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<td>-beating by the police for 3 consecutive days for they thought that she lied about her age problem of accommodation (room and bed)</td>
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<td>-Regretting for what he did -Started behaving well</td>
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<td>11</td>
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<td>Remaining reason</td>
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<td>13</td>
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<td>16</td>
<td>M</td>
<td>A.A</td>
<td>W.28 K.02</td>
<td>Group fighting</td>
<td>Feb'00</td>
<td>12 (But his mother told him recently that he is 16)</td>
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<td>14</td>
<td>M</td>
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<td>10</td>
<td>-</td>
<td>Food</td>
<td>-Problem of accommodation (He was sleeping on the floor in an open air (verandah))</td>
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<td>-Food</td>
<td>-Developing a desire to learn as he has no peer-influence which pushed him into committing the offense (doubtful Change)</td>
<td>Some guards beat him as he escaped once, the guards suspicious of his movements</td>
</tr>
<tr>
<td>11</td>
<td>-</td>
<td>Food bath</td>
<td>- (He said that he was treated nicely by the police. Because they knew him as a beggar before; they felt sorry for him)</td>
<td>12</td>
<td>-Food</td>
<td>- Developing the habit of work; he was a beggar before</td>
<td>He is tired of being beaten by some guards</td>
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<td>12</td>
<td>-</td>
<td>Food</td>
<td>-</td>
<td>12</td>
<td>-Food</td>
<td>-Developing the habit of obeying others and working</td>
<td>-Some of the guards prevent him from playing for fear of escape</td>
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<td>Address</td>
<td>Extending stay</td>
<td>Offence Date (Period)</td>
<td>Age at the time of the offence</td>
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<td>15</td>
<td>16</td>
<td>M</td>
<td>A.A</td>
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<td>Wello (Dawa)</td>
<td>Yesha Michael</td>
<td>Dec'99</td>
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<td>18</td>
<td>14</td>
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<td>-Beating by the police for not cleaning the room</td>
<td>20-50</td>
<td>-Food</td>
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<td>- Beating by some of the attendants and guards.</td>
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<td></td>
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<td>-Clothing</td>
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<td>-Counseling</td>
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<td></td>
<td>(Which he discontinued after he escaped)</td>
<td>-Maimaking</td>
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<td>Food</td>
<td>-Problem of accommodation (bed)</td>
<td>15-30</td>
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<td>-not being able to get health care</td>
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<td>-Clothing</td>
<td>-</td>
<td>-Food (the 'Shiro' is not cooked well)</td>
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<td>-health care</td>
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<td>-Clothing</td>
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<td>-Counseling (only once)</td>
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<td>-Vocational training (carpentry)</td>
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<td>- Hands getting hurt by the farm work</td>
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<td>Address</td>
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<td>No. of Participants of the offence</td>
<td>Whether or not Age determination in above</td>
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<td>A.A W.24 K.14</td>
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<td>March 99</td>
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<td>M</td>
<td>Wollo</td>
<td>Addis Ababa Woreda Piassa K.03</td>
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<td>Food</td>
<td>-Beating by the Police</td>
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<td>-Food</td>
<td>- Started behaving well</td>
<td>- A beating by another child of offender</td>
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<td>- Vocational (sewing)</td>
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<td>(He only stayed for 7 days which is too early to show a behavior change)</td>
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<td>(mat-making)</td>
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EXECUTIVE SUMMARY

Introduction

Child abuse and neglect is a serious social pathology prevailing in various societies across the world. The problem is multifaceted and complex (Hiatt, et al., 1998). It involves a number of intertwined economic, social, cultural and psychological factors.

So far, many scholars have exerted a lot of efforts to give meaningful and comprehensive explanations to the term child abuse and neglect. The famous definition given by David Gil explains child abuse and neglect as: "Any action of commission or omission by individuals, institutions or society as a whole and any conditions resulting from such actions or enactions which deprive children of their equal rights and liberties and/or interfere with their optimal development" (Gil, as cited in Kebebew, 1991:18). Despite its comprehensiveness and popularity, Gil's definition has never escaped criticism for being too broad to be practical.

In simpler and more direct terms, child abuse and neglect is stated as: "The physical or emotional mistreatment and neglect of children or their sexual exploitation, in circumstances for which the parents can be held responsible through acts of commission or omission" (Doyle, 1997:2.

Child abuse takes different forms: physical, such as battering, burning, homicide, abandonment and deprivation of basic necessities; sexual, including rape, child prostitution, incest, sexual intercourse with immature children, Female Genital Mutilation and early marriage; and emotional, such as verbal attacks, deprivation of attention/love, as well as confinement of children (CYAO and Italian Cooperation, 1995; Original, 1996; Moyeya, 1998).

Physical and sexual maltreatment of children have been witnessed throughout the history of mankind (Hiatt, et al., 1998). However, the issue of child abuse had never been given due attention until the last quarter of the nineteenth century, when the case of a battered and starved child named Merry Ellen got publicized. Starting from that time, pressure groups persuaded the American legislature in promulgating the first ever recorded statute or law against child abuse (Grumet, as cited in Amare, 1992). Later on, in 1924, there came the Geneva Declaration on the rights of children which served as a basis for the currently used and most ratified Convention on the Rights of the Child adopted by the UN, and played perhaps the initial role in presenting and forwarding the issue to a global level.

In the Ethiopian context, it is presumed that the first statutes concerned with child rights, in the modern sense, were provided in the 1957 Civil and Penal Codes. Nevertheless, issues related to child abuse and neglect have been handled in fragmented, inadequate and ambiguous manners (Amare, 1992).

Prevention of child abuse and neglect is something that deserves great attention from individuals, communities as well as governmental and non-governmental institutions, as this means protecting children (the future of a society) from the hazards of physical, emotional and sexual types of mistreatment.
However, once the problem of child abuse has occurred, what needs to be emphasized is the management of individual cases in the medico-legal and psycho-social contexts. In this regard, various professionals are liaised with one another in the handling of an abused child in the whole process of medical examination, treatment, rehabilitation of the victim and/or the abuser, and the prosecution of alleged perpetrator(s) (Doyle, 1998). In its broad sense, the process of child abuse management involves health professionals, the police, social workers, legal experts as well as the family and community members at large.

Apart from child abuse management, this study entertains issues related to the process of age determination for young offenders as well as ways and means of tackling juvenile delinquency. The process of age determination is mainly handled in the premises of a hospital or any other health institution that is capable of doing so, but indirectly involving the police, legal experts and some other professionals from various institutions.

Under the Ethiopian Criminal Law, a child offender or a juvenile delinquent is an individual whose age is between 9 and 15 years, and his/her case is to be seen in a special juvenile court (Getachew, 1994). Moreover, offenders who are less than 18 years of age are given immunity from such sentences as life imprisonment and death penalty... (CYAO, et al., 1996).

The need to medically ascertain the age of an alleged offender arises when the suspect conceals (or is presumed to conceal) his/her actual age and claims to be 15 or below, or when the alleged offender's physical appearance looks very young. Other factors, such as the severity of the crime committed and recidivistic nature of the individual would further evoke the need for age determination (CYAO, et al., 1996).

To ascertain the age of an alleged offender, the medical professionals use various methods in a complementary way, such as dental examination, close look at genital and endocrine development, distribution of pubic hair as well as the development of bones. On the basis of consensus, the professionals finally issue the age of the alleged offender mainly in a certain range. Then, the legal prosecution is made based on the age determination result.

General Objectives of the Study

The main objectives of this study are to assess all major issues involved in child abuse management and simultaneously investigate the process of age determination for young offenders as well as ways and means of tackling the problem of juvenile delinquency.

Research Methods and Materials

This is a qualitative type of study employing ethnographic methods of data collection, such as focus group discussion, in-depth interviews and case studies. Discussions and in-dept interviews were held with various professionals as well as detained child abusers and child offenders. All discussions and interviews were audio taped, transcribed, translated and interpreted. In addition, secondary data from relevant institutions as well as related literature from local and abroad have been utilized.
Major Findings

1. The Main Problems in Child Abuse Management

(a) Victims' failure to come to the health institution/police station in time makes the whole process very difficult.
(b) It is not practically possible to perform HIV test for every case of sexual abuse committed. In many cases, even tests for other STDs were missing.
(c) The physicians feel unsafe to report a case of child abuse to the police; children and parents are also ashamed of reporting especially sexual abuse.
(d) The health professionals take too much time to issue a medical evidence; the medical evidence is also so brief that it cannot contain the required details about the victim.
(e) There is shortage of senior physicians in the hospitals and consequently the number of cases to be seen and finalized is highly restricted.
(f) Teamwork and psychological treatment for abused children were not practiced in most cases.
(g) As there is shortage of child welfare institutions, it has been a major problem to help abused children after prosecuting their parents who have committed abusive acts; etc.

2. The Main Problems Encountered in the Process of Age Determination

(a) Lack of formally assigned medical personnel to do the job of age determination
(b) The whole process could be delayed if one of the doctors in the board is missing
(c) Transportation problem; the police and the child offenders often go on foot from the police station to the hospital
(d) The physicians give the least priority to age determination, as compared to other tasks
(e) The age determination task is performed only once in a week, the physicians considering about ten cases.
(f) The non-existence of organized clinic or lack of separate office that follows up the smooth running of matters related to age determination; there are times when age determination results are stolen and erased for the purpose of alternation.
(g) Lack of administrative personnel who can handle technical matters.
(h) Lack of essential equipment, and trained personnel for the purpose of age determination
(i) Time constraint on the part of physicians who are very much occupied by other activities in treating patients, and clients failure to appear in time, and so

4. Pertinent Measures Suggested:

Based on the findings of this study, the researcher recommends the following measures in order to improve child abuse management, facilitate the process of age determination for young offenders and tackle the problem of juvenile delinquency.

(a) All the concerned bodies ought to work in coordination and with mutual understanding, and thereby contribute to the improvement of children's conditions in general and child abuse management in particular.
(b) Medical evidences should indicate in detail the harm inflicted upon the abused child, and if possible, indicating the prospects of the victim in light of the damage faced. The health professionals should be well-informed as to what kinds of evidence the police want, and the police should also understand the limitations.

(c) Health professionals should report any form of child abuse to the Child Protection Units, making the necessary follow-ups then after, to see how the police and the law respond to the situation. Further, ways and means need to be devised whereby both health professionals and victims are encouraged to feel secured while reporting any cases of abuse.

(d) At a general hospital, specific persons who are directly responsible to deal with child abuse management should be assigned.

(e) Apart from hospitals, other health institutions (health centres and clinics) are required to pave the ways to handle cases of child abuse properly. To this effect, they need to have at least the basic facilities. Organizing a series of seminars and workshops for the practitioners should be emphasized.

(f) There is a need to separate the child from the abuser for some time after completing treatment at the hospital or any other health institution. In view of this, the establishment of child-friendly clinic which can provide victims with some sort of psychological support and handle other related matters is so essential.

(g) An institution or child-friendly clinic which can perform age determination and treat abused children should be established as a pilot scheme. Then, appropriate training ought to be given to those professionals who deal with these two issues in such a way that they do it effectively at their work place. Such a special centre can help in getting complete evidences with good judicial relevance.

(h) A clear protocol has to be developed and used for age determination, and the job needs to be handled in line with the established protocol. This is what usually creates delay of age determination results.

(i) There could be suspected child offenders who have birth certificates or registered birth dates; hence, before sending children to a hospital, thorough assessment has to be made. These help to make up for the questionable validity.

(j) Juvenile delinquents should only be seen in the juvenile court. If possible, in a separate and comfortable premise that makes them feel at ease. Besides, the judges, prosecutors and professionals who work for the preservation of the rights of the child should get some training on how to deal with children.

