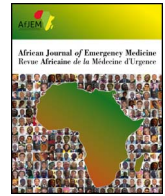




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REVIEW ARTICLE

A critical review of child abuse and its management in Africa

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ABSTRACT

Introduction: Child abuse in Africa is a major threat to the achievement of the sustainable development goals on the continent and has become increasingly topical with a dramatic increase in recognition and an appreciation of the long term harmful effects on the affected population. The aim of this review was to outline current management of child abuse (especially sexual abuse) and highlight current preventive practice that could be beneficial in a resource-limited environment.

Methods: A search of Medline and reference lists of the literature on child abuse in African countries and relevant world literature was conducted in December 2016. The review was written narratively, rather than systematically as a general overview was desired, instead of a focused view of individual aspects of child abuse.

Recommendations: Opportunities for early identification of child abuse, as well as research into preventative strategies should be prioritised. Establishing strong institutions and guidance to tackle abuse when it occurs is both beneficial to the survivors and the continent at large.

African relevance

- Compared to other world regions, there is very little published research on child abuse in Africa.
- Harmful traditional practices, like child marriage, are still prevalent in parts of Africa.
- Poverty significantly contributes to child abuse.
- Violence against women and children is a global public health and human rights concern.

Introduction

Child abuse is a serious and devastating problem not just in Africa, but the world over; however, the number of children on the continent who are abused has always been underestimated. Child abuse is defined by the WHO as “all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to the child’s health, development or dignity” [1]. Child labour is common in African countries where grinding poverty propels children into work. Persistence of domestic violence is a threat to basic human rights and a threat to achieving the Sustainable Development Goals. Corporal punishment can be defined as the intentional infliction of physical pain with the purpose of deterring unwanted behaviour. It remains an all too common phenomenon in African households and schools, where harsh physical punishment is associated with later aggression and other maladaptive behaviour [2]. Commonly practiced in

many regions such as south-west Ethiopia, parents have a poor understanding of any legal framework protecting their children from abuse [3]. It is widely accepted that corporal punishment as a means of correcting children in Africa could have negative consequences on future generations. Data on child protection issues are becoming increasingly available in countries like Ghana, Malawi, Kenya and South Africa, but there is still a dearth of reliable information on child trafficking, commercial sexual exploitation, street children and the prevalence of harmful sociocultural practices. This narrative review aims to outline the current management of child abuse (especially sexual abuse) and highlight the current preventive practice that could be beneficial in a resource-limited environment.

Epidemiology

Child abuse research in Africa is still in its infancy and there is a paucity of data from most African countries. Yet, globally an estimated 95 million children experience abuse annually, with the highest rates reported in the World Health Organization (WHO) African region [6]. Research is fairly hit or miss. The earliest study of child sexual abuse in Africa was probably by Westcott, et al. who described 18 cases of child sexual abuse at a Cape Town hospital back in 1984 [5]. More recently, in 2015, a South African study reported lifetime rates of 34% for physical abuse, 16% for emotional abuse and 20% for sexual abuse amongst 15–17 year olds [7]. In nearby Swaziland, nearly one-in-five females had experienced physical abuse in their lifetime with nearly one-in-

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twenty having experienced abuse that was so severe, that it required medical attention [8]. Alarming, child abuse only recently received recognition as a social problem in Nigeria, one of Africa's largest economies [4].

Risk factors identified for lifetime childhood physical abuse included maternal death prior to age 13, having lived with three or more families during their childhood, and having experienced emotional abuse prior to age 13 [8]. Data gathered by the United Nations Children's Fund (UNICEF) show that Ghana's statistics with regard to rape and defilement are so high that they rank in certain instances alongside countries that have a recent history of violent conflict like Sierra Leone or the Democratic Republic of Congo [9]. Child marriage is common in West Africa and in some countries in East and Southern Africa, especially Mozambique, Uganda and Ethiopia [10]. There is a significant amount of violence experienced in these early marriages and a study in Zambia from a Demographic and Health Survey showed a 33.3% level of spousal violence [11].

Under harmful traditional practices, female genital mutilation is another worrying trend on the continent. Girls from a young age undergo varying forms of genital excision leading to long term problems. The UNICEF estimates published in 2005 suggest that three million girls in sub-Saharan African, Egypt and the Sudan suffer from genital mutilation, with the highest prevalence in countries like Somalia, Ethiopia, Djibouti, Egypt and Sudan, as well as parts of East and West Africa [11]. It is practiced almost universally among Kenyan Somalis, the Masai and a few other groups, reaching a prevalence of 32% in Kenya as a whole [12].

