CSA since children in poor families may try to get financial support from other sources and thereby fall victim to sexual abuse. The categories *eroded social norm,* emanating from the interviews with professionals, and *myths to defend CSA* reflect a joint view of children being influenced by or victims of the behaviour of adults and what is seen in the media. Professionals and community members discussed the seriousness of existing myths that attribute sexual intercourse with children as a way of increasing wealth, or avoiding and curing HIV infection. Figure 7 mirrors the similarities and differences in the categories emanating from the analysis of interviews with professionals and the community members' focus group discussions.

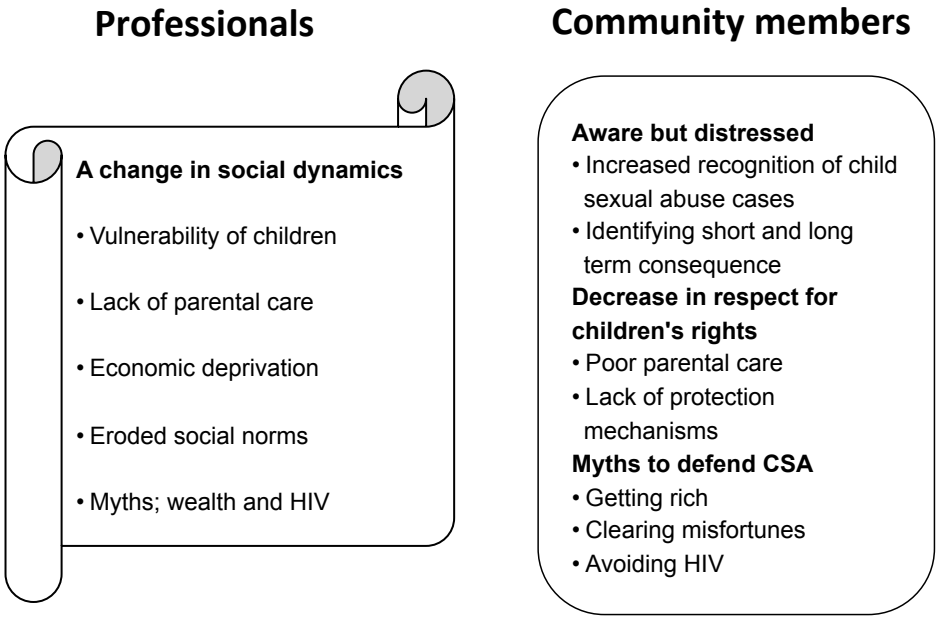


Figure 7. Professionals' and community members' perceptions of child sexual abuse.

Challenges for fair handling of sexual abuse cases (Papers I, II)

The interviewed police officers and magistrates played important roles in arraigning information and evidence from the investigation processes of CSA cases and the NGO staff offered a supportive role in advising victims as well as suspected perpetrators.

In Paper I, key professionals' views on the strengths and weaknesses of the legal system are captured in three themes: *a bargain with legal ambiguities, a plea for a more effective legal system,* and *legal handling compromised by community passivity, shame, and fear*. Police officers and magistrates felt that there were organized infrastructures in the police stations and court. They also felt that they were well-oriented to the legal processes of handling sexual offence cases. However, they were concerned about structural and systemic weaknesses such as lack of working spaces like camera rooms that would allow confidential communication and proper documentation of interrogations. They also complained that their investigations were challenged by lack of financial resources to cover costs such as transportation for site visits. If they wanted to do a good job, they had to use their own money or work on a voluntary basis.

With regard to the legal framework, the professionals pointed out challenges that ambiguities of different laws negatively affect child protection. On the one hand, the Sexual Offense Special Provision Act considered having sexual relations with a girl less than 18 years to be an offense. At the same time, Law No 5 from

1971 permits 15 year-old girls to marry upon parental permission, and Islamic law allows marriage for girls when they attain menarche.

The professionals were asked to reflect about their personal experiences of handling cases of CSA. The results focussed on how staff vulnerability in the context of limited resources may affect justice. The themes *a challenge to maintain professional distance* and *legal handling compromised by community passivity, shame and fear* illustrate how vulnerability is influenced by the social context. The fact that magistrates and other investigators live in the community they serve was seen as a challenge to neutrality in handling some cases. Victims and perpetrators could be neighbours, friends or landlords, putting the professionals at risk of retaliation or for accepting bribes. Corruption during investigations was mentioned as an important reason for victims having to accept unjust outcomes. Professionals also described how the required mandatory reporting of child sexual offenses by community members is often jeopardized because of shame and fear. The fear of perpetrator retaliation often resulted in lack of cooperation from the community and posed difficulties for professionals' establishment of evidence. Similarly, parents of victims delayed reporting due to shame. The delay results in the risk that important forensic evidence will be destroyed. The professionals were disappointed by community passivity that resulted in withdrawal of case by the victims. They were also concerned that withholding of information on sexual offences perpetuated the risk of perpetrators continuing offensive sexual behaviours. They underscored that economic deprivation resulted in case settlements with the perpetrators outside of the legal system. However, they also recognized the delays that emanated from deficiencies within the medico-legal system, such as harassment of victims by individual staff members. Much of their frustration was directed towards the medical professionals whom they had observed quarrelling when approached to complete PF3. They also pointed out that a lack of medical officers who are competent to provide expert testimony in court might hinder justice in sexual offence cases.

From the focus group discussions (Paper II), there was a strong *lack of trust in health care and legal systems*. Corrupt handling of cases was a major concern. Community members feared breach of confidentiality from both health care personnel and the police. They were also distressed that the legal system allows bail for perpetrators, thus giving them a chance to flee and avoid facing charges. This led to loss of hope that cases would be handled fairly and was believed to be one reason for not reporting cases. The category *disclosure threatened by stigma and community passivity* confirmed professional views of lack of cooperation from the community. Here it was obvious that CSA was felt to be shameful. Community members dreaded being involved because they feared retaliation by the perpetrators. Similar to professionals, they described how economically vulnerable families were less prone to report and more likely to accept informal settlements with financial gain. Figure 8 provides comparison of the themes, categories and sub-categories from the analysis.

Figure 8. Professionals' and community members' views on challenges for fair handling of child sexual abuse cases

Parental experiences of support from professionals and the community (Paper III)

The analysis of interviews with parents, who had experienced reporting a case of CSA, showed that their reactions, as well as the handling by community and professionals, differed depending on the type of abuse.

The innocent child portrays an abuse incident where a very young, vulnerable child was unwittingly exposed to an adult perpetrator. This type of abuse triggered feelings of anger and humiliation that, together with the sympathy from community agencies, supported action responses, thematically described as **"determined to seek justice"**.

The second type was labelled ***the forced sex youth***, and reflects youth trapped in a compromising situation and overpowered by a perpetrator against whom they were defenceless. The theme **"becoming a betrayer"** summarizes how parents struggled to support their child's development (for example, finding them a job with a friend) and were tormented with guilt and worry after learning that their child was trapped or forced into illegal sexual activities

by that same adult friend they had trusted. These feelings were compounded further by the community view of the parents as disgraceful and irresponsible.

The third type was ***the consenting curious youth***, representing the older, sexually mature youth with prior, uneventful sexual encounters with peers who found themselves entrapped in a legal process where the sexual partner was an adult. The theme **"uncertain about the way forward"** captures the parental dilemma of reporting this case where "the victim" denied the sexual abuse incident. When confronted with the facts, they were unwilling to participate in the court process. The theme also illustrates how a law forbidding sex before the age of 18 can be perceived as rigid, especially if the perpetrator is of a similar age.

The fourth and last type was ***the transactional sex youth***, which describes a consenting youth involved in sex with an adult as a deliberate commodity, primarily to alleviate poverty. The reaction from the parents was crystallized into the theme **"losing parental control".** The theme illustrates the shameful, moral feelings of parents when they discover their child is involved in transactional sex as a means of financial survival and a consequence of failure to provide adequately for them.