(k) The police should understand the law very well and act accordingly. They should take good care in assembling and keeping evidences, because intended or unintended destruction of evidences has been reported by some victims. Moreover, they need to take the detained children to the juvenile court within the acceptable time-frame.
(l) With appropriate transformations and the provision of essential materials and human resources, CPUs should be replicated and adopted on a larger scale, with more committed efforts to reach more children in distress in the city.

(m) The mass media should dedicate ample network time to children’s issues.
In every part of the world in general, and in a developing country like Ethiopia in particular, children experience difficulties because cities are generally not built with their "healthy, happy growth and development" in mind. As a result, in many developing countries, a lot of urban parents and children bear the additional burden of absolute poverty, insecurity of tenure, poor or nonexistent infrastructure, as well as inadequate and diminishing social, educational and health services (Blanc, 1994).

Compared with the rural sector, the urban sector may appear economically privileged, but it conceals severe problems of resource distribution. Because of their rapidly rising numbers, the shortcomings of municipal management, and the deterioration of the social and physical environment, urban living is often extremely harsh and exploitative for young people and children. The feelings of marginalization of urban poor families are augmented by the striking contrasts with more affluent urban families.

Current demographic indices show that, in Ethiopia, there is fertility level of 7.7 children per woman and the population grows at an estimated rate of 3.1 percent per year despite the high infant mortality as well as maternal morbidity and the low life expectancy at birth. The population age structure is usually pyramidal in shape with children occupying the broad base. The proportion of children below the age of 15 to the total population of the country has retrospectively been 33% in 1961, 46.5% in 1987, and 48.56% in 1994 showing an increase in the trend (Almaz and Gobena, 1994). This is also true for Addis Ababa's case which comprises 37.74 percent of the country's total urban inhabitants, children making almost half of its population with an annual growth rate of 4.3 percent (CSA cited in Getachew, 1994). About 60% of the dwellers of Addis Ababa live below poverty line and mother headed families prevail in one third to half of the city's population (UN-EPPG cited in Getachew, 1994). Hence this preponderance of young population and the widespread of poverty as well as disruptions of families could potentially mark the possible existence and high incidence or prevalence of abuses and other child related problems in the country. It is in view of this condition that the problems of child abuse and child offences are more severe in an urban area like Addis Ababa.

A wide range of conditions that are likely to affect either children's physical or emotional well-being or their normal development is referred to as child abuse. These conditions include physical injuries, failure to thrive, neglect or lack of adequate care, failure in stimulation, supervision, and protection, emotional/psychological abuse and sexual abuse. Moreover, actions such as exploitation, maltreatment, abandonment of children by their parents, guardians or caretakers which leave temporary or permanent physical and psychological problems on the child are referred to as child abuse.

There is no single agreed definition for child or young offender. A juvenile delinquent is defined as a child whose "... anti social tendencies appear (to be) so grave that he becomes or ought to become, the subject of official action" (Burt, as quoted in Andargachew, 1988).
When we come to child abuse management, abused children are seen at all levels of health institutions (clinics, health centers, and hospitals) and are usually brought to these places by the police or parents or relatives. Initial examination is done along with the sick children in the usual outpatient emergency department.

Sexual abuse (molestation or rape) is suspected from the history offered by the victim and is confirmed by a physical examination although not often diagnostic. Once the diagnosis has been made, the physician is expected to: (i) invite the social worker to help the victim, and (ii) urge the parents/guardians to report the case to the police as they are legally obliged to do so. The physician also conforms to the parents/guardians that the problem is manageable, and the goal of investigation is not to punish but to help parents with better ways of dealing with children’s needs and providing them with protection.

In principle, within one week from the first admission of an abused child, evaluations have to be completed, and the team should meet to decide on the immediate and long-term plans. The pediatrician coordinates the health care for an abused child, while the social worker is responsible for coordinating the home visit and evaluation of overall situation of the family.

The main problem seems to be the absence of well organized and smooth communication system. Even though the medical and surgical management is adequate, lack of social and psychological services in the management makes the work incomplete. Usually, physicians have no time to counsel abused children and their parents/guardians because of work overload. In addition, there is lack of coordination and team work between the physician, the social worker, the psychologist, and the police.

Almost all referrals for age determination come from police stations. So far, the work have been carried out in 2 hospitals in Addis Ababa, namely Tikur Anbessa and Yekatit 12 hospitals. Any child offender presented to the hospital has to pass through the registration room, examining doctors, the X-ray department and for the final decision the case is presented to the board which consists of members (radiologist, pediatrician or an internist and Medical Director). Both hospitals are obliged to limit the number of cases they deal with to less than fifteen per week due to staff shortage and work overload.

Delay in the production of medical evidences for both abused children and child offenders is attributed to absence of coordination, frequent shifting of board members, shortage of time (particularly on the part of physicians due to other commitments), absence of incentives as well as lack of good working system, training and essential facilities. Taking such problems into account, a series of meetings were held by Addis Ababa Administration Health Bureau, Addis Ababa Police Commission and Forum on the Street Children Ethiopia (FSCE). Ultimately, the concerned bodies agreed upon the idea that a study needs to be conducted in order to assess the prevailing problems, and design improved modes of operation.

This study is, therefore, relevant to the current situations where severe physical and emotional aspects of child abuse are being reported to the police, and actual cases of child abuse are presented by the media. Despite the severity of the problem in the country in general and in Addis Ababa in particular, our knowledge of the problems and processes involved in management of child abuse and age determination in health institutions is meager. The purpose of this study is to identify the existing problems in handling child offenders and abused children.
in the medical institutions in the city, and to come up with possible solutions to tackle the problems and pave the way to improve the existing mode of operation.

1.1. Objectives of the Study

General Objectives

To assess the management of abused children in health and other institutions; and to investigate the activities involved in age determination for child offenders as they are carried out in different health institutions in Addis Ababa.

Specific Objectives

♦ To identify the major problems in the production of medical evidences for abused children referred to different health institutions in the city.

♦ To identify the problems in determining the ages of child offenders in the two hospitals in Addis Ababa (Black Lion and Yekatit 12).

♦ To make feasible recommendations for the better management of child abuse and age determination for child offenders.

1.2. Methods and Materials

Study Design

Qualitative (ethnographic) methods of data collection, such as focus group discussions, in-depth interviews and case studies have been used.

Using the aforementioned study techniques, relevant data from ten police stations have been collected; these include woredas: 2, 3, 5, 6, 7, 13, 14, 15, 21 and 23. They were selected mainly because they have Child Protection Unit in their premises. In-depth interviews and focus group discussions were held with the police and para-social workers who have been engaged in the activities of the Child Protection Units as well as with criminal investigators of the police stations. The researcher had also an opportunity to interview child offenders in the custody of the respective police stations. Wherever possible, abused children and abusers were interviewed. Furthermore, relevant secondary information was collected from each of the police stations.

After completing data collection from police stations, the researcher switched to Region 14 health institutions. Data on age determination were collected from Yekatit 12 and Black Lion hospitals. Medical directors, radiologists, pediatricians, internists, endocrinologists, and orthopedists were interviewed on various issues in age determination. Relevant data on child abuse management were also collected from different health institutions. Three pediatric hospitals and four health centers were selected from Addis Ababa. The hospitals include: Black Lion, Yekatit 12 and Zewditu; and the health centers are those situated in such areas: Shiromeda, Yeka, Woreda 23, and Addis Ketema. All the interviews were audio taped, transcribed and translated.
Discussions (focus group and in-depth interviews) were held with concerned professionals (physicians, psychologists, social workers, judges, lawyers, etc); these are people who have participated in the handling of issues related to children. Attempts have been made to gather information on the possible causes of the problems and solutions they envisage as well as the experiences they have accumulated in the course of discharging their day-to-day duties and responsibilities. African Network for the Prevention of and Protection Against Child Abuse and Neglect (ANPPCAN)- Ethiopian Chapter, Region 14 Police Commission Child Protection Unit (CPU), Forum on the Street Children Ethiopia (FSCE), Rehabilitation Institute for Juvenile Delinquents, and Ethiopian Women Lawyers’ Association (EWLA) are some of the institutions included in the study. The educational backgrounds of the professionals are diverse, including lawyers, psychologists and sociologists working at different capacities in their respective institutions.

Twenty suspected and/or identified child offenders staying at Rehabilitation Institute for Juvenile Delinquents were also interviewed. Apart from these, interviews were held with mature children who were actually or reportedly abused by their parents and others. Although few in number, abusers whom we managed to find in the police custody were also interviewed.

Moreover, attempts have been made to gather statistical data on child abuse management and age determination process (from hospitals, health centers, child-care institutions, courts and police stations). However, it has been an unsatisfactory venture as recording of information in many institutions in this country is very poor and unsystematized. In addition, many foreign and local written materials were reviewed to have some basic ideas about the background of the problem.

Analyses and Interpretations

Qualitative research methodology utilizes analysis and interpretation procedures that produce descriptive data, presenting the respondents’ views and experiences in their own words (Sarantakos, 1993).

Interviews were conducted in Amharic by the principal investigator while the research assistant was taking notes. All interviews were recorded on audio tapes. In order to retain their original quality and richness in language and content, recorded interview sessions were transcribed verbatim. The data transcribed in Amharic language have been translated into English, prior to any form of analysis.

After meticulous reading and understanding of the recorded material, summarizing, coding and categorizing have been carried out in order to integrate, transform and highlight the data for presentation. These mainly involved identification of the most important aspects of the issue under consideration, and categorization of the material for the purpose of analysis. Essential pieces of information have been assembled around certain themes and points, categorized in more specific terms, and the results have been presented in text. Finally, patterns, trends and other explanations have been discovered in order to make decisions and draw conclusions pertaining to the research questions.

Pilot Study
The draft interview guides and questionnaires were pilot-tested with two to four subjects from each category to determine the feasibility and acceptability of the interview guides and questionnaires, in order to revise and modify these instruments before preparing the final version.

1.3. Ethical Implications

Written information that clearly indicates the researcher and the sponsoring organization was provided to the respondents in a way which is easy to understand and does not disempower them, and verbal consent was obtained in each case.
CHAPTER TWO
LITERATURE REVIEW

2.1. The Concept of Child Abuse and Neglect

Child abuse and neglect is a universal problem prevailing throughout the various societies of the world. The issue under discussion is so complex and multifaceted that making clear-cut demarcations in defining the phrase has been a very tedious job (Hiatt et al, 1998).

However, many scholars in the field have exerted and made their own efforts and contributions in giving meaningful explanations to the term. The famous definition so far given by David Gil states child abuse and neglect as "Any action of commission or omission by individuals, institutions, or society as a whole and any conditions resulting from such acts or enactions which deprive children of their equal rights and liberties and/or interfere with their optimal development" (Gil as cited in Kebebew 1991:18). Despite its wide acceptance, this definition is criticized for being very broad and hence impractical or unrealistic (Amare, 1992). Generally, in simpler and more direct terms, child abuse is explained to mean "The physical or emotional mistreatment and neglect of children or their sexual exploitation, in circumstances for which the parents can be held responsible through acts of commission or omission" (Doyle, 1997:2). While defining child abuse and neglect, Milner as cited in Litty, et al., 1996 gives emphasis to the physical aspects of the abuse (injury) that are inflicted upon a child through those means other than accidental, potentially having risks of death, impairment/disfigurement of health or of any of the body organs. This explanation, however, fails to incorporate the long lasting post-traumatic psychological problems that the child would develop thereafter.

Child abuse takes different forms including the physical, sexual and emotional types. Battering, burning, homicide, abandonment, inattention to health care, deprivation of basic necessities and the like are categorized under physical abuse (CYAO and Italian Cooperation, 1995). Child sexual abuse is any act by an adult towards a child which could be linked to sex in one way or another. Here a wide range of spectrums can be found like indecent exposure, rape, child prostitution, abduction, incest, and sexual intercourse with children not attaining maturity. Moreover, the so called invisible abuses- Female Genital Mutilation (FGM) and early marriage- are classified under sexual abuse (CYAO and Italian Cooperation, 1995; Original, 1996; Mayeya, 1998). The emotional category of abuse encompasses such behaviors as verbal attacks, deprivation of attention and confinement of children (CYAO and Italian Cooperation).

