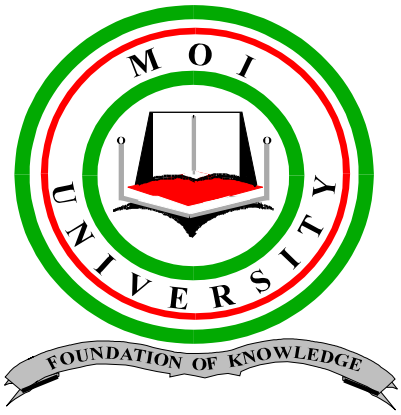

PERCEPTIONS OF THE CAREGIVERS ON THE FACTORS ASSOCIATED WITH CHILD SEXUAL ABUSE IN LONGISA AND MULOT DIVISIONS OF BOMET COUNTY

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THESIS SUBMITTED IN PARTIAL FULFILLMENT FOR THE REQUIREMENT OF THE DEGREE OF MASTERS OF MEDICINE (M.MED) IN FAMILY MEDICINE OF MOI UNIVERSITY.

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DECLARATION

This thesis is my original work and has not been presented for a degree in any other university or institution.

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- The administration of Tenwek Mission and Longisa County hospitals for approving this study
- My family for their patience with my frequent absences and unwavering support, without which this work would have been impossible.

DEDICATION

To my late mother, Ruth Too

You inspired me and made me who I am today.

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LIST OF ACRONYMS & ABBREVIATIONS

ANPPCAN	African Network for the Prevention and Protection against Child Abuse and Neglect
CSA	Child Sexual Abuse
DMOH	District Medical Officer of Health
EAMJ	East African Medical Journal
FGDs	Focus Group Discussion
HCWs	Healthcare Workers
HIV	Human Immunodeficiency Virus
IREC	Institutional Research and Ethics Committee
ILO	International Labor Organization
KNH	Kenyatta National Hospital
MS Access	Microsoft Access
MS Word	Microsoft Word
MS Excel	Microsoft Excel
PEP	Post Exposure Prophylaxis (against HIV)

STDs	Sexually Transmitted Diseases
UNICEF	United Nations International Children Emergency Fund
WHO	World Health Organization

ABSTRACT

Background: Child sexual abuse (CSA) is a rampant problem in the society though it is usually underreported especially in Kenya and other African Countries. Available literature on the causes is very limited due to limited studies done in this area. Several myths and hypotheses have been put forward on the possible predisposing factors. Parents and families of affected children often do not know which steps to take to assist their children who have been sexually abused. Effects of sexual abuse of children are so far reaching ranging from physical to long lasting psychological trauma. Longisa County hospital records show that 2 to 3 cases are seen every month.

Objective: To describe the community perception on the factors leading to child sexual abuse in Longisa and Mulot Divisions of Bomet County.

Study Design and Methodology: Descriptive study design employing both qualitative and quantitative approaches was used. The study was conducted among parents and guardians of child victims of CSA and key informants in Longisa and Mulot areas of Bomet County. Data was collected from parents or guardians using interviewer-administered questionnaire. FGDs were conducted among parents and in-depth interviews of key informants to elicit their perceptions and opinions on the subject matter. Qualitative data was transcribed, coded and categorized while quantitative data was entered using Epi info v10 and analysed using STATA v10.

Results: Girls between the ages 5-10 years from one parent homes are the most affected. Perpetrators are young men between the ages 18-25 years, working in casual jobs and familiar with the child. Family break-ups, abandonment of African traditional child rearing habits, unemployment and silence on the matter are among the perceived causes.

Conclusions: CSA is a rampant problem in the community studied that is often shunned than discussed and the perceived causes are multiple.

Recommendations: We recommend public health measures to educate the community on the prevalence and impact of CSA on the affected children and their families.

Limitation: the topic of CSA is a sensitive one to the victims, their families and the community and therefore eliciting information on the same is a challenge.

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

The problem of child sexual abuse in Kenya is a big and diverse one. It can be defined as the involvement of a child in a sexual activity that he or she does not fully comprehend,is unable to give an informed consent to, or to which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of a society (WHO, 1999).

CSA is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to satisfy or gratify the needs of the other person.

It typically includes unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person; genital touching or fondling; or penetration in terms of oral, anal or vaginal intercourse or attempted intercourse[1]. CSA can vary along a number of dimensions including frequency, duration, age at onset and relationship of victim to perpetrator.

However, the most common dimension used to define CSA is the type of abuse. Three categories are commonly reported in the literature. Noncontact abuse encompasses a range of acts and includes inappropriate sexual solicitation, indecent exposure or exposure of children to pornographic material. The two other categories are contact abuse, which includes touching or fondling, and intercourse, which includes oral, anal or vaginal

intercourse. In this study, the upper age limit used was 18 years, which is the upper age limit that defines a child in Kenya[7].

There is a general belief among the public, the media and experts that this problem is rampant in Kenya. It is not uncommon in Kenyan media to see headlines of a child or teenager impregnated by someone in authority or a relative. However, little data is available in the literature on the matter. This could be explained by the fact that there is very little research done in this area due to the sensitive nature of the topic and the fact that most research done on child sexual abuse in Kenya and Africa in general is unpublished in international literature and therefore difficult to refer to.

To stop some of these kind of sexual violence, which may cause great physical harm, death, psychological abuse, separation, divorce and other social ills, the Kenya Government has enacted the Sexual Offences Act No. 3 of 2006 (Revised 2007)[2].

1.2 PROBLEM STATEMENT

Child sexual abuse is a global public health concern. In Kenya it is a silent emergency that continues to be a challenge to parents, guardians, communities and the government. This is especially worsened by the fact that not many victims and their families are willing to speak openly about the vice. Historically, CSA has been shrouded in secrecy and silence, not only on an interpersonal level but also on a societal level (Sanderson, 2006). This has led to the denial of its existence and the generation of myths and stereotypes. Hardly a week passes by before a child sexual defilement case is reported in the Kenyan media, whether print or audio-visual. In the era of HIV/AIDS, the lives of so many innocent young girls and boys are being put at risk through this vice. The importance of involving

the affected communities and inculcating their opinions in prevention cannot be over emphasized. This study was conducted in the rural Kenyan setting where the vice had been reported before but no formal research had been done.

1.3 RESEARCH QUESTION

What are the perceptions of the community and the factors leading to child sexual abuse in Longisa and Mulot areas of Bomet County, Kenya?

1.4 OBJECTIVES OF STUDY

i) To describe the commonest age groups of the affected children and the socio-demographic and economic characteristics of their families

ii) To describe the socio-demographic characteristics of the perpetrators

iii) To describe the perception of the community on the factors leading to child sexual abuse in the named areas.

1.5 JUSTIFICATION

Sexual abuse of children is a global concern. It is an insidious, persistent and serious problem that, depending on the population studied and definition used, affects 2-62% of women and 3-16% of men as victims[1](ANPPCAN, 2000). Pain and tissue injury from sexual abuse can completely heal in time, but psychological and medical consequences can persist through adulthood. Associated STDs (including HIV) and suicide attempts can be fatal.

The vice is widely believed to be worse in developing countries where reporting is still very poor. Data from medical records in the hospitals indicate that both boys and girls are affected by this problem. The main challenge has always been the late presentation and sometimes non-presentation of the victims to the attention of healthcare workers. This is often due to ignorance on the part of parents and guardians concerning the vice and fear of reporting because of embarrassment. Other reasons might include risks of being victimized and the stigma associated with being sexually abused. This has made it difficult for the health care workers to give the victims proper medical attention in terms of trauma care, post-exposure prophylaxis (PEP) against HIV and other sexually transmitted diseases (STDs) and psychological and emotional support.

In most cases, the parents and guardians of the abused children do not know who to turn to especially in view of the fact that majority of the perpetrators are close family members, neighbors, friends or other people known to the affected child's family. Most of the families have often opted to "solve" the problem at home as the vice often threatens to break down the family and community tie. This often puts the victim's life or integrity at risk as they will not be brought to the attention of HCWs.

Medical records at Longisa County Hospital, which is the main hospital serving the study areas show that an average of 2 to 3 cases of child sexual abuse are seen every month[3]. This number is alarming bearing in mind that it might just be the tip of the iceberg as some cases go unreported.

This study aims to find out the community's perception on the factors leading to the rampant cases of CSA in the area. The two divisions were chosen based on the fact that majority of the cases seen at Longisa County hospital come from the 2 areas.

The study population is a rural farming community in Bomet County, Kenya where the vice is expected to be common based on the hospital records. There are few, if any, documented studies done in this population. The study results are expected to add to the existing knowledge base on the factors leading to CSA in this and similar communities in Kenya and hopefully, by extension assist in developing strategies to protect innocent children from sexual abuse.

