

An Exploratory Study of Beliefs and Understandings of Health Workers at Onandjokwe Hospital, Namibia Regarding Child Sexual Abuse

'The enormity of the problem of sexual abuse has been one of the most discouraging discoveries of our era. It is all the more discouraging in that it reveals our own failures as adults and as child welfare professionals historically to recognise a major source of suffering to young people'

David Finkelhor

Tarek Meguid

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**An Exploratory Study of Beliefs and
Understandings of Health Workers at
Onandjokwe Hospital, Namibia
Regarding Child Sexual Abuse**

Prepared in partial fulfillment of the requirements for the
Master of Philosophy in Maternal and Child Health
**Department of Paediatrics and Child Health
University of Cape Town**

by

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Rural Health, Namibia

DECLARATION

I, Tarek Meguid, declare that this dissertation embodies only my original work, except where acknowledgement indicates otherwise, and that no part of it has been, or is being submitted for a degree at this or any other University.

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Summary

The study presented here examines beliefs and understandings of health workers at Onandjokwe Lutheran Hospital, regarding sexual abuse of children.

The **introduction** gives background information on the area where Onandjokwe Hospital is situated and on the magnitude of the problem of sexual abuse of children here. It also provides information on what is known about beliefs and attitudes of health workers and on facts of CSA.

The **literature review** gives an overview of the literature on child sexual abuse. In this section an attempt is made to also look at the history of research in this area and at the specific problems of studying such a sensitive issue in cultural settings different from the setting of the researcher. This review includes literature on medical, social, anthropological, legal, cultural and political aspects of CSA. As much literature dealing with this subject in the African, Southern African and Namibian context as possible is included in this review.

The chapter on **methodology** explains the study design and its bi-phasic approach combining a qualitative and a quantitative phase. The qualitative phase consists of several focus group discussions leading to the formulation of questions for the questionnaire used during the quantitative phase of the study. Problems and limitations are also discussed.

The **findings** of the study are presented in two parts, one part for each of the two phases. The qualitative findings are based on three focus group discussions held with various categories of health workers. The quantitative findings are based on 186 questionnaires. They are shown mainly in tables and graphs. At the end of the chapter results are further analysed looking at specific sub-sets of respondents. Since analysis of the collected data could be very extensive and take many forms, a decision was taken to present descriptive exploratory data for the purposes of this dissertation. All answers to the main part of the questionnaire are shown in table 26 which is provided as an appendix so as to allow for further analysis if one may wish to do so.

In the **discussion** the overall findings emerging from this study are discussed first, followed by specific aspects of the analysis. The main results of the study are that CSA is perceived to be a significant problem in the study area and that health workers do not feel competent enough to handle this problem. They clearly express the need to be trained further in this field. Although the overwhelming majority of medical doctors are from abroad and a number of other health workers have been raised abroad; the majority of health

workers are Namibian, are nurses and have been raised in the area of the country in which the study was undertaken. The beliefs and understandings of CSA found in this study therefore reflect mainly 'local' views. The discussion then leads to the formulation of brief **conclusions and recommendations**.

An extensive **bibliography**, including all the available literature on CSA in Namibia to date, and the **appendices**, consisting of the Ndonga and English questionnaire and a foldout list of acronyms for convenience conclude this thesis.

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List of Acronyms

A copy of this list of acronyms can be found as a foldout sheet at the end of this thesis

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Clinic
CERPOD	Centre for Applied Research on Population and Development
CLE	Clerk
CSA	Child Sexual Abuse
CSO	Central Statistics Office
DR	Medical Doctor
EBM	Evidence Based Medicine
ELCIN	Evangelical Lutheran Church in Namibia
ELOC	Evangelical Lutheran Owambo Cavango Church
EN	Enrolled Nurse
FELM	Finnish Evangelical Lutheran Mission
HIS	Health Information System
HIV	Human Immune Deficiency Virus
IPPF	International Planned Parenthood Federation
KABP	Knowledge, Attitude, Belief and Practice
MOHSS	Ministry of Health and Social Services
MPH	Master of Public Health
MTI	Ministry of Trade and Industry
NA	Nursing Assistant
NANASO	Namibian Network of AIDS Service Organisations
NPC	National Planning Commission
NWHD	North West Health Directorate
OPD	Out Patient Department
PHY	Physiotherapist
PTSD	Post-Traumatic-Stress-Disorder
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
RM	Registered Midwife
RN	Registered Nurse
SARDC	Southern African Research and Documentation Centre
SASA	Security Association of South Africa
SIAPAC	Social Impact Assessment and Policy Analysis Corporation
SOC	Social Worker
STD	Sexually Transmitted Disease
TEC	Technician
UCT	University of Cape Town
UNAM	University of Namibia
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America
WIDSAA	Women in Development Southern African Awareness
WIPHN	Women's International Public Health Network

Introduction

Preface

This thesis describes the first study into beliefs and understanding of health workers at Onandjokwe Hospital regarding sexual abuse of children. Being the first such study carried out in this region, it is a descriptive exploratory study. It is hoped that this study will contribute to a better understanding and more awareness of the problem of CSA in Onandjokwe, which then might lead to more research into causes and effective preventative measures.

Ndapewa*

Ndapewa is six years old and comes to my consulting room together with her mother. She is a healthy looking schoolgoing child, dressed in neat clothes. She seems to be quite shy and her mother tells me that a neighbour has raped her daughter. The nurse assisting me in my office laughs when she hears this. The rape took place three weeks ago. Ndapewa's mother only heard about it today, since the child wouldn't tell. She noticed some bloody stains on her daughters' underwear and pressed her then to tell her the story. According to Ndapewa the neighbour's boy, who is twenty-one years old, asked her to help her in his hut and then raped her. He put his penis in her vagina. It did hurt a lot. After he was finished she ran home and hid in her hut. She did not tell anybody because she felt ashamed and was worried her grandparents would not believe her and punish her for telling lies. Her mother and her father both live in Windhoek but not together. Her mother comes home only a few times a year. After the rape she had much pain between her legs and a few days ago she noticed bloody water coming from her vagina. When her mother asked about it on her recent visit, she told her the story.

It is not too difficult to examine Ndapewa. She is cooperative but very afraid. The nurse working with me tries to put her at ease but raises her voice when Ndapewa does feel pain and retreat during examination. I can see that her hymen is torn. The laboratory tests show that she has an infection with gonorrhoea. Ndapewa's mother agrees to have an HIV test taken. When I ask what the mother plans to do, she says nothing. It is not possible to take the child with her to Windhoek, she says. She is not yet sure whether she wants to press charges against the neighbour. I try to get across that it wasn't Ndapewa's fault that this happened. I try to show her that I am concerned and that we will do everything to treat her infections. I ask whether she wants to ask me anything? She says no. I cannot see any trace of any emotion in Ndapewa, her mother or the nurse. When I ask the mother how she feels about this, she looks at me as if I had asked a completely irrelevant, almost an insulting question.

When Ndapewa and her mother leave I am full of questions and uncertainties. Did I fail to put Ndapewa and her mother at ease? Did I make it impossible for them to open up? Did they really not feel anything about the abuse? Why did the nurse laugh? Was she also uncertain and did she feel insecure? What should I do with this child once the infections have been treated? Should I insist that the

* The name of this child and some aspects of her story have been altered in order to protect her privacy

perpetrator be sued? Would it be a good idea to get Ndapewa interviewed by a Psychologist or Psychiatrist? Is it perhaps better not to pursue the matter any further than the pure physical side of it?

The result of the HIV test only comes after three weeks and is negative. A control HIV test four months later is positive.

I did not pursue 'the matter' any further. I feel I and my colleague health workers failed this child, but I am at a loss of ideas as to how to react appropriately. Phoning a friend back in Amsterdam who is a psychiatrist does not really help either.

This is an example of a child I have seen in my office. There are times we see up to six such children in one single week. Fortunately there are also times we see not a single child with a problem such as this for weeks on end.

Background Onandjokwe Health District

Until her independence in 1990, Namibia was illegally occupied and ruled by South Africa. According to the then prevailing apartheid-ideology of the ruling class the country was divided into 'homelands' according to ethnicity and the health care system was highly fragmented¹.

Most Namibians are living in the North, former 'Owamboland', an area, which suffered most during the war for independence. The border to this area was at Oshivelo. Onandjokwe District is situated in that part of the country.

The new government formed thirteen new regions in 1992. In an attempt to do away with the old colonial borders, Tsumeb, which is south of Oshivelo and a mining town, was integrated into a region together with Onandjokwe, which is in the heart of former 'Owamboland'.

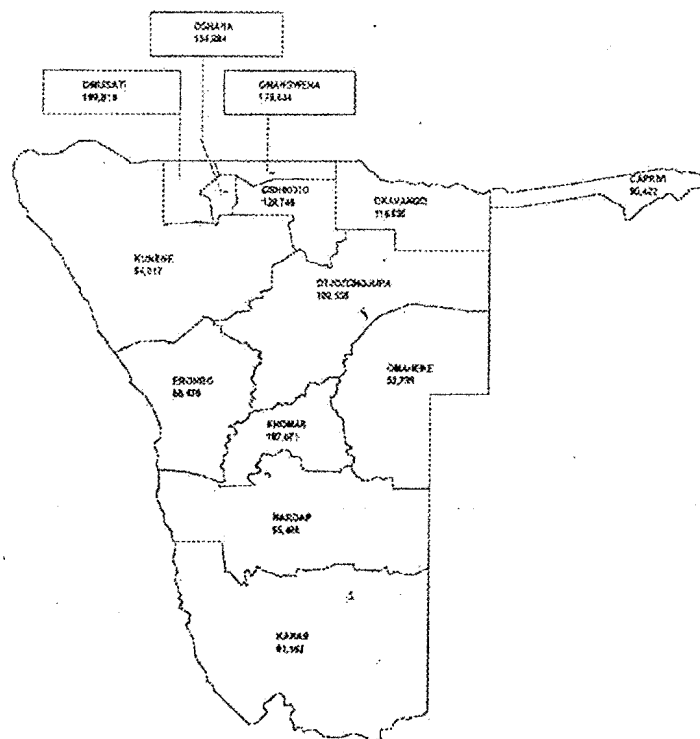


Figure 1 The Thirteen Regions of Namibia

Most Namibians are living or coming from north of Oshivelo.

Onandjokwe district is named after Onandjokwe Lutheran Hospital, which is situated in Oniipa. This hospital is the first hospital in the North and was founded in 1908 by Finnish missionaries through the Finnish Evangelical Lutheran Mission (FELM).

Onandjokwe Health District is one of two health districts in the Oshikoto Region.

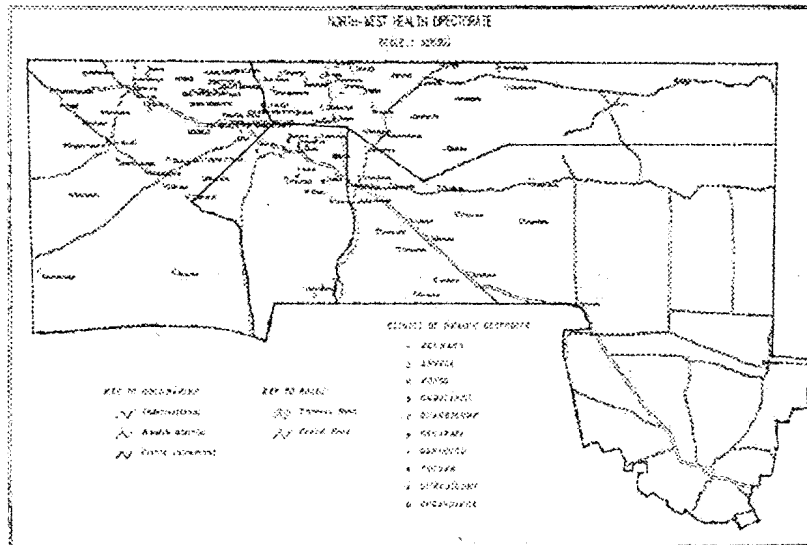


Figure 2 North West Health Directorate

Oshikoto Region comprises the south-eastern part of former 'Owamboland', the greater part of Ondangwa and the Magisterial District of Tsumeb. It covers an area of 26 607 km² (Figure 2).

Onandjokwe district is South of Ohangwena region, East of Oshana region, north of Etosha National Park and west of Okavango region.

Geographically it is characterized by an extremely flat plain which forms part of the Etosha depression and gradually descends as a shallow trough from North to South towards the Etosha Pan. The average elevation is 1090 – 1150 meters above sea level.

Numerous small pans are present all over the district, which are water filled after the rains. Two oshanas, dry rivers, Niipele and Oshigamba,

rise in the highlands of central Angola. After heavy rains in Angola, massive floods can occur in the district.

Ground water is retrieved via boreholes, which are mostly 25 meters deep or more. Because the whole area is very flat, dams to collect water during the rainy season are not an option.

The water of some households in the villages comes via Ruacana in the Northwest from the Kunene River, which forms the border between Namibia and Angola.

Vegetation in the West is mostly palm savanna (Makalani palms) and in the east dry woodland that changes to dry bush savanna.

Due to an enormous population and domestic stock growth over the last three decades the vegetation has been threatened to such an extent that severe deforestation is now giving desertification a real chance.

The weather is hot in summer (32°C mean maximum) and mild in winter (9°C mean minimum). Rainfalls vary between 255 mm and 828 mm a year. It is therefore a very dry area in winter and can be very wet after good rains in summer.

There is one good tarred road connecting the North with the South (or is it the other way round?). This road runs from Tsumeb, and in fact from Windhoek or even Cape Town, all the way to Angola. It has two main branches along the way. One via Oniipa, the center of Onandjokwe district, and Oshigambo and another one at Ondangwa via Engela to Angola².

The main center of the district is Oniipa, which is where the Evangelical Lutheran Church In Namibia (ELCIN) has its head office too.

Reliable demographic data on the district is very difficult to get. The 1991 census revealed a population for Oshikoto region of 128.745³. All subsequent population estimates are based on this single survey with an estimated annual growth of 3 - 4%. That would then mean that today the population of the Oshikoto region would be between 163.087 (3% growth) and 176.190 (4% growth). Most of these would live in Onandjokwe district and not in Tsumeb district. No data on the age and sex distribution of the population in our region is available. It seems, however, reasonable to assume that the largest proportion of the population is younger than 25 years old and that there are slightly more women than men⁴.

In contrast to the southern parts of the country most households are headed by women and not by men⁵. This probably reflects the fact

that a substantial number of men work in the South and see their families only during holidays.

Onandjokwe Health District has one hospital, Onandjokwe Lutheran Hospital, which is the first and oldest hospital in the North. It is the third biggest hospital in Namibia, after Windhoek and Oshakati. It functions as district hospital as well as referral hospital for Eenhana- and Kongo Hospitals, which are both situated in the Ohangwena region. The hospital is also the headquarters for all district health activities also coordinating the cooperation with the 15 clinics in the district⁶.

After independence many so-called returnees came back into the country. Some of these left Namibia when they were very young. Most of the returnees with a professional qualification received their professional training in the countries where they had been in exile, which could have been almost any country in the world. Most medical doctors working in rural Namibia, thus also in Onandjokwe District, are foreigners. They too have been trained in many different countries of the world. This means that the health worker who is seeing patients and clients and thus also children who became victims of sexual abuse is not a person easily defined by his/her training.

Health workers at Onandjokwe at the time of this study were trained in or came from the following countries, or both: Angola, Congo, Cuba, Cyprus, Finland, Germany, Namibia, Netherlands, Nigeria, Russia, South Africa, Tanzania, Uganda, UK, Ukraine and Zambia.

This is the land, and the situation, where the children such as Ndapewa are coming from and where health workers are seeing them.

Background to this Study

Looking at the records of our hospital one can clearly see that reported cases of child sexual abuse are increasing in our district⁷. Table 1 shows the number of children seen at Onandjokwe between 1995 and 1998 presenting either with a history of sexual abuse or clinical evidence of it, mostly a sexually transmitted disease (STD), or both. Only a minority of these cases have been reported to the police.

Data obtained from the Women and Child Abuse Centres at Oshakati and Tsumeb also show that reported CSA is on the increase^{8,9}. This also follows, or rather confirms, the national trend of increased reported rapes in Namibia¹⁰. It is important to realise that the increase might be due to either more awareness and subsequent more reporting of the problem or a real increase of CSA.

Table 1 Abused Children seen at Onandjokwe Hospital 1995-98

Table 1								
	1995		1996		1997		1998	
Age (years)	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys
< 1	-	-	-	-	-	-	1	-
1 - 5	1	-	1	-	-	1	4	1
6 - 10	1	2	2	-	3	1	10	3
11 - 13	1	1	2	-	1	-	8	2
14 - 16	1	-	3	-	5	1	4	-
ALL	4	3	8	-	9	3	27	6
♀ & ♂	7		8		12		33	

Sexual abuse of children is also world wide a growing problem, which has been researched intensively, internationally^{11,12,13}, regionally^{14,15} and locally^{16,17}. Aspects of sexual abuse of children that have been studied mostly are physical^{18,19,20}, psychological^{21,22} and legal^{23,24}.