2.2 Child Abuse Management

Once the problem of child abuse has occurred, what is of more emphasis is the management of individual cases in the medico-legal and psycho-social contexts. Here, various professionals are liaised with one another in the handling of an abused child in the whole process of medical diagnosis, treatment, rehabilitation or counseling of the victim and/or the abuser, and possible prosecution of alleged perpetrators (Doyle, 1998).
Providing emergency care is the immediate goal of the physician prior to giving medical advice and/or counseling to the abused children. Medical and surgical treatments are administered to victims on the basis of necessity. In the meantime, data are to be gathered and detail documentation are to be performed on the circumstances as well as the extent of the damage (injury) indicated, so as to verify the suspicion of abuses, with reliable and objective evidences (Getnet, 1994).

History taking should be quite unhurried and is to be done in a relaxed atmosphere. It must be taken devoid of bias in a nonjudgmental and neutral way. The information required is on details of the child's parental and social backgrounds, prior health status and history of abuse against the child, identity and relationship of the abuser to the child, and so on (Cannavan, 1981; Gordon and Jaudes; 1996; Nyathi, 1998; Iliff, 1998). In many cases, what the child tells is not detailed enough and more information (especially in sexual abuse cases) should be coaxed out, such as who took off the panties, what did the child see, how much of the ‘pencil’ penetrated, pain felt, smell, bleeding, what happened afterwards, has she washed, did she tell anyone, etc. If not, why was she threatened, a reward offered... (Nyathi, 1996:19).

Many researchers stress that the medical examinations are to be administered in such a way that children would not associate them with advances to further abuse particularly in cases of sexual abuse. As it is illustrated, in instances "...where a child has been violently raped, the examination may feel like another rape" (ibid). Abused children are mostly withdrawn, anxious and ashamed. Caution should be taken while dealing with sensitive areas or issues; if otherwise, children will refresh their memories of the abuse and helping them would become a complicated task. The pediatrician, during examination, has to start with less threatening parts like hands, feet, mouth, abdomen before going to genitals (Cannavan, 1981; Iliff, 1998). In some difficult circumstances, children have to be given oral sedation prior to the examination period or if a longer investigation is needed, the diagnosis should be done under a state of anesthesia (Cannavan, 1981; Nyathi, 1998).

Depending upon the severity of the injury incurred and for various other reasons, children could either be admitted in the hospital or would be seen as outpatient. Usually, for hospitalized abused children, the hospital wards serve them as "a place of sanctuary, refuge, safety and healing" (Nyathi, 1998:19). Follow-up visits are basically made and children will be given different medical treatments (Iliff, 1998).

The medical treatment alone can not bring about the desired change and result in the abused children. Such children are emotionally imprisoned by the very experiences of the abuse. The fear, mistrust, self denigration and isolation could continually and permanently persist inside them. In order to come up with good results, these children have to be released from such misconception and negative emotions they have developed throughout Dole, 1997). This could possibly be solved through counseling and rehabilitation of children by a multi-disciplinary team of clinical psychologists, social workers, psychiatric nurses and the like in combination with the medical professionals (Parsons et al 1998).

The psychotherapies (rehabilitation) could be done on an individual (one-to-one) basis, by working with children in the family context and through group work with abused children. In the former, the child is helped to feel safe and to have good sense of feeling through positive messages communicated to him/her. Moreover, the child is enabled to adopt new roles and is taught about his/her right never to be further abused. These are essentially achieved through more
than a single follow-up session. The next phase would be family therapy. It is done with the belief that helping the child should be within the family context for much of the abuse takes place there. This therapy helps to re-stimulate or arouse long-buried affection and to transform the family back into a normal state providing children with a 'good enough' environment. Further, family therapy goes in line with the system theory, as a change in an individual part will bring about change in the total system. The other method is to help abused children in different group settings. By bringing children with similar experiences together, it is intended to help them share their feelings so that they realize that it is not only them who have been so abused. In addition, positive messages could smoothly be reinforced since children (especially adolescents) are more influenced by their peers than grown-up professionals (Doyle, 1997).

Child abuse management guidelines already in use by health professionals in a developing country like Ethiopia reflect western models which constrain the physician to directly apply them to an economic and socio-cultural milieu of a different traditional society. Hence, a need arises to develop local indices of trauma which may not be the same as the western indicators (Getnet, 1994; Parsons, et al., 1998). Moreover, in a country with shortage of well trained human resources and poorly developed infrastructure such as ours, it is common sense that proper and coordinated management of abused children would not potentially be realized in the strict sense of the term. As a result, helping an abused child would hardly exceed beyond curing the bodily (physical) damages. This lack or inadequacy of the psychotherapeutic aspect of the treatment would then make the whole management incomplete.

In some countries, reports of child abuse are handled by special sections of the police force. In Zimbabwe, for instance, such cases are currently policed by Victim Friendly Units (VFUs) that are established in some police stations. In-service training is given to the members of the units by police college staff or provincial training centers, on methods of handling abused children. The VFUs came recently into existence after Zimbabwe ratified the United Nations (UN) Convention on the Rights of the Child (ibid).

Prevention of a problem (child abuse and neglect) can broadly take place at any of the three traditional levels: primary, secondary and tertiary. In the primary prevention, the whole population is involved and it takes place before the occurrence of any abuse or neglect. Hence, encompassed are education for students on parenting, teaching prospective and new parents on better ways of child bearing and the use of different techniques to increase attachment to newborns. Further, poverty reduction, alleviation of stressful situations, rendering of better employment opportunities could also be aimed at primary prevention. In the secondary level of prevention, high risk population groups with difficulty of parenting and in need of help are targeted in order to intervene before abuse actually occurs. These groups include: low self-esteem and isolated parents who were themselves abused in their childhood, and those (not necessarily always) living in poverty, under stressful situation, taking much alcohol or drug. The last one, tertiary prevention, is the least controversial and simply to mean treatment after abuse or neglect has already occurred. Under this, parents are initially treated to prevent the problem from recurring, to keep the family intact, to re-unite disrupted families, or when the need arises, to help other families take responsibility of caring for the child. In the mean time, children too are given various treatments in order to stop "the generational cycle of abuse and neglect" (Gray, 1981; Browne and Lynch 1994).

"In recent times, the main aim of intervention in child abuse case has been to 're-form' abusive families and only in the most serious and intractable cases to rescue the child and restrain the
parents” (Doyle, 1997:2). This could be a best strategy in a country like ours where foster cares or child welfare agencies are "hard to come by" and this need of reformation or rehabilitation could be further strengthened by the belief that children's needs are '.best met by their own parents until proven otherwise” even in those areas where there are favorable conditions for child protective services(Getnet, 1994:95).

2.3 Age Determination for Young Offenders

Under the Ethiopian Criminal Law, a child offender or juvenile delinquent is a person within the age range of 9-15 years committing crimes and whose case is particularly seen in special juvenile court (Getachew, 1994). This sets the age of criminal responsibility at nine and the privileges and special arrangements that those children under 15 would have before the law. Further, offenders less than 18 years of age are immune from such sentences as life imprisonment and death penalties. Apart from this, as a privilege, the Criminal Procedure Code "provides for the informal, incamera, unrecorded and quick disposition of juvenile cases by courts, without juvenile being subjected to the formal police investigator or judicial process” (CYAO, et al., 1996:ii).

Many of these special legal provisions for juveniles, however, are constrained from realization/implementation due to the existing unclear and less detailed rules as well as lack of the essential institutions for undertaking them (ibid). In the entire country, there is only one remand home located in Addis Ababa with a capacity of accommodating 150 male young offenders at a time (ibid; Getachew, 1994). More surprisingly, a single judge manages such cases in a country where children comprise half of the total population. Due to the reluctance of courts frequently seen in the handling of juveniles, the police intervene and in the absence of clear rules, "apply normal procedures of investigation applicable to adults” upon child offenders. Further, young offenders are detained together with adult criminals making the situation worse. In the investigation process as well, the police encounter a problem in determining the ages of the offenders, for there is no official birth recording system in the country (CYAO, et al., 1996).

In Ethiopia, school certificates, birth certificates by religious institutions and municipalities are the ones usually used for proving the age of an individual which, however, are often liable to forgery. Hence, child offenders are required to pass through relevant medical examinations to ascertain their actual age (ibid).

Though external appearances or facial changes could remark growth or development of an individual, they are not the fundamental basis or criteria and hence of little value in an estimation of age. Rather, dental or skeletal examinations by qualified physicians are the ones that usually give a far more reliable data or information needed in age determination (ibid), “During childhood, cranial development can be seen clinically and also with the aid of radiographs” (ibid, p.6).

Ages can be investigated from the teeth by employing anatomical, radiographic, microscopic and chemical techniques. Truly, the state of the teeth is more closely correlated to age than any other hard tissues of the body (Johanson, 1971). "In the age periods up to 14 years, there is a continuous change in the dentition and the jaws with formation, mineralization, eruption and loss of the deciduous (milk) teeth. At the same time the permanent teeth are formed, mineralized,
erupted and changed" (ibid:121). Radiographs (X-rays) can most easily give estimations during these ages (ibid). From soon after conception to early adult life, the development and fusion of centers of ossification helps to estimate ages with fair accuracy (Simpson 1964; Gee, 1968).

In the Ethiopian case, the need to medically ascertain ages of alleged offenders normally arises when these suspects conceal actual age and claim to be 15 or below (the maximum age for a juvenile delinquent) or when their physical appearances look so young. Other factors like the severity of the crime committed and recidivistic nature of the offenders would further evoke such a need (CYAO, et al., 1996).

Clearly, there are various problems that are linked to the age determination process of suspected young offenders. Court orders to medically ascertain the actual age are demanded "after the suspect has been detained for some time by the police". Even in some of the cases, such court orders are never sought. Further, production of medical evidences are usually sluggish due to the combined effects of budget/resource constraints that the police have as well as the reluctance or less concern on the part of the busy medical institutions to spend their time in examining the age of a "possibly culprit, healthy gangster". In many parts of the country where there are no hospitals or well-equipped medical institutions, the examination process do not involve X-ray and hence hardly exceeds beyond looking at the physical appearance of the suspect (ibid).

When the institutions finally issue certificates, the ages are usually stated in ranges with variations of two to three years. In these instances, the police consider the upper estimations as the age of the suspect where as in many of the cases, the courts take the lower age prescribed. If the medical finding affirm the age of the alleged offender to be under 15 years, then the child will invariably be released in most cases, after the case is presented to the court by the police. If, however, the result in the evidence is different from this, "the investigation and other procedures follow the normal course" (ibid).
CHAPTER THREE

Child Abuse Management in Different Health Institutions

3.1 The Role of Health Professionals in Child Abuse Management

Medical professionals interviewed in this study are from three hospitals (Yekatit 12, Black Lion and Zewditu) as well as from four health centres found at different parts of the city. One of the inquiries raised during focus group discussions is related to the kind of help they usually give to abused children. In reply to this and other queries raised during the discussions, the participants gave ample explanations.

3.1.1 Health Professionals’ Experiences/Knowledge about Child Abuse

Informants form Zewditu Hospital revealed that, on average, two to three abused children come to the hospital everyday. By the time this interview was held, the Pediatrics Department had passed only two days after its establishment. Only sexually abused children were treated. Other kinds of abuse were sent to Yekatit 12 and Black Lion Hospitals.

The respondents noted that while treating an abused child, the first thing to do is asking the child about what happened to him/her, how, when, etc. Then, the necessary physical examination is to be made. He/she is to undergo laboratory tests whenever necessary and possible. So far, victims have been treated individually. In the future, the treatment is likely to follow a team approach.