CHAPTER TWO: LITERATURE REVIEW

Child sexual abuse has been a topic of public health concern for a long time but many facts about it still remains unclear or in dispute. According to Jeanson (2004), CSA can be broadly divided into three groups[1]. The first category is the unwanted and inappropriate sexual solicitation of, or exposure to, a child by an older person. This is called noncontact abuse. The second category includes the genital touching or fondling. This is referred to as contact abuse. The third category includes penetration in terms of oral, vaginal or anal intercourse or attempted intercourse. In other literature, CSA has been defined as contacts or interactions between a child and an adult when a child is being used for the sexual stimulation of that adult or another person (National Center on Child Abuse and Neglect, 1981). Other studies have used a narrow definition of CSA to include contact and intercourse only. Definitions of CSA also differ depending on the age used to define childhood. Definition of childhood differs depending on the legal and socio-cultural context. In most countries, the legal cut-off age used to define childhood is 18 years. In some countries, the age of consent especially for sexual activity is lower. However, the most widely reported definition of childhood in large population surveys of CSA is 18 years or less. Furthermore, it has been shown that the first onset of CSA is less likely to occur between the ages of 15 and 18years than in younger children. The Kenyan constitution also defines a child as a person below 18 years of age. According to the Kenyan constitution any person who commits the offence of defilement is liable to imprisonment ranging from 15 years to life depending on the age of the victim (Sexual Offences Act, 2006). For this reason, the cut-off age used to define childhood in this study was set at 18 years.

Children are the most vulnerable group of people because of their position in society. They have neither the power nor the means to ensure their protection and the realization of their full growth and potential without the support of the adults. Sexual abuse of both girls and boys may happen in the larger context of gender based violence. It occurs across all socio-economic and cultural backgrounds. In many societies, including Kenya, families are socialized to accept, tolerate, and even rationalize domestic and sexual violence and remain silent about such experiences[4, 5]. An extremely serious concern is the increased incidence of rape involving very young children and babies due to the misconception that sex with a virgin is a cure for HIV/AIDS.

Both physical and psychological health problems that are associated with sexual abuse of children have been well documented in scientific literature. The physical health consequences include:

- Gastrointestinal disorders such as inflammatory bowel syndrome, non-ulcer dyspepsia, chronic abdominal pain
- Gynecological disorders such as chronic pelvic pain, dysmenorrhea and menstrual irregularities
- Somatization (attributed to a preoccupation with bodily processes) among others.

Psychological and behavioral symptoms that have been reported in child victims of sexual abuse include depressive symptoms, anxiety, low self-esteem, symptoms associated with PTSD, inappropriate sexual behaviors, cognitive impairment, and substance abuse among others. The mental and psychiatric effects of sexual abuse are usually under-diagnosed and victims suffer silently[5]. Sexual abuse by a family member is a form of incest, and can

result in more serious and long-term psychological trauma, especially in the case of parental incest.

The global prevalence of child sexual abuse has been estimated at 19.7% for females and 7.9% for males[6]. Using the available data, the highest prevalence rate of child sexual abuse geographically was found in Africa (34.4%), primarily because of high rates in South Africa; Europe showed the lowest prevalence rate (9.2%); America and Asia had prevalence rates between 10.1% and 23.9%. In the past, other research has concluded similarly that in North America, for example, approximately 15% to 25% of women and 5% to 15% of men were sexually abused when they were children. Most child sexual abuse is committed by men; studies show that women commit 14% to 40% of offenses reported against boys and 6% of offenses reported against girls. Most offenders who sexually abuse prepubescent children are pedophiles, although some offenders do not meet the clinical diagnosis standards for pedophilia (Clinical Psychology Review, 2009)

Although research and public awareness have endeavored to correct and dispel some of the long-held myths, some seem to have been particularly resistant to change, in particular to regard to the nature of CSA in terms of sexual activity, the incident and prevalence of CSA, the age of children involved, the stereotypes of abusers and the impact of CSA on the child and later adult. The magnitude of the problem in the African region is not known, and information from authoritative studies is scarce. WHO estimates that globally some 40 million children aged 10 to 14 years suffer some form of abuse and neglect requiring health and social care. The most devastating of these is child sexual abuse7. By extension, very limited prevalence studies have been done in this field in Kenya and other African countries. Some of the reasons accounting for this include challenges in the

definition of CSA and childhood as various studies and scholars define them with some variation. The age of sexual debut in Kenya is low (averaged at 12years by most studies). A good percentage of girls are sexually active by the age of 17 years. Therefore, separating sexual abuse from consented sexual activity sometimes is not easy. It is further coupled by the sensitivity and the emotive nature of the matter in the affected families making it difficult to extract information. In one study done to determine the extent and outcomes of CSA, Lalor (2004) observes that there is very little empirical data on sexual abuse in Kenya and Tanzania[8]. According to this study, it is widely perceived that the incidence of CSA may be increasing as a result of HIV/AIDs sufferers' attempts to "cleanse" themselves by having sex with minors. The study also implicates that the breakdown of traditional child care systems, foreign influences, poverty and the lowly position of girls in society impacts the incidence of CSA. It also identified that a degree of force, trickery, or material exchange is not uncommon in adolescent sexual relations. The study concluded that CSA is under-researched in Kenya and Tanzania[8,9].

Most communities are well informed of the occurrence of CSA in their midst but are ill-equipped to address it. An exploratory study done to investigate knowledge and ideas about sexual abuse among African Americans and Latinos through focus group discussions showed that the participants were aware of the magnitude of the problem in their communities and expressed their sense that family risk factors, unsafe institutions and breakdown of social ties were its root causes[10].

Studies by the UN agencies such as the UNICEF and the International Labor Organization (ILO) have focused on the commercial exploitation of children, to the neglect of the more pervasive abuse in children's own communities by family, relatives and neighbors[7].

In a retrospective study done at Kenyatta National Hospital and published in EAMJ, the peak incidence of sexual abuse was in the age group of 10-15years (38.1%) followed by 5-9 years age group (28.6%)[9]. In majority of studies, the perpetrators were people known to the child ranging from neighbor, family friend, family member or a stranger. In one study, 53% of the perpetrators were people known to the victims' family such as family member or family friend. CSA may lead to physical, emotional and psychological injuries or any combination of these. About 66.7% of victims presented with injuries ranging from perineal tears (19%), vaginal tears (19%), recto-vaginal fistulae (4.8%), vesico-vaginal fistulae and abdominal haematoma[11].The age disparity for CSA victimsis so varied ranging from 0- 18 years. However, in more than one study, the leading age group affected is 5-15years[7].

Several studies involving sexual offenders have linked various psychological or psychiatric disorders or history of childhood abuse in the sexual offenders. In one study, results indicated that childhood sexual abuse is associated with higher grandiose and manipulative interpersonal style, impulsive irresponsible lifestyle and antisocial behaviors later in life[6]. Childhood physical abuse and neglect are also associated with antisocial behaviors. Emotional traits of psychopathy such as lack of empathy and shallow affect are associated with childhood neglect in child molesters.

Counseling and psychotherapy for child victims and adult survivors are still woefully inadequate. Even in resource-privileged places where these services are available, still some children are placed on therapy waiting lists for a long time and some do not receive therapy at all. A convenient mistake is to assume that children survivors are well and do

not need counseling. Likewise, the families of child victims are often left alone to cope with the devastations of CSA[10].

This study aims to explore the community's perceptions on some of these factors in the study area. Understanding of these factors will guide the government, community, other policy makers and interested partners in formulating ways of curbing the vice and even reducing long term sequelae of the same on the victims and their families.

CHAPTER THREE: METHODOLOGY

3.1 STUDY AREA

The study was carried out in Mulot and Longisa areas, Bomet-East constituency, Bomet County, Kenya. The study was done both at the community level and three health facilities namely Mulot health centre, Bomet health centre and Longisa county hospital. Bomet County is bordered by Kericho county in the North, Nakuru County in the North East, Narok County in the East and Trans Mara County in the South West and covers an area of approximately 1, 416.2 km^2. The county population is estimated at 724, 420 (2009 census) and the male to female ratio is 100:94.5

The main ethnic community living in Bomet County is the Kipsigis, a sub-tribe of the Kalenjin. The main economic activity in this county is farming, mainly tea, maize, and dairy farming. The staple food for the people of Bomet is ugali served with vegetables and milk.

3.2 STUDY POPULATION

The study population constituted parents and guardians of children who were sexually abused during the study period and key informants in the community. The parents or guardians of these children were interviewed and recruited for focus group discussions (FGDs). Key informants and opinion leaders in the community including the local administration, teachers, administration police, health care workers and religious leaders were also interviewed during the in-depth interviews.

3.3 STUDY DESIGN

This is a descriptive cross-sectional study employing both qualitative and quantitative data collection approaches.

3.4 ELIGIBILITY CRITERIA

For one to be eligible to be included in the study, they had to meet the following criteria:

-Be a parent or guardian of a child who has been sexually abused during the study period

-Opinion leader or key informant from the village/location where the victim resides and willing to undergo an interview.

-Give a written consent

-Be willing to attend FGDs (for the parents/guardians)

3.5 SAMPLE SIZE

All the subjects who met the eligibility criteria were included in the study. Based on background information from literature search, we had projected to recruit 40 participants from the families of child victims. This target was achieved and 40 respondents were recruited for FGDs and interviews. However, out of the 40, 38 attended the FGDs. Further, we had targeted to recruit 16 respondents from the pool of key informants in the community. This target was also achieved and all the 16 key informants and opinion leaders were interviewed. They were each picked from the village/location where the child victim came from. This makes a total of 56 participants.