About 200,000 children are trafficked annually across borders in the sub regions of West and Central Africa, from and into countries such as Benin, Ghana, Nigeria, Mali, Burkina Faso and Mauritania [13]. Ghanaian children are particularly trafficked to Cote d'Ivoire, Togo, Nigeria and the Gambia for domestic service and exploitative labour [14]. Fishing on Lake Volta, Ghana by children is commonplace. These children experience a high level of maltreatment such as being forced to dive to remove trapped nets, as well as physical and verbal abuse, and sexual harassment [15].

Child sexual abuse

The definition for child sexual abuse is "forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening". These activities may involve physical contact, including penetrative (e.g. rape, defilement, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at or in the production of, sexual online images, watching sexual activities or encouraging children to behave in sexually inappropriate ways [16]. Studies considering child sexual abuse in the African context vary in terms of estimates depending on the country under study, type of sexual abuse studied, quality of the data collected (mainly retrospective studies) and the definitions used. Unsurprisingly, the majority of cases are not known by official agencies; however, it is believed that African rates of abuse likely surpass figures elsewhere, mainly because of rapid social change and patriarchal nature of most African societies – variables that have been known to foster sexual abuse [17,18]. Overall the highest prevalence rates for child sexual abuse reported in Africa are from Morocco, Tanzania and South Africa [19]. However, just because data exist does not necessarily mean that these are the main culprit countries. Other work has revealed that 47% of female child labourers in Nigeria had been sexually assaulted [20]. The National Child Protection study carried out by the Government of Ghana and UNICEF, published in 2014, found that transactional sex (having sex for money or other needed items such as shelter, food and clothes) and children watching pornographic images was the most prevalent forms of sexual abuse within the Volta, Upper West, Upper East, Ashanti, Western and Brong Ahafo regions [9]. The transactional sex figures were reported as above

average.⁹ A growing number of studies, particularly from sub-Saharan Africa, would suggest that many girls' first sexual experience is unwanted and forced [21].

Medical management of children who are victims of violence and abuse

Clinicians who regularly deal with children must maintain a high index of suspicion in order to identify abuse promptly. Bruising remains the most common finding in abused children of all ages [22]. Bruising itself is not dangerous but it may prompt recognition of significant abuse and a disordered family. In addition, it affords the opportunity to intervene to protect the child before serious injury occur. Physical abuse rarely exists on its own and it is important to recognise links with other forms of abuse [23]. Accidental bruises to children tend to occur over bony prominences and on the front of the body [24]. Once a child is walking, the most common accidental bruising sites are the shins and knees [23]. In contrast the most common site for abusive bruises is the head and neck [25]. Ghareman, et al. showed that 11% of children with non-accidental head injury presented with bruising to either the scalp or face [26]. In fact, abusive head trauma is the leading cause of death due to child physical abuse in young children worldwide [27]. The Pittsburgh Infant Brain Injury score (PIBIS) uses four clinical variables: abnormal dermatological exam, age more than or equal to three months, head circumference > 85th centile and haemoglobin < 11.2 g/dl to determine which infants with vomiting are at increased risk for brain injury and may benefit from neuroimaging [28]. In a major study to determine prior opportunities to identify abuse in children with associated head trauma, children that presented with vomiting, prior child protection concerns and bruising were found to be more likely to also have chronic subdural haemorrhage and healing fractures [29]. Diagnosis is not easy. Vomiting, lethargy, fussiness and decreased oral intake can of course be symptoms of brain injury, but it can also result from many other childhood diseases. Caregivers frequently do not provide a trauma history, or if they do provide one, it tends to be inaccurate or incomplete. Resultantly, abusive head trauma may therefore not be considered as part of the initial differential diagnosis [29]. Table 1 provides some common sense signs that should prompt suspicion.

Fractures and burns related to abuse deserves particular attention. Most abusive fractures present as occult injuries that are detected during an investigation for suspected child abuse although at times they may present when a child has had an X-ray for another clinical reason. These are characteristically multiple and may have been sustained over a period of time, thus showing different stages of healing on imaging [31]. A full skeletal survey is recommended in infants less than two years with suspected abuse and includes x-rays of all the bones of the body, including localised views of the hands, feet, spine, chest, pelvis and skull. Burns can occur anywhere with the face, head, buttocks, perineum and genitalia frequently involved.