Problems to be Investigated

The health worker is very often the first and only professional person to see a child who has been sexually abused. Clearly, the beliefs and understanding of this person concerning sexual abuse of children influences his/her attitude towards the child and his/her family, as well as the treatment options offered.

Sexual abuse of children has been in the Namibian media for quite some time²⁵ and it is a topic prone to elicit explicit and deep felt reactions and feelings in those discussing this issue or being confronted with it. It is therefore very important to look at the beliefs and understanding of this issue in the people who have to deliver a professional service to those who are victims of it. This then is the first step in trying to formulate a vision as to how best to cope with this problem as health workers.

Very few studies have been done to look into the beliefs and understanding of the health workers confronted with victims and perpetrators of the abuse^{26,27,28}.

Before attempting to think of realistic treatment options, other than pure medical care of wounds and STDs, for the children who have been sexually abused, it seems important to establish what health care workers actually think of this problem and what their understanding of it is.

To my knowledge no study looking into beliefs and understanding of health workers regarding sexual abuse of children has ever been done in Namibia.

Significance of Beliefs and Understanding and the Purpose of Investigating them

The beliefs we hold on certain things in life determine to a very deep degree how we behave²⁹ in life. These beliefs may be known to us such as 'medical knowledge', which leads to certain 'actions'. The beliefs may also be hidden in the unconscious and therefore be unknown to us³⁰.

There are many reasons why we wouldn't know about our beliefs concerning certain phenomena of life. The most obvious would be that we just didn't ask ourselves why we feel the way we feel about something. In clinical medicine this has been discovered relatively recently and lead to the establishment of what is called evidence based medicine (EBM), which is in fact nothing else than trying to ask why do we do what we do. What are the beliefs behind our actions and what is the evidence for those beliefs³¹.

The study presented here asks the first question: What do we believe? This is a first attempt to establish what kinds of ideas are living within the very heterogeneous group of health workers at Onandjokwe hospital.

The following lists the specific objectives of this research:

1. To assess health workers' knowledge about signs and symptoms of sexual abuse.
2. To determine the role if any which health workers see for themselves in helping victims of sexual abuse.
3. To describe the definition of sexual abuse as seen by health workers.
4. To determine the health workers' perception of sexual abuse of children as a problem.
5. To assess the explanations of sexual abuse of children by health workers.
6. To assess health workers' beliefs concerning the effects of sexual abuse on the child.
7. To determine the influence of the health workers' sex, place of upbringing and profession on his/her beliefs.

Ultimately it is hoped that a better understanding of both the issue of sexual abuse of children in the district and of the beliefs of the health

workers around it, would lead to a better service rendered to the children and their families and in fact the perpetrators too. It is also hoped that it will lead to more research into preventative, educative and psycho-curative efforts, in order to make the sexual abuse of a child, of anybody for this matter, a very rare incident and to minimize its effect on the victim.

This means that the purpose of this study is to make a contribution on the road to improve the quality of service rendered to victims of CSA in Onandjokwe.

Established Facts on Sexual Abuse of Children

Two widely accepted definitions of what sexual abuse of children is are³²:

- *'The involvement of dependent, developmentally immature children and adolescents in sexual activities which they do not fully comprehend, are unable to give informed consent to and that violate social taboos of family roles'*³³
- *'Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance'*³⁴

Sexually abused children can and usually do develop problems, which can be classified as being immediate, short-term and long-term effects of the abuse. These effects will also be influenced by the age of the victim and the relationship with the perpetrator, which can make it difficult to diagnose the effects exactly in any given case³⁵.

Immediate effects may include^{36, 37}

- physical trauma
- sexually transmitted diseases
- pregnancy
- shock

Short-term effects include^{38, 39}

- inappropriate sexual behaviour
- poor school performance
- low self esteem

- anxiety, depression
- shame, guilt, powerlessness

Long-term effects include¹⁰

- low self esteem
- prostitution
- abusive behaviour towards own children
- suicidal behaviour
- depression

It seems that generally speaking the following relationships have been established¹¹ concerning psychological effects of CSA:

- more traumatic effects in post-pubertal abuse than in pre-pubertal abuse
- greater impact in long duration abuse
- more harm if abuse was frequent
- greater impact when force or threats of force were experienced
- greater impact when penetration took place
- greater harm when father or stepfather was perpetrator, as opposed to stranger

The symptoms associated with these effects differ according to the age of the victim. The following symptoms have been associated with the corresponding age group¹². This is, of course, a guideline rather than a law:

Pre-school children may show the following:

- sexually explicit play
- wetting and soiling
- delayed language and development
- eating and sleeping disorder
- dysfunctional attachment behaviour
- withdrawn or over-active
- aggressive behaviour
- becoming mute

Six to twelve year old children may show the following:

- poor learning
- heightened sexual behaviour and arousal
- self neglect
- depression and anxiety

- psychosomatic illness
- physical risk taking
- avoidance of men or women (depending on gender of abuser)

Older children may also show the following:

- prostitution
- alcohol/drug abuse
- suicide attempts
- anorexia
- poor school performance
- isolation from peers
- sexually abusing other children

There seems to be a fair amount of agreement as to the above, although there is no commonly accepted conceptual framework that is used to explain children's responses to CSA⁴³. For the time being the health worker confronted with children who have been sexually abused the above-established facts are a guideline to diagnose CSA and to have an idea as to what impact it might have on the child.

The experts are divided, however, as to how to best manage victims of child sexual abuse⁴⁴.

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Literature Review

Past

Child abuse and neglect became an international issue following the publication of Kempe, Silverman, Steele, Droegemueller and Silver in 1962 called 'The Battered Child Syndrome'¹ in which detailed medical evidence of child abuse was presented.

The literature shows however that this issue had already been researched in the 18th century². Apparently 25% of rape cases prosecuted at the Old Bailey in London between 1730 and 1789 involved victims younger than ten years old³. The situation a hundred years later in France was similar, if not worse, with 45% of those charged with rape between 1858 and 1869 being accused of having raped a child⁴.

The infamous story of Sigmund Freud's seduction theory⁵ and his subsequent change of mind illustrate how difficult it must have been to appreciate the enormity of the problem⁶. In his seduction theory Freud describes sexual abuse of children and its effects, only to abandon it later in his life, saying that the accounts of sexual abuse given to him were 'a product of the patient's fantasy life'. It was Freud's contemporary Ferenczi who opposed him and conducted more research into sexual abuse of children⁷.

During the first half of the 20th century the idea of sexual abuse of children within the family was unpopular within the scientific world. It was thought that the perpetrator was a 'stranger' and a 'pervert'⁸. This way of thinking was followed by a period in which mothers were seen as the ultimate culprits because of their obvious failure to protect their children against the abuse⁹.

Present

The recent view on sexual abuse of children, as a very common phenomenon in which more often than not men who are known to the victims are the perpetrators, followed the 1962 'The Battered Child Syndrome' publication. This publication seemed to have induced a flood of other publications and research efforts into this problem. One of the first areas to be researched was the epidemiology of CSA first in the USA^{10,11}, Canada¹² and Europe, and later in other regions¹³.

There seems to be little doubt now, that CSA is a very wide spread problem all over the world and within all social groups. Estimates as to how many children are being sexually abused range between 7 and 62%^{14,15}. This wide range probably reflects different definitions of CSA used by different research groups.

Much research has been conducted into the physical signs of CSA^{16,17,18}. This was also urged by the legal implications of CSA. It became apparent that not all unusual medical conditions in even very small children necessarily reflect abuse^{19,20}. It even became necessary to look much closer into the normal anatomical variations of children's genitals^{21,22,23}. The most important outcome of these studies is, that physical evidence of sexual abuse is not as straightforward as one would think²⁴. Even the so-called 'normal' anatomy is not quite as 'normal'. It might be difficult to say with certainty from inspecting the genitals of the alleged victim, that even penetration in a small child took place. Together with research into physical signs of sexual abuse came research into children's deaths²⁵. The disturbing finding here is that children's deaths need to be thoroughly investigated, since in 1993 in the USA alone 1383 children lost their lives as a consequence of abuse²⁶, most of which was not sexual.

Challenges

All along researchers, mainly Psychologists, Psychiatrists, Social Scientists and Social Workers tried to investigate treatment options for the affected children and families²⁷. It was only much later that management options for perpetrators were looked at²⁸. A wide range of psychotherapies have been tried on these children. Psychoanalytical approaches²⁹, group therapy^{30,31}, play therapy³², arts therapy³³, drama therapy³⁴, family therapy^{35,36,37} and many more.

The vast variety of treatment options is a product of competing explanatory frameworks within the mental health disciplines. The need for a unitary 'theoretical framework' was and still is strongly felt.

The two most commonly used explanatory models of children's responses to CSA are the 'Post-Traumatic Stress Disorder' Model³⁸, where symptoms are seen as the result of 'an overwhelming event resulting in helplessness in the face of intolerable danger, anxiety and instinctual arousal', and the 'Four Traumagenic Dynamics' Model³⁹. In the latter the following four 'traumagenic dynamics' are seen as causing the symptoms: 1st Traumatic Sexualization, 2nd Betrayal, 3rd Stigmatization and 4th Powerlessness. The short and long term effects of CSA as outlined earlier are understood in the PTSD-model as being the result of 'coping' with the situation through 'accommodation' and 'adaptation'. A child might, for instance, provide sexual behaviour in

order to avoid punishment. The 'Four Traumatic Dynamics' model explains the effects of CSA as follows. The 'traumatic sexualization' can lead to sexual preoccupation and repetitive sexual behaviour and above all to confusion within the victim who is 'learning' that sex is the 'normal' or only way to show affection. The 'stigmatization' of the child then leads to isolation, which in turn enhances the chances of gravitation to stigmatized levels of society such as prostitution and the chances for low self-esteem. The 'betrayal' through CSA leads to disillusionment, which may lead to an intense need for trust and security. This need can manifest itself in behaviour of dependency in younger, and the search of a 'redeeming relationship' in adult victims. Anger and hostility are the possible opposite reactions of a victim to 'betrayal'. The fourth dynamic 'powerlessness' may lead to fear and anxiety because 'powerlessness' means being unable to protect oneself. This impotence may lead to depression and suicide or in some victims of CSA to a dysfunctional need to control and dominate. None of the explanatory models claims a one-to-one correspondence between dynamics and effects.

Other models have been published^{40,41} and used to underpin therapeutic approaches⁴². The theoretical explanation for the effects of CSA should inform the treatment offered to the victims⁴³.

As mentioned before, it seems evident that there are immediate⁴⁴, short^{45,46} and longterm^{47,48} effects of CSA on the child. They have been discussed in the introductory chapter. It has to be said, however, that research in this area has been criticized for poor or questionable methodology^{49,50}.

Prevention of CSA is another wide field with many different approaches^{51,52} and ideas⁵³. This is probably a function of several factors. They include a lack of agreement on prevention strategies due to the lack of theoretical coherence in the field; the complexity of the factors that may place a child at risk; and the fact that CSA occurs in private spaces not easily accessible to public monitoring⁵⁴. Empirical data suggests that there is a high rate of recidivism and that families at risk of CSA are likely to be spaces where CSA actually takes place^{55,56,57}. There is no identifiable single reason for CSA and the various different preventative approaches focusing on different factors, form the best possible strategy for prevention.

The picture that emerges is hazy and unclear at best. Much is still not known and has to be researched further. It seems that the general 'requirements' for all sorts of social and other ills such as poverty, broken social structures and the likes are also at play when it comes to CSA. Looking at specific risk factors for CSA is problematic and not much is known as fact. The possible risk factors associated specifically with CSA in Namibia include: poor childminding strategies and/or possibilities, 'cures' for AIDS prescribed by traditional healers

involving CSA, breakdown of family structures with many female headed households and consequently the presence of stepfathers and boy friends. These risk factors are probably at play within a very complex system involving factors concerning the individual children, the families, the general setting and the cultural situation. This complexity is also responsible for the multitude of preventative efforts and their relatively humble effects.

One theoretical framework concerned with prevention examines strategies aimed at influencing the four factors in theories of sexual abuse: emotional congruence, sexual arousal, blockage and disinhibition⁵⁸. The strategy aimed at 'emotional congruence' tries to alter the male sex role stating that '...in a society that encourages predatory male sexuality, that sexualises all intimacy, and that fosters male irresponsibility toward children, it will be hard to prevent sexual abuse ...'. 'Sexual socialization', how children are socialised about sex, is seen as another field for prevention since it will enable society to monitor children with 'unusual' sexual fantasies and allow for intervention before any molestation takes place. 'Deterrence' through the legal system⁵⁹ and with the support of the media is another strategy, especially when focused towards risk groups. 'Identifying risk groups' is a preventative effort on its own. There are some pointers indicating to stepfathers, abused boys and unemployed young families. In Namibia additional risk groups are probably 'traditional healers' and/or their clients.

'Out of America'⁶⁰

The issue of cultural and political problems of discussing and researching sexual abuse of children all over the world has been discussed previously. There seems to be a clear danger of 'cultural imperialism' as put by Levett⁶¹, when discussing this issue. This entails nothing other than imposing the cultural values of the researcher on the community (s)he is looking at. Cultural sensitivity, whatever that really means, when researching this issue in other cultures, is a prerequisite⁶².

There is a wealth of literature concerning culture and sexual abuse written by Anthropologists^{63,64}, Psychologists⁶⁵ and others. Much remains still to be investigated, but generally it is agreed that sexual abuse of children is in fact an international problem occurring in most, if not all, cultures⁶⁶. It is however, well recognised that confusion does exist at times, what exactly constitutes abuse in any given cultural setting^{67,68}. The question arising from this is whether the signs and symptoms of CSA are as universal as its existence? From this follows the question of therapies and their applicability in different cultural settings⁶⁹. As with therapies within a country

sharing more or less one cultural identity, it seems to be impossible to say what would be the right therapeutic approach for all victims of CSA. The variability of CSA, both in terms of symptomatology and prognosis has been recognized and will influence future research⁷⁰.

The 'international' literature on CSA followed more or less the route of the North American and European researchers: Relatively much information on epidemiological^{71,72}, medical^{73,74,75,76}, sociological^{77,78} aspects, some on gender aspects⁷⁹, and very few on perceptions of the abuse by those experiencing it⁸⁰. All the research done in Africa suggests and confirms that CSA is a huge problem in Africa as well.

The beliefs, understandings and resulting attitudes of health workers, legal practitioners, police(women), teachers, parents and others, who are or will be confronted with CSA have rarely been researched. Researching understandings and beliefs of CSA was mainly done by confronting the subjects with a written history and then asking whether or not they thought that sexual abuse took place^{81,82,83} or by asking them to fill in a questionnaire^{84,85,86}. Some studies were looking at beliefs and understandings and asked the subjects then to reach a judgement in a theoretical case^{87,88}. Only few such studies have been done looking at trans-cultural aspects of CSA⁸⁹.

Motivation for studies examining the beliefs and understandings of health workers was very often the fact that CSA seemed to be underreported even by (health)professionals who have an obligation in many countries to report CSA. In trying to find out more about their beliefs and understanding it was hoped to understand why some cases of suspected CSA were not reported⁹⁰. One of the reasons believed to be responsible for the failure of reporting CSA is countertransference⁹¹, which is, generally speaking, a phenomenon whereby the professional feels unconsciously or consciously fear, guilt, shame and sympathy 'transferred' to him by the client⁹², which then leads to complying with the client or his/her family.

Namibia

The Namibian situation has been looked at and written about relatively extensively. Most of the literature, however, is concerned with living conditions of women in general⁹³, violence against women^{94,95} and women and children^{96,97,98}. There is not much literature specifically dealing with CSA^{99,100} but much is written in the media on domestic violence and sexual abuse of children¹⁰¹.

Since Namibia is one of the countries with the highest HIV/AIDS rates in the world¹⁰², AIDS and sexual activities of children and adolescents have been the focus of research¹⁰³. Especially knowledge and attitudes

of adolescents towards sex^{104, 105}, condom use¹⁰⁶, teenage pregnancy¹⁰⁷ and academic choices¹⁰⁸ have been examined in some detail.

Domestic violence, wife battering and sexual abuse of children are all common in Namibia. The position of Namibian women and children in general seems to be very vulnerable¹⁰⁹ and characterized by subordination to men and one of relative to complete powerlessness. This is even true in circumstances where the woman is the (sole) breadwinner and or has had superior education to her male partner. The majority of households in the North of the country are headed by women¹¹⁰.

There is no literature on beliefs and understanding of CSA by health workers in Namibia.

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Methodology

Rationale

This study is an example of a KABP (Knowledge, Attitude, Belief and Practice) survey¹. The reason a bi-phasic approach was chosen, was to first generate issues and questions to be asked later in a quantitative manner. The underlying assumption for the choice of a KABP study was, that beliefs and understanding of health workers concerning CSA do indeed influence the service rendered by the health worker to the patient or client. Probably much in the same way as beliefs on the side of the patient or client influence his/her use of medical facilities.

The generation of questions can only be done qualitatively². The use of focus groups to elicit the information needed was seen as being appropriate since focus groups are seen as an excellent tool to collect qualitative data³.

Study Design

This study consisted of a qualitative and a quantitative phase. In phase one focus groups were held to generate issues and beliefs around CSA. The findings of phase one were then used to formulate a questionnaire to quantitatively assess beliefs and understanding of CSA in health workers working at Onandjokwe.