3.6 SAMPLING TECHNIQUE

Consecutive sampling technique was applied to locate the families or victims of CSA. Thirty out of forty of the parents or guardians of the affected children who participated in the study were recruited when they presented to the health facilities to report the sexual abuse of their children. Research assistants who had been trained and were the staff of the participating health facilities recruited the participants. The other 10 were identified from health records where they had gone to seek medico-legal evaluation. They were located and recruited via telephone calls and visit by the researcher at their homes. All the cases occurred during the study period. The opinion leaders were selected by convenience on the basis of representing the location, village or school where the victims came from. In 2 cases where the telephone call did not work, the researcher used the local area chiefs and village elders to locate the families after getting their villages of residence from the hospital records.

3.7 DATA COLLECTION METHODS

Data was collected between June 2013 and February 2014. It was collected in 3 levels. The first level involved use of interviewer-administered structured questionnaires to collect quantitative data from the parents or guardians of the affected children who met the inclusion criteria.

A participant from the qualifying family (parent or guardian) was administered a structured questionnaire to obtain socio-demographic characteristics of the victim and the perpetrator, the details and circumstances of the incident, the kind of medical and legal assistance received and other necessary details as specified in the questionnaire (appendix

iv). The questionnaire was administered by the researcher or one of the pre- trained assistants. The research assistants were 2 nurses and a clinical officer, one in each health facility. The questionnaire was divided into 6 parts, each part aimed at collecting different type of data. The categories were:

-Socio-demographic characteristics of the victim and their families

-Socio-demographic characteristics of the perpetrator

-Circumstances of the incident

-Type of sexual abuse

-Medical assistance received

-Legal assistance received

The questionnaire was chosen as the appropriate tool to collect this type of data for being easy to administer, cost-effective, objective and offers opportunity for the researcher to clarify questions to the participants and clarify the answers obtained to minimize vagueness. The questionnaire was translated into Kiswahili which was the main language of interaction.

The second level of data collection involved use of FGDs. The parents or guardians who had been interviewed were invited for FGDs in an identified common and central place. The FGDs were aimed at obtaining information on the perceptions of the participants on the subject of child sexual abuse. Males and females were separated in different focus groups so as to promote homogeneity in the groups and therefore enhance openness

during the discussions. FGDs were chosen as an appropriate data collection tool for this kind of data as it has been shown to be a cost-effective technique for eliciting views and opinions and obtaining insights into target audience perceptions, needs, problems, beliefs, and reasons for certain practices[12].

The FGDs were done in 4 sets: 2 for men and 2 for women. Out of the 40 participants identified, 38 attended. The FGD sizes ranged from 8 to 10 members and each lasted between 45-60 minutes. The principal investigator moderated all the FGDs while the assistants were involved in recording. A pre-developed and pre-tested FGD guide was used to collect the data (appendix v). The guide contained 9 questions which the moderator read and explained to the participants. The guide was also translated into Kiswahili which was the main language of interaction.

Data from the FGDs were recorded via audio recording and field notes. Both the questionnaire and the FGD guide were pretested during the pilot study and some modifications made. The pilot study was conducted among parents of children who had been abused in the past. This was done between March and April 2013. Approval for this modification was sought and obtained from IREC.

The third level of data collection involved in-depth interviews of opinion leaders and key informants in the villages where the abused children came from. Two area chiefs, 2 police officers,4 health care workers, 4 teachers and4 religious leaders were interviewed to further gather information on the subject matter. This is summarized in table 1 below. The data from the in-depth interviews were recorded in field notes.Data from the FGDs and the in-depth interviews constituted the qualitative data.

Table 1: FGD and In-depth interview sampling matrix

	Males	Females	Total
Victims' families (set 1)	8	10	18
Victims' families (set 2)	10	10	20
Chiefs	2		2
Teachers	2	2	4
Religious leaders	2	2	4
Law enforcement officers	1	1	2
HCWs	2	2	4
Grand total	**27**	**27**	**54**

3.8 DATA ANALYSIS & MANAGEMENT

The qualitative and the quantitative data were analysed separately.

3.8.1 Qualitative data

Content analysis was used to analyse data from the FGDs and the in-depth interviews. Verbatim notes from the interviews and the audio recordings of the FGDs were transcribed to provide a record of what was said. Transcription was done in Kiswahili language then translated to English while trying to maintain the meaning of words as much as possible. In some instances exact words used by the respondents were maintained.

The transcripts were analyzed and coded for themes that were then arranged into categories. The findings were then reported in the context of the question guide and the emergent discussion within the groups. Select quotes are used to illustrate different ways responses were expressed.

3.8.2 Quantitative data

Quantitative data entry was done using Epi info version 10 and analysed using STATA version 10. Descriptive statistics (Mean, Median) and frequency tables were generated for continuous and categorical variables respectively.

3.9 ETHICAL CONSIDERATIONS

Before the study was undertaken, we sought and obtained approval from the Institutional Research and Ethics Committee (IREC) of Moi University. Approval was also obtained from Tenwek hospital Research Committee as per protocol.

Permission was also sought and obtained from the Bomet County Commissioner (appendix iii), Bomet OCPD and the County Director of Health (appendix ii). Enrollment into the study was purely voluntary. All respondents were required to give a written consent prior to participating in the study (appendix i). Two respondents who had been enrolled and had participated in filling the questionnaire declined to attend the FGD and their decision was respected. Confidentiality of the information obtained was guarded at all levels of the study. As an ethical measure, those of the participants who were found suffering from any of the effects of sexual abuse were referred for medical, psychological or spiritual help at the nearest health or religious centers as was appropriate.

The outcome of this study will be made available to the particular parties involved and disseminated as widely as possible to add to the current understanding of CSA. It is anticipated that this study will lead to formulation of useful interventions in prevention of CSA and the treatment of survivors.

CHAPTER FOUR: RESULTS

4.1 Socio-demographic characteristics of the victims

There were a total of 40 respondents interviewed. Table 1 shows their socio- demographic characteristics. The commonest affected age group was 5-10 year olds and almost all were girls (38).62.5% (25) of them came from one-parent homes (either single or separated).

Table 2: Socio- demographic characteristics of the victims

Variable	Frequency N=40	Percentage	Variable	Frequency N=40	Percentage
Age victim			**Sex**		
5 to 10 years	24	60	Female	38	95
11 to 15 years	15	37.5	Male	2	5
>15 years	1	2.5			
Parents' marital status			**Parents' occupation**		
Married	12	30	Self-employed	26	65
Single	18	45		7	
Separated/	7	17.5	Employed		17.5
Widowed	2	5	Non employed	4	10
Other	1	2.5		3	7.5
			Other		

Relationship between the victim and the perpetrator

Of the 40 victims almost all 98% identified the perpetrator. 17 of the perpetrators (42.5%) were identified as neighbors while 8 (20%) were family friends. Only 4 (10%) were identified as a blood relative to the victim. Figure 1 illustrates this relationship between the victim and the perpetrator.

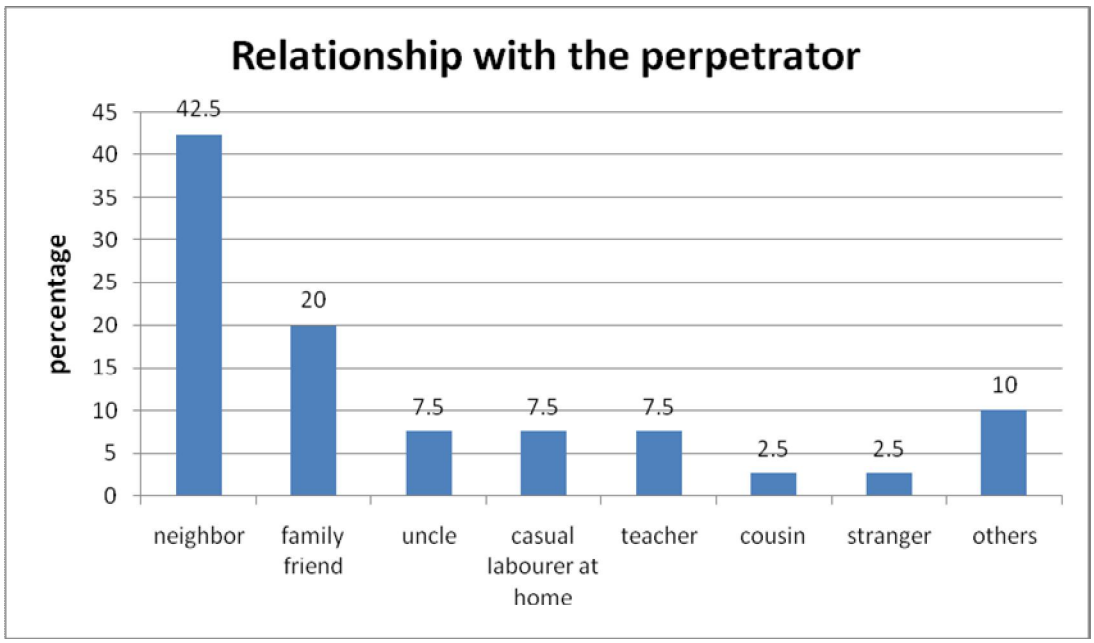

Figure 1: Relationship between the victim and the perpetrator

Socio-demographic characteristics of the perpetrators

All the perpetrators were men and the commonest age group was 18 to 25 years comprising up to 70% (28) of the cases. More than half of them had received primary level of education and were employed as manual labourers. 65% had no known mental illness. This is summarized in the table below.