Some issues cut across themes. For example, an imbalance in power relations results in male perpetrators being more likely to use young girls or boys for sexual gratification. All the informants represented a selected group for whom the benefits of reporting and taking legal action far outweighed the barriers of fear, shame and financial costs. Although each of them reported receiving plea bargain proposals and advice to withdraw the case and/or accept compensation from the perpetrator, none of them had accepted this solution. Encounters with professionals and the community varied without a specific pattern, but the overriding parental concern was the delays within the health care and court systems.

Suggestions for change (Papers I and II)

When asked about their wishes for the future, there was a plea for *a more effective legal system* among the professionals (Paper I). This addressed the need for a more conducive work environment and harmonizing the relevant laws to better promote protection of children. They also recognized that their work would benefit from increasing transparent collaboration between key actors, i.e., medical doctors, magistrates, the police, and NGOs. They further reflected on the need for educating the community to raise awareness about sexual offenses, the rights of children, and their roles as preventive agents.

The focus group discussions with community members (Paper II) revealed similar concerns in their desire for procedural change. The main measures mentioned were the need to reduce corruption and to deny bail to perpetrators. They also stressed the importance of professional responsibility. The community members expressed their wish to provide more assistance in cases of CSA, given

that they receive adequate support from the local leadership. The existing "ten-cell" leadership was seen as an important entry point for assisting survivors of violence, but they also identified external actors as important for ensuring the rights of children (Figure 9).

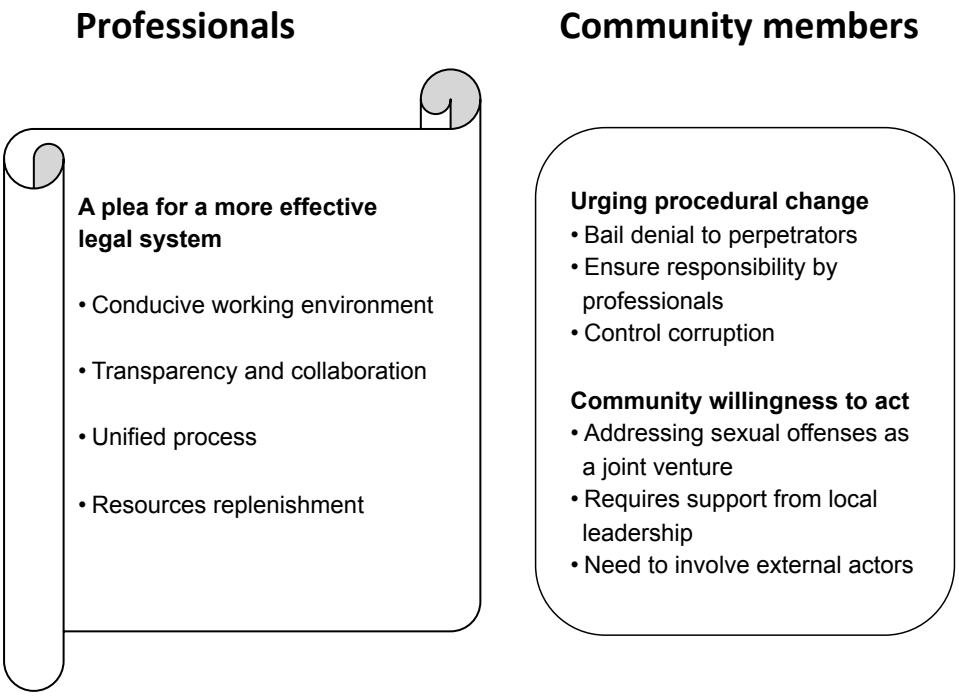


Figure 9. Professionals and community members' wishes for change.

The magnitude of child sexual abuse and its health consequences (Paper IV)

The school-based survey reported in Paper IV clearly indicates the seriousness of CSA in the Tanzanian context. Among the 1359 students, 26% of girls and 30% of boys (p=0.06) experienced at least one sexual abuse incident. Figure 10 shows the most prevalent types of abuse by sex. Being forced to watch pornographic materials was the most common incident reported more often by boys than girls (26% vs. 19%; p=0.008). A significantly higher proportion of girls had been forced or demanded to "look at his/her genitalia" (p<0.001), and 0.8% of boys vs. 3.5% of girls "had fingers or objects introduced into one's body" (p=0.002). Experience of penetrative sex was reported by 9.1% of the students (boys=9.8%, girls=8.7%; p=0.30).

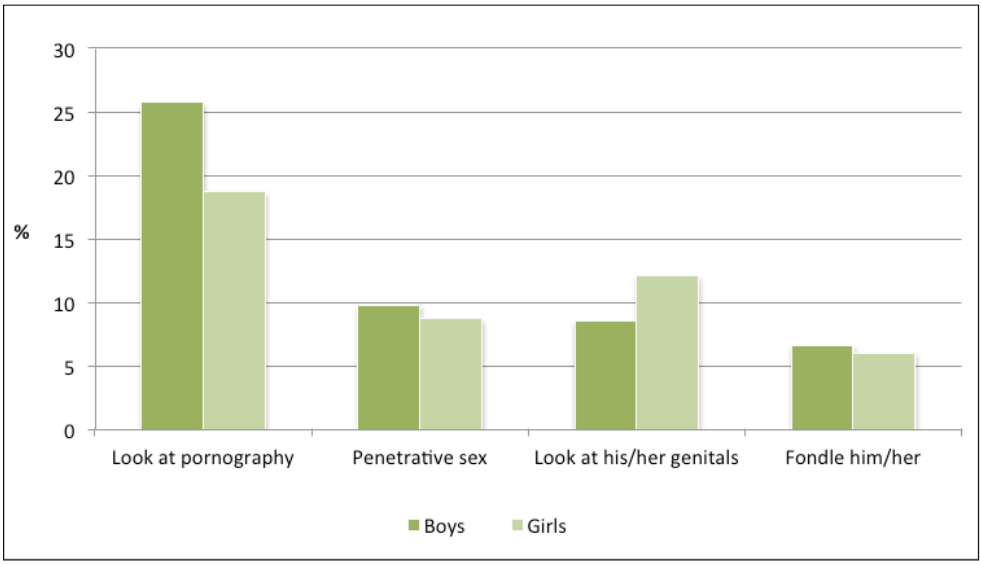


Figure 10. Most prevalent types of forced abuse by survivors' sex.

The most commonly reported perpetrators were neighbours followed by teachers, peers, family and friends. Figure 11 gives the relationship between survivors and perpetrators by sex.

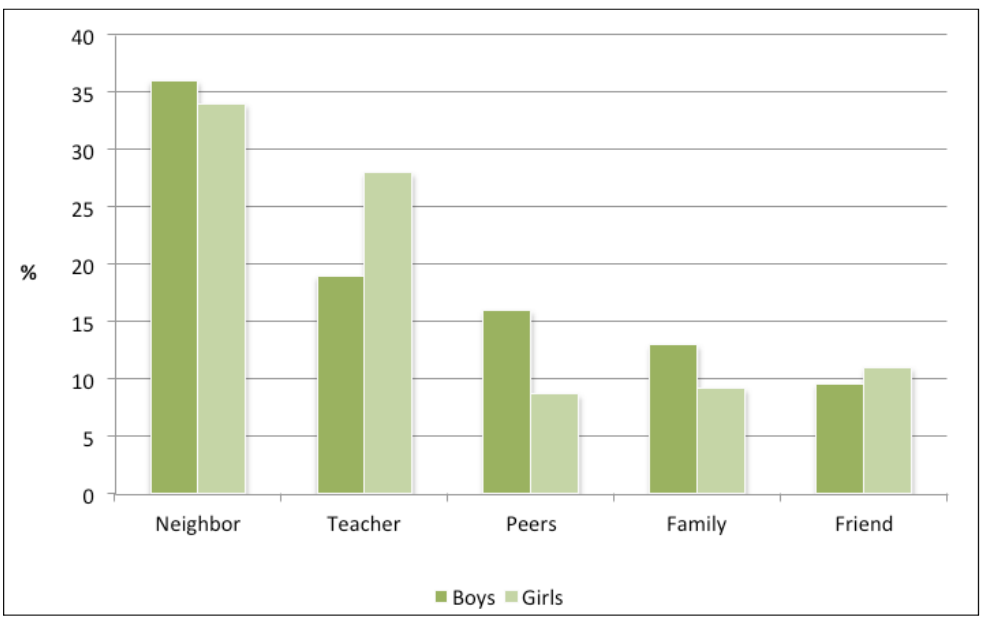


Figure 11. Most frequently reported perpetrator by survivors' sex.