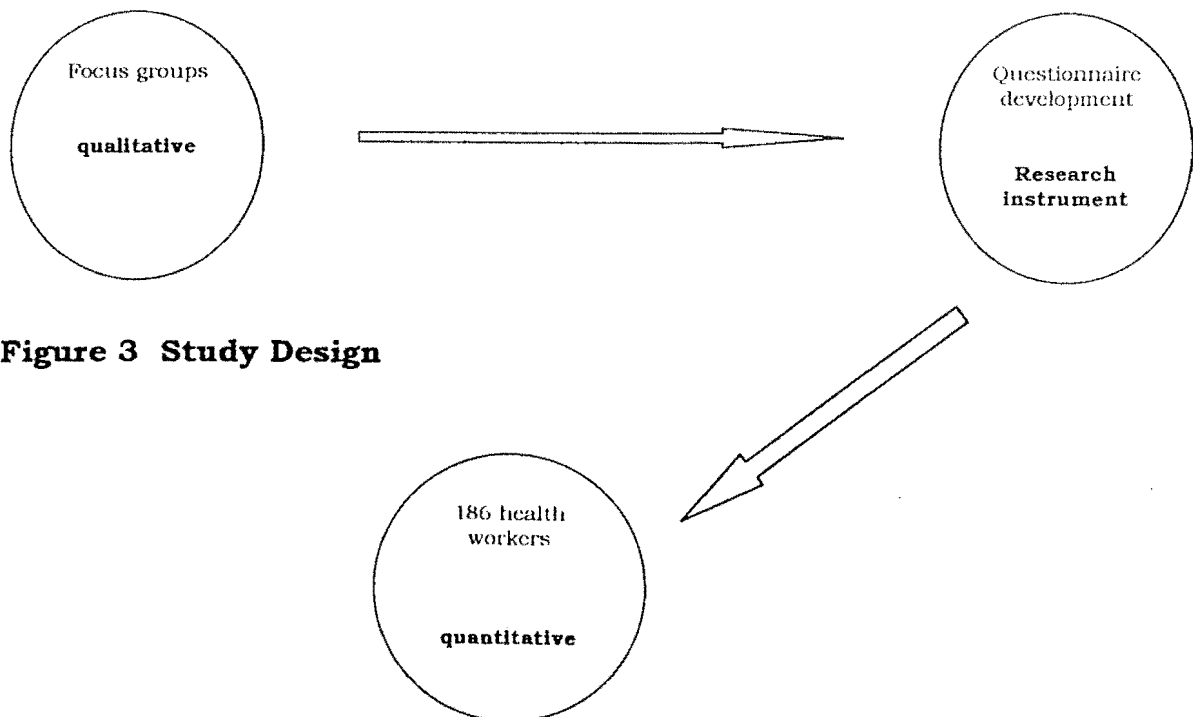


Figure 3 Study Design

Phase 1

Three focus groups (three to four persons per group) were held with health workers working at the following departments in the hospital: Gynaecology and Paediatrics, STD/HIV Counseling and Casualty. The members of the focus groups were chosen not only on the basis of where they worked within the hospital, but also looking at where they had been trained. This was done to accommodate the fact that health workers at Onandjokwe do have such a diverse professional, educational and cultural background. The members of one focus group were four female registered nurses working at the departments of Paediatrics and Obstetrics & Gynaecology; the next focus group had three members, two women and one man, two enrolled nurses and one medical assistant working at the STD/HIV counselling office; the last focus group consisted of three doctors, two female one male, from Uganda and Cuba working at Paediatrics. The members of the focus groups were representative of the categories of health workers who received the questionnaire later.

The aim of these focus groups was to find out what health workers believe concerning the following five questions:

1. What is sexual abuse?
2. Is it a problem in Onandjokwe?
3. Why does it happen?
4. What are the effects of sexual abuse on the child?
5. What should we do about it?

The answers to these questions led to the formulation of the questionnaire for phase 2 of the study.

Conducting the focus group discussions was not problematic. The three sessions lasted between 60 and 80 minutes and all five questions noted above could be covered. It was an advantage that the groups were small.

Phase 2

In this second phase the questionnaire⁴ derived from the focus group discussions was presented to 250 health workers working in all departments at Onandjokwe Hospital. The questionnaire was divided into three parts: part A containing data on the health worker, such as age, sex, rank etc., part B consisted of seventy statements to which the health work had to agree or disagree using a 5 point Likert scale format and part C which contained fifteen questions to be answered by choosing an option out of several possibilities.

The questionnaire was designed in such a way as to allow for internal validity. The questions were counterbalanced and formulated in both positive and negative terms and then randomised to reduce response bias. The questionnaire was translated into Oshiwambo (Ndonga)⁵ using the method of first translating it into Ndonga by one translator followed by translating it back into English by another and then discussing unclear words with both translators.

As an incentive to fill in the form, each health worker received a decent pen.

¹ Richter L, Kuhn L. (1997) Knowledge, attitude, belief, and practice (KABP) surveys. In: Katzenellenbogen JM, Joubert G, Abdool Karim SS (Eds). *Epidemiology. A Manual for South Africa*. Oxford University Press Southern Africa, Cape Town

² Denzin NK, Lincoln YS. (1994) Introduction. *Entering the Field of Qualitative Research*. In: Denzin NK, Lincoln YS (Eds). *Handbook of Qualitative Research*, Sage, London

³ Knodel J. (1993) The Design and Analysis of Focus Group Studies: A Practical Approach. In: Morgan DL (Ed). *Successful Focus Groups: Advancing the State of the Art*, Sage, Newbury Park

⁴ Appendix 1

⁵ Appendix 2

Findings

General Remarks

The findings of this study will be presented for each phase separately followed by a section of further analysis and a concluding section on problems and limitations of the study.

Qualitative Phase

What is Sexual Abuse? (Definition)

There was much agreement within and between all focus groups as to how to define sexual abuse of children. CSA was seen to be:

- *Unlawful*
- *Harmful*
- *Could be result of force or seduction*

A clear distinction was made between abuse and rape.

- *Rape was ALWAYS against the will of the victim which was forced upon her or him*
- *Abuse could be the result of seduction which was against the interest of the victim*

'The child is seduced but does not understand what sex means'

male nurse, 43 years

Nobody suggested that children do seduce perpetrators, it was understood that some perpetrators seduce children and do not use physical force or even 'emotional blackmail'.

There was some debate as to what was the minimum age at which a person could give consent for sexual intercourse

- *Age for consent was seen as somewhere between 16 and 18 years*

It was clear during the focus group discussions that most nurses felt that consent for sexual intercourse could only be given when a person is 18 years old, while at the same time everyone agreed that 'of course'

it happens much earlier. Doctors felt more strongly that consent could be given before a person has reached legal age.

One can speculate as to what the reasons could be for this clear difference between nurses and doctors. It could be that nurses who are from the area have a tendency to deny the problem of 'normal' children having their first sexual experiences well before the age of 18 simply because they are embarrassed. It is also possible that nurses are more conservative than doctors in the group studied here. Both nurses and doctors were both male and female.

Other points which were raised by different groups and on which there was no agreement:

- *Not only consisting of physical contact but also exposure to sexual acts was a form of CSA*
- *Even seeing parents naked was seen as a form of CSA*

Some focus group members strongly felt that children should definitely not see their parents naked, while others felt that seeing ones parents naked should be part of a 'normal upbringing'.

'It is not good to talk about sex with children'

female nurse, 51 years

'It is necessary and good to talk about sexual matters with one's children'

female nurse, 40 years

While sex education was seen by all focus group participants as an essential part of child raising, exactly how explicit parents should be was a difficult point. The quotes above illustrate that well.

Is it a Problem in Onandjokwe? (Epidemiology)

Again there was agreement on the fact that CSA is indeed a problem in Onandjokwe. The estimates as to how many children are affected by it were different in different groups. This is an interesting finding, since very different estimates were all seen as indicating the same severity of the problem. The focus group that estimated the lowest rates of CSA consisted of health workers who had been trained abroad.

- *10-12% of all children might be victims of CSA was seen as a very big problem by health workers from abroad*
- *40-80% of all children might be victims of CSA was seen as a very big problem by health workers coming from 'the North'*

There was a striking difference between focus groups held with people from the 'North' and those from abroad. Both felt that CSA was an extremely big and serious problem at Onandjokwe district, but their estimates were strikingly different; this is not to say however, that those from the 'North' would have felt that CSA would not be a big problem if they would have estimated it to be less frequent than they actually did.

One group defined the severity of the problem of CSA not only in numbers of victims, but also in terms of impact on society. This group elaborated on the economic, cultural and gender effects, saying that (usually male) breadwinners would have to go to prison leaving their families with less money or none at all, the already declining traditional values and loosening cultural ties would do so even more and women's subordination to men would be cemented when they would drop out of school.

'If daddy is in prison the children cannot go to school and then the girls will still not be able to stand up for themselves in the future'

male nurse, 43 years

'Fathers should be at home, if they are not, more traditional values are lost'

female doctor, 38 years

One can again speculate as to the reasons for the striking differences in estimated cases of CSA. One obvious reason could be that those health workers who are from Onandjokwe just 'know' that CSA is a very frequent problem. It could indeed mean that CSA is, if not normal, at least very common. It could also mean that the nurses have been exposed to victims of CSA much more than doctors.

Why does it happen? (Explanation)

There was much discussion around the possible causes of CSA. Those listed hereunder were those mentioned by all three groups:

- *Traditional values have been lost and replaced by TV and printed material promoting sex*
- *Alcohol abuse is very common*
- *Beliefs around curing AIDS through sexual intercourse with an 'innocent' child*
- *Parents became 'careless' leading to poor child minding or none at all*
- *Poverty and lack of education of parents and lack of education possibilities for children*
- *General lack of recreational facilities and high unemployment rates leading to boredom on the side of the potential perpetrators*

- *Poor housing where boys and girls sleep in the same rooms and even in the same beds*
- *System of foster parents, whereby many children do not live with their biological parents but at places which are perceived as being better, for instance closer to school*

'Parents do not care for their children anymore. Parents look better after themselves. They are also afraid of the children'

male nurse, 40 years

'Parents are less educated than their children and cannot therefore advise them'

female nurse, 38 years

'Parents do not speak to their children'

male nurse, 39 years

The following explanations have been given by single groups only:

- *Promiscuity is also seen by the youth as a status symbol*
- *Some men with an obvious STD 'use' children because the children will not complain*
- *Many traditional healers recommend sex with a child to heal all sorts of ills (not only AIDS)*
- *Lack of sex education leading to complete ignorance concerning this problem on the sides of both parents and children*

'Some men with condylomata accuminata on their private parts sleep with children because the child will not know what the condylomata are'

female nurse, 51 years

'Traditional healers even prescribe sex with your mother for some illnesses'

female nurse, 51 years

The more specific reasons given for CSA here, such as lack of supervision of children, and prescribed intercourse with a child to cure AIDS correspond well with the literature.

There was no agreement within and between groups as to whether CSA was a new or an old problem, but there was a general feeling that it was increasing.

What are the Effects of Sexual Abuse on the Child? (Impact)

All groups said CSA constitutes a trauma that will have effects on the child. Possible effects are:

- *Aversion against or fear of sex*
- *Become homosexual*
- *'Enjoy sex too much' and become prostitutes*
- *Become 'an adult'*
- *Feel shame and confusion*
- *Develop depression and in severe cases become suicidal*
- *Poor academic performance, failure at school*
- *Social isolation, parents (adults) would not believe the child if (s)he would report the abuse*

Interesting ideas were discussed about some of the effects mentioned.

Physical trauma through the abuse was seen as being significant, because the extent of the physical trauma would determine the psychological trauma; even to the extent that there would be no effect on the child's further development if there was no physical wound.

The physical wounds inflicted through the abuse or STDs as a result of it, would lead to talk and this talk would be harmful, not necessarily the abuse as such.

Suicide would also occur only in cases of rape, not in other instances of CSA.

School dropouts could be the result of two things. Either the child became obsessed by sex after the abuse and 'wanted more' leading to loss of interest in school, or the child felt so much shame and isolation that (s)he could no longer concentrate.

No one felt that a history of having been sexually abused as a child would jeopardize a woman's chances to get married in any way.

'If a child has been raped and this fact became known to the community the child might commit suicide out of shame'

male nurse, 43 years

'Only if the child got a big wound through the rape will it develop other problems later in life'

male nurse, 39 years

'Some children taste sex through abuse and then want more'

female nurse, 35 years

The reluctance of many nurses to see a direct link between CSA and emotional harm in the victim is interesting and should be analysed through further research. One can only speculate as to what the reasons for this point of view are. It is possible that confrontation

with this aspect of CSA could be too frightening if the nurse her/himself has been the victim of CSA. It could also be the case that the nurses are showing signs of a 'burnt-out-syndrome' so often seen in health workers who are overwhelmed by too much work and too much misery.

What should we do about it? (Tasks)

Apart from the medical care health workers should offer to the victims, such as suturing and treating STDs, the two main fields seen where the health worker should have a role were education and encouragement.

- *Encourage parents to engage in sex education*
- *Encourage the family of the victim to report the case to the police*
- *Generally encourage the victims to engage in normal life as soon as possible*
- *Encourage the victims to take part in social events*
- *Educate the victims and the victim's parents about CSA*
- *Educate the community about CSA*
- *Educate and influence policy makers and traditional leaders about CSA*
- *Educate traditional healers about CSA and their role in it*
- *Referring to social worker and/or spiritual workers*
- *Give support to the child and remove her feelings of guilt*

There was a feeling in all groups that ideally the following tasks are also part of the health workers' role, but that (s)he is not equipped with enough skills and knowledge to carry out those tasks:

- *Counseling of victims*
- *Counseling of parents and families of the victims*
- *Specifically counseling fathers!!*
- *Counseling perpetrators*
- *'Treat' the victims*
- *Counseling of health workers*

Most of the discussion around the tasks of the healthworkers had a feel of 'learned response'. While all focus group members felt, for instance, they should try to influence policy makers and traditional leaders, they said so with a big sigh of hopelessness and the feeling that this is an illusion anyway.

These results were then incorporated in the questionnaire¹.

Quantitative Phase

Two hundred and thirty questionnaires were distributed to all categories of health workers throughout the entire Onandjokwe hospital. Health workers who were unlikely to see potential victims of CSA, such as, colleagues distributing medications in the pharmacy, were not asked to fill out a questionnaire.

Of the distributed 230 questionnaires, 189 (82.2%) were returned, of which 3 (1.6%) were unsuitable for analysis, which left us with 186 forms for further analysis.

No form was filled in completely. This fact will be indicated by question marks whenever appropriate.

Data on Respondents' Characteristics

The basic demographic characteristics of the respondents are summarized in table 2. Most respondents are female, have more than two children and are experienced.

Table 2 Characteristics of Respondents

Table 2					
Sex		Female		Male	Total
		145 (78.0%)		34 (18.3%)	179 (96.3%)
Age	< 30 y	30 - 39 y	40 - 49 y	> 50 y	Total
	12 (6.5%)	64 (34.4%)	62 (33.3%)	32 (17.2%)	170 (91.4%)
Experience	< 5 y	6 - 10 y	11 - 15 y	> 16 y	Total
	8 (4.3%)	38 (20.4%)	23 (12.4%)	45 (24.2%)	122 (61.3%)
Students		Yes		No	Total
		52 (27.9%)		130 (69.9%)	182 (97.5%)
Children	None	1	2	>2	Total
	18 (9.7%)	24 (12.9%)	36 (19.3%)	106 (57.0%)	184 (98.9%)
Characteristics of respondents					

Table 3 illustrates the background of the respondents. Only about six percent of the nurses have actually been raised outside the North of Namibia.

Table 3 Background of Respondents

Table 3					
Born	A North		B Namibia	C Abroad	Totals
	155 (83.3%)		6 (3.2%)	21 (11.3%)	182 (97.8%)
<i>Of whom Raised</i>	A	B	C	B	C
	146 94.2	2 1.3	7 4.5	6 100	21 100
Raised	A North		B Namibia	C Abroad	Totals
	146 (78.5%)		8 (4.3%)	28 (15.1%)	182 (97.8%)
Background of respondents					

The qualifications or training of the health workers and their duty stations within the hospital are shown in table 4. Most respondents were nurses.

Table 4 Qualifications and Workplace of Respondents

Table 4										
Type	CLE	TEC	PHY	SOC	NA	EN	RM	RN	DR	?
	1 (0.5)	12 (6.5)	2 (1.1)	2 (1.1)	17 (9.1)	71 (38.2)	4 (2.2)	56 (30.1)	17 (9.1)	4 (2.2)
T's	Paramedics		Nurses			Doctors		?		
	17 (9.1%)		148 (79.6%)			17 (9.1%)		4 (2.2%)		
Place	Admin		Lab	Others		OPD	IP		?	
	4 (2.2%)		12 (6.5%)	17 (9.1%)		94 (50.5%)	51 (27.4%)		8 (4.3%)	
Qualifications and workplace										

CLE: clerk; TEC: technician; PHY: physiotherapist; SOC: social worker; NA: nursing assistant; EN: enrolled nurse; RM: registered midwife; RN: registered nurse; DR: doctor; Admin: administration; Lab: laboratory; OPD: out-patient-department; IP: in-patient (departments)

Tables 2 to 4 show several characteristics of the group of respondents. In the following analysis of data some of these characteristics will be compared to answers given in the questionnaire.