Table 3: socio-demographic characteristics of the perpetrators

Variable	**Freq N=40**	**Percentage**	**Variable**	**Freq N=40**	**Percentage**
Age in years			**History of mental illness**		
15-17	4	10			
18-25	28	70			
>25	8	20	None	26	65
			Unknown	14	35
Highest Education level			**History of sexual offence**		
	23	57.5			
Primary	14	35	None	23	57.5
Secondary	3	7.5	Unknown	11	27.5
Tertiary			Yes	6	15
Occupation					
Manual	26	65	Farmer	1	2.5
labourer	5	12.5	Other e.g	3	7.5
Professional	2	5	student	3	7.5
Self-employed			None		

Circumstances of the incident

Use of coercion or inducement

Of the 40 respondents 37 (92.5%) reported that there was coercion or inducement. The forms of inducements experienced ranged from small gifts such as sweets or foodstuffs to promises of free marks at school or pardon from punishments. The types of coercions included threats to life or harm if the victim reported the incident or the perpetrator.

Place of incident

Up to 43% of the respondents reported that the incident occurred within the victims' home or home environment. Figure 2 below summarizes the place of the incident.

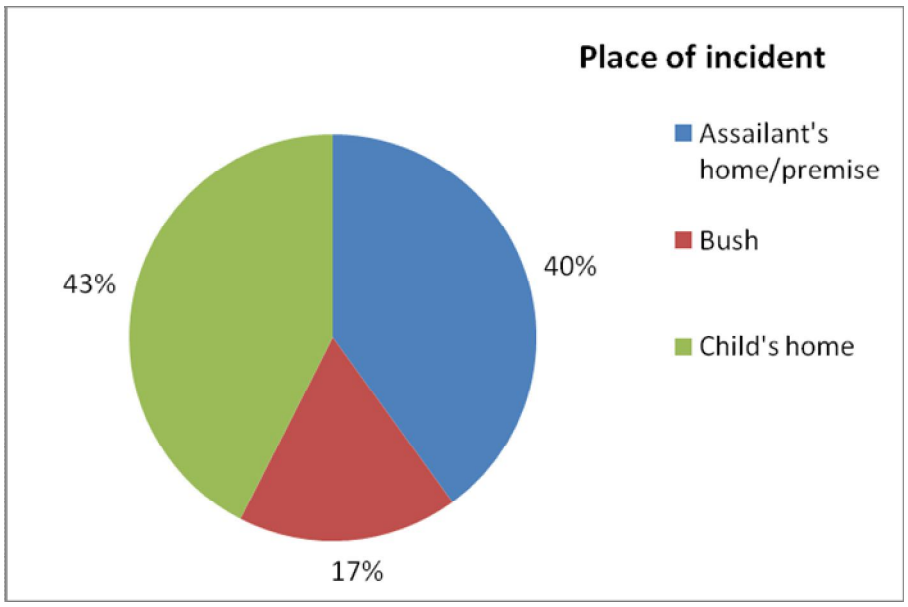

Figure 2: Place of the incident

4.2 Type of sexual abuse

The commonest type of CSA reported was vaginal penetration comprising 85% (34) of the cases. Majority of the victims (57.5%, 23/40) also reported fondling and inappropriate touching either as isolated or together with vaginal penetration.

The least reported form of CSA was anal penetration, reported by 2 (2.5%) of the respondents and affecting boys alone. Figure 3 below demonstrates the various types of CSA reported.

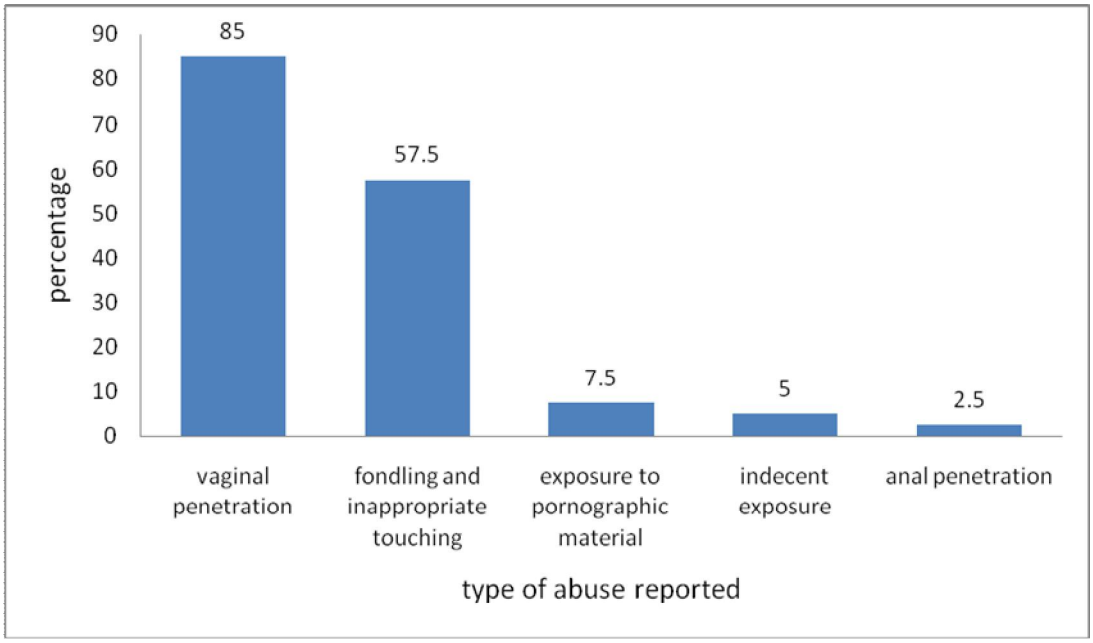

Figure 3: Type of sexual abuse

Medical treatment received

Up to 80% (32) of the respondents reported that they were aware of the urgent medical treatment required by victims of sexual abuse while only 77.5% (31) actually took their children for urgent medical treatment. The reasons given for not taking the children for treatment included: the children appeared well, the cases were reported late to the parents or not reported at all or fear of embarrassment and stigmatization.

More than 90% (28 out of 31) of the respondents who took their children for treatment did so within 72 hours after abuse. This is important as far as PEP is concerned. Table 4 below shows the action taken by the parents while table 5 highlights the varying time interval between the occurrence of the incident and reporting to a medical facility for treatment.

In terms of treatment received by the victims who were taken to a health facility, about 58% (18) of the victims received post-exposure prophylaxis (PEP) against HIV and a similar number received counseling. Only 50% (16) of them had laboratory tests done (including urinalysis, pregnancy test and HIV). This is further exhibited in figure 4 below.

Table 4: Action taken by the parents

Variable	**Frequency**	**Percentage**	**Variable**	**Frequency**	**Percentage**
Rescuer			**Treated**		
parent	2	5	No	9	22.5
neighbors	1	2.5	Yes	31	77.5
self/none	22	55			
others e.g. other children, passersby	15	37.5			
Aware of treatment			**Reported to police**		
No	8	20	Yes	30	75
Yes	32	80	No	10	25

Table 5: Time interval before treatment

Time interval (hours)	**Frequency N=31**	**Percentage**
0-24	9	29
25- 72	19	61.3
>72	3	9.7

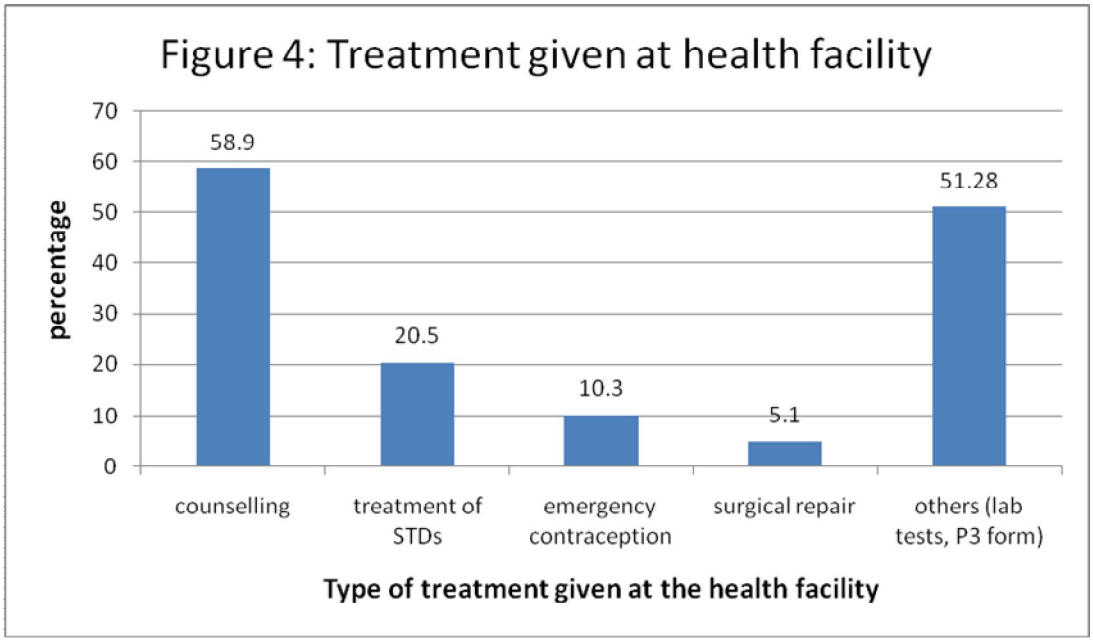

Figure 4: Treatment given at the health facility

4.3 Legal assistance received

Of all the respondent 30 (75%) reported the incident to the police while the remaining 10 did not. The reasons given for not reporting the incident to the police included the following*:

Fear of embarrassment (N=6)

Lack of money to bribe the police (N=3)

The issue was “solved” locally (N=3)

The child was healthy or did not show any signs of illness (N=2)

There was no need to report since there was no penetration (N=1).