According to the information secured from Black Lion Hospital (Department of Gynecology and Obstetrics), it is usually the parents who bring abused children to the hospital; of course, teenagers come with their friends. Common cases were young girls who made an appeal for being raped. Apart from these, there never existed a case treated with suspect, based on the claim of the alleged victim. The informant further argued that out of 150 cases, only three girls who had prior sexual experience dared to ask for physical examination as well as the subsequent medical evidences. The rest had witnesses and were rescued either by the police or other people. From this, one can infer that being raped and losing one's virginity mostly match in our country.

Only medical treatment and provision of evidences were carried out in the Department of Gynecology and Obstetrics. The medical treatment includes STD and pregnancy prevention if victims come to the hospital soon after the incident has taken place, and STD treatment for those who come relatively late. The department is not capable of performing HIV test. The sperm cell test is seldom done, to support an appeal against a rape committed in the absence of a witness. There has not been a psychological treatment even if the reminiscences of a rape case have damaging effects.

In a related discussion, it was remarked that treating children who know what happened to them needs a lot of patience and time. Such children are disturbed, and they are frightened by people in the surrounding environment, since they may think that everybody around them is a potential rapist.
So far, treatment of abused children has not been carried out on a team basis; this is due to lack of the required facilities. Nevertheless, the department has begun paving the way by preparing a protocol on management of child abuse cases. It is also working with staff from other departments on ways of mitigating the psychological trauma that emanates from abuse or injury.

While discussing about the issues of referring the abused child and/or parents (abusers) to psychologists for counseling as well as handling the cases using a team-approach, respondents from Yekatit 12 Hospital indicated that there are problems in these areas; there is no responsible body in the hospital for following up cases of abused children. This issue has not been given enough attention. Besides, the health professionals do many curative jobs, and consequently, child abuse as an antisocial act or behavior has not been given due consideration. Team approach to the problem is also lacking.

The other obstacle is that many people do not want to take the responsibility of carrying out the job on a voluntary basis. Short-term training and workshops have not been availed to the health professionals; consequently, they do not think that they are capable of dealing with the issue of child abuse management. There are no specialists who have distinctively prepared themselves for the job in focus. As nobody takes care of this issue seriously, there have been no properly identified cases. Even reporting certain cases of child abuse started only recently.

Informants from Yeka Health Centre pointed out that what caretakers or guardians have been saying about causes of victim's sickness are to be taken with caution. There were many emergency cases treated; however, there were only a few cases of physical abuse identified. In contrast, rape cases were found to be usual incidents.

Health professionals noted that pregnant girls falling in the age-group 14-16 were common and referred to hospitals, bearing that the delivery might be difficult. Among them were rural girls with fistulae problem resulting from the fact that they were not physically mature enough to get pregnant. Moreover, as they lacked psychological readiness to get married, some of them were those who ran away from their homes either when they knew that they were pregnant or after they had given birth to a child.

An instance of rape was a girl brought by her grandfather. She had a tear around her vagina. The girl's grandfather told the doctor that she had fallen down, but that was not satisfactory to explain the girl's trauma. Suspecting that the girl might have been raped, the doctor asked the girl's grandfather if there were boys in the house. Yet, he denied. Later on, the mother came and told the doctor that her husband's male relatives live in the house, and one of them might have raped the girl. The professionals from this health centre treated both boys and girls with genital discharge. The discharge indicates that they were infected with STD; they presumed that a forcible sex has been committed as the children were too young to experience sexual union on consent.

So far, Yeka Health Centre has been providing such services as medical treatment and writing referrals for certain cases. A report has never been made to the police because they probably did not know their responsibility to do so, felt insecure, or else the health professionals have been concentrating on the medical aspect of the matter, putting aside the legal one. A corresponding fact is that none of the respondents knew about the Child Protection Units that have been established at ten police stations in Addis Ababa.
An informant from Woreda 23 Health Centre asserted that she has treated some cases of child abuse. She added that there must have been many such cases she has treated without knowing that they were abuses in essence. Because the reasons given by care-takers as to what happened to the victims blotted out her suspicions.

While referring to her actual experience of child abuse, the informant explained that the first one was a girl aged around six. She was brought to the health centre by a policeman. The policeman informed the physician that the girl was in the custody of some relatives who used to beat her several times; and the beating was reported to the police by some people in the neighborhood.

The second case was that of a girl aged around five. In this case, the victim was brought to the health centre by her parents. They had not seen anything happening to their daughter, but the little girl told them that an attempted rape was committed to her by an older boy whose parents were the lessors of the girl's parents. What the parents wanted to know was if the girl was still virgin or not. The physical examination assured that she was. Surprisingly, they did not want to accuse the boy fearing that they would be forced to move out of their house. Instead, they made an apology for creating discomfort and possibly embarrassment to the family. Ultimately, however, the parents were given some advice to leave the house for good and pursue the boy in court.

According to the informant, the number of sexually abused children increases by two-folds every year, though it is not wide of the mark. Anyhow, it shows that there is awareness about some sorts of child abuse. So, it is enough to present two exceptional cases in which victims were brought by people other than parents or guardians.

A victim was brought by a representative of a certain local NGO. As the victim was from a poor family, she was obliged to work for a man in the neighborhood. Meanwhile, the man raped her several times, and ultimately she was infected with a sexually transmitted disease. The other one was a-seven year-old girl. Her father died, and her mother was living abroad. Thus, the girl was under her uncle's custody. In fact, it was another woman who brought her to the health centre. The girl was brought not because she was abused, as the woman said, but because she was ill. However, the medical examination testified that she was infected with a sexually transmitted disease. After a lot of probing, the girl told the doctor that she had been sleeping with her uncle and raped by him.

The services rendered at Woreda 23 Health Centre were performing physical examination and extending medical advice. The health professionals did not make any report to the police.

The health professionals at Addis Ketema Health Centre revealed that they were treating mostly cases of physical abuse. A case in point is a boy beaten by his own mother; it was the mother who brought him to the centre. As he was badly injured, the boy was referred to a hospital. The sole rape case was a girl sent by a certain women's association. Although there was a pediatrician at that time, she was referred to a hospital since the case was beyond the therapeutic capacity of the health centre.

Respondents remarked that the seminar organized by Region 14 Health Bureau enabled them to be conscious of their responsibility in reporting suspected cases of child abuse, which was not customary before, and to keep a sharp lookout for children who come with genital discharges.
Before the seminar, they used to regard lack of personal hygiene as the cause of genital discharge. In contrast, it was revealed at the seminar that genital discharge might be an indicator of a sexual abuse.

Except a rape case there was not any case of physical abuse treated at Shiro Meda Health Centre. Respondents from this health centre admitted that there might have been cases of child abuse treated without recognition, as it happened in other health institutions. The respondents further explained that there were children treated with genital discharge, without suspecting that it could be one symptom of sexual abuse. Further, one of the informants pointed out that whenever children with physical injuries came, the main concern was giving first aid. The issue of identifying cases of child abuse was not known since there has not been a responsible body that could protect children against all sorts of abuse or harm.

Another informant remembered a case of ‘group-rape’ committed seven years ago. The girl was rescued by the police. She was able to tell him what had happened after regaining her consciousness. The physician actually referred her to a hospital where she could get a better treatment and a medical evidence. This being the case, no report was made to the police due to lack of awareness.

Respondents from Yekatit 12 Hospital indicated that parents are the ones who often bring the abused children. In certain cases, the offenders themselves bring the victims to the hospital. The offenders can be natural parents, step parents, neighbors or strangers. The police may also bring the abused children. However, in cases where the offenders bring the abused children, they usually do that a long time after the occurrence of the incidents, and on top of that provide false information on the abuse cases.

Following this, the respondents were asked about the measures they take whenever they come across child abuse cases. In reply, they remarked that identifying and reporting the cases are crucial issues. However, since the required training are not offered, first of all there is a problem of identifying cases of child abuse. Once the physician has understood the case is child abuse, it would be necessary to report. Nevertheless, there are situations in which the doctor cannot report a case. As reporting adds job burden on the physician, he/she tends to avoid reporting.

3.1.2 How Do the Professionals Identify Child Abuse?

According to the informants from Zewditu Hospital, the ability to identify a child abuse case varies from one professional to another. The highly qualified staff can easily identify a child abuse case, assisted by their ample knowledge and access to current medical information. The less qualified staff, however, can be off the scent for their nodding acquaintance with the subject. In any case, it is still not difficult to differentiate an accident from an abuse. Among other things, it is helpful to analyze the victim's responses to the questions asked by the doctor and some indicative reactions during physical examination.

Informants from Yekatit 12 Hospital explained that, in most cases, there are ways to suspect whether child abuse has taken place or not. In fact, the process can deviate from the normal medical trend. The accident that happens to the body is crucial here. Injuries or wounds around the eye indicate that somebody else has beaten or kicked or boxed the victim. The same holds true for damages occurring to the head.
On the other hand, respondents from Yeka Health Centre remarked that there is lack of awareness about child abuse. Especially in the Ethiopian context where there is a strong adhesion to social norms, values and religion, it is difficult to suspect that parents and relatives can cause all sorts of harm to a child. However, the mass media have nowadays exposed many cases of child abuse and that has increased public awareness about the matter. Thus, the concerned professionals should be suspicious of physical conditions like scar, discharge and bleeding. Nevertheless, many informants highly stressed on the need for seminars, short-term training and workshops in order to achieve better child abuse management as well as preventive endeavors.

A respondent from Woreda 23 Health Centre stressed that an in-depth probing of victims and individuals who bring them to the health institution is very essential since it helps to know who the real care-taker is, to what extent his/her care is reliable and how important is the child to the parents or guardians. Besides, the health professional should not pin his/her hopes on what the victim or the care taker says; rather he/she should make unbiased investigations and judgment. It was also noted that child abuse is not only the usual beating, whipping, burning or rape. Negligence is also another sort of child abuse. For instance, a rash on a baby skin due to nappies that are not changed in time is child abuse by itself. Therefore, any wound that is observed on the child's body should not be seen as something simple. That was why the need for making value judgment was emphasized.

It was generally remarked that one's commitment and diligent effort are required in order to identify cases of child abuse and make the necessary follow-ups until the matter is settled.

### 3.1.3 Summary of the Major Activities of Health Professionals in Child Abuse Management:

1. Rescuing the victim from the offensive situations.
2. Taking history - documenting as to when the abuse was committed and who the perpetrator is, as far as possible.
3. Physical examination of the abused body part.
4. Medical treatment for the admitted victim.
5. Contacting the police through social workers.
6. Offering psychological treatment, especially when the victim has mental disorder or depression.
7. Rehabilitation for the victim on release from the hospital.
8. Providing medical evidences

### 3.2 Controversies and Problems that Revolve around the Provision of Medical Evidences and Writing a Report

Respondents from the various health institutions included in this study indicated that they had encountered the following problems.

- Victims do not come to the health institution in time. Thus, it is difficult to know the harm inflicted upon them. As a result, provision of a medical evidence becomes problematic too.
• The difficulty in performing HIV test is another problem. In the first place, a hospital or health centre does not perform HIV test since there is shortage of facilities; sending samples to other hospitals or medical centres is also costly. Secondly, there has to be a follow-up test every three or six months. In general, as rape is an offence committed mostly in the lower class, the expensive HIV test is not affordable. Moreover, it was remarked that a child who is raped today, may not have HIV if tested tomorrow. It takes time until she becomes seropositive; as there is a time gap known as window period, she has to be tested after 3 or 6 months. It is after the window period that the result is indicated as negative or positive.

• The health professionals pointed out that there is a format for reporting sexual abuse. If one tries to report everything related to sexual abuse, three pages would not suffice. There are many things to be written such as HIV, STDS, and hymen details. It is difficult to accommodate these within a given space of six lines. The first problem is related to the report format used. Secondly, the physicians revealed that they do not exactly know what others (police, court etc.) want to be included in the report. Writing more technical things would not be helpful. They did not clearly understand what the court and the police actually require from them, as far as the report is concerned. It was remarked that it would be better if the format came from them. It would not have been problematic to fill the format accordingly.