General points to remember in handling abuse in the hospital or community setting is that the child's safety should always come first. Most abused and neglected children do not require admission to hospital but a family or social situation may make placement in hospital as a temporary, safe and supportive environment desirable. Genuine accidents do occur. The examiner must always be polite and considerate

Table 1

As a rule of thumb, non-accidental injury should be suspected when [30].

1. There is significant delay between the time of injury and the presentation for medical examination
2. The explanations provided do not fit with the injuries sustained
3. The descriptions of the mechanism of injury are inconsistent and change on retelling
4. Evasiveness or anger from caregivers as further details are sought
5. The explanation provided is at variance with the developmental level of the child
6. There is a history of abuse in the child or their siblings

to parents or caregivers, and never force an examination; consent is always required before examination. As a rule of thumb, and especially when suspected, a doctor or healthcare professional should always perform a full general examination, noting cleanliness, emotional state and the reaction to caregivers. In the emergency centre, the body map from burns chart can be used to document superficial findings. It is important that injuries be described how they appear (e.g. blue bruise) and that an attempt at guessing the age of an injury (e.g. three-day old bruise) not be made. Aftercare following child abuse is important. The child's overall progress should be monitored, with attention given to developmental needs (e.g. failure to thrive, language delay, behavioural disturbance, etc.). It is also important to ensure a child returns to a safe environment and a medical examination can be carried out on follow-up to check for signs of healing. In many cases appropriate referrals for therapeutic support like mental health services, or follow-up by a social worker is required.

Managing child sexual abuse

Most doctors and other healthcare professionals lack confidence when it comes to handling sexual abuse cases. There are seldom specific guidelines available in African Emergency Centres, or outpatient services, and with several different presentations it can be quite challenging to identify and manage. Child sexual abuse must be considered with the following presentations (Table 2) [32].

Interpretation of the findings of the genital examination requires an understanding of normal female genital anatomy and how this changes with age and pubertal status. For legal purposes, penetration of the vagina does not have to involve penetration through the hymen; in the United States of America, penetration is defined as penetration of the genitalia however slight [34]. It is also important to note that both hymenal and non-hymenal injuries heal remarkably well leaving little or no evidence of previous trauma. McCann et al. provided an important reminder on the healing of accidental and non-accidental injuries from a cohort of 113 pre-pubertal girls and 126 pubertal girls examined at one hour and three days post injury [35]. Essentially this means that a fair number of children who are sexually abused have no identifiable injuries. It is important to note that the practice of measuring the width of the hymen is no longer recommended due to difficulties in obtaining accurate measurements. Congenital absence of hymenal tissue has also been reported [36]. Ideally any forensic examination should be carried out by an experienced and trained clinician or suitably experienced paediatrician. Such an examination should consist of the following components: the clinical history, a general examination, and an examination relevant to the alleged abuse as well as age and development stage of the child [37]. Further actions include detailed documentation of clinical findings (e.g., including use of body

maps and line drawings) to an accepted forensic standard, photo-documentation using a colposcope or equivalent where available, obtaining relevant forensic samples for trace evidence and toxicology, risk assessment for post exposure prophylaxis (e.g., hepatitis and HIV infection), emergency contraception or pregnancy testing where appropriate, attending to child protection needs, assessment of risk of abuse to underage siblings, arranging any necessary aftercare, arranging appropriate laboratory and X-ray investigation, and writing the report. In a resource limited setting it is recommended that the child is referred to a district or regional hospital. A clear referral pathway must be available to all healthcare workers including doctors, nurses, psychiatrists, public health practitioners, clinical psychologists and dentists. Presently, in Ghana, physician's assistants working in rural areas are being trained in child protection procedures including basic examination to confirm abuse. Public health nurses can have a designated focal person to receive all children who have been abused.

Child abuse prevention in Africa

There are fairly little reliable information on child abuse for most African populations. The family and community as the base units of child protection are crucial, and there is an urgent need to build community capacity to protect children, rather than rely on health or legal services. The communal nature of most societies means the main actors like customary chiefs and queen mothers, women's groups and community health workers play an important role for the welfare of children. Paediatricians and family physicians see daily evidence of unhelpful parenting and yet largely remain silent on the issue. Advocacy on good parenting and awareness-raising on child protection should be taken up by paediatric associations across Africa and involve national leaders and opinion leaders in the community.

A comprehensive system for regular data collection and information sharing between agencies working in child protection should be mandatory. Most health institutions in Africa have well established structures for collecting routine data but oddly child protection data is not captured. This remains a key reason why specific data on child violence, abuse and exploitation is lacking on the continent. Governments should be specifically lobbied to include child protection data. Harmful cultural practices should be confronted by the full force of the law. Child marriage for instance and female genital mutilation are against the law in most countries that have ratified the United Nations Convention on the Rights of the Child. As breaches of national law, sanctions must be applied by Governments. Africa still has a long way to go regarding entrenched, harmful, cultural practices.