Respondents' Answers to the Statements on the 5-scale Questions

Table 26 is a summary of all the answers given on the 5-scale questions, part B, of the questionnaire. This is the basis of all findings presented here and forms appendix 3².

The 70 questions of part B relate to the five broad themes elaborated during the qualitative phase of the study: 1st Definition, 2nd

Epidemiology, 3rd Explanation, 4th Impact and 5th Tasks. Distributing the questions according to themes is a bit arbitrary and therefore the distribution is presented here in detail. Opinion items on the various themes are summarized in table 5.

The five point scale used for the knowledge, belief and opinion items, was converted into an 'agree/disagree' two category scale for purposes of analysis. This was done because preliminary analysis showed that responses clustered at either end of the 5-point scale rendering this more sensitive measure largely redundant for the purpose of this descriptive study.

Table 5 Knowledge and Opinion Items

Table 5		
Theme	Total	Questions
Definition	17	2-3-4-5-6-7-10-12-13-14-15-16-17-18-19-37-39
Epidemiology	9	8-20-21-24-28-30-43-46-63
Impact	12	1-11-22-41-42-44-45-47-49-51-52-53
Tasks	15	55-56-57-58-59-60-61-62-64-65-66-67-68-69-70
Totals	70	
<i>Knowledge and Opinion Items</i>		

Knowledge and Opinion Items

Table 5 shows the items used to test current knowledge and opinion and sometimes estimates, when it comes to epidemiology for instance. A response to an item was regarded as 'correct' when the respondent answered in accordance with established findings and the predominant opinion in the literature regarding the item in question. For instance opinion item 6: *'It is almost always also the fault of the child when (s)he is sexually abused'*. This 'opinion' is not correct in the sense that most authorities would not agree to this statement even if the child would have 'seduced' the perpetrator. Therefore, a respondent who indicated agreement with the statement would be coded as giving an incorrect response. A further example is item 21: *'Most perpetrators are not likely to be known to the child'*. This statement is incorrect, and a respondent who recorded disagreement with the statement would be coded as giving a correct response. Most epidemiological studies show that the majority of perpetrators are known to the child.

The overall knowledge analysis, based on what is current knowledge and/or current opinion as expressed in the literature, is shown in table 6. Table 6 shows a summary of the answers to the opinion item.

As stated in the literature discussion, it is clear that much is not known and some so-called 'established facts' might well not stand the test of further research.

Table 6 Answers to Knowledge and Opinion Items

Table 6		
Theme	Number of items per theme	% Giving correct answer
Definition	6	54.5%
Epidemiology	2	66.6%
Impact	4	50%
Tasks	2	100%
Totals 24	14	58.4%
<i>Answers to Knowledge and Opinion items</i>		

The overall answers suggest that in most cases there was relatively poor knowledge. Further analysis of the generally poor answers shows indifferences between the professional groups. All professional groups are summarized to three professional groups as shown in table 4, and only themes are shown. This presentation allows for clear presentation but hides the differences in each question. A substantial number of answers in each professional group were incorrect, even if the majority of answers were correct.

All answers given by all members of the three professional groups were collected for each theme and then the percentage of correct and incorrect answers calculated as shown in table 7.

Table 7 Answers to Knowledge and Opinion Questions per Professional Group

Table 7			
Theme	Correct answer %		
	Para-medics	Nurses	Doctors
Definition	42.8	37.3	71.7
Epid.	70.6	61.7	90.2
Impact	47.8	45.0	61.8
Tasks	76.5	76.0	79.4
Totals	59.4	55.0	75.8
<i>Percentage of correct and incorrect answers per theme per professional group</i>			

Since it is difficult and to a certain extent irrelevant to collect and present all possible opinions on all aspects of CSA, the following presentation was chosen to illustrate the most striking findings.

Definition

One third (33.3%) of all respondents were of the opinion that the private parts of children are not as private as those of adults.

More than a quarter (26.8%) thought that it is also the fault of the child when (s)he is sexually abused.

Three quarters (75.9%) think that children have the right to protect themselves against unwanted contact, even if that contact is with their parents.

Epidemiology

The vast majority of respondents (71.2%) believe that CSA is in fact a problem in Onandjokwe District.

Almost half of the respondents (41.3%) do not believe that victims of CSA have friends they could talk to about the abuse.

More than one third (38.7%) believe that parents expect their child to be sexually abused during childhood.

More than half (56.4%) think that the word of a child is less reliable than that of an adult.

Explanation

While only a minority of 21.7% of respondents feel that the rights of adults are more important than those of children, the vast majority (80.4%) believes that children are the property of their parents and that children must always obey (71.5%).

Slightly more than half of the respondents are of the opinion that most parents are fairly careless concerning child minding (56.9%) are unaware of the problem of CSA (60.3%) and that foster parents feel less responsible towards their foster children as compared to their own children (51.6%).

Poor housing (82.3%) and lack of recreational facilities in the district (57.7%) and alcohol abuse (69.0%) were all seen as contributing factors.

Fear of contracting AIDS and 'cures' prescribed by traditional healers are seen as being important reasons for CSA by 55.9% and 59.8% of respondents respectively.

Impact

More than two thirds of respondents thought that CSA leads to loss of values in the child (86.7%), alcohol abuse of the child (79.1%) and that the abuse of a girl would decrease her chances to get married if the abuse is known (68.4%).

Only 5.9% feel that a sexually abused child actually enjoys the sex.

Tasks

A high proportion of the sample (82.5%) are of the opinion that the victims of CSA have to be counseled by the health worker; while 37.3% feel the health worker should attend to the physical side of the abuse only.

Approximately two thirds of the respondents (69.0%) think the health worker should report the abuse to the police.

More than ninety percent of respondents (91.6%) feel that perpetrators of CSA have to be counseled and 75.2% think that should be done by the health workers.

Health education focussing on CSA is seen as an important task of health workers. A vast majority of respondents are of the opinion that health workers have the task to educate parents and care givers on CSA (91.0%) and traditional healers (73.5%). A significant proportion (62.1%) feel health workers should actively encourage parents to engage in sex education of their children.

Most respondents (58.1%) think health workers have the task to also try and influence policy makers in order to improve services offered to victims of CSA. A need for stronger ties in the community to improve childcare is felt by 75.4% and it is felt by 76.4% that the church should actively look into ways to serve victims of CSA.

While 53.3% of respondents say health workers possess enough skills and knowledge to serve children especially, 74.9% also feel the need to get additional training concerning CSA. This seems to support the findings reported earlier of the relatively low level of knowledge concerning the problem of CSA.

Special Aspects of the Opinion Items

Leaving the themes and turning to an examination of other aspects of the opinion items the following picture emerges. Under each heading the opinions are expressed together with the percentage for each statement.

Children

- Children are the property of their parents (80.4%)
- Children have always to obey adults (71.5%)
- Children have no sexual desires (59.7%)
- The word of a child is less reliable than that of an adult (56.4%)
- Adults will believe a child claiming to be sexually abused (75.3%)
- Children have the right to protect themselves against unwanted contact with an adult (75.9%)
- Rights of children are as important as the rights of adults (71.4%)
- The private parts of children are as private as those of adults (57.5%)
- Abused children live in fear and shame (90.8%)
- Most children have no friends to talk about their abuse (41.3%)

Perpetrators

- Both men and women can abuse children (54.6%)
- Most perpetrators are not known to the child (59.3%)
- A man who has abused a child is looked down upon (85.8%)
- Many men seduce children to protect themselves against AIDS (55.9%)

Parents

- Most parents are careless when it comes to child minding (56.9%)
- Parents are unaware of the problem of CSA (60.3%)
- Most parents do not expect their children to be abused at some stage in life (40.9%)
- Foster parents feel less responsible towards their foster children than towards their biological children (51.6%)

Traditional healers

- Many traditional healers 'prescribe' sex with a child (59.8%)
- Most traditional healers are aware of the problem of CSA (38.8%)

Respondents' Answers to the Un-scaled Questions of the Questionnaire

Age at which a person can give consent for sexual intercourse

Table 8 indicates the age at which a person can consent to sexual intercourse. A very high proportion (83.0%) of respondents feel that consent for sexual intercourse can only be given when a person is 18 years or older.

Table 8 Age for Consent

Table 8											
Age	?	10	11	12	13	14	15	16	17	18	>18
	8	1	1	2	-	4	4	8	3	40	111
%	4.4	0.5	0.5	1.1	-	2.2	2.2	4.4	1.6	22.0	61.0
<i>Age at which consent for sexual intercourse can be given</i>											

Childhood

Table 9 indicates the age at which respondents believed childhood ended. More than 80% of respondents feel that childhood ends at the age of 18 years or above.

Table 9 End of Childhood

Table 9										
Age	?	11	12	13	14	15	16	17	18	>18
	6	7	4	2	2	5	3	6	82	69
%	3.2	3.8	2.2	1.1	1.1	2.7	1.6	3.2	44.1	37.1
<i>Age at which childhood ends</i>										

Estimates of abuse

Table 10 summarizes the estimates given by health professionals concerning the number of abused children and the adults who abuse them in Northern Namibia. More than a quarter of respondents felt that more than 80% of all children were sexually abused and more than 80% of all men do sexually abuse children!

not know. Table 13 indicates that half of all health workers felt that only half of the health workers could diagnose CSA correctly.

Table 13 Health Worker's Competence

Table 13											
%	?	<5	10	20	30	40	50	60	70	80	>80
Detection of CSA	23	21	31	16	12	5	17	8	9	6	38
	12.4	11.3	16.6	8.6	6.5	4.3	9.1	4.3	4.8	3.2	20.4
<i>Estimated ability of health professionals to detect CSA correctly</i>											

Perceived timeframe of the problem of CSA, alcohol abuse and AIDS

Health workers were asked within which time frame the three problems, CSA, alcohol abuse and AIDS developed in Onandjokwe. Table 14 shows the answers. Most respondents felt that all three problems existed or increased over the past ten years.

Table 14 Time Frame of Problems

Table 14								
Years	?	No	1	5	10	20	50	>50
CSA	16	3	1	46	92	21	13	No option
	8.3	1.6	0.5	24.0	47.9	10.9	6.8	
Alcohol abuse	18	10	5	17	65	44	8	19
	9.7	5.4	2.7	9.1	34.9	23.7	4.3	10.2
AIDS	8	-	3	32	114	24	5	No option
	4.3		1.6	17.2	61.3	12.9	2.7	
<i>Time since when the problem exists or is increasing</i>								

Most important reasons for CSA

Table 15 indicates the reasons for CSA as seen by the respondents. Alcohol abuse, loss of traditional values and fear of AIDS were named as the top three reasons for CSA.

Table 10 Estimated Magnitude of CSA

Table 10											
%	?	<5	10	20	30	40	50	60	70	80	>80
Children abused	9 4.8	15 8.1	37 19.8	18 9.7	10 5.4	8 4.3	18 9.7	9 4.8	6 3.2	8 4.3	48 25.8
Abusive men	13 7.0	19 10.2	27 14.5	22 11.8	6 3.2	9 4.8	15 8.1	11 5.9	7 3.8	9 4.8	48 25.8
Abusive women	22 11.8	82 44.1	28 15.1	10 5.4	7 3.8	8 4.3	6 3.2	-	3 1.6	4 2.2	16 8.6
<i>Estimated abuse in percent of children, by men and by women</i>											

Estimates of abused children seen by health professionals in their professional and their private lives are shown in tables 11 and 12. Only about 10% of health workers do not see a single case of CSA per month. Almost half of the health workers knew more than ten sexually abused children in the community.

Table 11 Victims of CSA seen in Hospital

Table 11						
CSA/month	?	0	1	2	3	>3
Number of respondents	4	18	24	34	23	83
% of respondents	2.2	9.7	12.9	18.3	12.4	44.6
<i>Number of sexually abused children seen per month at the hospital</i>						

Table 12 Victims of CSA 'seen' at Home

Table 12							
Cases of CSA	?	0	1	2	3	>5	>10
Number of respondents	14	5	5	15	19	36	92
% of respondents	7.5	2.7	2.7	8.1	10.2	19.4	49.5
<i>Number of sexually abused children known to health workers in their private lives</i>							

Professional competence concerning CSA

The vast majority of respondents (83.9%) feel that they are 'in need of further training' or not competent when it comes to CSA. Only 8.6% feel that they are competent to deal with this problem, while 7.5% do

Table 15 Causes of CSA

Table 15			
Ranking	Reason	No	%
1 st	Alcohol abuse	124	66.6
2 nd	Loss of traditional values	84	45.2
3 rd	Fear of AIDS	62	33.3
4 th	Cure for AIDS	56	30.1
5 th	Breakup of the family	44	23.7
6 th	System of foster parenting	24	12.9
7 th	?	7	3.8
Ranking of causes for CSA			

Most important perceived consequences of CSA for the child

In table 16 the consequences as perceived by the health workers are indicated. Depression, suicidal tendencies, mental illness and prostitution are all perceived as being a consequence of CSA by more than half the respondents.

Table 16 Perceived Consequences of CSA

Table 16			
Ranking	Consequence	No	%
1 st	Depression	111	59.7
1 st	Suicidal tendencies	111	59.7
3 rd	Mental illness	108	58.1
4 th	Prostitution	104	55.9
5 th	Poor academic performance	91	48.9
6 th	Hatred for the opposite gender	76	40.9
7 th	Social isolation	74	39.8
8 th	Aversion against sex	63	33.9
9 th	Inability to trust	60	32.3
10 th	Homosexuality	58	31.2
11 th	?	6	3.2
Ranking of perceived consequences of CSA for the victim			

Further Analysis of Data

With the exception of the opinion items, all findings have so far been presented for all respondents together. In the following section findings of selected issues will be presented for certain sub-groups of respondents.

Age at which consent for sexual intercourse can be given

As shown in table 17 only a small minority of respondents felt consent for sexual intercourse could be given at an age below 14 years. Figure 4 visualises the responses according to gender and professional category of the respondents.

Table 17 Age for Consent further Analysis

Table17											
Age	?	10	11	12	13	14	15	16	17	18	>18
all	4.4	0.5	0.5	1.1	-	2.2	2.2	4.4	1.6	22.0	61.0
♂	-	2.9	2.9	-	-	5.9	5.9	8.8	2.9	38.2	32.4
♀	5.6	-	-	1.4	-	1.4	1.4	2.8	1.4	16.6	69.4
Dr	-	-	-	-	-	5.9	5.9	23.5	5.9	35.3	23.5
Nurse	5.4	-	0.7	1.4	-	1.4	1.4	1.4	0.7	21.0	66.9
PM	-	5.9	-	-	-	5.9	5.9	11.8	5.9	17.6	47.1
'N'	5.3	0.6	0.6	1.3	-	1.3	2.0	2.0	1.3	19.3	66.0
Nam	-	-	-	-	-	-	-	12.5	-	12.5	75.0
Alien	-	-	-	-	-	7.1	3.6	14.3	3.6	35.7	35.7

Age when consent for sexual intercourse can be given by respondents gender, professional group and place of upbringing in percent

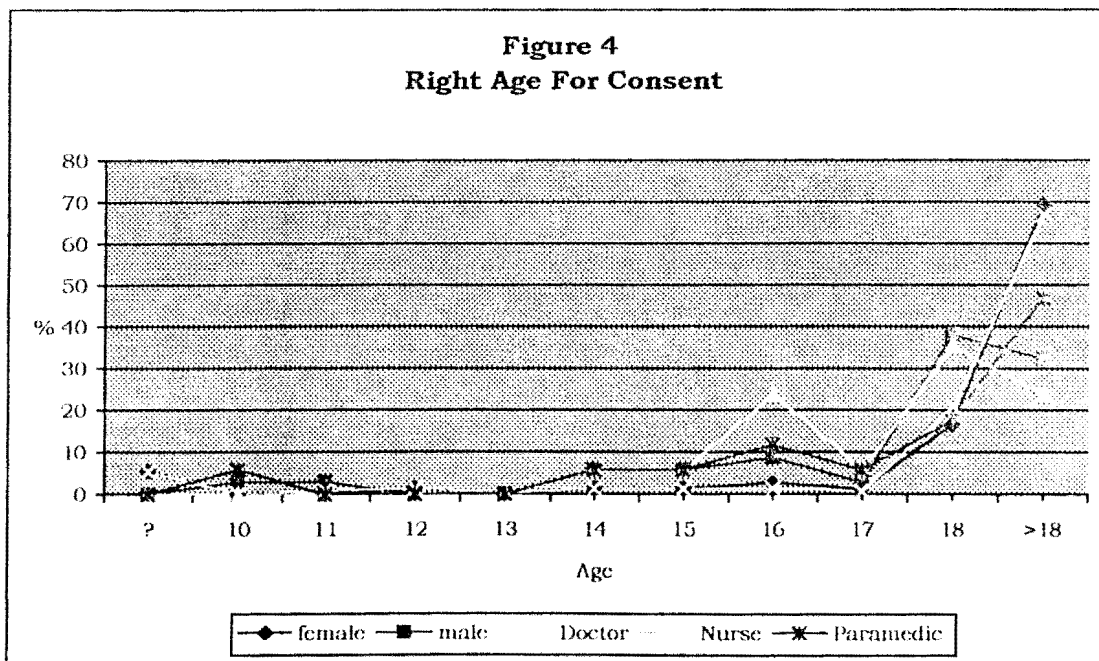


Figure 4 Right Age For Consent

Age at which childhood ends

Further analysis of the responses to the inquiry into the end of childhood is shown in table 18. More than 10% of the doctors felt that childhood ends at age 16.