• Reporting to the police is a complicated process by itself. If a doctor reports that a girl has been raped, he/she will be asked for evidences that support his/her report which is time-consuming. A case in point is the one cited by respondents from Yekatit 12 Hospital. They tried to visualize the process of reporting from legal perspective. They explained that physicians fear reporting for legal reasons. A physician may say: "If the case reaches the court, I may be called upon as a witness." Nobody wants to be involved in such affairs. Above all, the physician is a busy person who passes much of his valuable time with patients. Moreover, the respondents stated that the physician does not want to report because what he reports as an abuse case may turn out to be otherwise. It depends on several unforeseen factors. The following is quoted from what a participant in the focus group discussion said.

  If the case is a suspected child abuse, the law should give me a protection. If the reported case is not as such a real abuse, the perpetrators may accuse me of false allegation. Under such circumstances, the law should defend the physician. Because, if I do not feel safe, I have the right not to report the suspected or identified cases. In cases where there is suspected abusive acts, there must be something that professes them.

• One of the physicians involved in the focus group discussion narrates his experience as follows:

  If I report that sexual abuse was committed, it means that I am a witness. The perpetrator may also accuse me, denying that he did not do it. When I was working in Yirgalem Hospital, I wrote a report on a rape case. I was then working under the guidance of a foreign physician. He wrote the report in English and I translated it into Amharic, and we released the report. The abuser was a high school director. It was unfortunate that I had to travel from Yirgalem to Awassa, now and then for 3 months. Initially, I refused to go to Awassa when they repeatedly came to give me a warrant. Then after, they took me to the court
forcefully. I had a difficult time for several months. Finally, I was fade up with the situations there, and moved away from Yirgalem to Addis Ababa.

- The respondents stated that they do not know when to give the medical evidences. It takes them two to three months to heal a child with broken leg, but the court urges them to give medical testimonies earlier than that. Sometimes the condition may be connected with insurance. There can be temporary or permanent disability or a total cure. Health professionals have their own procedures to manage the injury case, and put the estimated disability in percentile. The court, however, demands them to report within a short period of time. On the part of the health professionals, it is not feasible and appropriate to release the report until all the processes and procedures are complete. This is the cause of delay in medical reports.

- Some health professionals indicated that they usually fail to report due to lack of knowledge, shortage of facilities and the prevailing problems in their working conditions. The participants further narrated the problems encountered on their job:

  ...If the child comes with broken leg, he/she will be treated and sent back. Then after, the police come to conduct interrogations and the whole thing changes to accusation. In fact, following up a case of child abuse is not meant for accusation, or for attacking others. It should rather be used for teaching purposes.

- Some police staff show negative bias towards the doctor who is handling the case, when they want to help the offender. For example, they tell the doctor that the act cannot be considered rape for the girl might be willing to indulge in sex. They take the doctor as a person who wants to do everything in the medical evidences as a calumny. In some cases, the police take the medical evidence themselves, while it has to be taken by the victim. There are police staff who do not take rape as a serious crime. Such a talking-point could be trivial to them. So, they are likely to be reluctant in following up the case and taking legal action against the offender.

- In contrast, the police alleged that some doctors lack awareness about the problem of sexually abused children, and they take rape as something occurred due to the willingness or fault of the child; consequently, they handle such cases reluctantly. They added that thorough examination is not done for an abused child unless he/she has some acquaintance or relatedness to any of the hospital staff.

- Pertaining to supportive evidences for a rape case, it was explained that if the victim comes to the health institution soon after the incident, it is possible to identify the existence of sperm cells; however, it is not possible to identify whose sperm cells they are. In a related discussion, an informant revealed that there are physicians who provide fake evidences; a case in point is an evidence given by a physician that the hymen of a raped girl was intact while it was not there.

- Being ashamed of the rape committed to their daughters, some parents do not feel comfortable to come to a hospital or health centre right after the abuse. Thus, it is difficult to give testimony for something that occurred a long time before.
• After spending much time on the physical examination, the physician confirms that the harm made to the victim is not a recent phenomenon, especially in rape cases. This favors the rapist more if he denies the act. Similarly, victims are required to bring an action against someone who has made harm to them without any evidences; and they may get healed by the time the evidence is produced. Consequently, the action becomes less punishable as there is no evidence to show the extent of the injury.

• Child abuse cases that are committed in the absence of witnesses often fail to be supported by other tests like blood.

• The fact that rape usually occurs under concealed circumstances hardens the process of producing medical evidences. With regard to this fact, the health professionals forwarded some ideas. Theoretically, there is a test done to prove such sexual abuse. In this test, the semen taken from a suspected person is examined. This is, however, an expensive test, and it is usually done in the developed countries. In our country, this is not feasible. What the physician can indicate is whether the child has been raped or not.

• Evidences on child abuse are not easy to get because, for one thing the act is mostly clandestine; for another, the child might be too young to explain what happened to him/her adequately.

• What is written on the medical evidence form consists of information that the police need, but not every observable phenomenon of the abuse. For instance, an informant from Woreda 23 Health Centre admitted that medical evidences are incomplete; they show only the currently observable injury inflicted upon on the child. Any possible harm that can occur in the future is not included.

• There are different departments in the hospital. Pieces of information from diagnoses of all types are summarized. Each diagnosis is interpreted. Whether it is a dog bite or a burn, the diagnosis is developed into a report. Then, the report goes to different departments to be seen by the respective heads. Afterwards, it is typed, duly checked, signed by the medical director, and finally released. The health professionals have different codes for various situations and the codes will be filled. When writing an evidence or medical certificate, there is a special section handling the translation. Medically, physicians often use some Latin words or expressions. Translating Latin into Amharic is a cumbersome task by itself. Let alone the Amharic version, at times even there is shortage of English equivalent for some Latin words. This really makes the whole process of translation a very difficult task.

• Sometimes, only parents or guardians come to a health institution in order to report a case of child abuse. Since the physician has to see the victim and assess the actual situations, he gives an appointment, but that is time-consuming by itself.

• The difference between an original medical evidence written by the physician and its translation is an observable problem as reported by the police. However, some physicians argued that there cannot be a big difference between the two versions, because there has never been a request from the police to do the translation again.
• Besides the aforementioned problems, there is shortage of senior doctors; consequently, the number of cases assessed and finalized becomes highly limited. Thus, the releasing of medical evidences is usually delayed.

• The other controversy is regarding the complaint related to the time when child sexual abuse actually occurred; i.e., whether it is old or fresh injury. The respondents remarked that there are many things on which even gynecologists cannot be dead sure. If it is a fresh injury that has taken place in the period of 24 hours, the blood, the hymen and the torn place can be witnessed. If it is an old bruise or wound, it is difficult to clearly identify what was done earlier. In that case, it is easier and safer to report it as a suspected case.

• Pertaining to the inquiry why they write evidences of abuse only in terms of the present situation of the child, ignoring the prospects of the child, physicians attributed the problem to the type of format used. They further explained:

> If there were a special format, the problem would be resolved at least partially. For instance, if a child has had a blow on the head and got cranial crack, he may be released from the hospital upon cure. However, there are likely complications in the future, such as epilepsy, decrease in I.Q and diminished learning abilities. We can write the report indicating the possible future conditions...If a child is released from the hospital after receiving treatment for a week, we can write the deficits in charge or liability on discharge; however, the future complications are surely known only to God. It is a very problematic issue, and we do not know how the court improves such things. It is even difficult for them to make decisions per se. We only write the major impacts/effects and those that are readily visible. Anyhow, we hope that these problems would be resolved in the due course of time...

• Apart from these, the health professionals admitted that their laboratory facilities are also poor. Although they have the theoretical knowledge, the deficiencies in the laboratory remain stiff obstacles.

**Some Other Problems in Child Abuse Management**

⇒ Team-work and psychological treatment for abused children were not practiced in most cases.

⇒ When the child is sent back home after receiving medical treatment, there could be some problematic situations awaiting him/her at home. This is beyond the control of both the medical professionals and the police. What the social worker can do is perhaps counseling the parents. Reporting to the police has not been effective as such. Because of all these constraints and problems, a child who has been beaten in the leg and treated today, may come back to the hospital tomorrow with his leg cut. Children may even die as they are made go back to their offenders. The offender on his/her part, does not recognize where the crisis lies.

⇒ The lack of uniform level of motivation and commitment among the different agents, the medical professionals and the police is a typical challenge to a coordinated work in child abuse management.
In the Child Protection Units, awareness creation about the rights of children has been carried out. However, as there is shortage of child welfare centres to accommodate children after legally persecuting their parents, the police keep them in detention centres. This is a big challenge to the process of child abuse management. The action also creates a persistent damage to the relationship between the abused children and their parents.
CHAPTER FOUR

AGE DETERMINATION FOR YOUNG OFFENDERS

4.1. The Legal Requirements of Age determination and Its Wider Impacts and Implications

Abduction is the area where the impact of age determination is clearly observable. The law sets restricting conditions under which an abduction case can be a serious illicit action or not, such as if the girl is under the legally acceptable age, the abduction is committed on her own volition, and if she marries the man. However, as a legal expert from Ethiopian Women Lawyers’ Association elaborated, these conditions encourage the abductor to commit a crime behind the scene since the girl is threatened to admit that she has given her consent. According to the informant, in most cases of abduction, age determination apparently shows that the abductor is not mature enough while the girl is of legally acceptable age. Therefore, the abductor escapes punishment and the girl remains his wife at a tender age.

According to a legal expert from the Rehabilitation Institute for Juvenile Delinquents, the rehabilitation centre admits child offenders even if their age is not determined. If the police bring such children accompanied by their parents, the children are handed over to the parents, ordering the age determination and related investigations to be carried out as soon as possible. However, there are certain cases that are transferred from the juvenile court to the ordinary/adult court. The informant added that they even directly accept child offenders brought by their own parents, as per the law.

While discussing about dalliance in age determination, the legal expert stressed that the question of age is a fundamental one. Even the police face difficulties to which court to take a case because of the child's age. In most cases, they try to follow what the child tells them. However, children may not know their age exactly. As age determination takes a long time, still one cannot ignore the complaint that comes from the police because of dalliance in the process.

As to the validity of the age determination result, the informant indicates the existence of some doubts. As some health institutions do not keep records well, there have been some discrepancies witnessed. Because of this, the legal experts from the juvenile court started to refer to the child's previous file, if there is one, in order to verify the age determination results. In this case, it was remarked that the precautionary arrangements for children seem to encourage them to conceal their actual age.

4.2. The Actual Process of Age Determination: Prospects and Problems

4.2.1. The Activities in Age Determination at Yekatit 12 Hospital
Concerning the process of age determination and related issues, an interview was held with three physicians working at the hospital. These include the medical director, a radiologist and a pediatrician. All of them had a two-year experience in age determination.

With respect to what problems they encountered in the process of age determination, the interviewees reported that they had overlapping duties (much workload), and consequently, clients could not obtain the age determination results within the required period of time. However, the problem has been tackled within the new budget year. According to the respondents, there were also some problems on the part of the police. To resolve the problem, they have been arranging suitable work schedules with the police.

The other point of discussion is related to the methods employed in age determination. The respondents explained that there are two main categories of such methods: clinical investigation and skeletal examination. In clinical method, the physicians examine the endocrine. Here, the focus is on the testicular and penile size if the individual is male; they actually measure the size of the testicles and penis. In the case of female, they investigate the condition of her breast and the distribution of pubic hair as well; and this can give them the approximate age of the individual. Complementary to this, the skeletal examination emphasizes on the X-ray results and related facts. Although they usually carry out both clinical and skeletal methods, the physicians did not hide that the actual age of the individual is better known from the oral report of the child; i.e., if the child can tell his birth date, or from the information provided by the parents, or other people who know the child very well. All these pieces of information are gathered as supplementary facts to determine the age of the child. They also remarked that birth certificates can furnish them with essential information about the age of the child.