One potential solution for rural districts in resource poor countries can include so-called "Child Panels". These are made up of representatives from both government and traditional institutions to deal with cases that are not serious enough to go to courts like the Circuit or High courts. Family Tribunals and Juvenile Court Panels can be set up in a similar way. At the community level, local protection systems should ideally be fully owned and led by community members elected through representative processes. It should be noted that the vast majority of services which exist in communities to deal with child protection cases (e.g. religious, educational, administrative, health and police bodies) are general community structures rather than specialised services for children who have been harmed [9]. As a result, children in need of such a service are less likely to know of their existence. That said, most countries in resource limited settings are likely better off exploiting the most prevalent existing community-level services (such as churches, mosques, teachers, traditional leaders and District Assembly persons) through targeted awareness, sensitisation and capacity building work to improve the confidence of community members to approach them [9]. Community-based child protection bodies can encourage open discussion of violence against children in communities and can identify services and persons whom children trust in the schools, institutions, villages and police stations to safely and

Table 2

Child sexual abuse must be considered with the following presentations.

1. Where a child makes an allegation of sexual abuse to anyone at any time
2. Where a responsible adult is worried about child sexual abuse
3. Pregnancy in a child aged less than sixteen years
4. A sexually transmitted infection in a child
5. Ano-genital injury in a girl or boy with an absent or implausible explanation
6. Unexplained vaginal bleeding with an absent or implausible explanation
7. Unexplained rectal bleeding in a child with an absent or implausible explanation
8. Vaginal discharge in a child
9. Insertion of a foreign body into the anus or vagina
10. Soiling, bowel disturbance, or enuresis
11. Behavioural-related problems, including: self-harm, aggression, poor school performance, sexualised behaviours, recurrent abdominal pain, enuresis or headaches
12. Evidence of physical abuse, emotional abuse or neglect should prompt a concern for child sexual abuse

* Urethral prolapse is a fairly common finding in the Child Protection Unit at Korle bu Hospital, Ghana [33].

Table 3

Recommendations for protecting children from abuse in resource poor settings [39].

1. Multi-disciplinary and integrated systems should be established in every country to ensure, not only that laws to protect children are in place, but are enforced by a suitably trained and supported criminal justice system
2. Education in the recognition of abuse must be evidenced based but also accompanied by an immediate and effective system available to protect that child or other members of the family as relevant
3. Certain kinds of abuse, which involve personal or financial gain must be addressed by an adequately trained, funded and forensically supported victim support police unit
4. All health facilities must have staff and systems in place to recognise and manage abuse in any child presenting with symptoms and/or signs of this common cause of serious health problems
5. Those who work to protect children from abuse must be supported in this difficult work and when necessary also protected; mandatory reporting of abuse may facilitate this process
6. Some aspects of healthcare are harmful and healthcare associated abuse to children must be addressed

confidentially report and talk with.

At the hospital level, creating specific guidance, and setting up designated child friendly areas should be encouraged (such as the one set up at Korle bu Hospital in Ghana in 2009) [33]. A good approach to setting up such centres has been summarised by Molyneux and colleagues in Malawi as the A-F of building a multi-agency, child protection team (Box 3) [38]. Southall and MacDonald in their landmark paper on protecting children from abuse in resource poor settings made the recommendations described in Table 3 [39]. In their paper they recommended a global action plan for child protection to take forward their recommendations.

Conclusions

Child abuse is one of the major public health challenges currently facing most African countries. The lack of data, and more worryingly the lack of guidelines to manage child abuse in most emergency settings, hospitals and healthcare facilities looking after children has created a huge gap in child protection service delivery. This trend can be reversed with education of the public on forms of violence and the rights of children as long as governments, along with its health sectors, social services and justice systems wake up to this serious threat, not only to African children, but of course to its future adults as well. More research on the economic impact of child abuse such as child trafficking, child labour, commercial sexual exploitation, the direct financial healthcare implications of abused children presenting to healthcare providers, and how income levels and poverty impacts on child protection will go a long way to convince Governments to resource local child protection and prevention services.

Conflicts of interest

The authors have no conflicts to declare.

Authors' contributions

EB produced the entire manuscript from conception and drafting to the final version.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.afjem.2017.09.002>.

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