**Some respondents gave more than one reason for not reporting the abuse to the police.*

Parents' expressions concerning CSA in the community

A common and often repeated statement by the parents of affected children concerned the general emotional and psychological pain they went through when their children were sexually abused. Some of these emotions were unresolved as depicted by feelings of revenge or feelings of inadequacy as a parent. To quote one respondent:

"there are no words that can describe the pain I felt. It was like a spear pierced directly into my chest..."

"it never occurred to me that somebody I entrust to my children on daily basis can even think of doing this…"

Table 6 below summarizes the other phrases used by the victims' parents to express their general feelings towards CSA as it happened to their children.

It feels so bad
It is so painful
I better forget than remember
Feels like a spear in my chest/ stab in the chest/ direct attack on myself
Feelings of revenge / killing the perpetrator
I lost trust with men
Feels like failure as a father/ failed to protect my children

Felt like killing myself/ I deserve to die

How the community handles cases CSA

We attempted to find out how the community generally handles the problem of child sexual abuse. Majority of the participants categorically referred to traditional values in the community that protected children. Both men and women generally agreed that children were more safe in the traditional set ups than they are now. These values included the fact that children protection and upbringing was viewed as a responsibility of every member of the community. Majority of the participants also alluded to the presence of punishments that were instilled on child abusers and that the deterioration of these values and punishments systems were responsible for the increasing cases of child sexual abuse.

"our community had its own ways of protecting children. There was nothing like my child. It was our child… but these days no one even talks or teaches about these values"

However, a section of the participants reported that they entrust this role to the local chiefs and the elders.

"I did not have much to say when my daughter was abused, the chiefs and the elders discussed…"

Table 7 shows responses on how the community generally handles cases of CSA

Responses
Traditionally, children were protected by some value systems that protected children
Punishments including fines existed for the offenders of child sexual abuse
The elders and the chief decides what to do, including fining the offender
People find it embarrassing to talk about sexual matters
We don't know what to do
Fear reporting to the police/ authorities
Sex with young girls has become the norm/ acceptable
The offender is forced to marry the girl and pay bride price

Perceptions of parents on the way the police and the local administration handle cases of CSA

When asked what their opinions were concerning the way the police and the local administration handle cases of CSA, more than half of the respondents believed that they handle them poorly while only a small number believed that they handle them well. A large number of the participants reported that the chiefs and village elders preferred to solve the problem locally without involving the police and the other legal systems through a procedure commonly referred to as "*kipgaa"* which literally means "homely" or "local".

"Sometimes, the village elders and the chiefs discuss the problem and agree on the way forward locally…"

All the 30 respondents who answered in the negative reported that they are required to pay money to the police before they are issued with the medico-legal (P3) forms. The amount charged by the police invariably ranged from Ksh 1000 to Ksh 2500.

It is worth noting that the participants who said that the police and the local administration were doing a good job quoted specific cases.

"In my case, the police were very helpful. They helped me bring the child to the hospital. They also arrested the perpetrator immediately…"

Table 8 below lists parents' or guardians responses concerning the manner in which the police and the local administration handle cases of CSA reported to them**.**

Responses
The police ask for money before issuing P3 forms
The chiefs and the elders solve the problem locally (via a system called *"kipgaa")*
The police ask for bribes in order to release the suspects
Sometime the police ask for bribes in order to arrest suspects
They ask many/ embarrassing/ difficult questions

The police and the chiefs release suspects on grounds of lack of witnesses
The police take too long to respond
Ask for witnesses before arresting the suspects
The police do a good job
They keep delaying cases in court/ don't produce files in court/ poor investigation of cases

Opinion of parents on the way HCWs handle children who have been sexually abused when presented to them

The parents' were asked to give their opinions on the way HCWs handles cases of CSA when presented to them. A large majority of the participants gave a positive response saying that HCWs actually do good job. However, a section of the participants categorically expressed negative opinions. As in the case of police officers, negative expressions concerning HCWs were specific to a particular case. For example:

"Medical workers were very kind to me. They were very sensitive to me and my child…"

or

"she (HCW) asked me so many questions when I was hurting... it's like she blamed me"

Two participants used neutral phrases to describe their opinion. Almost all of the parents' complained that HCWs ask for money before filling a P3 form. The average amount ranged from Ksh. 500 to Ksh. 3000 depending on the cadre of HCW filling the form.

These responses are summarized in table 9 below.

Table 9: Parents' opinions on the way HCWs handle victims of CSA

Responses	
➢ Ask for money before filling P3 form ➢ Empathetic/ kind/ sensitive ➢ some are not well trained ➢ The procedure is too long ➢ Some facilities do not have the ability to examine sexually abused children	➢ they do a good job ➢ they ask a lot of questions ➢ Ask embarrassing questions ➢ HCWs are harsh/ insensitive to the victims

4.4 Health Care Workers

On average HCW attend to 2 to 3 cases per month. All the cases recalled by the HCWs involved girls. On the question of HCWs' preparedness to handle victims of CSA, all the 4 (100%) stated that they were not well prepared. To quote one of the HCW:

"My first experience of managing a sexually abused child was when I was posted to this place. I did not know how to approach the patient, so I referred them to Longisa County hospital…"

The responses were as summarized in the table below:

Table 10: Perceptions of HCWs on their preparedness to handle victims of CSA

Responses
HCWs not well trained on collection and preservation of specimens
Some facilities lack PEP
HCWs not well versed with legal procedures/ requirements for abused children
More training needed on examination of abused children
More training needed on counseling of abused children and their families
Some lab tests are not routinely available e.g. urinalysis

Police and the local administration

All the police officers and the chiefs interviewed (4 out of 4) agreed that the problem of CSA is rampant in the community. All of them used different expressions to explain the fact the problem is not well discussed and many incidences go unreported.

"this problem is so common here. I deal with them almost on daily basis… many parents prefer to deal with it silently rather than reporting to us… I don't know what they fear…"

Both chiefs interviewed reported that many cases are solved locally at home without involving the police through a system popularly referred to as "*kipgaa*" which literally means "homely" or "local".

Both chiefs admitted that they have "solved" a number of cases that way at the request of village elders or the abusers' families. The police officers shared the same sentiments of the cases being handled at home without involving the legal systems. The community finds this system easier, more friendly and cheap. However, on many occasions it is manipulated by some victim relatives for selfish gains. One police officer was quoted as saying:

"*Somebody can report a case and obtain a P3 form. Once this form is obtained, he or she takes it and waves to the possible suspect, that if he doesn't part with some cash, for example, he may end up in prison. The suspect will settle for that. By the time the police arrive, the matter has been settled…".*

They also expressed concerns that the community generally perceive sexual relations with teenage girls as consensual and not abuse and therefore do not report them.

The two police officers expressed concerns that many parents of abused children fear the legal procedures and therefore do not report the cases to them.

4.5 Teachers and spiritual leaders

When asked to share their opinions concerning the problem of CSA in their community, all the 4 teachers and the 4 spiritual leaders interviewed agreed that the problem of CSA is rife in their community. All the 4 teachers were aware of the cases that happened in their school during the period of the study (and whose parents/ guardians were part of the study).All were of the opinion that the problem is not well discussed and many cases go unreported.

The other responses generated were as summarized below:

Table 11: General perceptions of the teachers and religious leaders concerning the problem of CSA in the community

Responses
The problem is rampant/ very common
The community generally don't talk about it openly but everybody knows that CSA is happening
Parents find it embarrassing to report when their child is abused sexually
Sexual relations with older/teenage girls is common/ not viewed as abuse
The problem is getting worse
It is a taboo to discuss sexual matters in this community
People are now more free to discuss sexual abuse than before
Girls don't report cases to parents or teachers

Causes of CSA according to parents and key informants

The parents and key informants were asked to discuss the causes of CSA in their communities. A common and often recurrent theme noted among almost all participants was break up of family units or separation as the major cause and predisposing factor.

"The problems in families should be blamed. These are some of the results of the decay in families. Children are just victims of circumstances…"

Similarly, alcoholism was mentioned by a good number of FGD participants. Alcohol abuse or alcoholism in the community was a common theme that was mentioned by almost all the categories of key informants.

"Drunkardness is so rampant in this village. Many of the cases of child abuse happen when the man is drunk".

In addition, fading African traditional values in favor of Western values was a common theme as far as the causes of CSA are concerned both from parents and key informants. All the police officers and the local chiefs were also in agreement that idleness or joblessness is a major contributor. These sentiments were also echoed by HCWs. All the 4 health care workers mentioned alcohol abuse as the major contributor to cases of CSA in the area, while 2 out of 4 suggested idleness or joblessness among the youth.