Furthermore, the respondents indicated that there is a method called Tanner Classification which can serve as one way of determining the age of an alleged child offender.

The other inquiry is regarding the final decision on the age of the child under question. The informants responded that the final decision is reached upon through consensus. That means, if the X-ray results indicate 16 and the clinical method shows 18, the age of the child is determined to be 17; this is done on the basis of common agreement. The physicians also revealed that they use some experiences from other countries as a frame of reference.

The issue of protocol is another important point of discussion. The respondents revealed that they did not have any clear protocol or policy pertaining to age determination. In fact, they admitted that the absence of this protocol was a great hindrance to their work. However, as they had a dire need for such protocol, they tried to develop a working protocol which is fairly relevant to the actual situations in our country. The protocol is currently in the Department of Radiology. They have just succeeded to come up with a cocktail type of protocol on mutual agreement, and they are ready to employ it objectively.

In a related discussion, the physicians disclosed that they have great problems with respect to females as they often utilize foreign standards; and the problem arises from the fact that there is a greater variation with respect to females. Despite this problem, the physicians remarked that there are still certain things that they can draw from their own practical experiences as well as the foreign ones.
Clinically, as the physicians pointed out, one can determine whether a male child is at puberty or below the puberty age. If he lacks hair under his armpit, pubic hair and his penile size is small, the child is considered below puberty. However, it is still difficult for the physicians to classify him/her if the child is already found to be below puberty age. If the child is below puberty age, the X-ray results (findings) and the clinical examination can give some clues; nevertheless, making the actual determination of age in terms of a specific number of years remains a difficult task. One of the physicians rightly indicated that he often faces a problem in reporting the age of children below 12. It is difficult to say the child is 6, 8 or 10. He admitted that he would simply write: "... the age of the child is below 12."

According to the informant, females do not grow hair before puberty age. For ages below 12, the distribution of the pubic hair can indicate the child's age. In adult cases, the pubic hair spreads further down to the trunk of leg. If the pubic hair is little and triangular in shape, white in color, the child is identified as 'below puberty age'. If it is dark, curly and thick the child is of puberty age. The Tanner classification shows this condition. It gives information about the testicular and penile sizes and the distribution of hair with the corresponding age level. Besides, there are X-ray results to be considered. Taking the average for reporting purpose, the physicians usually settle the technical matters.

The respondents were also asked whether they are working on age determination simply because they are physicians or if they have taken special training in the field. They replied that they have not taken any special training; they have been carrying out these activities on the basis of the knowledge they acquired during their respective studies in medical sciences.

The issue of time is crucial in the activities of medical professionals. With regard to this, the respondents replied:

> From priority point of view, what we call age determination should not exist. We do have many patients to care for. Of course, we started performing age determination on a voluntary basis. As we got involved in the job, we have developed sympathy for the children since there are large numbers of young offenders in detention centres. Nevertheless, within the limit of time at our disposal, we devote only one hour per week for age determination purpose. Apart from this, it would be difficult for a physician to take the job assignment as additional duty. As we embarked on it accidentally, we are just doing it. Otherwise, nobody wants to do it.

Extending their explanations, the respondents commented that age determination should be carried out not only on a voluntary basis, but also on thoroughly planned schedule. The respondents indicated that they investigate and finalize about ten cases of child offenders per week (in the allocated one hour time).

In a related discussion, the physicians gave some remarks on the complaints arising from dalliance in age determination results and refusal to accept what the police usually suggest. As they pointed out, the police cannot bring about changes in the ways they do their activities at the hospital. Nowadays, the number of people that are given appointment for age determination is greater than before. However, few people come on appointment. When the police are asked why this is happening, they tell the physicians that the alleged offender has disappeared. One of the informants stressed that it is difficult to accept the complaints coming of the police. For instance,
the police may arrange appointments for 15 people, but bring only 10 people on the scheduled day....There are also times when people who were not given appointment come and urge the staff to do age determination for them. This makes things chaotic and haphazard. The police could not make use of the opportunities given to them.... Ultimately, the physicians hold the police responsible for delay in age determination, as they do not come on time in line with the appointment given, and also bring other children (some from their home) while they are waiting to receive those whom they have appointed and who are in detention.

The other reason which was cited as a cause for the delay of age determination results was the absence of responsible office boy/girl to follow up the document before and after it is signed. The physicians sign the document after reaching upon an agreement. Then, the report is sent to the record (documentation) office. After that, it is duly signed by the medical director and goes back to the record office. Amidst all these procedures, there is no clearly responsible person for taking the report to and fro the concerned departments. Even in such conditions, it is issued within two or three days after the examination is completed.

Apart from the aforementioned obstacles and constraints, the respondents mentioned that the demand for age determination is highly increasing. The demand is very high but their capacity is limited. The other related problem is that many people do take appointments, but the number of people actually coming for the requested examination is lesser. Sometimes, they come with children whom they accidentally come across. According to the data they have at hand, in 1991 EC, the physicians examined 419 cases, which means 9 to 10 cases per week. Since there are activities that deserve priority, it is not possible to accommodate more number of cases.

4.2.2. The Activities in Age Determination at Black Lion Hospital

At this hospital, the age determination is done by a committee which comprises a radiologist, an internist (endocrinologist), and an orthopedist. The types of methods employed to determine the age of a child offender are clinical, dental and skeletal examinations. The clinical is done by the internist (Endocrinologist), while the skeletal is the duty of the orthopedist and the radiologist. Clinical and radiological evaluations are given in terms of range; that means, exact ages are not stated.

The clinical type of investigation indicates hormonal profile which gives clues to a child's age based on the established scientific facts. Because, after a certain age, the production of sex hormones increases, followed by a change in the physical characteristics. By assessing these, the child's age is determined. Generally, clinical evaluation shows growth pattern and development. The skeletal evaluation helps to know the 'bone age'. It is done by looking at which bones are appearing and which ones join with others. For example, when the epiphysis on the long bone certify well, the child is above 18 years of age. In other words, skeletal evaluation helps to indicate the maturity level of bones.

Dental evaluation is done to complement the aforementioned methods of age determination. This type of evaluation emphasizes on the number of teeth and the kinds of teeth that grow when the child's age increases. A child whose three of the wisdom teeth are grown and the fourth is on its way is above 18 years old. Dental evaluation can be done through X-ray, side by side with clinical assessment.
Pertaining to the availability of a clear protocol that is used as a guiding document, the informants indicated that it was not there. However, they still have a guideline that shows the age ranges in which the bone plates appear and cease to appear. It was not developed by the hospital but copied from a standard textbook. Most of the time, reaching upon a consensus has never been problematic for the physicians. Because the parameters of analysis are a few and everyone plays his/her own part based on areas of specialization. Minor discrepancies were witnessed seldom, and they were resolved through discussions.

As far as the validity of the age determination is concerned, it was confirmed that the methods are reliable though the application of sophisticated equipment is not within an easy reach. According to the informants, 10 to 15 cases of age determination are investigated per week. The age determination process can take four to five weeks but the decision of the board is made and signed within the same day of evaluation.

4.3. What Do Others Say about Age Determination?

In the eyes of professionals from other institutions, however, the process of age determination involves time-consuming as well as controversial procedures and results. At times, it involves discrepancies that have serious implications. A legal expert cited a case of age determination done by a certain hospital which described the offender as a fourteen-year-old child, while the age determination of the same child done by another hospital testified that he was 19. Such discrepancies in age determination often help the offenders to escape legal punishment.

Moreover, an informant from FSCE stressed that health institutions play a crucial role in age determination of child offenders and in the production of medical evidences for abused children. Their defects, thus, do not remain in their own circle; they rather affect the performances of other institutions in the law enforcement system. In this case, the juvenile court is highly affected by any defects in the age determination process. For instance, the police are supposed to present evidences on the cases of abused children, filling the charge by themselves or passing the cases over to the public prosecutor. However, since health institutions delay the results, the police are often unable to do that.

The informant further explained that health institutions have their own internal problems that cause the delay of age determination results. The medical doctors have many other priorities, especially in the Black Lion Hospital - a referral hospital for the whole country. Consequently, age determination is given very little attention.

It was because of the persistent pressure which FSCE exerted on Addis Ababa Health Bureau that Yekatit 12 Hospital was given the mandate to perform age determination (in addition to Black Lion Hospital). Despite the efforts made to resolve the problem, there is still delay in the release of age determination and medical evidence results, and in the meantime, the rights of children have been violated.

In developed nations, cases of child victims and age determination are mostly handled by specific health centers/clinics, or department in a hospital. They work in a team comprising highly qualified staff in the relevant areas. In our case, it is very much doubtful whether separate efforts can be a lasting solution.
Regarding the age determination of child offenders, the lack of vital registration in Ethiopia is posing a problem. Concerning such problem, the informant commented that if we had established the vital registration system, that would have automatically resolved the problem of age determination. In the absence of such system, they have been trying to get evidences on the age of children from the registration of Iddirs, because it has been envisaged that better vital registration system can be in place only in the long run. Nevertheless, a brief study conducted by FSCE has shown that the new initiative has many constraints. First, the task of vital registration has been made the exclusive duty of the government according to the Ethiopian Penal Code and the UN standards. Secondly, Iddirs have low level of efficiency in record keeping apart from the possibilities of being corrupt. Hence, there has been a shift of interest towards kebele and woreda administrations. If this option does not bring about better results, other means are to be sought.

Similarly, members of the Child Protection Units indicated that previously, age determination for a child offender used to take about three months for it was only Black Lion Hospital which had the mandate. Nowadays, however, Yekatit 12 Hospital has additionally taken the mandate, and the delay has declined to a period of about one month.

Apart from the problem of dalliance in age determination results, the police complained that the results do not show specific number of years; the age of a child offender is rather given in terms of interval. The police also indicated the following possible reasons for delay in the age determination results:

- If one of the doctors in the board is missing, the whole process is delayed;
- There are no formally assigned medical personnel to do the job of age determination;
- There is a transportation problem; the police and the child offenders often go on foot from the police station to the hospital;
- The physicians give the least priority to age determination, as compared to other tasks; and
- The age determination task is performed only once in a week, the physicians considering about ten cases.

**Summary of Problems Encountered in Age Determination**

- Time constraints.
- The non-existence of organized clinic.
- Lack of statistician specially assigned for the purpose.
- Lack of administrative personnel who can handle technical matters.
- Lack of separate office that follows up the smooth running of matters related to age determination; there are times when age determination results are stolen and erased for the purpose of alternation. The administrative personnel are sometimes doing the job that should be settled clinically. There is too much workload. There also exists incompatibility between the job to be done and people doing the job. Clients do not appear on time.
- Lack of essential equipment, and trained personnel for the purpose of age determination.

Sometimes, the court sends children of 10 or 11 which anyone can easily identify as below puberty age or 15.
4.4. Solutions Suggested

- In case there are no voluntary physicians, the activities will eventually be halted. Therefore, there is a need for a separate clinic to take up the activities in age determination. Therefore, an institution which can perform age determination and treat abused children should be established as a pilot scheme. Then, appropriate training ought to be given to those professionals who deal with these two issues in such a way that they do effectively at their work place. Rather than trying to upgrade the capacity of all health institutions here and there, it is better to establish independent clinic or hospital. Such a special centre can help in getting complete evidences with good judicial relevance.

- If a separate clinic/centre is required, it has to have trained personnel, as well as sufficient rooms and equipment for doing the job.

- Some informants, however, remarked that establishing a separate centre for the purpose of age determination may be expensive; hence, it is better to establish a responsible unit in each hospital and provide the appropriate equipment and human power.

- A clear protocol has to be developed and used, and the job needs to be handled in line with the established protocol. This is what usually creates delay of age determination results. If there were a clear protocol, the job would not take more than 5 minutes.

- Researches should be conducted in such area.

- Private hospitals should be given the authority/mandate to do age determination and provide medical evidences.