Table 18 End of Childhood further Analysis

Table18											
Age	?	10	11	12	13	14	15	16	17	18	>18
all	3.2	-	3.8	2.2	1.1	1.1	2.7	1.6	3.2	44.1	37.1
♂	2.9	-	2.9	-	2.9	-	2.9	5.9	2.9	64.7	14.7
♀	3.5	-	4.2	2.8	0.7	1.4	4.2	0.7	4.2	39.6	41.6
Dr	-	-	-	-	-	5.9	-	11.8	5.9	58.8	17.6
Nurse	3.4	-	4.7	2.7	0.7	0.7	2.7	0.7	2.7	39.9	41.9
PM	5.9	-	-	-	5.9	-	5.9	-	5.9	58.8	17.6
'N'	4.5	-	5.2	2.2	0.7	-	3.7	-	2.2	44.0	37.3
Nam	-	-	-	-	-	-	-	16.6	-	33.3	50.0
Allen	-	-	-	-	3.8	3.8	-	7.7	3.8	50.0	30.8
Age at which childhood ends by respondents gender, professional group and place of upbringing in percent											

Estimates of abuse

The following three tables (tables 19–21) show the estimates of the magnitude of CSA, committed by men and women. Each table shows the estimates by gender, professional group and place of upbringing of the respondent.

The tables are then followed by some graphs highlighting special aspects of the comparison.

Table 19 Estimated Magnitude of CSA further Analysis

Table 19											
%	?	<5	10	20	30	40	50	60	70	80	>80
Abused children	4.8	8.1	19.8	9.7	5.4	4.3	9.7	4.8	3.2	4.3	25.8
♂	2.9	14.7	41.2	8.8	11.8	-	2.9	5.9	-	-	11.8
♀	5.6	6.3	15.3	9.0	3.5	4.9	11.8	4.9	4.2	5.6	29.2
Dr	-	11.8	41.2	11.8	5.9	-	5.9	17.6	-	-	5.9
Nurse	5.4	6.8	16.2	10.1	4.7	5.4	10.8	2.7	4.1	4.7	29.1
PM	5.9	17.6	23.5	5.9	11.8	-	-	11.8	-	5.9	17.6
'N'	6.0	7.5	16.4	9.7	4.5	5.2	11.9	4.5	3.7	4.5	26.1
Nam	-	-	16.6	16.6	-	-	-	-	-	16.6	50.0
Allen	3.8	7.7	30.8	7.7	15.4	3.8	7.7	11.5	-	-	11.5
Estimated abuse of children in percent by respondents gender, professional group and place of upbringing in percent											

Table 20 Estimated Abuse through Men

Table 20											
%	?	<5	10	20	30	40	50	60	70	80	>80
Abusive men	7.0	10.2	14.5	11.8	3.2	4.8	8.1	5.9	3.8	4.8	25.8
♂	2.9	26.5	26.5	14.7	8.8	5.9	5.9	-	-	-	8.8
♀	7.6	6.9	11.8	9.7	2.1	4.9	9.0	7.6	4.9	6.3	29.2
Dr	-	35.3	23.5	17.6	-	-	11.8	5.9	-	-	5.9
Nurse	6.8	6.1	12.8	12.8	2.7	6.1	7.4	6.1	4.1	6.1	29.1
PM	11.8	23.5	17.6	-	11.8	-	5.9	5.9	5.9	-	17.6
'N'	8.2	7.5	13.4	11.2	3.0	5.2	9.0	6.7	5.2	5.2	25.4
Nam	-	-	-	-	-	-	16.6	16.6	-	-	66.6
Alien	3.8	30.8	15.4	15.4	3.8	7.7	7.7	3.8	-	-	11.5
<i>Estimated abuse by men in percent by respondents gender, professional group and place of upbringing in percent</i>											

Table 21 Estimated Abuse through Women

Table 21											
%	?	<5	10	20	30	40	50	60	70	80	>80
Abusive women	11.8	44.1	15.1	5.4	3.8	4.3	3.2	-	1.6	2.2	8.6
♂	8.8	44.1	23.5	5.9	5.9	5.9	-	-	-	2.9	2.9
♀	13.2	43.8	13.9	4.9	3.5	2.8	4.2	-	2.1	2.1	9.7
Dr	5.9	52.9	17.6	-	11.8	5.9	5.9	-	-	-	-
Nurse	11.5	43.2	16.2	6.1	2.7	4.1	2.7	-	2.0	2.0	9.5
PM	11.8	52.9	5.9	5.9	5.9	5.9	5.9	-	-	-	5.9
'N'	11.9	47.0	11.2	6.7	3.0	3.7	3.0	-	1.5	2.2	9.7
Nam	16.6	33.3	16.6	-	-	-	-	-	16.6	-	-
Alien	8.8	44.1	8.8	-	8.8	8.8	2.9	-	-	-	-
<i>Estimated abuse by women in percent by respondents gender, professional group and place of upbringing in percent</i>											

The following three graphs (figure 5 – 7) show the comparisons and illustrate that there is some disagreement when it comes to estimating the magnitude of CSA and the attribution of it to male perpetrators. There is much agreement when it comes to female perpetrators.

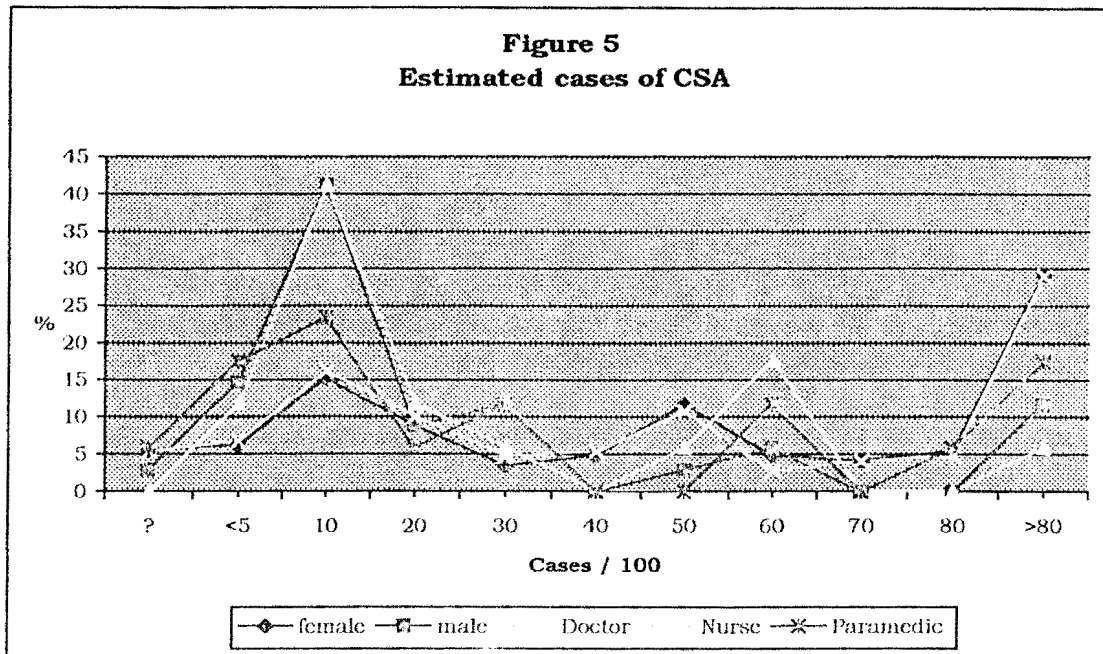


Figure 5 Estimated Cases of CSA

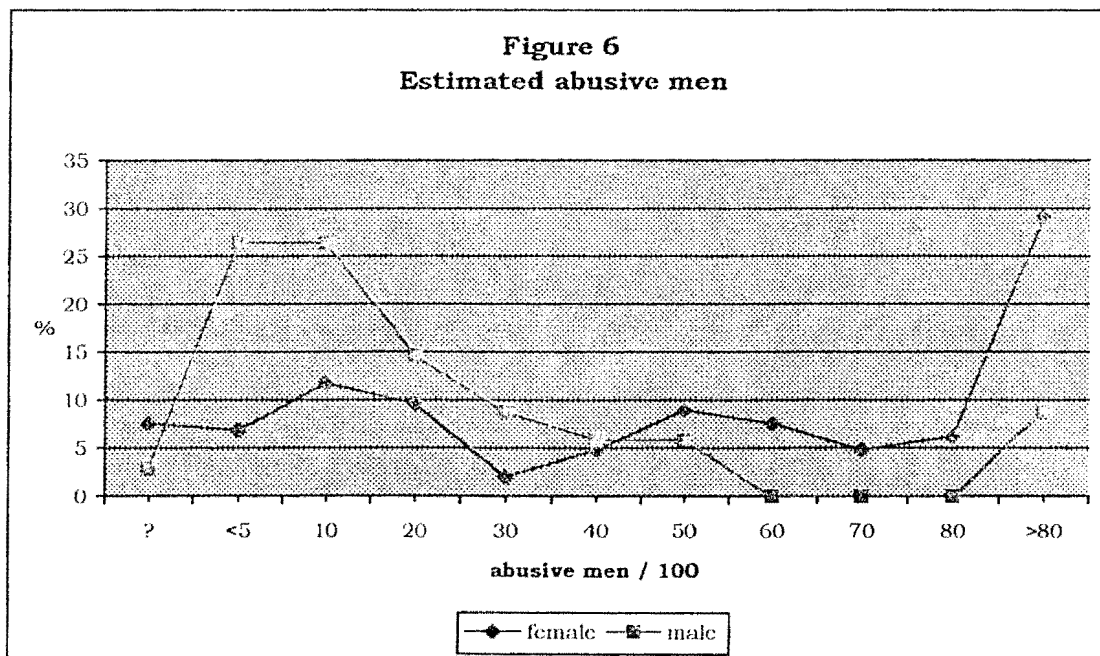


Figure 6 Estimated Abusive Men

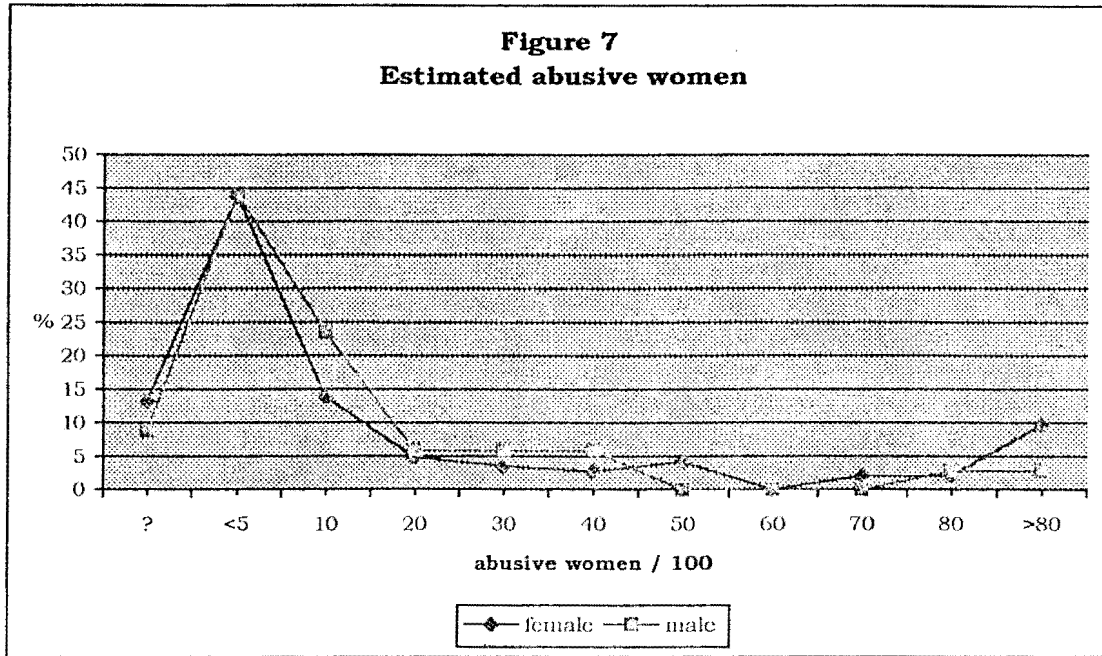


Figure 7 Estimated Abusive Women

Personal competence and experience in handling the problem of CSA

The following four tables (tables 22-25) show the personal professional and non-professional experience of CSA, plus the estimated own competence and the estimated competence of all health workers in dealing with the problem of CSA. Each table shows the estimates by gender, professional group and place of upbringing of the respondent or only part of these if relevant.

The tables are then followed by some graphs highlighting special aspects of the comparison.

As indicated in table 22 paramedics saw most victims of CSA per month.

Table 22 Victims of CSA seen per Month

Table 22						
CSA victims per month at work	?	0	1	2	3	>3
Doctors	-	23.5	29.4	5.9	5.9	35.3
Nurses	3.4	6.8	12.2	20.3	13.5	43.9
Paramedics	-	11.8	5.9	11.8	11.8	58.8
<i>Children seen per month in percent</i>						

Table 23 shows that more than half of the health workers from the area know more than 10 victims of CSA in the community.

Table 23 Victims of CSA Known to Health Worker outside Work

Table 23							
CSA victims known outside work	?	0	1	2	3	>5	>10
Doctors	-	23.5	11.8	5.9	11.8	17.6	29.4
Nurses	2.7	6.1	1.4	8.8	10.1	19.6	51.4
Paramedics	-	17.6	5.9	5.9	5.9	11.8	52.9
'North'	3.0	4.5	2.2	9.7	8.2	19.4	53.0
Namibia	-	-	-	-	-	33.3	66.6
Alien	-	30.8	7.7	7.7	15.4	15.4	23.1
<i>Children known to be victims of CSA outside of work in percent by professional group and place of up-bringing</i>							

As indicated in table 24 doctors were most confident when it came to feelings of own competence concerning CSA.

Table 24 Feelings of Competence

Table 24				
Feeling	?	Competent	In-competent	In need of training
Doctors	-	23.5	17.6	58.8
Nurses	8.8	7.4	9.5	74.3
Paramedics	5.9	5.9	11.8	76.5
<i>Feelings concerning own competence by professional group in percent</i>				

As shown in table 25 nurses had most trust in health worker's competence.

Table 25 Competence by Professional Group

Table 25											
%	?	<5	10	20	30	40	50	60	70	80	>80
Dr	-	17.6	35.3	11.8	11.8	-	11.8	-	-	-	11.8
Nurse	14.2	9.5	14.2	8.1	6.8	3.4	8.8	4.7	5.4	2.4	21.6
PM	11.8	11.8	23.5	11.8	-	-	5.9	5.9	5.9	5.9	17.6
<i>Estimated competence of health workers concerning CSA in percent by professional group</i>											

The following three graphs (figure 8 - 10) show the comparisons and illustrate that there is most disagreement within the professional groups within the professional groups between doctors and nurses, with paramedics being in between.