Table 12: summarizes the respondents' responses on the causes of CSA

Causal factors
1.Break up of family units/ separation/ marital failures
2. alcoholism/ drunkardness/ alcohol abuse
3. loss of African traditional values
4. older girls make themselves vulnerable to abuse by the way they dress
5. older girls consent to sex with adults and conceal from parents
6. exposure to pornographic videos/ content in the video halls and the internet
7. idleness or joblessness
8. lack of parental closeness/ improper raising up of children (girls)
9. it is a trend for older girls to be engaged in sexual relationships
10. curses or punishment from God
11. drug abuse specifically Bhang
12. peer pressure for older girls

13. inherited from parents/ runs in families

14. men use alcohol as an excuse

15. HIV/AIDS

16. fathers raising children/ daughters not biologically their own

17. form of punishment of wives by their husbands following separation

4.6 Prevention of CSA

Parents'/ guardians' suggestions on the prevention of CSA

Concerning the prevention of CSA, a large percentage of the parent participants suggested strengthening of family ties and enhancing parental connectedness between parents themselves and between parents and children. A good majority also suggested stricter penalties for CSA offenders. Strong sentiments were expressed concerning the kind of penalties that should be imposed on perpetrators of CSA. Among the penalties that were suggested included death, castration and life imprisonment. Similar sentiments were echoed by the police and the local administrators. The issue of strict penalties for the offenders and strengthening family units was recurrent in all the FGDs and the in-depth interviews.

"anyone who spoils the life and the future of someone's child, does not deserve to live. They should also be killed…"

Asked the same question, all the 4 administrators mentioned regulation or control of alcoholism in the community and provision of job opportunities for the youth as the first steps in prevention of CSA.

The other responses generated were as shown in table 11 below.

Table 13: Respondents' suggestion on prevention of CSA

Suggestions	
✓Strengthen family units/ parental connectedness/ family togetherness	✓Instill moral values among children and teach girls to identify potential abusers
✓Stricter penalties for offenders (death/castration/ life imprisonment)	✓Discourage single parenthood
✓Control alcoholism/ drug abuse	✓Enlighten the public on child legal rights and child protection
✓Promote African traditional way of living	✓Teach girls to be suspicious
✓Educate girls on sexual matters	✓Prayer/ belief in God
✓Prompt response by the police	✓Blacklist all families with history of sexual child abuses
✓Discourage local solutions to CSA "kipgaa"	✓Kill all the offenders of CSA
✓Ban videos rooms/ distribution of pornographic materials	✓The government should regulate access to social media/ internet by the children
✓Employment of the youth	
✓Close all video shops in town centres	
✓Encourage reporting to police	

CHAPTER FIVE: DISCUSSION

5.1 Socio-demographic characteristics of the victims of CSA

The majority (95%) of the sexually abused children in this study were girls between the ages 5 and10 years. Only 2.5% were above 15 year age groups. Almost all reference discussions on CSA in this community referred to a girl. These findings are not unique to this study. A study in Ibadan, Nigeria by Ige O.K and colleagues (2012) evaluating the medical care of CSA victims showed that all the abused children were female11. Other similar studies have also found that the 5 to 10 year age groups are the most vulnerable to sexual abuse. For instance, a meta-analysis of 22 studies, found that the onset of sexual abuse was consistently more prevalent in the 5-14 year group, though categorization of ages varies across studies.[11]In a similar study in 3 Central American countries, majority of first abuse was found to be below the age of 11 years[12].

The low prevalence rates of CSA in ages above 15 years is postulated to be due to low rates of reporting by the teenagers and the likely consensual nature of sexual activities in this age group. This was more apparent from the results of FGDs where many respondents thought that many cases of CSA especially among older girls are never reported to the parents.

Concerning the marital status of parents of the affected children, 65% of the parents were non-married at the time of the incident (either single, separated or divorced). In line with this finding, the dysfunctional family environment was a common theme raised by the parents and key informants. Family environment is one of the most commonly reported mediating factors in the CSA literature. Aspects of family environment including parental

functioning and relationships, domestic violence, parental separation during childhood, growing up away from parents, poor parental warmthand alcohol or drug abuse by parents have been shown to put children at risk of CSA.[5]

Majority of the perpetrators were people familiar to the child though they were not necessarily related. Almost all the victims or their families identified the perpetrator. Whereas many studies describe the perpetrators as close family members irrespective of the community studied, our findings slightly differed as only 10% of the perpetrators were family members[6]. It suffices to say that incest in this community is probably low. Another study of characteristics of victims and s of sexual violence in Denmark reported that 69% of the victims knew the perpetrator. These findings however contrasted those from a study by Dereje et al in South-Western Ethiopia where 35% of the abusers were unknown followed by schoolmates at 31.5%. However, the study was done among high school students and not their parents[13]

5.2 Socio-Demographic Characteristics of the Perpetrators

The commonest age group of the perpetrators was 18-25 years which constituted 70% of the cases. 57.5% of them had achieved primary level of education while only 35% had been to secondary school. Only 3 of them had achieved tertiary level of education. These findings were in tandem with results from FGDs and in-depth interviews where parents of the victims and opinion leaders in the community invariably mentioned joblessness or idleness among the youth as a predisposing factor to CSA in the community.

About 65% of them were employed at the homes of the child victims as manual labourers mainly herding cows and working in the farms. Their proximity with the children

probably made the victims so familiar and comfortable around them and therefore vulnerable to abuse. It is worth noting that 3 of the perpetrators were professionals (2 teachers 1 unspecified).

In this study, none of the perpetrators were reported to be suffering from any known mental illness. However, there could have been a reporting bias as the responses were obtained from the victims' parent or guardians who did not have any medical knowledge and might not have been privy to medical history of the specific perpetrators. This is especially so as the high prevalence of mental illnesses among perpetrators of CSA was documented by Ndetei et al (2007)in a study of psychiatric morbidity among convicted male sex offenders at Kamiti prison, Kenya, where more than 69% of the sex offenders were reported to be suffering from various mental illnesses.[14]

Only 15% of them had a known history of sexual offence. It is possible that some of them were repeat offenders but this was not known by the families of the victims.

Majority of the cases involved some form of coercion on the victims or inducement by the perpetrators. The forms of inducements varied from small gifts to foodstuffs. In the 2 cases where the perpetrators were teachers the inducement reported were in the form of promise of good marks in class and pardon from a punishment. Most cases reported threats of harm to the victims if they reported the incident.

As far as the site of the incident is concerned, 43% of the incidences occurred at the victim's home. This is however lower than what has been reported in other African studies where the incident is reported to happen at the child's familiar environment. [9]

5.3 Type of Sexual Abuse

Vaginal penetration and fondling and inappropriate touching either as an isolated type of CSA or in conjunction with another type were the commonest forms of CSA in this study. Anal penetration was reported in the 2 cases involving boys. In contrast, *S.N.* Maddu et al (2000)reported that kissing accounted for 86.7% of abuse cases and vaginal penetration accounted for only 28.9% of cases in South Africa[15]. The study populations in the two studies were however slightly different. Whereas this study was a community study and the respondents were the parents or guardians of abused children, the latter was done in a school and the respondents were children themselves. It can also be postulated that only the contacts types of CSA such as vaginal penetration were taken more seriously by the parents and thus the reporting while the non-contacts types were ignored.

Medical and legal assistance received by the victims

As expected, many respondents were aware of the need for urgent medical treatment for sexually abused children. However, a significant percentage of them never took their children for medical treatment. Several reasons were given for not taking children for medical treatment including lack of awareness of the need, the fact that the victim child appeared well or the incident was disclosed late to the parents or fear of embarrassment. These reasons were more apparent from the FGDs where the parents admitted their lack of knowledge of the need for urgent medical treatment for abused children.

The lack of disclosure by the victims to the parents is not a new phenomenon in this study. Some studies have shown that boys and girls are more likely to open up to friend of

their own age about abuse than their parents. In one such study the disclosure rate to parents was 81% among girls and 69% among boys [16].

An encouragingly large percentage of the respondents who took their children for medical attention following sexual abuse did so within 72 hours; which is crucial as far as administration of post-exposure prophylaxis (PEP) against HIV is concerned[20]. Among the victims treated in a health facility, 58% (18) received PEP against HIV, and a similar percentage received some form of counseling. Only half of the victims had some laboratory tests done. These rates are very low as at least every abused child should receive at least PEP against HIV, HIV testing, counseling and basic laboratory tests as a minimum. It was apparent from the health care workers interview that majority of them are not comfortable prescribing PEP against HIV and this may explain the small numbers of CSA victims receiving PEP. This finding compares to the findings by O.K Ige and colleagues (2012) in a study to evaluate the medical care of CSA victims in a general hospital in Nigeria. This study found that only 60% of the victims had any laboratory tests done, emergency contraception prescribed in 12.2% and only 15.3% received some form of counseling[11]. This shows that there is still a lot to be done in terms of general medical care of victims of CSA in our hospitals. As was revealed in the in-depth interviews of HCWs, most HCWs admit inadequacy in training and experience in handling CSA victims and feel that they need more training on the same.

Despite the common notion that many incidences are never reported, more than three quarter of the respondents in this study reported to the police. Those who did not report gave various reasons for not doing so. These included fear of embarrassment, lack of

money to bribe the police or the fact that the problem had been "solved" locally by the chiefs and the elders via a system popularly referred to as "*kipgaa*".