- All Hospitals should be capable of performing age determination or if possible be handled by a separate hospital that specializes only in such cases.

- There could be children who have birth certificates or registered birth dates; hence, before sending children to a hospital, thorough assessment has to be made.

- The police should be aware of the procedures of presenting a case to the court, filling a charge.

- It is very helpful to establish age determination unit/centre near or within the premises of the juvenile court, supplying the necessary instruments and professionals for the sake of speedy certification.

- Besides their own observations and the medical results, judges should be able to use evidences/clues like birth certificates, other documents, as well as witnesses who know the child very well to estimate his/her age. These help to make up for the questionable validity.
CHAPTER FIVE

CASE STUDIES*

Case No. 1

Genet Abebe is an orphan of only twelve years of age. She was born in Yifat (Shoa). Genet has no siblings. Her mother died when she was an infant. Her father had been a lorry driver before his death about two years ago. Soon afterwards, she was brought to Addis Ababa to live in her uncle’s home. There, the life she came across was very difficult. Her uncle is a guard and a diabetic patient spending much of his earnings for buying medicine. Her uncle’s wife used to assist the family’s meager income by baking and selling injera (flat and soft traditional pan-cake made from cereals), but later on stopped that for she was unable to afford the rising electric bill. In such situations, Genet was being maltreated in her new family.

Meanwhile, Genet was approached by a man in the neighborhood who is single and in his forties; in the course of their relationships, she was repeatedly raped by him. The rapist offered some money as well as food items to her; moreover, he threatened her not to tell anyone about the incident.

After a few months, Genet developed incontinence and her guardians first thought it was due to ‘ayne tila’ (illness traditionally thought to be caused by evil spirit). Later on, however, they took her to the nearby clinic, and her guardians were told that she had been sexually abused which led to the discharge. Thereafter, Genet revealed to her guardians the identity of the rapist. The case then was reported to Woreda 2 Police Station by her guardians. She was referred by the police to Yekatit 12 Hospital for examination. In the mean time, TV and radio men recorded her case and the media (police program) gave her a coverage. Ethiopian Women Lawyer’s Association (EWLA) after being contacted by Genet’s guardians, took the case seriously and referred her to Addis Ababa Fistula Hospital. Genet was hospitalized there for about a month and was given medical and surgical treatments free of charge.

However, it took Genets guardians about three months to get medical evidence from Yekatit 12 Hospital which would enable them to prosecute the abuser. Moreover, they complained to have spent much money for buying gloves (which the doctors would use for examination), and for translation of the evidence. The medical evidence they received shows only the physical situation of the genitalia (i.e. rupture of the hymnal opening) after the abuse. It does not indicate the occurrence of HIV or any other STDs as well as other essential sequel on the sexual assault.

* The names mentioned here are pseudo names
Due to the economic problem of Genet's family, the case did not reach the court, and the abuser was released on bail after he had been detained for about 3 months in the police station which if otherwise would have been sentenced with rigorous imprisonment reaching up to 15 years or more. This loophole was advantageous for the perpetrator and would hardly prevent him from further abusive actions against other female children. In this case, the alarming fact is that the same abuser has had four charges of rape on persons other than Genet.

Genet did not receive any continuous counseling in the medical institutions she had been through and is still depressed, morbid and withdrawn. As a matter of fact, such psychotherapy is hardly established in this country for cases of abuse as that of Genet. Hence, the unfortunate children like Genet, who had been in difficult situations at early childhood, have to carry the burden of psychological trauma for the rest of their lifetime unless there is a change in the medical management of health institutions, incorporating psychotherapy as well.

**Case No. 2**

Hirut Mengistie is 17 years old, and she was born in Addis Ababa. Her parents were divorced and she is living with her father and three of her siblings. After the divorce, her father, who is an employee in a company and earning good salary, has not been remarried for the last 12 years. Her uncle came once to their home for a visit, and stayed there for some time. During his stay, Hirut's uncle committed a sexual abuse against her; that actually happened on 10/03/92 EC. The next day, she was referred to Yekatit 12 Hospital by the Woreda 2 Police Station while the perpetrator remained in custody.

Hirut was muchreserved during the interview. She was exhibiting feelings of depression, hopelessness and frustration after the incestuous incident. Moreover, she frequently startles at bed time. Nevertheless, she has not been given any counseling or psychotherapy in the hospital except for some medical treatment. The result of medical examination was readily available after a month (on 14/04/1992 EC). The medical evidence indicated an old hymnal rupture and presence of discharge from the vaginal canal. Since the incubation period for HIV is relatively long, Hirut was told to come back for such test after 3 to 6 months time. As Hirut's father boldly commented, the law has to be strictly enforced and teachings on morality should be widely given. Besides, children should be provided with sufficient recreational places and services.

**Case No 3**

Zinet Ahmed is 13 years old, and was born in the Guraghe Region. She has four siblings and was living with both of her parents. She came to her aunt's home in Addis Ababa about three years ago and stayed there for some time. Then, she was employed and started working as a domestic servant. On 10/03/92 EC, she was violently raped by her employer despite her resistance and cry for help which, unfortunately, no one heard. Afterwards, he forced her to leave the house. Zinet, who at that time was so desperate, called her brother who is living in Addis Ababa and told him the whole story on the phone. Then, the case was reported to Ghandi Memorial Hospital to give her a medical examination on 14/03 92 EC, while the perpetrator was put in police custody. The doctors were very much cooperative in handling Zinet's case and the result of the examination (or medical evidence) was readily available within only two days (on 16/03/92 E.C.). The medical evidence shows that the hymnal rupture or laceration as fresh but there was no indication as to the presence of any STDs. Zinet did not receive any form of counseling (psychotherapy) from the
hospital. She was having abdominal pain after the incident but later on she fully recovered from the tragedy and the bodily symptoms are fading. Zinet is currently living with her nephew.

Case No 4

Fana Kebede is 10 years old, and she was born in Addis Ababa outside wedlock. She has two brothers and is living with her mother and step-father who is a guard, earning only 100 birr per month. For some time, Fana was staying in her aunt's home, and during that time she was approached by a man in the neighborhood who is a servant in a 'Tej-bet' (a house where locally brewed alcohol is sold). The man raped her on 15/08/91 EC, while she was alone at her aunt’s home, and he threatened her not to tell anyone about the incident. The case was reported to the police two days after the incident and she was referred to Yekatit 12 Hospital for examination. The medical evidence was produced within 15 days. After four months, she developed symptoms of STD and was again sent to Yekatit 12 Hospital on 17/12/91. From there, she was then referred to ALERT hospital for radiotherapy where the infection in her reproductive system was treated by means of radiation. However, the treatment did not help her much and her health condition has not shown improvement. Fana has been seriously affected by the incident as well as the subsequent infection with STD. The abuser has for the moment disappeared from the area and the police are still trying to trace him.

Case No. 5

Selam Bekele is 14 years old, and she was born in Guraghe Region. Her parents were separated and now she is living in Addis Ababa with her mother, step-father and sister. Her step-father is employed in a hotel while her mother does a domestic work as a housewife.

Selam's mother frequently beats her with a stick and electric chord, bites her with her teeth, slaps and kicks her now and then. Selam always cries when she remembers the punishment she has gone through all the time. One day, her classmates saw her crying and inquired about the matter. Having understood her problem from what she told them, they brought Selam to Woreda 2 Police Station on 14/04/92 EC. She was not yet referred to any hospital for treatment at the time of interview. Selam was extremely tired of the excessive punishment by her mother and does not want to go back home any longer. She rather wants to work as a domestic servant elsewhere. She advocates the view that children should be appropriately punished but not abused to such extent.
Case No. 6

Hanna Asfaw and Bethelem Tiruneh are 11 and 10 years old respectively. They were both born in Addis Ababa. Both live in the same vicinity and were sexually abused by the same person. The perpetrator is a guard, and initially he created good relationship with them by offering some money and playing with them; and finally he raped both of them. Surprisingly enough, the perpetrator is a married man having grown-up children of his own. The rape cases were reported to Woreda 7 Police Station on 6/13/92 EC, three months after the sexual abuse was committed. The delay was due to the fact the victims were afraid and did not disclose the matter to their parents soon. Upon the report, the perpetrator was soon put in police custody and the children were referred to Yekatit 12 Hospital for medical examination. At the hospital, they were given medical treatments (some antibiotics); however, the parents were unable even to afford buying such drugs. The doctors gave them some piece of advice, but there was no counseling (psychotherapy) offered in the strict sense. At the time of interview, the abused children were relatively in a better condition, and did not show bad memories of the incident as such.

Case No. 7

Abebech Tilahun was only 3 years old when she was raped by a man aged 28; the incident took place in Metehara Town. Initially, the man called her when she was playing with other children and told her that he wanted to buy her a candy. Then, he took her into a sugarcane plantation and committed sexual abuse against the small girl. After the incident, Abebech was seriously hurt and was sent to Adama Hospital (Nazareth); from there she was referred to Black Loin Hospital. After giving her some medical treatment, the hospital administration reported the case to Woreda 3 Police Station. Abebech was suffering from incontinence (fistula) after the incident and was hospitalized for two months where the injury was surgically treated. The rapist was immediately detained by the police with the blood stains still on his cloth. His case was presented to the court, and in June 1990 EC, he was sentenced to ten years imprisonment.

Case No 8

Konjit Getachew is an old woman aged 50. She was born in Wollo and spent most of her lifetime there. She is illiterate and leads her life by begging on the streets of Addis Ababa with her small child who is 7 years old. She was detained for fifteen days in Woreda 5 Police Station for not properly handling her daughter, (for not giving her enough food and for forcing her into intense begging). The case was first reported by a person who witnessed Konjit physically abusing her daughter in front of his shop. As Konjit was trying to justify her action, she was slapping and pinching her daughter when she unnecessarily spent the meager amount of money earned for buying chewing gums. Konjit considers punishing her own child as her right and insists that the punishment deters her daughter from becoming delinquent. Konjit explained that she was also brought up being punished by her parents when she committed any mistakes.
Case No. 9

Zenas Getahun is 19 years old, and she was born in Merhabete (Shoa). She came to Addis Ababa 3 years ago and started working as a domestic servant (baby-sitter), earning 50 birr per month. Her father is a widower, and she has three siblings. She was put in police custody on 27/02/92 EC. for burning the hands of a child (who is one and a half years old) with a heated spoon. The child was her employer's son and Zenas abused him like that when he refused to eat the food she had prepared for him. Zenas has been attending school and she is in grade 3. She has had no criminal record prior to her arrest. However, during her childhood, Zenas herself was physically abused by her father when she refused to eat food; and her step-mother was also verbally abusing her. While she was staying with her aunt, her aunt was biting her with her teeth as a form of punishment for the mistakes she made. Zenas has regretted her misdeeds against the baby; still she wants to punish children when they make her very angry, even though she prefers giving a piece of advice to physically punishing them. Zenas did not get counseling service from the police up to the time of interview.

Case No 10

Azeb Germew is 15 years old. Azeb was born in Gondar, and she has eight siblings there. Her father had died, and she came to Addis Ababa at the end of 1991 EC. On her arrival in the city, Azeb was employed as a domestic servant. Azeb is illiterate. She was put in police custody since she poured a boiled water over the body of a boy aged 15. She explained that the boy was repeatedly insulting her and always made her angry. Lastly, she could not tolerate his provocation and committed such abuse against him. Azeb has regretted her abusive act, it was for the first time that she was arrested. As she claimed to have been under-aged, Azeb was sent to hospital to medically ascertain her age; and she was found to be so.
CHAPTER SIX

ANALYSES OF INTERVIEWS HELD WITH 20 CHILDREN AT REMAND HOME

Analyses of the interviews held with the child offenders staying at the remand home are presented briefly and concisely as follows (See the attached table for detailed information).