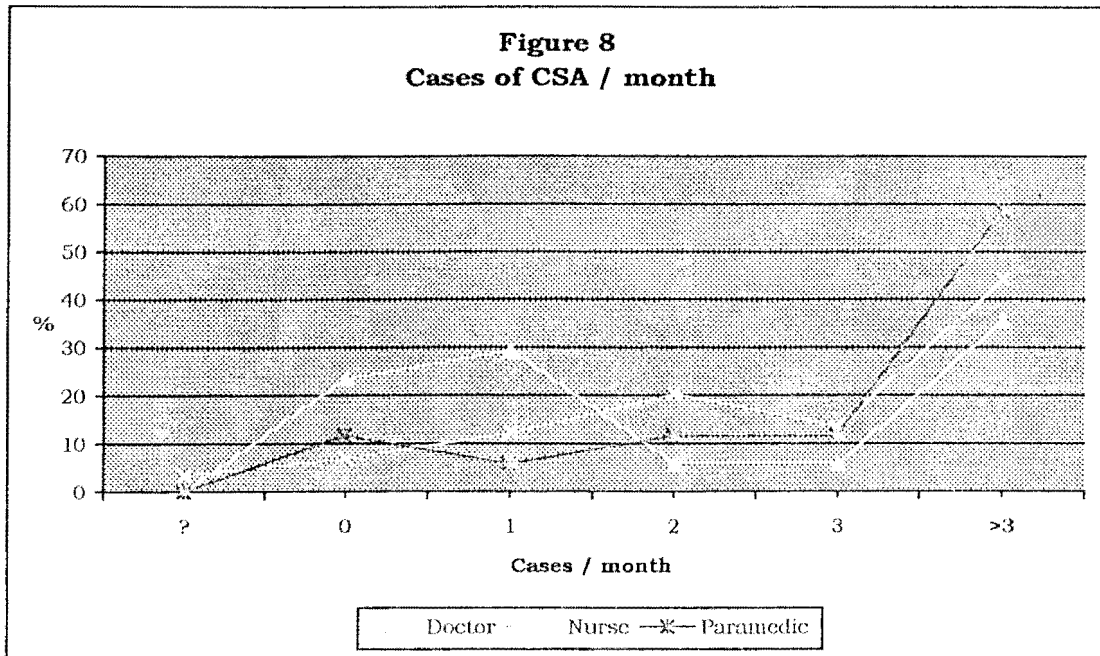


Figure 8 Cases of CSA per Month

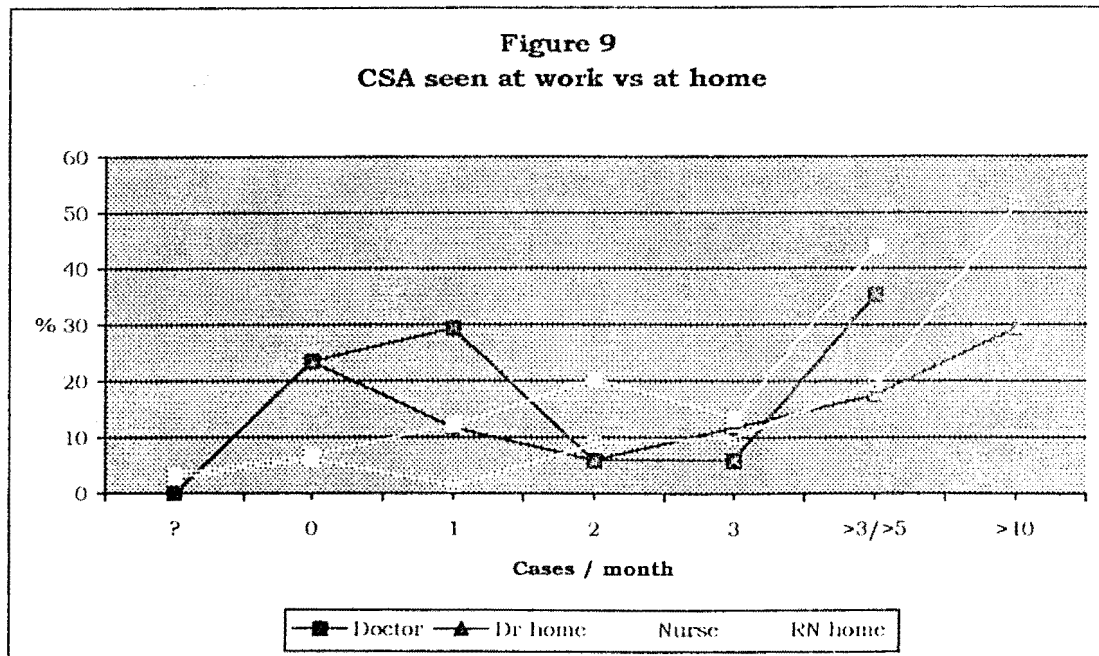


Figure 9 Cases of CSA seen at Work vs at Home

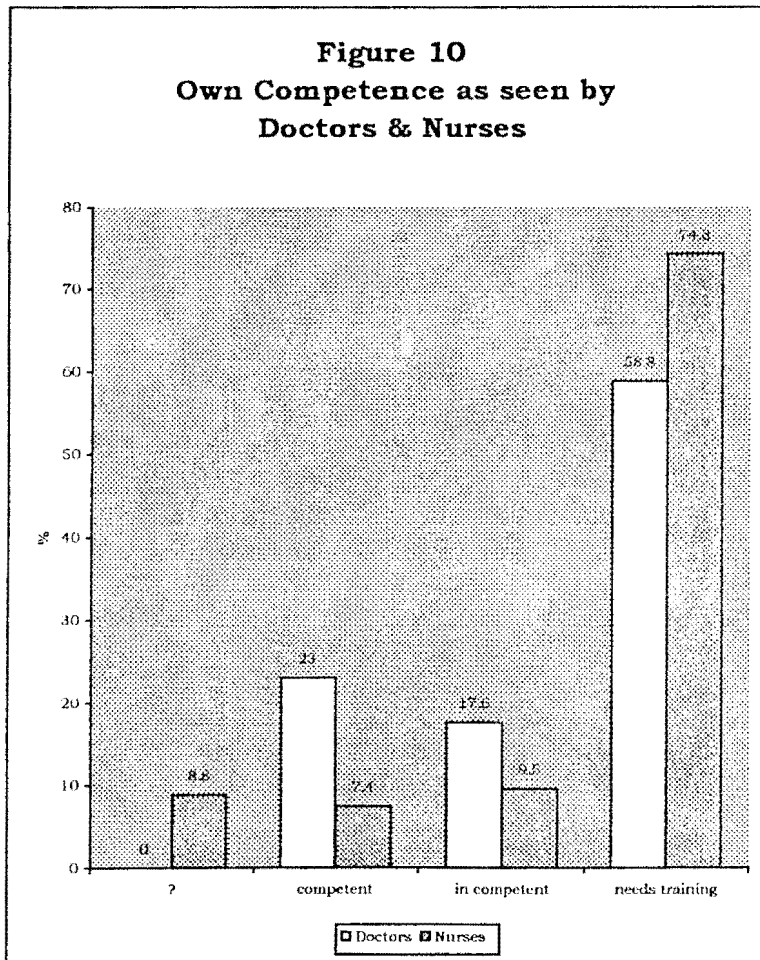


Figure 10 Own Competence of Health Workers

The findings presented in this chapter are the basis from which the discussion of the following chapter departs.

Problems and Limitations of the Study

Much has been written on the cross-cultural problems of defining and researching sexual abuse of children^{3,4}. The dangers of cross-cultural research lies mainly in the fact that cultural values of the researcher

could be imposed in a different situation, the situation of the researched person. What might be seen as sexual abuse in one country might not be seen as such in another and vice versa.

The debate on 'cultural imperialism' is ongoing and difficult. What it mainly entails is again imposing foreign cultural values on and in a different cultural environment. Since culture is both difficult to define and in constant flow and changing, this debate is prone to continue to be ongoing indefinitely. The main point for this study concerning 'cultural imperialism', is the awareness of it and the knowledge of its possible influence on the study results. The focus group discussions should also be seen as an attempt to look for issues foreign to the researcher, such as the idea that the psychological effect(s) of CSA on the child in question are directly related to the initial physical effect(s).

When looking at the lists given in the previous chapter on established facts, it is obvious that symptoms such as prostitution, low self esteem, depression or even anorexia are definitely not as well defined as one would hope. They are all coloured through the culture in which the person who uses them lives⁵.

It seems however that the concept of child sexual abuse is a universal one⁶. This study might never the less have suffered from misunderstandings arising from different (cultural) understandings of words used in the questionnaire.

Another closely related problem might have been the translation of the questionnaire. While both translators could reach full agreement when discussing their versions of the questionnaire, and also most respondents said to have understood the questions, some doubts remain. The main problem being the fact that there seems to be a scarcity of 'acceptable' words for sexually explicit terms in Ndonga^{7,8}.

Lack of recording equipment during the focus group discussions and the fact that there was just one researcher was another problem. All notes were taken by hand during the sessions. It is obvious that this could have led to loss of data⁹.

¹ Appendix 1

² Appendix 3

³ Korbin JE (Ed). (1981) Child Abuse & Neglect. Cross-cultural Perspectives. University of California Press, Berkley and Los Angeles

⁴ Levett A. (1994) Problems of cultural imperialism in the study of child sexual abuse. In: Dawes A, Donald D (Eds). Childhood & Adversity: Psychological perspectives from South African research. David Philip, Cape Town

⁵ Howard GS. (1991) Culture tales: A narrative approach to thinking, cross-cultural psychology and psychotherapy. *American Psychologist*, 46(3), 187-197

⁶ Demause L. (1991) The universality of incest. *Journal of Psychohistory*, 19(2), 123-164

⁷ Pirronen TE. (1986) Ndonga - English Dictionary. ELOC Printing Press, Oniipa

⁸ ELCIN Church Council Special Committee. (1996) English - Ndonga Dictionary. ELCIN Printing Press, Oniipa

9 Skinner D, van der Walt H. (1997) Qualitative Methodology: An Introduction. In: Katzenellenbogen JM, Joubert G, Abdool Karim SS (Eds). *Epidemiology. A Manual for South Africa*. Oxford University Press Southern Africa, Cape Town

Discussion

Qualitative Phase 'versus' Quantitative Phase

Since the qualitative phase was the requirement for the quantitative phase and the basis for the questionnaire, this phase of the study will be discussed alongside the quantitative results. There will therefore be no separate discussion of each of the phases of the study.

The overall Picture

This discussion is limited to the findings presented in the previous chapter in an attempt to answer the questions set out under specific objectives for this study. The wealth of data would allow for much more analysis than is possible here given the limits of this dissertation. All interested persons will be able to look at many other aspects by using table 26 in the appendix¹.

The vast majority of health workers agreed on the definition of CSA.

The quite clear opinion that the 'right' age at which a person is able to give consent for sexual intercourse is 18 years or over is surprising. This opinion was shared by all professional groups and by people from different backgrounds. The same is true when it comes to defining the end of childhood, which was generally seen to come when a person reaches the age of 18 years or more. This is also in stark contrast with the legal and 'obstetric' situation in Namibia.

'Under the existing Namibian law on rape, girls are considered to be able to give (...) consent to sexual intercourse at age 12. (...) boys are considered able to give (...) consent at age 7². This was the legal situation in Namibia at the time of conducting this study. In the meantime³ the law on rape has changed and a person, male and female, is considered to be able to give consent for sexual intercourse at age 14⁴. According to data available at Onandjokwe 1.9% of expecting mothers visiting ANC are younger than 16 years and an additional 13.8% of expecting mothers are between 16 and 19 years old⁵.

Determining the end of childhood to be at the same time as when consent for sexual intercourse can be given seems to leave out the concept of adolescence completely. This leads to questions, such as, when are children to learn about becoming adults? When and how is sexual awareness and competence been learned? And what does it

mean when health workers disagree so much with what is actually happening in 'real life'?

The vast majority of health workers are aware of the problem of CSA and feel that this is a huge problem. Both in their estimations of how many children are being abused and in what they themselves see in their private lives and at work, health workers say that CSA is an enormous problem. If more than a quarter of health workers feel that more than 80% of all children are sexually abused, then there clearly must be a problem! If the answers given are correct, then health workers at Onandjokwe see at least a total of 12 to 24 abused children a month or 144 to 288 victims of CSA a year. These numbers are very high if one looks at the numbers of abused children registered as such at Onandjokwe which are no higher than 33 a year for 1998⁶. The difference between these numbers is so big that it is difficult to explain this by reluctance and failure to report, inadequate HIS data or poor answers alone. It might well be that the real magnitude of the problem of CSA has not yet been fully appreciated.

This seems even more likely if the answers to cases of CSA known to health workers in their private lives are anything to go by. Outside their work situation health workers at Onandjokwe know of a total of at least 1000 sexually abused children!

As enormously high as this number seems, it still would be relatively low if the estimated abuse rate by the respondents of 80% of all children were to be true. With an estimated population of 150,000 people in the area⁷, and a conservatively estimated rate of 30% pre-adolescent children, 80% sexually abused children would amount to an astronomical 40,000 children!

If that were in fact the case, it would be likely that health workers would know about many more such children. If the thousand children reported by the health workers were true then that would point towards a 2% rate of CSA in the area.

Given the concerns about the problem of CSA this might mean that health workers over estimate the problem.

Doctors and those raised abroad, which includes almost all doctors, do know of much fewer children who are victims of CSA in their private lives than those health workers raised in 'the North'. This could mean that CSA is more common in this region than elsewhere. It could also mean that non-doctors are living in communities in which they are more likely to encounter CSA.

While all respondents agreed that women are not very commonly those committing CSA, there was not much agreement concerning men. A majority of female respondents felt that 50 - >80% of men are

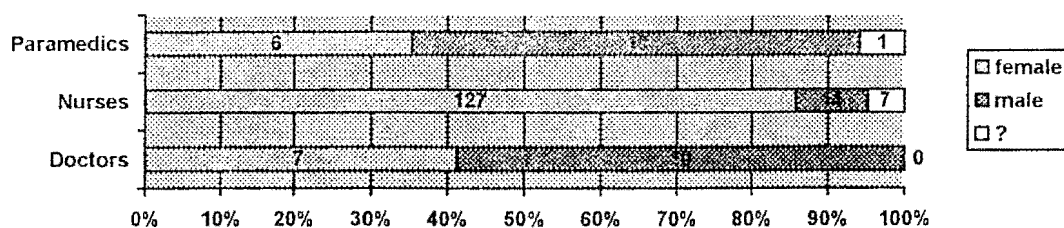
abusing children sexually while a majority of male respondents felt that 'only' <5 – 20% of men are sexually abusing children. The same picture emerges when one compares doctors, nurses and paramedics, (with the latter being somewhere between nurses and doctors). This similarity cannot be explained solely with the fact that more doctors are male than female.

Figure 11 shows the sex distribution within the three different professional groups. This could mean several things. Male respondents might want to 'defend' men, while female respondents might be too 'pessimistic' when it comes to men. Being women they might also be more aware of the 'true picture' since they have been 'at risk' of CSA and might have more access to victims of CSA. The more highly educated might be more conservative in estimating the degree of CSA. Does higher education 'virilize' women? There is a clear difference between male and female responses. The doctors' responses are similar to the male even though the gender distribution within the doctors is almost 1:1. This means that female doctors responded the same way as males (doctors and non-doctors).

The absolute numbers of female respondents are so much higher than the males ($\text{♀}:\text{♂} = 4.1:1$), that the differences could also be attributed to characteristics other than gender.

Figure 11 Sex Distribution in Health Workers Groups

Figure 11 Sex distribution within three professional groups



This possible bias is illustrated in figure 12 where the place of upbringing within each professional group is shown. In comparing figure 11 with figure 12 it becomes clear that the overwhelming majority of respondents are female and also brought up in 'the North' which makes it difficult to attribute responses to either gender or place of upbringing.

Figure 12 Place of upbringing within three professional groups

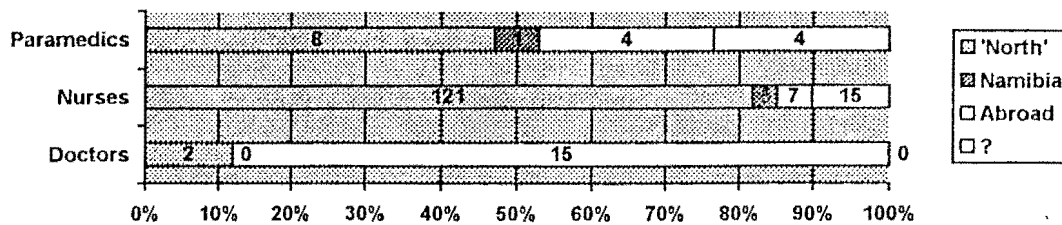


Figure 12 Place of Up-bringing in Health Workers Groups

Looking at the 'top five' reasons given for the incidence of CSA in Onandjokwe (alcohol abuse, loss of traditional values, fear of and cure for AIDS, breakup of the family) it becomes clear that CSA could be seen as a symptom of social distress. One can discuss at length which factor comes first, for example, the breakup of families or the loss of traditional values, or the abuse of alcohol followed by the breakup of families. In order to engage in strategies to prevent the sexual abuse of children, a number of social and personal factors need to be considered, not least the causes of the break down in the local social and cultural fabric.

Knowledge in all professional groups in the hospital survey seems to be lacking when it comes to the possible impact of CSA on the child. The concept of somatisation does not seem to be understood by the health workers. It is also an interesting detail that there was agreement during the qualitative phase of the study that suicide was a rare event in victims of CSA while suicide was seen as being the number one consequence of CSA during the quantitative phase. One of the reasons for this might be that the focus group members were, at least in this regard, not representative of all health workers working at Onandjokwe.

The opinion items as shown in table 5 and subsequent tables, give an indication of the level of knowledge of the health workers. It is important here to point out that this study is exploratory. There is therefore room for further studies to examine the CSA knowledge of health workers in more detail.

If CSA is so very common and many health workers can indeed not see the psychological impact of it for the child, then this raises the possibility that some health workers might be in denial, possibly because of their own abuse.

The health workers see their two main roles as supporting the victims through encouragement and counseling, and education of the

community. It is not easy to see how proper counseling and education can be provided by health workers who lack the necessary knowledge, not to mention the skills.

The health workers in this study are aware of their need to be trained further with over two thirds feeling they need further training. Looking at the opinion item scores, all health workers are in need of such additional training. It is interesting to see that doctors, as compared to nurses, see less victims of CSA, score better on the opinion item questions, feel less need for further training and are less optimistic when assessing the health workers ability to detect victims of CSA. This could mean that doctors do not have much trust in the abilities of the nurses. The fact that more doctors than any other group feel incompetent when it comes to CSA and yet feel least enthusiasm for further training, might show that doctors may not see this problem as one they should attend to. All these considerations are however relative comparisons; it remains true that the need for further training is very high for all professional groups and felt as such by them.