5.4 Parents' Perceptions on CSA

In this study, parents of CSA victims used various phrases to describe their feelings towards the vice in the community. A good majority felt that the feeling was difficult to describe in words but the weight could be seen in their facial and non-verbal cues. Others used expressions such as "feeling of a spear in my chest" or "feeling like I have failed as a father". It is worth noting that some respondents harbored feelings of revenge against the alleged perpetrator while others harbored suicidal thoughts whenever they starting thinking about the incident. These groups of respondents were recommended and referred for psychological and pastoral counseling and support at the nearest hospitals (Tenwek Mission Hospital and Longisa County Hospital).it is not uncommon for parents or close relatives of abused children to harbor these kinds of thoughts or feelings as was described by Dereje et alin a study of CSA and its outcomes among high school students in and their parents in South western Ethiopia. This study reported that the rates of suicidal ideation and suicide attempts were high among victims of CSA and their parents. [13]

All the participants in the FGD acknowledged the rampant presence of CSA in the community. In a similar study done in Nigeria, 84% of the respondents agreed that CSA occurred in their community[13]. Similar findings were reported by Mathoma and colleagues (2006) in a study carried out in Botswana and swaziland[17].

More than half of the parents (65.8%) suggested that traditional value systems protected children against sexual exploitation and their deterioration has probably increased the incidence of CSA in their community. Some participants (37.6%) felt that it is embarrassing to discuss CSA in the community. This kind of perception is probably contributing to the high rates of CSA occurrence in this community. However, this is postulated to be declining as reported in some literature due to wide media coverage of cases of CSA in Kenya.

5.5 Causes of CSA

Almost 90% of the parents respondents suggested that break up of family units and discords in marital relationships are the major contributors. The diminishing role of parents in children's up bringing cushions abuse of children. Parents have been faulted with abdicating or ignoring their parenting duties. Weakened family fabric and fluid family situations governed by the 'absentee' father are more common today. It was apparent from the results from this study that raising children in two-parent homes seemed to be a protective factor against abuse of children. The same results were found by *Lalor K.* (2004) in a study of CSA in Kenya and Tanzania[6, 7]. Similar sentiments were echoed by teachers and spiritual leaders during the in-depth interviews.

Loss of African traditional values and child raising practices in favor of modernity was mentioned by almost 80% of the parents. The general feeling was that children were more vulnerable to abuse in the modern ways of living as compared to traditional ways of life. These findings have also been described by Lalor K. and Wambui *N.* (2009) in study to describe cultural protective and risk factors about CSA in Kenya[16].In most Kenyan

communities, premarital sex and pregnancy was discouraged and the punishment for the offenders was brutal. One of the respondents was quoted saying "*today girls are giving birth to one or two children before they get married and the society seems to be okay with it"* (teacher).Similarly a high percentage of the parents (84.2%) mentioned alcoholism as a major cause of CSA in this community. Many respondents believed the perpetrators were either drunk or under some drug influence when they committed the act. The most mentioned drug apart from alcohol was bhang.

An interesting cause of CSA that was explored was the conspiracy of silence, fear, shifting of blame or distancing oneself from an act of CSA. It was apparent that for the majority, the first reaction to CSA is to hush it. Sexual abuse is particularly afflicted with the syndrome of blaming the victim and absolving the perpetrator. This can be illustrated in the response of dressing among young girls as a cause of CSA as summed up in this excerpt: "*sometimes it is the fault of girls because some of the wear very short skirts and pass in front of men. Some men are filled with lust so they can immediately rape them"* (parents FGD).

Unlike similar studies employing qualitative methods conducted in South Africa, a small percentage of the respondents (7.9%) mentioned HIV/AIDS as a cause of CSA [17]. This shows that there are variations in attitudes and perceptions about CSA in African communities.

The negative attitude towards the police and the local administration and the general belief that they do no do a good job as far as handling cases of CSA is concerned is part of the factors exacerbating the situation. The low rate of reporting cases is fueled by the

perception that the police will always ask for money in order to issue medico-legal (P3) form or to arrest the suspect. Many respondents reported having parted with Ksh 2500 to Ksh. 7500 in order to have this vital document issued.

Majority of the parent respondents used positive terms to describe their opinion on how HCWs handle victims of CSA while a minority categorically expressed their dissatisfaction on the same. However, almost all of them complained that HCWs ask for money before filling the Medical examination forms (P3). The amount required ranged from Ksh. 1500 in the government health centre to Ksh.7500 in a mission hospital. It worth noting that more than 70% of the parents feel that the questions they are asked are either too much or embarrassing. This may be an indirect demonstration by CSA victims and their parents on their lack of trust with HCW on issues to do with CSA. It might also be explained by the observation that clerking of patients in health centres including CSA victims is done with very little privacy, if any.

5.6 Suggestion of Parents on Prevention of CSA

Strengthening of family units, parental connectedness with children, stricter penalties for offenders and control of alcohol abuse in the community ranked top as ways of preventing CSA according to the parents of the victims. These findings are in line with the general themes from a recent qualitative study in Kenya by *Plummer and Njuguna* (2009)[18.] In this study, parents-suggested CSA prevention strategies were most often parental guidance and close supervision, prayers for children, protection and harsh deterrents for the perpetrators. Teachers and spiritual leaders were more emphatic on the stricter penalties for the sexual offenders including castration and capital punishment.

According to Daro (1994) there are three levels of prevention of CSA: primary prevention (curriculum based education, support groups, crisis hotlines); secondary prevention (education and support offered to parents) and tertiary prevention (services to known perpetrators that often take the form of therapeutic interventions).Some other studies have also concluded that parents can reduce access to their children by potential abusers by increasing supervision (United Nations Children Fund, 1999).

5.7 Health Care Workers

It is noted with concern that HCWs by their own admission are not generally well trained to handle cases of CSA. All the interviewed HCWs admitted that they need more training in handling CSA. This is important information to the governmental authorities and other policy makers who design and implement training programs for HCWs especially in small rural facilities. Further training on medical examination, treatment, and medico-legal requirements for sexually abused children is required.

5.8 Police and the Local Administration

All the police officers and chiefs interviewed admitted that the problem of CSA is rampant in the community. This is not unique to this community as was shown in a recent study by Mathoma and colleagues (2006) whereby local and government authorities acknowledged the prevalence of CSA in Botswana and Swaziland.

In the same line, they also agreed that many cases go unreported and the problem could be worse than is known. Some studies however support that there is a recent improvement in

case reporting rates for CSA in Sub-Saharan Africa [19]. This may be attributed to widespread media coverage of CSA in Kenya and other Sub-Saharan African countries.

In the same breath, teachers and spiritual leaders in the community who were interviewed admitted that the problem is rampant and lamented about the few cases being reported to the police or being prosecuted. It is also notable that the teachers, spiritual leaders and the police were concerned about the fact that consensual sexual relations between teenagers and adults is being viewed as "normal" and thus tolerated. It has been documented that the age of sexual debut among girls in Kenya is decreasing, average 12 years (KDHS 2008/2009).

5.9 STRENGHTS AND LIMITATIONS

5.9.1 Strengths

This study was undertaken in a rural population. The findings were derived from the respondents who had experienced the pain of CSA first hand and all the cases occurred during the study period. Recall bias was therefore minimized. The participants were interviewed at their usual places of residence or familiar environment. This way, they were more likely to feel at home and therefore were more likely to volunteer more information than if they had been interviewed in unfamiliar environment such as the hospital.

Use of FGDs and in-depth interviews to collect qualitative data contributed to the strength of this study. Qualitative research techniques are more appropriate for this kind of topic as

it gives room for the participants to air their perceptions, attitudes, feelings and opinions on the subject matter without restrictions.

Accuracy and reliability of primary information collected on study respondents are assured as was collected real-time from the time of enrollment and during the FGDs.

5.9.2 Limitations

The greatest challenge with this study was extracting the correct and accurate information on the subject matter without re-awakening the past emotional wounds. CSA is a very sensitive subject both to the victims, their families, the accused and the community at large. Letting people talk about it freely is always a potential challenge.

In order to overcome this challenge, the researcher was careful to identify such clinical and psychological effects of CSA as post-traumatic stress disorder (PTSD), depression, anxiety disorders, sleep disturbances, behavioral abnormalities and so on. Psychosocial and pastoral counseling and medical advice was offered to some participants as was necessary. This was done by referring them to Tenwek Hospital or Longisa District Hospital where such help is available. Even expression of suppressed emotions may in itself be therapeutic. This way the study helped put the victims and their families on the healing path. In addition, confidentiality was emphasized right from the onset and at all stages of the study.

Research assistants were trained nurses and a clinical officer by profession and therefore they were more likely to be sensitive to the feelings of the respondents. They were also trained on all the research procedures and confidentiality requirements.

To safeguard confidentiality of the sensitive legal information obtained from the victims, no names were used. Unique numbers were used to represent victims' parents or guardians and to label the questionnaires and FGD guides. Permission was also sought from police authorities (OCPD) and the county commissioner prior to data collection.

It is important to note that the parents or guardians who were studied are those who either took their children to health facilities for medical care or those who reported the incident to the legal authorities. There is a population of parents who did not report the incident and this group might hold different opinions from the ones who reported the incident.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

This study has identified strengths and weaknesses in parents' and community leaders' perceptions on child sexual abuse in this rural Kenyan community. The problem of child sexual abuse is rampant in this community. However, it not openly discussed both by leaders and the parents and the community at large.

The commonly abused children in the sample studied are girls of age groups 5-10 years from one parent homes. The extent of abuse of older teenage girls or younger ones below 5 years is not known. The perpetrators of CSA are likely to be men between the ages 18 and 25 years, mostly unemployed or working as casuals in the victims' homes and well familiar with the child. The rate of incest in this community seems to be low.