Three of four (76%) girls and two of three boys (66%) disclosed their experience of abuse. One third of the students disclosed to teachers, one fourth to family, and one fourth to friends with no difference by sex (Figure 12).

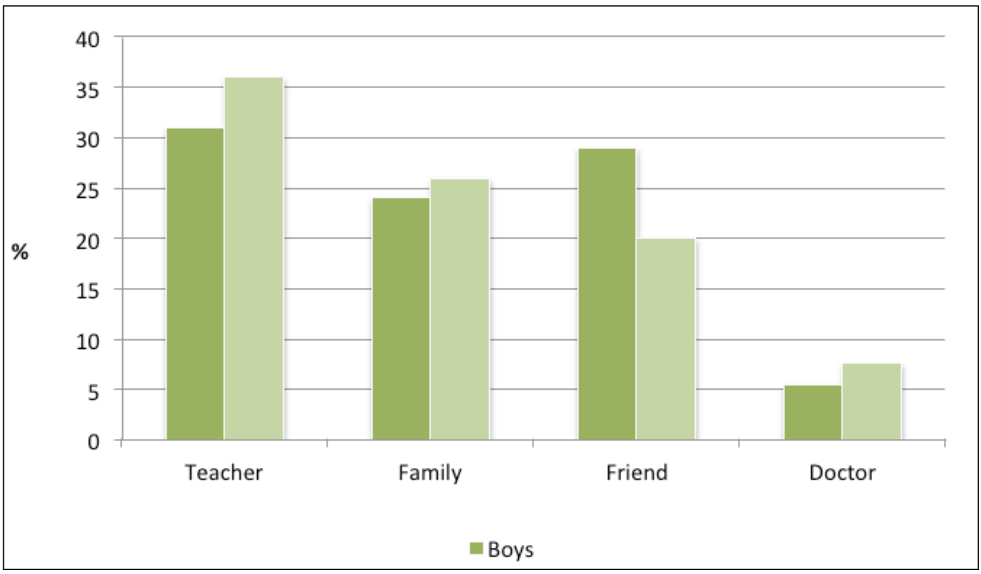


Figure 12. Persons to whom disclosure was made by survivors' sex.

Of the ever-abused students, 21% sought help, 13% asked that the information to be kept secret, 10% felt that nothing should be done about the abuse, and 9.2% asked that the matter be handled by the police (data not shown).

The risk for ever being sexually abused (Table 4, Paper IV) was higher in the 15-17 year old (OR=1.6; 95% CI: 1.1-2.3) and 18-25 year old age groups (OR=1.5; 95% CI: 0.9-2.7) than in the 12-14 year old age group. The risk was also significantly elevated for those who rated their socio-economic status as poor/very poor (OR=1.9; 95% CI: 1.1-3.2) compared with the rich/very rich, and those who rated their health status as poor/very poor (OR=11; 95% CI: 7.7-17) or good (OR=3.1; 95% CI: 2.3-4.3) compared with those who rated their health status as very good/excellent.

A similar pattern was revealed when measuring the risk of being exposed to penetrative sex (Table 5, Paper IV). The OR increased by increasing age from 3.2 (95% CI: 1.7-6.4) in the 15-17 year old age group, to 5.0 (95% CI: 2.1-12) among 18-25 year olds as compared with the 12-14 year old age group. The risk also increased by increasing knowledge of CSA. Finally, the risk for being exposed to penetrative sex increased from 2.7 (95% CI: 1.6-4.6) for those who assessed their health as good, to 9.4 (95% CI: 5.7-16) for those who assessed their health as fair/poor in comparison to those who assessed health as excellent/very good.

All measures indicate that health consequences are more prevalent among the abused compared to the non-abused children. Prevalence among those exposed to penetrative sex is even higher. Figure 13 shows that the health consequences are serious, as measured by poor self-rated health. The difference between boys and girls was considerable. Among boys 7.0% of the non-abused, 26% of the abused, and 35% of those exposed to penetrative sex rated their health as fair/poor. The corresponding figures for girls were 6.3%, 41% and 53%, respectively.

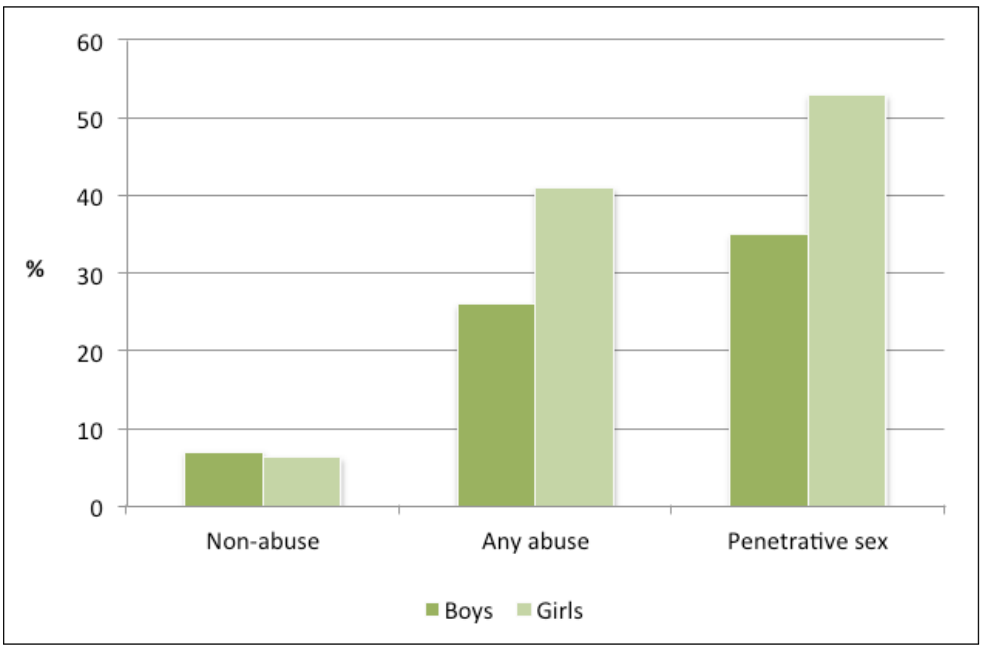


Figure 13. Percentage of non-abused, abused and exposed to penetrative sex boys and girls rating their health as poor/fair.

As seen from Figure 14 the health consequences of penetrative sex are similarly severe. Among boys, suicidal thoughts were present in 3% of the non-abused, 10% of the ever abused, and 12% of those exposed to penetrative sex. The health consequences were more severe among girls, with rates of suicidal thoughts at 7.1% of the non-abused, 15% of the ever abused and 26% of those exposed to penetrative sex. Boys who reported suicidal attempts were 1.1% of the non-abused, 1.9% of the abused and none for the penetrative sex. The corresponding figures for girls were 2.1%, 3.7%, and 6.9% respectively.