Paramedics see most victims of CSA, probably due to the fact that they either work in the laboratory examining vaginal swabs of suspected victims or are social workers counseling the children concerned and their families.

Specific Aspects

Health workers working at Onandjokwe Lutheran Hospital seem to think about children as outlined in the chapter of findings under 'children'. These opinions, agreed to by the majority of health workers are full of contradictions, which will be discussed here briefly.

On the one hand children are thought to have the right to protect themselves against unwanted contact with an adult, including a parent, on the other hand children have always to obey adults. On the one hand children are believed to be believed when they claim having been sexually abused, on the other hand the word of a child is seen as being less reliable than that of an adult. On the one hand children's rights are seen as being as important as the rights of adults, on the other hand children are seen as being the property of their parents.

Obedience and a strong position of the father figure at home are part of the 'traditional values' and are certainly seen as important factors in the normal upbringing of children; not only in this part of the world. These contradictory images of children and their relationship to adults possibly is a source of vulnerability. In many ways this ambiguous position of children is probably not uncommon in many societies. These findings suggest that it might be fruitful to study these issues cross-culturally and observe whether the incidence of

CSA is higher in contexts in which such ambiguities are very apparent.

It might be very difficult, especially at a time when families seem to be under great strain and traditional structures fall apart, to rethink these values. Looking at children as more independent people who do not always have to obey and who are no property might be perceived as being risky and not in the best interest of the children. It is debatable to state that in a situation where CSA takes place it would be in the interest of the child to be (more) disobedient and (more) independent.

More independence of children would also increase their accessibility to potential perpetrators. This is something that is in fact already happening. The 'traditional value' of a strong father figure is disappearing very quickly in reality. 'The North' is the only area in Namibia where more households are headed by women than by men⁸; and children are alone for most of their time after school.

The contradictions in the respondent's answers, and indeed the problem of CSA as such, might reflect the fact that this region is in a period of transition at this point in time. Ten years after independence, which had a huge impact on the region, with the end of war, the disappearance of colonial rule, and the 'home coming' of many who have been in exile, people are still struggling to find the 'normal way of life'. Most respondents felt that CSA, alcohol abuse and AIDS are problems which exist or have significantly increased over the past ten years; (CSA 47.9%, alcohol abuse 34.9%, AIDS 61.3%).

This state of affairs might lead to a situation where care givers are confused about their roles and are caught in between different options, such as 'traditional values' and relatively greater freedom. This might then lead to a situation where CSA as such is one problem and the lack of defense against, or dealing with it another. Where values and guidelines are lost, the risk of neglect is higher. This might then provide another explanation why perhaps relatively few cases of CSA are reported, recorded and dealt with. As mentioned in the introduction, many children are seen with an STD and treated as if they were adults, without going into the likely problem of abuse at all.

While so many health workers seem to have first hand experience with CSA both at work and outside of it, most respondents tend to believe that the perpetrators do not know the child in question. Those children and/or their families who are coming forward with a complaint of being sexually abused tend to know the perpetrator quite well. It is the exception rather than the rule that the perpetrator is not known to the victim. Why then do health workers in a majority say that most perpetrators are not known to the victims?

One possible explanation could be that this is a symptom of denial of the fact that people close to the child are most frequently responsible. To accept this would mean that the community has to face this possibility of taboo behaviour in their midst. Acknowledging that most perpetrators are in fact known to the victims and at the same time estimating this problem to be as huge as they do, health workers would then have to face the possibility that very many fathers and people close to the family would have to be the perpetrators. Who else?

On the other side are the victims of the abuse. It seems there too is something unacceptable. The majority of health workers feels children have no sexual desires. Following this idea sexual abuse of a child cannot be the result of seduction, since arousal without the ability for sexual desire is not possible. Consequently the majority also feel CSA is never the result of seduction and sexual abuse is not possible without physical contact then always leading to physical evidence of the abuse. The idea of children seducing adults has not been offered during the qualitative phase of the study. The only suggestion coming close was that CSA might lead some children to 'like sex so much that they become adults and prostitutes'. The formulation of this question was a direct result of the focus groups discussions. Since this study was not concerned with prostitution no further attempt was made to go into this. It should nevertheless be clear that no suggestion is made here that there is a direct or even causal link between liking sex and engaging in prostitution.⁹

The question of sexual desires in children is complex and leads, if to no other questions, back to the concept of adolescence and the phase in life when children discover their own sexual needs, desires and identity. It seems that in the eyes of most health workers sexuality has no place in adolescence, since most felt children do not have sexual desires and sexual intercourse could only be consented to at the age of 18 or above.

It would be very interesting to look into the traditional ways in which boys and girls were initiated and developed their sexual persona in this part of Namibia.

AIDS does seem to be seen as having an effect on the problem of sexual abuse of children. There are two ways of looking at this. One is to see CSA as a form of 'cure' and the other is to see AIDS as a threat against which CSA could 'serve' as 'protection'. Most respondents believe that CSA could be seen as an attempt by men to 'protect' themselves against AIDS. The idea here is that children are seen as not being infected with the HIV virus and could therefore be 'used' sexually without the risk of infection for the adult. Traditional healers even seem to 'prescribe' CSA for the very same reason and as a 'cure'. The role of traditional healers in this region is not quite clear.

Whatever the case may be, what the answers around CSA and AIDS do suggest, is that AIDS is seen as a threat to health but not as a reason to practice safe sex. If there is any truth in the relationship between CSA and fear of contracting AIDS then one has to speak of a change in sexual behaviour, albeit a very sad one. If one does not believe in this change in sexual behaviour then the whole argument might not be true. Then, in fact, one should focus on one of the results of the qualitative phase of the study, which says that some men sexually abuse children because children might not be able to detect that the perpetrator does have an STD. There was little or no consideration on the effect of AIDS on the abused children.

On a sidetrack, AIDS seems to be very much on the minds of the health workers, being the only problem which was not denied at all, this in contrast to alcoholism and CSA.

Two presumably important issues not as directly connected to the 'human factor' of the CSA problem as the above, are housing and recreational facilities in Onandjokwe. Lack of recreational facilities and poor housing were seen as very important contributing factors to CSA, though not so much as causes. Everyone who has ever travelled along the main road connecting the South of Namibia with 'The North', has seen and been impressed by the huge number of cuca shops along this road. These are places where alcohol is served and they are the main places where (young) people spend their free time. According to the Ministry of Trade and Industry report on small businesses in 'The North' there are between 900 and 1000 such shops in the Oshana region alone and 70% of all manufacturing in this part of the country is alcohol related¹⁰.

The housing situation is more often than not so bad, that many people live and sleep in the same room with no space, or any hope for any privacy for both parents and children. The average household size is 6.2 persons while the national average is 5.7 and the size of households in Windhoek is 4.7 persons per household on average¹¹. Of course the issue here is household density and not size but it is also clear that the likelihood of higher density increases with the household size in areas such as Onandjokwe district, which belongs to the economically disadvantaged areas of Namibia.¹²

There is much agreement within the health workers that it is also a task of health workers to try and influence policy makers to make sure better services are made available to victims of CSA. At the same time a clear feeling that this is not realistic is very prevalent. There is a strong feeling that the churches have a role to play here and that generally ties within the community should be strengthened to safeguard the children.

¹ Appendix 3

² Legal Assistance Centre. (1999) N – of combating of rape bill, Windhoek

³ Menges W. (2000) Tough new rape act in force. *The Namibian*, 19th June 2000, Windhoek

⁴ Hubbard D. (2000) Rape re-defined; a summary of the new combating of rape bill. *The Namibian* 3rd March 2000, Windhoek

⁵ HIS. (2000) Health Statistics Onandjokwe District, MOHSS, Onandjokwe

⁶ HIS. (1998) Health Statistics Onandjokwe District, MOHSS, Onandjokwe

⁷ CSO. (1994) 1991 Population and Housing Census, National Planning Commission, Windhoek

⁸ CSO. (1996) Living Conditions in Namibia. The 1993/1994 Namibia Household Income and Expenditure Survey. National Planning Commission, Windhoek

⁹ Brown, L. (2000) Sex Slaves. The Trafficking of Women in Asia, Virago Press, London

¹⁰ MTI. (1998) Small Business Survey, MTI, Windhoek

¹¹ UNDP. (1998) Namibia Human Development Report 1998. Environment and Human Development in Namibia. UNDP, Windhoek

¹² Mendelsohn J, el Obeid S, Roberts C. (2000) A profile of north-central Namibia. Gamsberg Macmillan, Windhoek

Conclusions and Recommendations

The following points summarise the outcomes of this study.

- Child Sexual Abuse is perceived as being an enormous problem in Onandjokwe District.
- Most health workers feel that they lack the competence to deal with the CSA problem.
- An overwhelming majority of health workers, particularly nurses feel they are in need of further training concerning CSA.
- The concept of adolescence seems to be alien to most health workers.
- The vast majority of health workers believe that most men sexually abuse children.
- The overwhelming majority of health workers at Onandjokwe are female, trained as nurses and brought up in the North of Namibia.
- There is a feeling that CSA, AIDS and alcoholism all started or have grown significantly in the last ten years.
- Alcoholism, loss of traditional values and fear of AIDS were seen as the most important reasons for CSA.
- Most health workers feel that suicide among the victims of CSA is a common consequence.
- Health workers feel that it is also their job to inform the public and to influence policymakers when it comes to the topic of CSA.
- Children seem to be in an ambiguous position in relation to adults.

On the basis of this study the following recommendations seem appropriate in both deepening the understanding of CSA in the region, and contributing to the development of preventive and treatment strategies for sexually abused children.

- Research into the true prevalence of CSA in Northern Namibia is urgently needed.

- Research into specific risk factors of CSA in the region should be conducted.
- Research into the level of family disintegration and social distress has to be conducted.
- Research into the causes and consequences of alcoholism either as part of the above or on its own is needed. In addition, it would be useful (although very difficult) to establish whether a high proportion of perpetrators of CSA are intoxicated at the time of such assaults. This would permit to observe whether in fact alcohol abuse and CSA co-occur.
- Recreational facilities encouraging healthy entertainment should be developed and supported. It would be important to think of both the possible perpetrators as well as the potential victims in this regard. This would suggest supervised recreational facilities for children and adolescents, as well as provision of leisure facilities (and work skills training) for adult males – particularly for those who are out of work.
- Facilities to serve victims of CSA need to be strengthened. Psychological services are urgently needed in the area.
- Social skills workshops aimed at strengthening self-esteem and self-defence and the ability to communicate problems to others, especially to adults, should be introduced in schools and places where children and youngsters are coming together, in order to reduce children's vulnerability. These could be opportunities to also talk about the AIDS catastrophe.
- Ways to help (single) mothers supervise their children should be discussed in the community. In this way children would become less accessible to potential perpetrators.
- All categories of health workers should receive further training in dealing with victims and perpetrators of CSA. The data of this study indicates that this is necessary.
- Data collection for the HIS has to be improved. This data, in this instance concerning CSA, then has to be shown to the health workers who collected them in order to make the collection meaningful and worthwhile. This will serve as a reminder to health workers that CSA is a major problem that needs to be recognised.
- The MOHSS should discuss CSA and its implications more vigorously and actively encourage health workers to communicate their experiences and opinions. This will heighten awareness and

might lead to a broader discussion of the issue in local communities.

- Children must be taken seriously. A special institution such as an independent reporting person or ombudsman should be formed to allow children to air their complaints. This is especially important since children are likely not to be believed, in particular, when their complaint is directed against their father, step-father or other close relative.

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Appendices

Appendix 1 Questionnaire in English

Appendix 2 Questionnaire in Ndonga

Appendix 3 Answers to 5-scale Questionnaire

Appendix 4 List of Acronyms (Repeat)

Questionnaire in English

QUESTIONNAIRE SEXUAL ABUSE OF CHILDREN Onandjokwe Lutheran Hospital – 2000

Part A

I am ...

- | | | |
|---------------------------------|--|--|
| <input type="checkbox"/> male | <input type="checkbox"/> 29 years or younger | <input type="checkbox"/> less than 5 years working |
| <input type="checkbox"/> female | <input type="checkbox"/> 30 - 39 years old | <input type="checkbox"/> 6 - 10 years working |
| | <input type="checkbox"/> 40 - 49 years old | <input type="checkbox"/> 11 - 15 years working |
| | <input type="checkbox"/> 50 years old or older | <input type="checkbox"/> 16 - 20 years and more |

NA EN RM RN Soc./clergy/physio Technician Doctor

NA(student) EN(student) RM(student) RN(student)
 Soc./clergy/physio(student) Technician(student) Doctor(student)

I have

1 child 2 children more than 2 children

I am working at ...

- | | | |
|---|------------------------------------|-------------------------------------|
| <input type="checkbox"/> OPD | <input type="checkbox"/> Ward I | <input type="checkbox"/> Casualty |
| <input type="checkbox"/> In-patients | <input type="checkbox"/> Ward VII | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> PHC | <input type="checkbox"/> Ward III | <input type="checkbox"/> STD |
| <input type="checkbox"/> Administration | <input type="checkbox"/> Ward VIII | <input type="checkbox"/> other |

I am from ...

Owamboland outside Owamboland but from Namibia abroad

I have been raised in ...

Owamboland outside Owamboland but in Namibia abroad

In the questionnaire that follows, please give your opinion.

Place a cross where appropriate.

01. A person is able to give consent for sexual intercourse at the age of at least

10 11 12 13 14 15 16 17 18 older than 18

Part B

WHENEVER THE WORD CHILD IS USED IN THIS QUESTIONNAIRE, THIS REFERS TO A CHILD THAT HAS NOT YET REACHED PUBERTY. THIS MEANS IN MOST CASES A CHILD OF 11 YEARS OR YOUNGER.

In the statements that follow a scale that looks like this is used: Strongly Agree (1), Agree (2), Unsure (3), Disagree (4), Strongly Disagree (5).

Put a cross on the number which indicates your view. For example, if you strongly agree with the statement, put an X on 1; if you are unsure, put your X on 3. If you disagree to some extent place the X on 4, and so on.

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
01. A child that is sexually abused enjoys the sex	1	2	3	4	5
02. Rape is always against the will of the victim	1	2	3	4	5
03. Sexual abuse is never the result of seduction	1	2	3	4	5
04. Children have no sexual desires	1	2	3	4	5
05. A child cannot be sexually abused without physical contact	1	2	3	4	5
06. It is almost always also the fault of the child when (s)he is sexually abused	1	2	3	4	5
07. Only when the perpetrator is an adult can one speak of sexual abuse	1	2	3	4	5
08. The word of a child is less reliable than that of an adult	1	2	3	4	5
09. Children have always to obey adults	1	2	3	4	5
10. Only men can sexually abuse a person	1	2	3	4	5
11. Sexual abuse is harmful for the child	1	2	3	4	5
12. It is a form of sexual abuse if a child is exposed to sexual acts even if (s)he is not part of it	1	2	3	4	5
13. Parents should not be seen naked by their children	1	2	3	4	5

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
14. It is sexual abuse if two children engage voluntarily in sexual activities without an adult being involved	1	2	3	4	5
15. Sexual abuse always leaves the victim with physical evidence of the abuse	1	2	3	4	5
16. Sexual abuse only occurs in certain parts of society	1	2	3	4	5
17. Even when a child has been raped and penetration took place, there can be inconclusive evidence of it at physical examination	1	2	3	4	5
18. To prove sexual abuse it is not important to gather physical evidence through the laboratory services	1	2	3	4	5
19. Women cannot sexually abuse children	1	2	3	4	5
20. Sexual abuse of children is a problem in Onandjokwe	1	2	3	4	5
21. Most perpetrators are not likely to be known to the child	1	2	3	4	5
22. Sexual abuse of children leads to loss of values in the children	1	2	3	4	5
23. A child is the property of her/his parents	1	2	3	4	5
24. Sexual abuse of children is a growing problem	1	2	3	4	5
25. Children should be seen, but not heard	1	2	3	4	5
26. A man who is known to have sex with a child is looked down upon	1	2	3	4	5
27. A child who is known to have sex with an adult is looked up at by her/his peers	1	2	3	4	5

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
28. In some communities it is normal for adults to have sex with children	1	2	3	4	5
29. A foster parent feels less responsibility for her/his foster children than for her/his own children	1	2	3	4	5
30. Most parents expect that their child will be sexually abused during childhood	1	2	3	4	5
31. Many men seduce young girls in an attempt to protect themselves against AIDS	1	2	3	4	5
32. Many men seduce young girls in an attempt to cure themselves of AIDS	1	2	3	4	5
33. Many traditional healers 'prescribe' sex with 'an innocent child' to cure different diseases	1	2	3	4	5
34. Most parents are fairly careless concerning child minding	1	2	3	4	5
35. Most parents are unaware of the problem of sexual abuse	1	2	3	4	5
36. Most traditional leaders are aware of the problem of sexual abuse	1	2	3	4	5
37. Children have a right to protect themselves against unwanted contact with any adult including their parents	1	2	3	4	5
38. Lack of recreational facilities in our region contributes to the problem of sexual abuse of children	1	2	3	4	5