The perceived contributing factors to CSA in this community are multiple. They include breakdown of family ties, abandonment of African traditional values concerning child rearing, alcohol abuse, silence on the matter and unemployment.

6.2 Recommendations

We recommend aggressive public health measures by all governmental and nongovernmental authorities responsible for child protection to educate the community on the prevalence and impact of CSA on the affected children and their families, the medical needs of child victims and the legal avenues available for the affected families. These

strategies should also encourage the community to openly discuss issues around sexual abuse of children with the aim of prevention.

We also recommend further studies on this subject in this community using statistically interpretable sample size to correlate the socio-demographic characteristics of abused children and the perpetrators identified in this study to the actual act of CSA.

Further studies are also recommended to assess the contribution of unemployment, alcohol and drug abuse, single parenthood, internet and social medial to CSA in this community.

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APPENDICES

APPENDIX I: INDIVIDUAL CONSENT FORM

PERCEPTIONS OF THE CAREGIVERS ON THE FACTORS ASSOCIATED WITH CHILD SEXUAL ABUSE IN LONGISA AND MULOT AREAS OF BOMET COUNTY.

I ..... (Name), Age.....

Of ..... (Address) do hereby give consent to take part in the above study.

The nature and purpose of this study has been explained to me. I understand that I will be asked a number of questions concerning child sexual abuse. I also understand that this information will be kept confidential and will be used for no other purpose except for the study purpose which has been explained to me.

Signed by the participant.....

Date.....

Researcher/ Research assistant:

I..... (Name) have explained the foregoing to the participant and answered his/her questions concerning the study.

Signed.....

Date.....

APPENDIX II: LETTER TO COUNTY DIRECTOR OF HEALTH REQUESTING CONSENT FOR STUDY

THE COUNTY DIRECTOR OF HEALTH,

BOMET COUNTY.

Dear Sir/ Madam,

RE: CONSENT TO CARRY OUT RESEARCH STUDY IN LONGISA AND MULOT AREAS OF BOMET COUNTY

I am a resident in Family Medicine at Moi University School of Medicine currently based at Tenwek Hospital which is one of the training sites for the program. As a partial fulfillment of my MMED in Family Medicine I am required to submit a thesis and defend it as well. I have chosen to undertake a descriptive study to assess the perception of the caregivers on the factors associated with child sexual abuse in the above named areas.

Interviews and focus group discussions will be conducted among the parents and guardians of children victims of sexual abuse. Selected teachers, local chiefs, police officers, spiritual leaders and health care workers will also be interviewed.

The outcome of this study will duly be shared with your office and all interested parties.

Yours sincerely,

DR. RONALD KIBET T.

APPENDIX III: LETTER TO THE COUNTY COMMISSIONER, BOMET COUNTY.

To the County Commissioner,

Bomet County.

RE: CONSENT TO CARRY OUT RESEARCH STUDY IN LONGISA/ MULOT AREAS OF BOMET COUNTY

I am a resident in Family Medicine at Moi University, School of Medicine currently based at Tenwek Hospital which is one of the training sites for the program. As a partial fulfillment of my M.Med in Family Medicine I am required to submit a thesis and defend it as well. I have chosen to undertake a descriptive study to assess the perception of the community on the factors predisposing to child sexual abuse in the above named areas.

As part of my data collection, I will interview local chiefs and administration police officers and hold focus group discussions with them as well. I am seeking your permission on the same.

The outcome of this study will duly be shared with your office and all interested parties.

Yours sincerely,

DR. RONALD KIBET T.

APPENDIX IV: QUESTIONNAIRE

ENROLLMENT QUESTIONNNAIRE

COMMUNITY PERCEPTION ON THE FACTORS LEADING TO CHILD SEXUAL ABUSE IN LONGISA AND MULOT AREAS OF BOMET COUNTY

1. Study Serial Number: .....
2. Date: .....

I. DEMOGRAPHIC CHARACTERISTICS

1. Age of the respondent (complete years).....
2. Marital status of the respondent
    - Single
    - Married
    - Widowed
    - Other (specify)
3. Level of education of the respondent(highest)
    - None
    - Primary incomplete
    - Primary complete
    - Secondary incomplete
    - Secondary complete
    - Tertiary
4. Occupation of the respondent

- Unskilled
- Skilled
- Professional
- Student

5. Relationship to the victim
    - Father
    - Mother
    - Auntie
    - Uncle
    - Other (specify)
6. Age of the victim (at the time of the incident)
    - 0-1 year
    - 1-5 years
    - 5-10 years
    - 10-15years
    - More than 15 years
7. Victim’s parents marital status
    - Married
    - Single
    - Divorced
    - Separated
    - Widowed
    - Other (specify)
8. Victim’s parents occupation

- Employed
- Self-employed
- Non-employed
- Others (specify)

II. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE

1. Did you identify the perpetrator?
    - Yes
    - No
2. What is the relationship of the perpetrator to the affected child?
    - Father
    - Brother
    - Uncle
    - Neighbor
    - Teacher
    - Family friend
    - Stranger
    - Other (specify)
3. Was the said perpetrator familiar to the affected child?
    - Yes
    - No
4. What is the age of the perpetrator?
    - Below 15 years
    - 15-18 years
    - 18-25 years

- More than 25 years

5. What is the level of education of the perpetrator ?
    - None
    - Primary
    - Secondary
    - Tertiary
6. What is the occupation of the perpetrator?
    - Professional
    - Manual labourer
    - Skilled
    - Other (specify)
7. Has the perpetrator ever been diagnosed with a mental problem?
    - Yes
    - No
    - Unknown
8. Has he/she ever been accused of a sexual offence before?
    - Yes
    - No
    - Unknown
9. Did the perpetrator use any form of inducement or coercion to trick the victim?
    - Yes
    - No

If yes please specify……

III. CIRCUMSTANCES OF THE INCIDENT

1. Where exactly did the incident happen?
    - Child's home
    - 's home/premises/office
    - Bush
    - Others (specify)
2. Has this child been sexually abused before?
    - Yes
    - No

    If the answer is yes, give details

    ……

    ……

3. If the answer to (6) above is yes, was it by the same perpetrator?
    - Yes
    - No

IV. TYPE OF CSA

1. What type of sexual abuse did the child experience?
    - Exposure to pornographic material
    - Fondling or inappropriate touching
    - Indecent exposure

- Vaginal penetration
- Anal penetration
- Oral sex
- Other (specify)

V. TREATMENT RECEIVED

1. Were you aware that children who've been sexually abused need urgent medical treatment?
   - Yes
   - No
2. Who rescued the child?
   - Self
   - Parent
   - Other (specify)
3. Was the child seen in a health facility?
   - Yes
   - No
4. If the answer to question (2) above is No, please give reasons

   i)

   ii)

   iii)

5. If the answer to question (2) above is Yes, what treatment was given to the child? (circle all that apply)
   - PEP

- Counseling
- Emergency contraception
- Treatment of STD
- Surgical repair
- Others (Specify)

VI. LEGAL ASSISTANCE RECEIVED

1. Was the incident reported to the police?
   - Yes
   - No
2. If the answer to question (1) above is yes, what step did the police take?
   - Arrested the suspect
   - Took no step
   - Any other (specify)……
     ……
     …..
3. If the answer to (1) above is NO, please give reasons
   i.
   ii.
   iii.

APPENDIX V: FOCUS GROUP DISCUSSION GUIDE

First, the participants will be welcomed and made to feel free and comfortable. The topic is then introduced and the reasons why they are there is explained to them.

PART 1: PARENTS/GUARDIANS OF THE AFFECTED CHILDREN

1. What do you think of sexual abuse of children as a problem in your community? (specify the locality)
2. Please describe how you felt when your child (or relative) was sexually abused
3. What do you think is the root cause of this problem in your locality?
4. How does your community handle this problem?
5. What do the people in your locality say is the reason why children are sexually abused?
6. What steps do you take when you hear that your child or a child under your care has been sexually abused?
7. Please comment on the way the police and the local administration is handling the issue.
8. What's your opinion on the way the health care workers handle the children who have been sexually abused when they are brought to them?
9. What steps should be taken to curb this vice in the community?

PART B: HEALTHCARE WORKERS

1. Have you ever attended to a child who was sexually abused in your medical practice?

2. If Yes, would you please describe the circumstances of the event as you found out
3. On average how many cases of child sexual abuse are seen in your facility in a month?
4. What do you think are the factors predisposing to child sexual abuse in this community?
5. Do you think the HCWs are well equipped to handle this problem? Please explain

PART C: POLICE AND THE LOCAL ADMINISTRATION

1. Have you ever assisted a child or family in a case of child sexual abuse? Please describe the circumstances
2. As a law enforcer, what do you think of this problem in this community?
3. In your opinion, what do you think is the real cause of this problem in this community?
4. What should be done to control this problem in this community?

PART D: TEACHERS/ SPIRITUAL LEADERS

1. Have you heard of any cases of child sexual abuse among children in your care (the school or church etc)
2. What are the views of this community on child sexual abuse?
3. What do think are the factors that make children vulnerable to sexual abuse?
4. What do think should be done to curb sexual abuse of children in this community?

THANK YOU FOR PARTICIPATING.