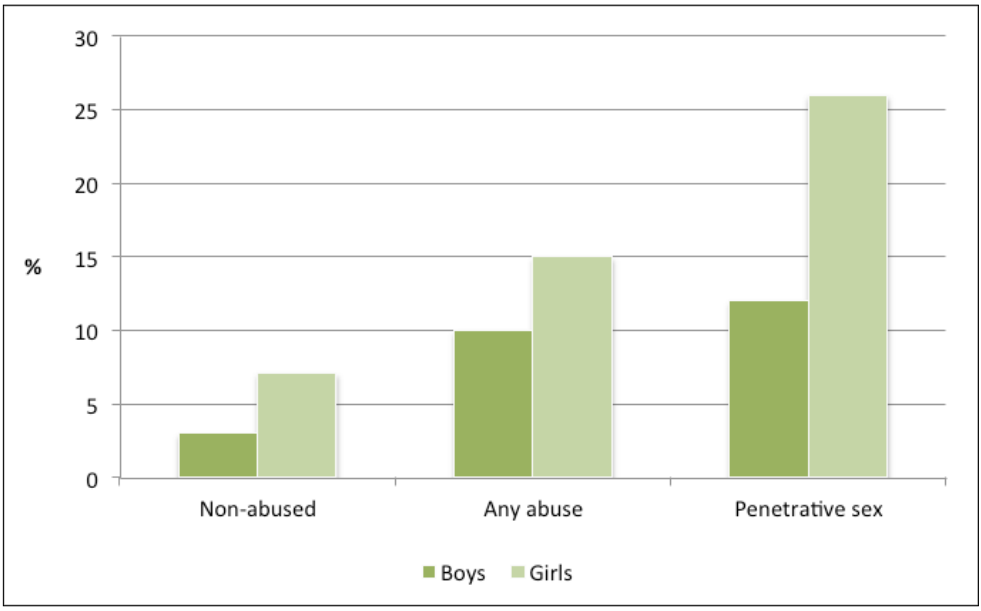


Figure 14. Percentage of non-abused, abused and exposed to penetrative sex boys and girls suicidal thoughts.

METHODOLOGICAL CONSIDERATIONS

Strengths

The use of both qualitative and quantitative research methods is a major strength of this thesis. Interviews, analysed with qualitative content analysis, were used to explore professional perceptions and experiences of handling child sexual abuse cases as well as for asking parents about their experiences of reporting cases of CSA (Papers I and III). The interview method for data collection was chosen since individual experiences of this nature may be difficult to discuss in groups. For eliciting perceptions, attitudes and norms at community level, focus group discussions were regarded as best since they build on interaction and are analysed at the group level. In this case, Grounded Theory was used (Paper II). Adding a quantitative approach was used to determine the magnitude of the problem among secondary school students, as well as to measure the associations with socio-economic factors and health outcomes. This questionnaire-based approach gives further possibilities for an in-depth understanding of child sexual abuse in Tanzania.

Trustworthiness of the collected information for the qualitative components relies on *credibility* (how well the research questions are captured), *dependability* (how the researcher has taken changes in the research process into consideration), *confirmability* (how the researcher can show that the interpretation is grounded in the data) and transferability (to what extent are the results applicable to other settings) (Dahlgren et al, 2007). Measures to enhance *credibility* in the qualitative studies included prolonged engagement in the field of child sexual abuse. This entailed several field visits and informal interviews to familiarize himself with community members and professionals in order to understand the socio-cultural context of the study area. Peer debriefing discussions with the multi-disciplinary research group were held at every stage of data collection, analysis and report writing, as well as member checking for sharing and feedback from the study informants on the interpretation of the results. *Dependability* was considered with a study guide that was focussed but still flexible. This increased the possibility that the researcher could be open for change and further probing based on emergent interpretation of the data. To increase *confirmability* of the interpretations, quotes and examples of the data analysis process were presented. This was a way to be transparent about the steps taken and to provide an "*audit trail*". Efforts were made to bracket own pre-understanding, especially during the data collection phase. All studies were performed in the same study area, thus limiting the *transferability* of the results to other settings. However, the *audit trail*, together with a *thick description* of the study context, provides an opportunity for others to judge how the results may apply outside the study area.

Use of an anonymous self-administered questionnaire to learn about experiences of abuse among school children was a way to increase the *validity*, i.e., to give the students the opportunity of disclosing information about sexual abuse

incidents without threatening confidentiality. The fact that the questionnaire was based on previously used instruments and pre-tested in a school outside the study area increases the likelihood of reflecting the true magnitude of CSA and associated factors in the target population. The random sampling process and the high response rate also contribute to study *validity*.

Limitations

The order of the qualitative sub-studies created some limitations in follow-up of certain issues. Since the focus groups with community members were held after the interviews with the professionals, it was not possible to follow-up on some of the negative views of professional handling of CSA cases. If this had been possible, it could have increased the depth of the interview data. For the focus group discussions, variation in experiences was enhanced by inviting people from different socio-economic strata. However, even if the group discussions were scheduled after working hours, there were few employed participants. The sampling criteria and the time available for data collection in the study of parental experiences limited the number of informants. Only eight parents who had gone through, or were in the final stages of the court process, were able to be recruited. This limited the saturation of that study.

The *validity* of information from the school survey (anonymous questionnaire) could be biased by the required parental consent, since this may have prevented children with experience of abuse within the family from participation. However, the strategy of labelling the study without mentioning CSA decreased this risk. Also the high participation rate of 84% indicates that this probably did not influence the results. When asked about the relevance of the questions, more than 60% of the students found it useful and interesting and this decreases the risk of the answers not being trustworthy. The cross-sectional design limits the opportunities for determining causational relationships regarding risk factors and health outcomes, but because of the sensitive nature of the subject, there are almost no longitudinal studies on CSA.

DISCUSSION

Using a mixed methods approach allows an in-depth understanding of how CSA is perceived and handled in the urban context in Tanzania. In-depth interviews with professionals illustrate the dilemmas in handling cases of this kind that are faced by magistrates, police and non-governmental organisations. Results from this study could then be mirrored in the norm systems surrounding CSA as expressed by ordinary community members and in actual parental experiences of seeking support from professionals and the community. Finally, the school survey highlights the magnitude of the problem and health consequences of abuse. Findings from the qualitative sub-studies will be discussed jointly and complemented with the information from the school survey. Together they form the basis for recommendations to improve handling of CSA in order to safeguard the rights of children in Tanzania.

From the in-depth interviews with professionals (Paper I) and the focus group discussions with community members (Paper II), CSA was clearly perceived as a serious problem that is increasing. The community acknowledged being aware of CSA but found it difficult to act without appropriate support. Professionals and the community attributed such incidents to poor parental care, eroded social norms, and various myths that relate having sex with a child will prevent or cure certain diseases, dissipate misfortunes, or provide wealth. Such myths are also reported to drive CSA in other parts of sub-Saharan Africa (Meel, 2003; Seloilwe & Thupayagale-Tshweneagae, 2009).

Poverty adds to the complexity of CSA and is seen as an important risk factor for abuse at all levels. Poverty also influences the court process for those who report abuse. This study clearly indicates how poor parents, having experienced CSA and reported the case, face an economic burden that often makes them drop the case or agree to informal settlements with the perpetrator. Children from poor families, who feel they are not adequately provided for, may solicit financial support from outsiders. This puts them at increased risk for sexual abuse. *The consenting curious youth* and *the transactional sex youth* (Paper III) have sexual affairs at young ages, and with older men, that are initiated or maintained for financial reasons. This is not surprising since transactional sex at a young age is reported from north-western Tanzania (Wamoyi et al., 2010a). Transactional sex is reported to be responsible for one in every 25 female children aged 13-17 years who experience sexual exploitation in Tanzania. A Liberian study among school youth describes how the student's first sexual experience may be from curiosity, but later turns into transactional sex with the so-called "big, big men" who provide financial support for personal upkeep and school fees (Atwood et al., 2011). Similar experiences are reported from Uganda; there it is called "something-for-something love" (Samara, 2010).

This study illustrates how shame and stigma about CSA influences how such incidents were handled. Many cases recanted as a strategy to hide the associated

shame, self-blame, and stigma, and also to protect the perpetrator from prosecution that might create shame for the family. A qualitative study among survivors in Israel established shame and stigma as barriers to sexual abuse disclosure. When the perpetrator is familiar, the cases are especially unlikely to reach the legal system. Researchers established that such families are often closed systems, characterised by chaos and isolation (Hershkowitz et al., 2007). In a Canadian study, Allagia (2010) describe how families that experience CSA incidents may also experience intimate partner violence. In these families, the sexually abused children encounter difficulties in disclosing the abuse to their mothers, who are facing violation by the same perpetrator. The same study (Allagia et al., 2010) describes how non-disclosure might occur to preserve family integrity when intra-family sexual abuse is identified. Such barriers to disclosure are referred to as "*micro-system level factors*" (family environment factors). Finkelhor and colleagues (2001) described a similar situation with parents and survivors suffering self-inhibition toward seeking care because of their embarrassment and shame.