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
39. The private parts of children are not as private as the private parts of adults	1	2	3	4	5
40. Poor housing where boys and girls are sleeping in the same rooms and beds contributes to the problem of sexual abuse of children	1	2	3	4	5
41. A girl who has been sexually abused has less chances to get married than a girl that has not been abused	1	2	3	4	5
42. The effect of the sexual abuse on the child depends on the physical seriousness of the abuse. If there are no physical wounds, then there will be no other effect	1	2	3	4	5
43. It is important that the sexual abuse is not known to the surrounding community	1	2	3	4	5
44. If the perpetrator is coming from within the abused child's family then the effect on the child is less traumatic	1	2	3	4	5
45. The younger the child is at the time of the sexual abuse the less likely (s)he is to develop problems later in life	1	2	3	4	5
46. Most children and teenagers have no friends they can talk to about being sexually abused	1	2	3	4	5
47. Children who are sexually abused live in fear and shame	1	2	3	4	5
48. Adults will believe a child who claims to be sexually abused	1	2	3	4	5
49. Alcohol abuse is a consequence of sexual abuse	1	2	3	4	5

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
50. Sexual abuse is a consequence of alcohol abuse	1	2	3	4	5
51. In small children delay of speech development could be a sign of sexual abuse	1	2	3	4	5
52. When children show explicit sexual acts in their play, then that is more likely to be due to what they have seen on TV than to actual sexual abuse	1	2	3	4	5
53. A person who has been sexually abused is not likely to abuse her/his own children	1	2	3	4	5
54. The rights of adults are more important than the rights of children	1	2	3	4	5
55. The health worker has to attend to the physical side of the sexual abuse, such as wounds, STDs etc., only	1	2	3	4	5
56. Health workers seeing the victim of sexual abuse must tell her/him that the abuse is not her/his fault	1	2	3	4	5
57. Health workers must not counsel the victims	1	2	3	4	5
58. Health workers must counsel the perpetrators	1	2	3	4	5
59. It is the responsibility of the health worker to report (suspected) sexual abuse of a child to the police	1	2	3	4	5
60. Health workers have the task to educate parents and caregivers of children on the dangers and nature of sexual abuse	1	2	3	4	5

Statement	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
61. Health workers must not encourage parents to engage in sex education of their children	1	2	3	4	5
62. Health workers have to try and form a team to handle the problems of victims of sexual abuse	1	2	3	4	5
63. The health worker must ensure that evidence of sexual abuse is collected	1	2	3	4	5
64. Traditional healers practicing in Onandjokwe should be approached by the health workers to inform them on the problem of sexual abuse of children	1	2	3	4	5
65. It is not the task of the health worker to try and influence policy makers to improve the services offered to victims of sexual abuse	1	2	3	4	5
66. There is no need for health workers at Onandjokwe to be trained in handling the problem of sexual abuse of children	1	2	3	4	5
67. The health workers have generally enough knowledge and skills to address problems specific to children	1	2	3	4	5
68. The church should actively look after victims of sexual child abuse	1	2	3	4	5
69. There is no need for more and stronger ties in the communities to supervise and care for children	1	2	3	4	5
70. It is necessary to offer counseling to perpetrators of sexual abuse of children	1	2	3	4	5

Part C

01. Childhood ends when a person has reached the age of

10 11 12 13 14 15 16 17 18 more than 18

02. Sexual abuse is against the law in Namibia

yes no

03. Out of every 100 children I estimate that the following number has been or is abused sexually

less than 5 10 20 30 40 50 60 70 80
 more than 80

04. Out of every 100 men I estimate that the following number has sexually abused a child

less than 5 10 20 30 40 50 60 70 80
 more than 80

05. Sexual abuse of children has increased over the following number of years

1 5 10 20 50 not increased

06. In my work the number of children I see with (suspected) sexual abuse in one month is

0 1 2 3 more than 3

07. Concerning sexual abuse of children I feel professionally

competent incompetent in need of further training

08. Out of every 100 women I estimate that the following number has sexually abused a child

less than 5 10 20 30 40 50 60 70 80
 more than 80

09. The number of children I know in my non-professional life who have been sexually abused is

0 1 2 3 more than 5 more than 10

10. AIDS is a problem in Onandjokwe for the following number of years

1 5 10 20 50 is no problem

11. The most important reasons for the sexual abuse of children here are (mark no more than three):

Fear of AIDS Cure of AIDS Alcohol abuse Loss of traditional values
 Breakup of the family System of foster parenting

12. Alcohol abuse is a problem in Onandjokwe for the following number of years

1 5 10 20 50 more than 50 is no problem

13. A child that has been sexually abused can develop the following later in life (mark as many as you like):

- Aversion against sex Hatred against the opposite sex Engagement in prostitution Homosexuality Poor academic performance Social isolation
 Inability to trust Suicidal tendencies Depression Mental illness

14. Out of 100 health workers the following number is able to detect victims of sexual abuse

- less than 5 10 20 30 40 50 60 70 80
 more than 80

15. Sex education should start

- before primary school in primary school in junior secondary school
 senior secondary school

Questionnaire in Ndonga

**OMBAPILA YOMAPULO KOMBINGA
YOMAHEPEKO GAANONA PAMILALO
Onandjokwe Lutheran Hospital – 2000**

OSHI TOPOLWA A

Ngame o...

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> omulumentu | <input type="checkbox"/> oomvula 29 nenge dhi vulike | <input type="checkbox"/> oomvula < 5 tandi longo. |
| <input type="checkbox"/> omukiintu | <input type="checkbox"/> oomvula 30 - 39 | <input type="checkbox"/> oomvula 6-10 tandi longo |
| | <input type="checkbox"/> Oomvula 40 - 49 | <input type="checkbox"/> oomvula 11 - 15 tandi longo |
| | <input type="checkbox"/> Oomvula 50 nenge dhi vule po | <input type="checkbox"/> Oomvula 16-20 nenge dhi vule po. |

- | | | | |
|--|-----------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Omuyakupangi | <input type="checkbox"/> Omupangi | <input type="checkbox"/> Omuvalithi | <input type="checkbox"/> Sestela |
| <input type="checkbox"/> Omuniilonga gwonkalathano/Omusita /Omuyuli gwoontuma nomasipa | | | |
| <input type="checkbox"/> Omupangeli/Omutekenika | | <input type="checkbox"/> Omundohotola | |

- | | | |
|--|--|--|
| <input type="checkbox"/> Omuyakupangi(omulongwa) | <input type="checkbox"/> Omupangi(omulongwa) | <input type="checkbox"/> Omuvalithi(omulongwa) |
| <input type="checkbox"/> Sestela(omulongwa) | <input type="checkbox"/> Omuniilonga gwonkalathano/Omusita/ Omuyuli gwoontuma nomasipa (omulongwa) | <input type="checkbox"/> Omundohotola(omulongwa) |
| <input type="checkbox"/> Omunautekenika(omulongwa) | | |

Ondi na

- | | | |
|------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Okanona 1 | <input type="checkbox"/> Uunona 2 | <input type="checkbox"/> Uunona u vulithe 2 |
|------------------------------------|-----------------------------------|---|

Ohandi longo ko...

- | | | |
|--|--|---|
| <input type="checkbox"/> Oshitopolwa shaavu yopondje | <input type="checkbox"/> Omukunda I | <input type="checkbox"/> moka hamu thikile iiponga naamboka taye ehamenene. |
| <input type="checkbox"/> Aavu yomeni | <input type="checkbox"/> Omukunda VII | <input type="checkbox"/> Omweelo gwombinzi |
| <input type="checkbox"/> Uundjolowe wopetameko | <input type="checkbox"/> Omukunda III | <input type="checkbox"/> Okapangelo kornikithi dhohoni |
| <input type="checkbox"/> Oombelewa dhelelo | <input type="checkbox"/> Omukunda VIII | <input type="checkbox"/> Yilwe |

Onda za ...

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> mOwambo | <input type="checkbox"/> pondje yoOwambo ndele omoNamibia | <input type="checkbox"/> pondje yoshilongo. |
|----------------------------------|---|---|

Onda putudhilwa/tekulwa mo...

- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> Owambo | <input type="checkbox"/> pondje yoOwambo, ihe omoNamibia | <input type="checkbox"/> pondje yoshilongo. |
|---------------------------------|--|---|

Komapulo taga landula, alikana gandja omadhilaadhilo goye.

Tula okakombo mpoka ta ka opalele.

01. Omuntu ota vulu okugandja eziminino lyokuya momilalo okuza poomvula.

- | | | | | | | | | | |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|--|
| <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 | <input type="checkbox"/> 13 | <input type="checkbox"/> 14 | <input type="checkbox"/> 15 | <input type="checkbox"/> 16 | <input type="checkbox"/> 17 | <input type="checkbox"/> 18 | <input type="checkbox"/> oomvula dhi vule 18 |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|--|

OSHI TOPOLWA B

UUNA OSHITYA OKANONA TASHI LONGITHWA MOMBAPILA NDJIKA YOMAPULO, OKWA DHILAADHILWA OKANONA HOKA INA KA ADHA 'OKAMUKONDA PWEYU'. SHIKA OTASHI TI, MOOMPITO ODHINDJI OKANONA KOOMVULA 11 NENGE DHI LI KOHI.

Momatumbulokankameno taga landula ota ku longithwa oshiyekitho sha tya ngeyi: Otandi zimine noonkondo (1), Otandi zimine (2), Ondi li pokati/kandi shi wo nawa (3), Itandi zimine (4), itandi zimine nandonando (5).

Tula okakombo ponomola ndjoka tayi tsu kumwe nomadhilaadhilo goye. Oshiholelwa, ngele oto tsu kumwe thiluthilu netumbulokankameno, tula okakombo pu 1, ngele ku shi wo/wu li pokati, tula okakombo koye pu 3. Ngele ito tsu kumwe naanaa tula okakombo pu 4, nosho nosho.

Etumbulokankameno	Ote zimine noonkondo	Ote zimine	Ondi li pokati	Ite zimine	Ite zimine nandonando
01. Okanona hono ta ka longithwa nayi pamilalo oha ka tyapula iipala.	1	2	3	4	5
02. Ekwatongonga aluhe oli li kondje yehalo lya nakukwatwa.	1	2	3	4	5
03. Elongitho nayi lyomilalo haaluhe hali landula sho omuntu a hekwa-hekwa.	1	2	3	4	5
04. Aanona kaye na omahalo giipala.	1	2	3	4	5
05. Okanona itaka vulu okulongithwa nayi pamilalo uuna ina ka gumwa kolutu.	1	2	3	4	5
06. Konyala aluhe oshi li wo ondjo yokanona ngele ta ka longithwa nayi pamilalo.	1	2	3	4	5
07. Oha ku popiwa ashike okuhekela aanona momilalo, uuna nakuya momilalo nokanona e li omukuluntu.	1	2	3	4	5
08. Omapopyo gokanona ka ge shi naanaa okwiinekelwa ngaashi gaakuluntu.	1	2	3	4	5
09. Aanona oye na aluhe okuvulika kaakuluntu.	1	2	3	4	5
10. Aalumentu oyo ayeke taa vulu longitha nayi omuntu pamilalo.	1	2	3	4	5
11. Okuhekela okanona miipala ohashi ke ehameke mokukala kwako.	1	2	3	4	5

Etumbulokankameno	Ote zimine noonkondo	Ote zimine	Ondi li pokati	Ite zimine	Ite zimine nandonando
12. Oshi li omukalo gwokulongitha nayi okanona pamilalo, uuna ta ka talithwa omalangathano nonando kokene ina ka kutha ombinga	1	2	3	4	5
13. Aavali ina ya monika kaanona ye li kowala	1	2	3	4	5
14. Oshi li wo elongithonayi lyiivalitholyo uuna aanona yaali taa yi momilalo pahalo lyawo yene nopwaana ekuthombinga lyomukuluntu	1	2	3	4	5
15. Elongithonayi lyiivalitholyo aluhe oha li thigile ngoka oye oshihakanwa omandhindhiliko goshinima shika kolutu lwe.	1	2	3	4	5
16. Elongithonayi pamilalo ohali holoka ashike maantu yomoongundu dhimwe po moshigwana.	1	2	3	4	5
17. Nonando okanona oka kwatwa koonkondo 'nokakuti ka ya lela meni molungu', otashi vulika pwaa ha kale uumbangi wi ihwa po uuna iilyo yolutu tayi konaakonwa.	1	2	3	4	5
18. Mokukonga uukwashili welongitho nayi lyopaivalitho inashi simana okulongitha omandhindhiliko ngoka taga vulu okumonika kolutu nekwatho lyomayakulo goko mweelo gwombinzi/Labora.	1	2	3	4	5
19. Aakiintu iha ya vulu okulongitha nayi aanona niipala.	1	2	3	4	5
20. Elongitho nayi lyaanona paipala olyo omukundu mOnandjokwe.	1	2	3	4	5
21. Oyendji yaamboka ye na ondjo moshinima shika ihaa kala naanaa ye shiwiki kokanona.	1	2	3	4	5
22. Elongithonayi lyaanona pamilalo oha shi kanitha mo ongushu yuuntu mokanona.	1	2	3	4	5
23. Okanona oko eliko /oshinima shaavali yako	1	2	3	4	5

Etumbulokankameno	Ote zimine noonkondo	Ote zimine	Ondi li pokati	Ite zimine	Ite zimine nandonando
24. Elongithonayi lyaanona pamilalo oshi li omukundu ta gu koko.	1	2 3		4	5
25. Aanona ngele taa indile sha nomuthindo ya hala shi ningwe, ohashi kudhile aavali yako.	1	2 3		4	5
26. Omulumentu ngoka a tseyika kutya oha lala nokanona oha talwa ko nayi.	1	2 3		4	5
27. Okanona hoka ka tseyika kutya oha ka lala nomukuluntu oha ka talwa ko nawa kaanona yepipi lyako	1	2 3		4	5
28. Maakwashigwana yamwe, oshu uka omukuluntu ta lala naanona.	1	2 3		4	5
29. Omutekuli gwaanona ine ya vala oha kala u- uvite e na oshinakugwanithwa oshishona pakuyeleka naamboka a vala mwene.	1	2 3		4	5
30. Aavali oyendji oya tegelela kutya aanona yawo otaya ka longithwa nayi pamilalo pethimbo lyuunona wawo.	1	2 3		4	5
31. Aalumentu oyendji ohaa hekele aanona yaakadhona aashona momilalo monkambadhala yokwiigamena yaa ha kwatwe koAIDS	1	2 3		4	5
32. Aalumentu oyendji ohaa hekele aanona yaakadhona aashona momilalo, monkambadhala yokwiyaludha koAIDS.	1	2 3		4	5
33. Oonganga odhindji dhopamithigululwakalo ohadhi 'utha' okulala 'nokanona kaa n' ondjo' mokupanga omikithi dhi ili nodhi ili.	1	2 3		4	5
34. Oyendji yomaavali kaye na ko naanaa nasha netonatelo lyaanona.	1	2 3		4	5
35. Oyendji yomaavali ina ya ndhindhilika uupyakadhi welongithonayi pamilalo.	1	2 3		4	5
36. Odhindji dhomoonganga dhopamithigululwalo odha ndhindhilika uupyakadhi welongitho nayi lyaantu pamilalo.	1	2 3		4	5

Etumbulokankameno	Ote zimine noonkondo	Ote zimine	Ondi li pokati	Ite zimine	Ite zimine nandonando
37. Aanona oye na uuthemba wokwiigamena kokugumwaagumwa inaye ku hokwa okuzilila kaakuluntu sha kwatela mo naavali yawo	1	2 3		4	5
38. Ompumbwe yomahala gomainyanyundho moshitopolwa shetu otashi etitha uupyakadhi welongitho nayi lyaanona pamilalo	1	2 3		4	5
39. Ivalitholyo yaanona kayi li naa 'yopaumwene' ngaashi iivalitholyo yaakuluntu yi li 'yopaumwene'	1	2	3	4	5
40. Ompumbwe yomagumbo mpoka aanona yaamati naakadhona haa lala mondunda yimwe nokombete yimwe ohashi etitha uupyakadhi gwelongithonayi lyaanona pamilalo	1	2	3	4	5
41. Okakadhona hono ka longithwa nayi pamilalo oke na ompito oshona yokuhokanwa pakuyeleka naahoka inaka longithwa nayi pamilalo.	1	2	3	4	5
42. Ondjundo yelongitho nayi lyokanona pamilalo osha hanga kutya oka ehamekwa noonkondo ngiini kolutu. Ngele inaka ningwa iilalo, nena itashi ka etele uupyakadhi wa sha.	1	2	3	4	5
43. Osha simana opo elongithonayi lyopamilalo li kale inali tseyika kaantu yopomudhingoloko	1	2	3	4	5
44. Ngele omukawulinyanga ogwomezimo lyokanona hoka ka longithwa nayi pamilalo nena oshilanduli itashi ehameke naanaa okanona noku ka thiga oshaadhi sha sha.	1	2	3	4	5
45. Okanona ngele okashona pethimbo lyokulongithwa nayi pamilalo, iha shi ke etele naanaa omaupyakadhi monkalamwenyo komeho.	1	2	3	4	5