Despite perceiving having the necessary infrastructure, a legal framework and trained staff, professionals acknowledged inefficient handling of CSA cases (Paper I). Inadequate working space and working tools were seen as major drawbacks that contribute to these deficiencies. Similar systemic pitfalls were described at police stations and health facilities in Kenya where lack of equipment and essential supplies were felt to contribute to inefficient handling of sexual abuse cases (Ajema et al., 2011).

Conflicting laws are a major complaint raised by the magistrates. They feel they are in an awkward position, especially when they handle sexual offences involving youth who consent to sex with age-mates. Magistrates argue that allowing youth aged 14-17 years to marry, while labelling consensual sex between sexually mature youth of similar age as sexual abuse, feels ambiguous. SOSPA (URT, 2002) and the Law of the Child Act (URT, 2009) both point out the age limit of 18 years, below which a person is considered a child. This is in conflict with the law regulating the marriage act (URT, 1971) which grants circumstantial permission to the marriage of 14 years old girls. This law vide section 13 (2) states that "*...the court shall, in its discretion, have the power, on application, to give leave for a marriage where both parties are, or either of them is, below the ages prescribed in section* (1) if (a) *each party has attained the age of 14 years*; and (b) *the court is satisfied that there are special circumstances which make the proposed marriage desirable*" (URT, 1971 page 5). The conflicts between laws are even noted by the media, as illustrated by a newspaper cartoon (Figure 15).

Figure 15: Newspaper cartoon portraying the dilemma of conflicting laws. (Source: Guardian local newspaper, June 2012, Tanzania)

This conflict is also noted in Paper III. There, parents with an abuse incident characterised by *"the consenting curious youth"*, felt uncertain about the direction forward and what measures to take. At the same time, they wanted to protect their child/youth from the cultural or religious shame involved in experiencing pre-marital sex. Just as parents struggle to protect their children from risky sexual behaviours, the absence of reproductive knowledge transfer to youth remains an individual struggle. The youth remain exposed to the danger of falling prey to whoever provides them with sexual education. Silbersmith and Rasch (2001) described how adolescent girls from poor families engage in high risk sexual behaviour by being sexually exploited by individuals (some are married men) who provide them with financial and material support on temporary relationships. Many such girls have to accept the supporter's demands even if they demand sex without condoms with resultant spread of sexually transmitted infections and unwanted pregnancies.

Court processing of cases of CSA is described by informants for the three qualitative sub-studies (Papers I, II and III) as time-consuming from the point of disclosure until justice is reached. Paper III also shows that detecting family level abuse, when faced with incidents characterised by "*the innocent child*" or "*the forced sex youth*", is easier than for incidents related to "*the consenting curious youth*" or "*the transactional sex youth*". Innocent child survivors faced more immediate and offensive complications of sexual abuse. These made it easier for parents to enquire about the abuse and for the children to ask for help. The community and professionals sympathized, and provided support without hesitation. This response was possible since the involved children could recount the abuse. Other studies document that very young children are rarely able to

communicate about abuse. This is an individual barrier to disclosure and may result in health consequences. In a Canadian study of adult survivors, Allagia (2010) describes how survivors of young child abuse victims suffer from temper tantrums, while adolescent survivors tend to withdraw and run away from home. In other settings, non-disclosure of childhood sexual abuse manifests in secrecy, helplessness, entrapment, and retraction of the report (Lyon, 2002).

According to the professionals (Paper I), many survivors report long after they have calmed down and cleaned themselves. In such cases, important forensic evidence cannot be corroborated to support the sexual abuse allegations. This may be attributed to survivors' not being informed about the need for early reporting and the necessity of preserving forensic evidence from the perpetrator. Findings from a study of government health facilities in three Kenyan provinces (Ajema et al., 2011) reveals a similar scenario; survivors of sexual violence report late and no forensic evidence can be collected. In such cases, it will be difficult to convict perpetrators and the cases may be dismissed.

Both community members and professionals (Paper I and II) expressed passivity in assisting survivors or giving information about perpetrators from the community. Explanations include fear of breach of confidentiality by professionals, and fear of perpetrator retaliations. In such situations, professionals find it frustrating and difficult to establish sexual abuse allegations. This results in the actual perpetrators being freed. Community level factors such as this are referred to as '*exo-system level factors*' in the Canadian study, but it features community members as uncaring or unknowledgeable rather than fearful (Allagia, 2010).

Leniency towards sexual offenders is also mentioned as an important factor that denies justice to survivors. Informants in Paper III expressed being overwhelmed with plea bargains during their case deliberations. They were troubled by the possibility that the perpetrators would be granted bail. In other settings, plea bargains deter registered cases from reaching prosecution or are used to lower the amount of punishment given to perpetrators (Martone et al., 1996).

The professionals (Paper I) and the community representatives (Paper II) pointed out that poverty constrains the health care and justice seeking of CSA survivors. Poor survivors (Paper III) say that health care costs for medico-legal expenses are exorbitant and that they must rely on relatives for financial support. In other settings, financial costs also contribute to under-reporting of CSA cases. Not only do survivors incur immediate medical costs, but they also must pay for their legal cases within the justice system (Finkelhor et al., 2001).

The professionals (Paper I) call for a conducive working environment as well as essential working tools. They identified a need for increased collaboration between the police, court and NGOs. This was also the case in Kenya, where a comprehensive national framework needed to be developed to address sexual violence (Ajema et al., 2011). In Zambia, a "One-Stop Centre" was introduced for managing CSA survivors at Lusaka University Teaching Hospital. The necessary equipment, supplies and professionals were available at one station. CSA survi-

vors received full, coordinated services (Chomba et al., 2010). This might be a feasible solution in Tanzania. From a community perspective (Paper II), keeping the court corruption-free was identified as an important measure. Since corruption is a major political issue affecting different levels in Tanzania, this will be a long-term process. Within the health care system, corruption exists in different forms. For example, informal payments are shared disproportionally by different groups. Sometimes staff will be bribed to provide urgent attention to a patient jumping the waiting queue, good service in labour ward, or prescribe medications (Mæstad and Mwisongo, 2011). The legal system is equally affected by corrupt staff that may take bribes and assist perpetrators in evading justice (Ng'walali and Kitinya, 2006).

The school survey results (Paper IV) show that 28% of the students had experienced at least one sexual abuse incident and that sexual abuse was slightly more common among boys than girls. This confirms the seriousness of the situation illustrated also in the interviews with professionals and community members. Similar estimates were reported by McCrann et al (2006) based on self-reported data in a lecture hall and Andersson et al (2012) based on the TDHS. Findings from the population-based national survey of violence against children conducted by CDC and UNICEF among adolescents aged 13–24 years in Tanzania show similar overall prevalence figures but a different pattern between girls and boys (URT, 2011). In that study 28% of the girls and 13% boys reported having experienced at least one incident of sexual abuse before reaching 18 years of age. The lower estimate for boys might be due to the data collection method as the study was based on face-to-face interviews at home while this school survey estimate was based on anonymous self-reported data collected in the class room.

In all the qualitative sub-studies examples were given of perpetrators being known to the survivors. Also this information was confirmed by the school-survey showing that the majority of perpetrators were neighbours, teachers and peers. Similar results were shown in the national survey (URT, 2011), where neighbours (girls=32%, boys=17%) followed by strangers (girls=32%, boys=26%) were the most common perpetrators. In the school-survey teachers were among the common perpetrators but at the same time they were among the common confidants for disclosure and support. This indicates the important role of teachers as role models but also a power relation where they as adults may take an advantage of their position in relation to their students.

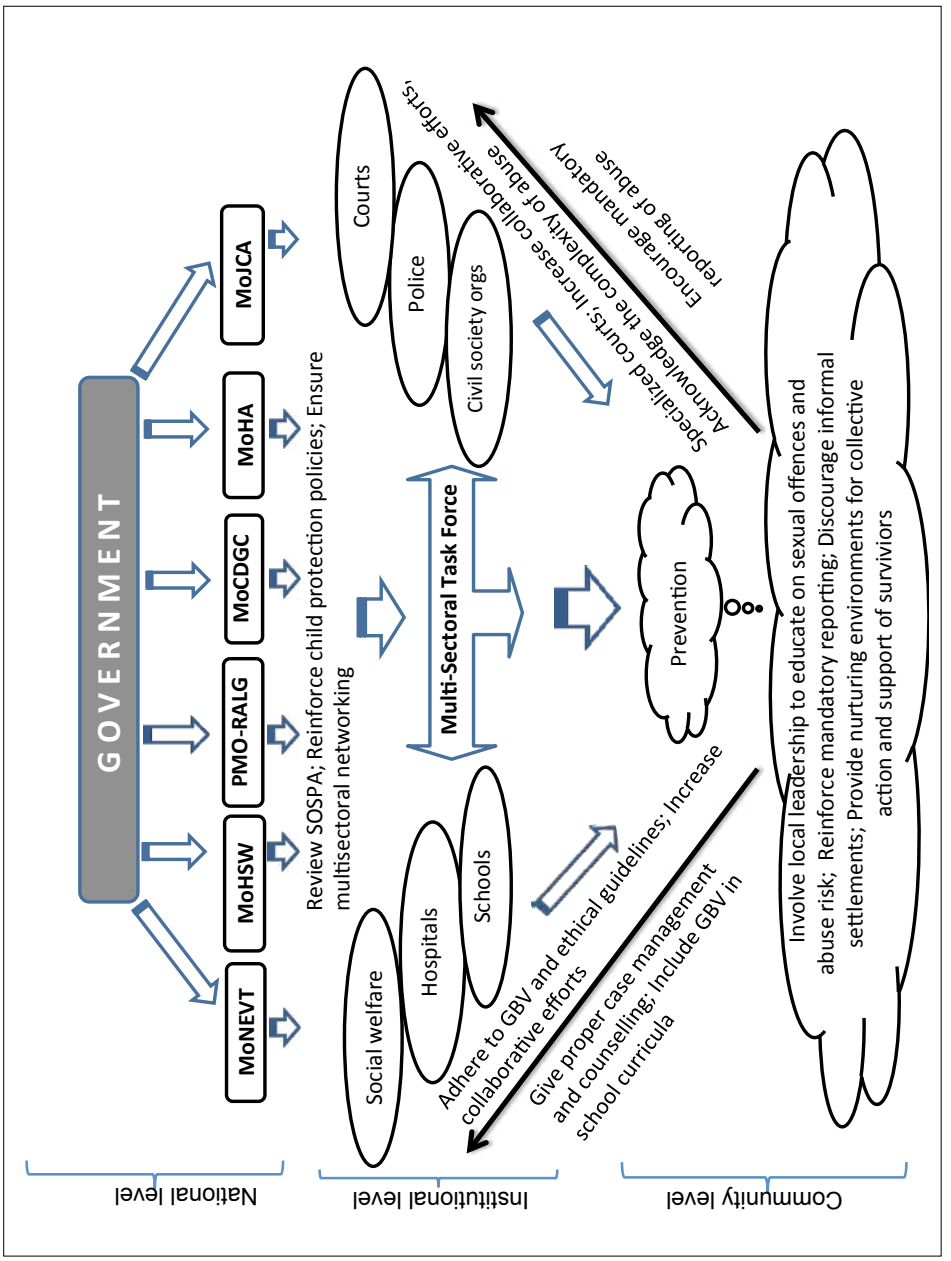
The health consequences of CSA were highly acknowledged in the qualitative studies. Through the school survey it was possible to show that sexual abuse was significantly associated with poor self-rated health. The study also revealed that a higher proportion of the abused students had suicidal thoughts and had made suicidal attempts, than the non-abused, and that this was more pronounced for the girls. The association between CSA suicidal thoughts and attempts is confirmed in many studies. A study by Mallya (2011) among secondary schools in Kinondoni district of Dar es Salaam reported more suicidal thoughts and attempts

among the abused but did not observe any sex differences. In a study from China a significantly higher proportion of those exposed to CSA reported suicidal attempts but did not measure sex differences (Lin et al., 2011). Devries et al (2011) found that CSA was a strong risk factor for suicidal thoughts and attempts in many of the study sites of the WHO multi-country study, but the results only applied to women. However, this study is supported by Romito and Grassi (2007), in their study on gender difference in experiences of violence, among university students in Trieste, Italy. They found also that exposure to CSA had greater impact on several health outcomes for girls' including suicidal thoughts and attempts, than on boys. This indicates that health consequences of CSA may be more serious for girls than for boys. The explanation is probably complex and could depend of differences in type and severity of violence and/or socio-cultural expectations resulting in a higher degree of stigma, shame and self-blame for girls than for boys. Further studies are needed to explore the differences in boys' and girls' experiences of CSA.

Conclusions and recommendations

CSA is a public health problem in Tanzania. CSA manifests in both contact and non-contact forms. This thesis shows that nearly one in every three school children experiences an incident of CSA. More boys than girls are exposed to most forms of abuse. The non-contact forms, e.g., being forced to look at pornography or adults genitalia, are the most common. Approximately one in every ten students is forced into penetrative sex or fondling of an adult. The health consequences differ by sex. Girls exposed to any abuse, or forced to have penetrative sex, have a higher risk of poor perceived health, suicidal thoughts, and suicidal attempts than do boys. The thesis has shown that the professional handling of sexual abuse cases is currently not fully protecting the rights of children and that preventive measures are needed to engage the government in policy changes as well as to enhance community involvement in improving the situation.

Thus, based on the results from this thesis, preventive measures are needed at different levels, illustrated in Figure 16 and spelled out below.



MoNEVT = Ministry of National Education and Vocational Training, MoHSW = Ministry of Health and Social Welfare, PMO-RALG = Prime Minister's Office Regional and Local Governments, MoCDGC = Ministry of Community Development Gender and Children, MoHA = Ministry of Home Affairs, MoJCA = Ministry of Justice and Constitutional Affairs, GBV = Gender-based violence

Figure 16. Strategies needed for prevention child sexual abuse at different levels in Tanzania

At the national level, there is need to:

- review the SOSPA and related marital law to provide full protection of children;
- reinforce policies that target child welfare and development;
- ensure that the newly formed multi-sectoral task force stipulates the roles of each sector and establishes an essential networking among different stakeholders
- Institute measures for controlling corruption

The institutional and non-governmental level should:

- collaborate to ensure that there are adequate human, material, and financial resources to support structures and staff motivation;
- ensure adherence to rape management guidelines and ethics within the medico-legal institutions;
- increase effectiveness and efficiency by establishing a specialized court branch to speed up the process of sexual offences;
- be aware of the complexity of CSA that results in various actions and reactions of parents, survivors, community members, and professionals;
- stablish a "one stop centre" to carter for sexual offence suvivors;
- include gender based violence in school curricula;
- encourage mandatory reporting.

At the community level, it is crucial to:

- educate the community on the sexual offense laws;
- reinforce early and mandatory reporting of CSA;
- garner support for victims during the investigation process;
- discourage informal settlement (plea bargains) of sexual offence cases in order to increase the convictions of perpetrators;
- involve local leadership to provide a nurturing environment for collective action, in order to support survivors and prevent the occurrence of sexual offenses;
- give local leaders and activist groups instrumental roles in educating caretakers on sexual offenses, and abuse risks.

Dissemination of findings

The findings have already contributed to change in the way people are interviewed or interrogated after experiencing sexual offenses. After the dissemination of study findings to different stakeholders, the Tanzania Media Women Association (TAMWA) initiated campaigns for the creation and piloting of "*gender sensitive desks*" in Dar es Salaam police stations (USAID, 2008). This innovation allowed clients to discuss their problems more freely and with less fear of breach of confidentiality. As a result, extension to each up-country police station will take place.

In the future, the findings from this PhD thesis and the two other PhD theses emanating from the project "*Violence against women and children*" "*Prevention of intimate partner violence-community and health care workers' perceptions in urban Tanzania*" (Laisser, 2011), and "*Rape against women in Tanzania*" (Muganyizi, 2010) will be incorporated into a collective report that reflects each of these forms of violence. The findings will be disseminated to relevant stakeholders and form the basis for further discussions on the implementation of the suggested measures to protect the rights of women and children in the Tanzanian setting.

THE RESEARCHER

My interest in the field of CSA goes back to 1997-98 when I conducted research about "*Where referral is difficult or impossible*" within the Integrated Management of Childhood Illness (IMCI) strategy in Mpwapwa District, Tanzania. In one health centre, I met a clinical officer who asked me to assist him examine a 4 year old girl who was raped by a herdsman the previous day. She encountered him on her way to fetch water from a swamp located about 1 kilometre from her home. I found the child, in severe pain, in the paediatric ward. After establishing rapport and taking a brief history I asked if I could examine her. Due to severe pain, she was unable to abduct her lower limbs wide enough for examination. I could only see that she had sustained an extensive vaginal tear. This was an emotionally challenging case to examine, especially since no anaesthesia was available. I provided transport for a referral to the district hospital for better management. From that day onward, I was concerned about the CSA cases that appeared in the newspapers. It took some time before I became involved in research on CSA in Tanzania. The 'Violence against Women and Children' project provided an opportunity for me to develop a research plan within the bilateral collaboration on 'Reproductive Health'. Since 2006, this research has been funded by the Swedish International Development Agency (SIDA) as collaboration between MUHAS, Uppsala and Umeå Universities. Two of my colleagues presented their theses on '*Rape against Women*' and '*Intimate Partner Violence*'. Now it is my turn to defend my work on '*Child Sexual Abuse*'. I hope that our joint efforts will contribute to a change so that the human rights of women and children include the right to live a life without violence.

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APPENDIX

Questionnaire

DO NOT WRITE YOUR NAME ON THIS QUESTIONNAIRE **DATE [……/……../2010]**

QUESTIONNAIRE ON CHILDREN HEALTH AND LIFE EXPERIENCES

Few questions require filling in your response but most of them require you to tick in the box corresponding to your answer ***See the example*** [√]

Q1	**Name of school?**	……
Q 2	**How old are you?**	…… years
Q 3	**Are you a boy or girl?**	1. Boy ☐ 2. Girl ☐
Q 4	**What is your home region and district?**	Region …… District ……..
Q 5	**What is your tribe?**	……
Q 6	**In which form are you?**	1. Form I…… ☐ 2. Form II…… ☐
Q 7	**Are your parents married?**	1. Yes…… ☐ 2. No…… ☐
Q 8	**What is the level of your biological mother's education?**	1. No formal education…… ☐ 2. Primary education…….. . ☐ 3. Secondary education…. ☐ 4. College education…… ☐ 5. Others, specify……
Q 9	**What is the level of your biological father's education?**	1. No formal education…… ☐ 2. Primary education…… . ☐ 3. Secondary education…… ☐ 4. College education…….. ☐ 5. Others, specify……
Q 10	**Whom do you live with**? (*Several answers possible*)	1. Mother and father…… ☐ 2. Mother only…….. ☐ 3. Father only…….. ☐ 4. Step father…… ☐

		5. Step mother…….. ☐ 6. Grand father…… ☐ 7. Grandmother…… ☐ 8. Fellow student…….. ☐ 9. Alone…….. ☐ 10. Others, specify…….....
Q 11	**What type of accommodation do you currently live in?**	1. I live with parents in a rented House…… ☐ (Go to Q12-14, 17-19) 2 I live in a rented room…… ☐ (Go to 14-19) 3. I live with relatives who own a house…… ☐ (Go to Q13-14, 17-19) 4. I live in my parent's house .. ☐ (Go to Q12-20)
Q12	**How many rooms does your family house have?**	.....
Q 13	**How many sleeping rooms does the house have?**	.....
Q 14	**With whom do you share your sleeping room?**	1…… 2…… 3……
Q 15	**What kind of toilet facility does your current accommodation have?**	1. Water closet…… ☐ 2. Ventilated improved pit latrine… ☐ 3. Pit latrine with slab.. ☐ 4. Pit latrine without slab/ open pit.. ☐ 5. No toilet facility…. ☐ 6. Others specify ……

Q 16	**In the place you live, what is the main source of drinking water?**	1. Piped water in to the house….. ☐ 2. Piped water in to the compound ☐ 3. Piped water standpoint…… ☐ 4. Protected well…… ☐ 5. Unprotected well…… ☐ 6. Bottled water…….. ☐ 7. Others specify……
Q 17	**Does your family or any member of the household possess;** (*Tick all items the family/ family member has*)	1. Iron…… ☐ 2. Radio…… ☐ 3. Television set…….. ☐ 4. Telephone…… ☐ 5. Refrigerator…….. ☐ 6. Bicycle…….. ☐ 7. Motorcycle…… ☐ 8. Car…… ☐
Q 18	In the community there are families and individuals that are very poor, poor, average, rich and very rich. How rich or poor do you consider yourself as a family or household in comparison to others?	1. Very poor…….. ☐ 2. Poor …… ☐ 3. Average …… ☐ 4. Rich …… ☐ 5. Very rich …….. ☐
	READING OF A NEWSPAPER SCENARIO TAKES PLACE BEFORE ATTEMPTING TO ANSWER THE REST OF THE QUESTIONNAIRE	
Q19	**Here are some statements on child sexual abuse**. **Do you rather agree or disagree with these statements**	
	1. Some children are sexually abused by elder children	**Agree I disagree I don't know** ☐ ☐ ☐
	2. Most people who sexually abuse children do not belong to the child's family	
	3. Most of the time children are abused when they are alone at night and usually outside their home	**Agree I disagree I don't know** ☐ ☐ ☐
	4. Only girls are victims of sexual abuse	☐ ☐ ☐

	5. Sexually abused boys are usually not homosexuals	☐ ☐ ☐
	6. Children from reputable families are not victims of sexual abuse	☐ ☐ ☐
	7. Children who report not necessarily placed in foster care following these revelations being victims of sexual abuse are	☐ ☐ ☐
	8. Few children are victims of sexual abuse	☐ ☐ ☐
	9. Only young children are victims of sexual abuse	☐ ☐ ☐
	10. Boys are not sexually abused	☐ ☐ ☐
	11. A majority of sexual abuse perpetrators are retarded or mentally ill	☐ ☐ ☐
	12. Even if one lets a year go by before talking about a sexual abuse situation, it is still possible to do something about it	☐ ☐ ☐
	13. In sexual abuse cases, the child himself/ herself is never responsible	☐ ☐ ☐
Q20	**Have your parents ever talked to you about child sexual abuse?**	**Yes** ☐ **No** ☐ ***(If No, go to Q22)***
	1. Which parent?	**Father** ☐ **Mother** ☐ **Both** ☐
	2. Did they explain that children may be sexually abused by family friends or family members?	**Yes** ☐ **No** ☐ **I don't remember** ☐
	3. Did they tell you to let an adult know if it happened to you?	**Yes** ☐ **No** ☐ **I don't remember** ☐
Q21	***1.*** **Did you take part in the information session before today's questionnaire**?	**Yes** ☐ **No** ☐ **I don't remember** ☐
	2. Before the information session, **were you ever told about sexual abuse to children at school**, i.e. 'Facts of life' classes	**Yes** ☐ **No** ☐ **I don't remember** ☐

	or in a play, a movie or an exhibit?	
Q22	**Were you told about sexual abuse somewhere else** (i.e. outside of home and school)?	**Yes** ☐ **No** ☐ **I don't remember** ☐ If 'yes' please specify who told you about it (eg. friend, scout, doctor, etc) ……
Q23	**Has an adult or an older child ever not respected you by demanding you or forcing you to**;	
	1. Look at his/ her genitals?	**Yes** ☐ **No** ☐ **I don't remember** ☐
	2. Undress and show him/ her your genitals?	☐ ☐ ☐
	3. Watch him/ her masturbate?	☐ ☐ ☐
	4. Undress with another child and fondle each other?	☐ ☐ ☐
	5. Be fondled (caresses, rubs, kisses on the whole body and / or your genitals?	☐ ☐ ☐
	6. Fondled him/ her (caresses, rubs, kisses on the whole body and his/ her genitals?	☐ ☐ ☐
	7. Look at pornographic pictures, drawings, films, videotapes or magazines?	☐ ☐ ☐
	8. Be naked and to expose your genitals for picture taking or filming?	☐ ☐ ☐
	9. Submit to full sexual intercourse with penetration?	☐ ☐ ☐
	10. Submit to having his/ her fingers or an object introduced in your body?	☐ ☐ ☐
	You may wish to give a more detailed answer. Write your comment on the space to the right	……..

Q24	**If you experienced several of the situations described in question 24, one of them must have affected you far more than others. If so, please indicate *which one* stands out by providing the corresponding number in the list (i.e. 1. – 10.)**	…… [I***f you never experienced any incident, skip to question No 37]***
	If you were subjected to several situations described in question 24, answer the following question (Q25) with the situation that affected you most in mind, i.e. the one you just provided for question Q24.	
Q25	**If you were subjected to one (or more) situation/s described in question 24, it happened to you**;	1. How many times ……. 2. I can't remember ..... ☐
Q26	**How old were you when it happened the first time?**	1. Age……years 2. I can't remember..... ☐
Q27	**At present, are you still subjected to these situations?**	**Yes** ☐ **No** ☐ **I don't remember** ☐
Q28	**If not**, **how old were you the last time it happened to you**?	1. Age ……years 2. I can't remember ☐
	If you were subjected to several situations described in question 24, answer the following question (Q30) with the situation that affected you most in mind, (i.e. the one you provided in question 25)	

Q29	**At the time it happened did you feel**; 1. Threatened or in danger?..... 2. Unable to say no out of embarrassment / shame or fear?.. 3. Forced to accept for other reasons? 4. Neither forced nor threatened? **Were you;** 5. Subjected to physical abuse 6. Able to avoid the situation/s by refusing to go along, running away, etc	**YES NO It never happened** ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ If you wish to use this space below to complete your answers freely…… ☐ ☐ ☐ ☐ ☐ ☐
Q30	**1. What was the gender of the person** (or people) **who got you in this** (or these) **situation/s**? (*Several answers possible*)	**Male Female It never happened to me** ☐ ☐ ☐
	2. How old would you say he/ she was or they were	1. 1st person [……] years old 2. 2nd person [……] years old 3. 3rd person [……] years old

Q31	**This person (or these people) was (or were) a**: (*Several answers possible*)	1. Stranger…….. ☐ 2. Baby sitter…….. ☐ 3. Family friend…… ☐ 4. Neighbor…… ☐ 5. Teacher…….. ☐ 6. Instructor …… ☐ 7. Peer …… ☐ 8. Father……. ☐ 9. Mother…… ☐ 10. Mother's friend……. ☐ 11. Father's friend…….. ☐ 12. Brother…….. ☐ 13. Sister…… ☐ 14. Half brother……... ☐ 15. Half sister…….. ☐ 16. Uncle…… ☐ 17. Aunt …….. ☐ 18. Grand father…… ☐ 19. Grand mother…… ☐ 20. Someone else (specify without giving name…… ☐ 21. It never happened to me ☐
Q32	**Did you ever talk to anyone about this (these) event/s**? (*Several answers possible*)	**Yes** ☐ **No** ☐ **It never happened to me** ☐
	Please, describe what happened? 1. I was helped……..... 2. I was not believed …….. 3. Nothing changed……..... 4. I asked that it be kept secret 5. I asked that nothing be done to me 6. I requested it to be reported to the police……	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Q33	**Who did you talk to about this (these) event/s**? (*several answers possible*)	1. Father…… ☐ 2. Mother…… ☐ 3. Brother…….. ☐ 4. Sister…….. ☐ 5. Grand parent…… ☐ 6. Other family member ……. ☐ 7. Aunt…… ☐ 8. Someone teaching Facts of life class…….. ☐ 9. School health master/ nurse. ☐ 10. Doctor …… ☐ 11. Friend…….. ☐ 12. Another person outside the family (Specify without providing name…… ☐ 13. It never happened to me…... ☐
Q34	**What measures were taken by the person(s) you reported to?** **(***Several answers possible*)	1. They reported to the village government ..... ☐ 2. They reported the matter to the police ..... ☐ 3. The parents discussed and resolved the matter…… ☐ 4. They ignored the matter ..... ☐ 5. The perpetrator was punished at his home…… ☐ 6. The parents had a fight ..... ☐ 7. The incident was taken to court ☐ 8. The perpetrator payed to my parents ..... ☐ 9. Nomeasures were taken ..... ☐ 10. Others, speciy.....
Q35	**What happened to the perpetrator?**	1. He/ she disappeared from the village ..... ☐ 2. He/she was in police custody .. ☐ 3. He/she was in jail ..... ☐ 4. He/ she has an ongoing case in the court …… ☐ 5. He/ she never got punished .. ☐ 6. Others, specify.....

36	**What are the possible health consequences following child rape**	1. Contracting sexually transmitted diseases …… ☐ 2. Becomming pregnant ..... ☐ 3. Spread of HIV ..... ☐ 4. Getting vaginal tear ..... ☐ 5. Failure to conceive later ..... ☐ 6. Death from bleeding ..... ☐ 7. No health consequences ..... ☐ 8. Others, specify .....
Q37	**Do you know of another youngster who experienced similar events who spoke to you about them**?	**Yes** ☐ **No** ☐
Q38	**Now I'd like to ask you some questions about the kind of support you have received from adults in your community. Please tell me whether you *strongly agree, agree, disagree, or strongly disagree* with the following statements;**	Str ongly Agree / Agree / Disagree / Strongly D/agree / Dont Know
	1. I think that the people in my neighbourhood/ community/village can be trusted.	☐ ☐ ☐ ☐ ☐
	2. I feel like people in my neighbourhood/ community/village are willing to help their neighbours.	☐ ☐ ☐ ☐ ☐
	3. I feel safe and secure in my community.	☐ ☐ ☐ ☐ ☐
Q39	Would you say that, in general, your health is: excellent, very good, good, fair, or poor?	1. Excellent ..... ☐ 2. Very good ..... ☐ 3. Good ..... ☐ 4. Fair ..... ☐ 5. Poor ..... ☐ 88. Don't Know ..... ☐ 99. Refused ..... ☐

Q40	About how often during the past 30 days did you feel nervous, tense or worried? Would you say none of the time, some of the time, most of the time or all of the time?	1. None of the time ..... ☐ 2. Some of the time ..... ☐ 3. Most of the time ..... ☐ 4. All of the time ..... ☐ 88. Don't Know ..... ☐ 99. Refused to answer ..... ☐
Q41	During the past 30 days, about how often did you feel so sad or unhappy that nothing could cheer you up? *(Interviewer if necessary say: none of the time, some of the time, most of the time or all of the time?)*	1. None of the time ..... ☐ 2. Some of the time ..... ☐ 3. Most of the time ..... ☐ 4. All of the time ..... ☐ 88. Don't Know ..... ☐ 99. Refused to answer ..... ☐
Q42	The next two questions ask about things that have ever happened to you. **Have you ever had thoughts of ending your life**?	1. Yes ..... ☐ 2. No ..... ☐ 88. Don't Know ..... ☐ 99. Refused to answer ..... ☐
Q43	**Have you ever attempted to kill yourself?**	1. Yes ..... ☐ 2. No ..... ☐ 99. Refused to answer ..... ☐
Q44	**How did you find this questionnaire**?	**Yes** **No** 1. Useful ☐ ☐ 2. Boring ☐ ☐ 3. Clear ☐ ☐ 4. Too difficult ☐ ☐ 5. Embarrassing ☐ ☐ 6. Interesting ☐ ☐ 3. Too long ☐ ☐

If you wish please add comments here

……

……

You have been to the end of the questionnaire.

Please go through the questionnaire and check if you answered all the questions

Please remain seated at your desk we will collect all the questionnaire at the same time

THANK YOU FOR THE GOOD COOPERATION YOU GAVE TO THE TEAM