Background Information on The Child Offenders

A total of 20 detainees are found under the care of the remand home. The detainees are composed of 18 male and 2 female offenders. In fact, the girls are sojourning at the centre due to lack of a separate place for them. The respondents' age ranges from 10 to 16, with the exception of two children who claimed to have not known their actual age. Another boy, whose age at the time of offence was designated as 13, also asserted that he lately knew he is 16. The study also reveals that 70% of the offenders are originally from Addis Ababa, and the rest 30% came from other parts of the country. In this case, one may presume that city life contributes a lot to child offences.

Offences Committed By The Detainees

The offences committed are comprised mostly theft accounting for about 80%, and the rest 20% goes to participation in homicide, group-fighting as well as damage to property. The most recent offence was committed a month ago at the time of the researcher's visit in March and the remotest one occurred two years back. Among the offences, 13 were perpetrated by the children alone while in the other cases, friends were offering help.

Age Determination

Age determination has been done for 17 offenders whereas the rest 3 brought birth and baptism certificates. Out of the 17 age determination cases, 13 were done at Black Lion, 3 at Yekatit hospital, and strangely enough, one was done at a health center in Assaita.

A maximum of 3 to 4 physicians have participated in the age determination cases done. There were 2 physicians (7 out of 17 cases) and one physician (6 out of 17 cases). The shortest time taken by the physicians to do the age determination was one day (the one done at Assaita Health Center), and longest took two months time.

Age determination done fully (clinical, dental and skeletal) consists of 35% of the whole cases. So does the skeletal type only. The skeletal and dental types of age determination account for 30%. The sole age determination done by the Assaita Health center involves the clinical, dental and skeletal types, without taking X-ray pictures; this, however, makes the accuracy of the result questionable.
Discrepancies have been observed between age claimed at the initial time of detention and the age estimated by the physicians. There were 5 cases of discrepancies where the variations ranged from 1 to 3 years.

**The Situation at the Police Custody**

Some of the respondents stated that the services rendered by the police station include food (once in 24 hours), as well as bathing and clothing. Food covers the largest portion of the services, i.e. 81%. All in all, 16 children were users of these services. The remaining four have never received them.

Regarding problems faced in the due process, 13 detainees indicated that they faced beating by the police, harassment, problem of accommodation (bed and room), and lack of health care. Many of the beatings took place when the offenders were under police interrogations. An instance of accommodation problem is a boy who was sleeping on a verandah. The rest of the detainees did not mention any problem. In fact, uniquely there was a boy who received a special treatment at the police station because the police previously knew him as a beggar and felt sorry for seeing him committing an offence.

The detainees also explained that there were adult prisoners detained with them. These account for 85% of the cases. Among these, one case is a boy who was detained with 2 adult female prisoners. This being the minimum number, the maximum was estimated to be 50.

**Services of The Remand Home**

The services offered to the child offenders at the remand home include food, clothing, education (both formal and vocational), health care and counseling. While evaluating the situations in the remand home in terms of the services provided, 8 children rated the services as good and having no problem. In contrast, complaints about food was made by 2 respondents, the other 2 about the health care and one with regard to the farm work. The remaining 7 children mentioned that there have been beatings by some guards and attendants.

According to the respondents, the beatings are perpetrated by those guards and attendants who interpret every movement of the children as a trial to break out of the remand home for many of them are recidivists.

With respect to the changes in behavior or personality observed, which is the major task of the remand home, 30% of the respondents said that they did not feel any difference; (of course one case was too early to show such changes as he had been brought to the remand home only 7 days before). Some sort of change in behavior was felt by 50% of the detainees, which was characterized by developing a desire to learn and work, quitting insulting and quarreling with one another, showing a desire to quit or actually quitting smoking cigarettes, chewing chat and drinking alcohol, as well as beginning to behave well, accept other's advice, show obedience, and a regret for previous misdeeds. Even if the rest 20% also claimed to have achieved behavioral changes, it does not seem realistic as they were still showing some dangerous acts like attempting to commit suicide.
### Information Obtained from Children Staying at Remend Home

<p>| Code No | Age | Sex | Place of Birth | Current Address | Remaining Reason | Offense Date (Period) | Age at the Time of the Offense | No. of Participants in the Offense | Whether or Not Age Determination was Done | Hospital where the Age Determination was Done | No. of Children Referred (for the Age Determination) | Type of Age Determination Done | No. of Physicians Participated | Estimated Age | Time taken to do the Age Determination |
|---------|-----|-----|----------------|-----------------|------------------|-----------------------|-------------------------------|--------------------------------|------------------------------------------|---------------------------------------------|----------------------------------|-----------------------------|------------------|----------------------------------|
| 01      | 14  | M   | Arrogatke (Chaha) | Arrogatke Village area | Theft            | Before 10 months     | 14                            | -                            | yes                                      | Black Lion                               | 2                                | Skeletal and Dental | 2                | 13-14                             | 1 week                          |
| 02      | 12  | M   | A.A             | W.21. K.23 A.A | Theft            | Before 10 months    | 11                            | -                            | yes                                      | Black Lion                               | 3                                | Dental &amp; Skeletal | 2                | 8-9                               | 21 days                          |
| 03      | 15  | M   | A.A             | W.5 K.15 A.A   | Theft            | Before 11 months    | 14                            | -                            | yes                                      | Black Lion                               | 7                                | Dental          | 3                | 14-15                             | Two Months                      |
| 04      | 14  | M   | A.A             | W.19 K.57 A.A | Polyphexing       | Before 9 months      | 13                            | -                            | yes                                      | Black Lion                               | 2                                | Dental &amp; Skeletal | 2                | 14-14                             | 3 Weeks                          |</p>
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<td>Services at the prison (when staying under the police custody)</td>
<td>Problems faced in the prison</td>
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<td>Food</td>
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<td>-Beating by the police</td>
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<td>-Beating by the police</td>
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CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.1. Conclusions

In the preceding chapters, efforts have been made to present and analyze some of the pertinent issues related to child abuse management and age determination for young offenders as depicted by different professionals working in these areas of concern. Now the central question is, what conclusions can be drawn from this research.

Harmony and cooperative atmosphere need to be established among the various organizations that work towards realizing the rights of the child. Because child abuse and delinquency originate from many sources, no long-term results can be achieved without the mobilization of a broad range of people and institutions. Basic changes can occur only when different sectors of society have achieved new visions of children and families living in poverty. Improved division of tasks, coordination and intersectoral convergence among government agencies and NGOs at federal, regional and/or municipal level can make demonstrably more effective results possible in relatively shorter times. There are many NGOs and governmental organizations working on juveniles both in Addis Ababa and other regions. There is considerable problem of lack of coordination among NGOs themselves and with government agencies working on the same issues. They are, therefore, unable to contribute to efforts of solving child abuse, delinquency and other problems of children. Collaboration, therefore, needs to be constructed with many built-in checks and balances in order to ensure that no single organization can manipulate the situation; instead, each institution, whatever its strengths or weaknesses, is able to realize its potential. There ought to be a common forum on which all the concerned institutions discuss relevant issues and develop common plans with regard to ways of improving child abuse management and age determination for young offenders; in this case, teamwork needs to be emphasized. Ultimately, various partners ought to be convinced showing them concrete examples of the advantages of working together. The problem of child abuse management and age determination, therefore, can be addressed when federal, regional and municipal administration, sectoral ministries (MOLSA, police, courts, health institutions, Ministry of Education), NGOs and the city residents themselves strike an alliance and jointly seek ways to address the problems. There is a need for establishing a special office or agency that creates a common forum on which the police, hospital staff, social workers and other concerned professionals can meet and discuss issues related to child abuse management. Instead of blaming one another for having poor child abuse management, all concerned institutions should come together and work out the activities systematically.

The success in solving the problem of child abuse management can be attained if we go beyond expending large sum of money and treating the physical injuries only. It should go on into looking the psycho-social traumas that entailed the violence. There is a felt need for psychologists/psychiatrists to be available in the hospitals or in the clinic to be established in order to deliver counseling services to abused children as well as child offenders. As lack of counseling can block proper child abuse management and correctional process, this constraint has to be tackled.
The health professionals involved in the study indicated that they usually fail to report child abuse cases to the police and other concerned institutions due to lack of knowledge, shortage of facilities and the prevailing problems in their working conditions. Besides, there is shortage of senior doctors; consequently, the number of child abuse cases assessed and finalized becomes highly limited. Thus, the releasing of medical evidences is usually delayed. Apart from these, the health professionals admitted that their laboratory facilities are also poor. Although they have the theoretical knowledge, the deficiencies in the laboratory remain stiff obstacles. Team-work and psychological treatment for abused children were not practiced in most cases. The lack of uniform level of motivation and commitment among the different agents, the medical professionals and the police is a typical challenge to a coordinated work in child abuse management.

In the Child Protection Units, awareness creation about the rights of children has been carried out. However, as there is shortage of child welfare centres to accommodate children after legally persecuting their parents, the police keep them in detention centres. This is a big challenge to the process of child abuse management. The action also creates a persistent damage to the relationship between the abused children and their parents. When the child is sent back home after receiving medical treatment, there could be some problematic situations awaiting him/her at home. This is beyond the control of both the medical professionals and the police. Because of all these constraints and problems, a child who has been beaten in the leg and treated today, may come back to the hospital tomorrow with his leg cut. Children may even die as they are made go back to their offenders. Further, child abuse cases, (especially sexual types) are reported to the police or health institutions after weeks or even months have elapsed; in most cases, nobody comes with fresh evidences like bleeding body part.

Similarly, main problems encountered in the process of age determination as reported by the concerned professionals include: time constraint on the part of physicians who are very much occupied by other activities in treating patients, shortage of essential facilities, clients failure to appear in time, and so on.

The problems mentioned above dictate the need to establish a separate child-friendly clinic that should mainly deal with child abuse management and age determination for young offenders. Both governmental and non-governmental organizations should recognize the existence of child abuse as major social problem, and show readiness to tackle it. This readiness includes organizing preventive and rehabilitation services.

7.2. Recommendations

Generally, long-lasting solution for the problem of child abuse management and age determination for young offenders requires a long-term commitment and hard work, appropriate fact-finding and careful analyses over time with the active collaboration and direction from the different sectors of society. Perseverance and follow-up, collaboration and the building of partnerships, are some of the essential elements of effective interventions. We need to offer constructive alternatives, both broad and specific, and be willing to adjust them according to their needs. Although Ethiopia is a poor country to address such prevailing problem adequately, there is a need to be more visionary and daring, willing to dream of a better future. As the problems of child abuse management and juvenile delinquency have far-reaching implications on a society,
proper attention needs to be given to find reasonable solutions through allocating the required resources in terms of materials, trained personnel, etc. With this in mind, the researcher would like to forward the following more specific and short-term recommendations to alleviate the problem of child abuse management and age determination for young offenders.

1. Medical evidences should indicate in detail the harm inflicted upon the abused child, and if possible, indicating the prospects of the victim in light of the damage faced. With regard to rape cases, the medical reports need to show whether or not the rape involved serious physical violence against the victim. The medical evidence format needs to be revised, and the concerned professionals ought to get short-term training on how to write the medical reports rightly. The police should come into terms with the health professionals. The health professionals should be well-informed as to what kinds of evidence the police want, and the police should also understand the limitations.

2. Health professionals should report any form of child abuse to the Child Protection Units, making the necessary follow-ups then after, to see how the police and the law respond to the situation. To this effect, the Ministry of Health should consider the time spent in such additional activities, and the police need to safeguard the safety of these health professionals. Ways and means need to be devised whereby both health professionals and victims are encouraged to feel secured while reporting any cases of abuse.

3. At a general hospital, specific persons who are directly responsible to deal with child abuse management should be assigned. Efforts need to be directed towards giving medical treatment, once children have been exposed to abusive situations. Following medical treatment, there comes rehabilitation. To this effect, hospitals should be strengthened through allocation of the required resources. Within hospitals, a centre of excellence should be established, so that children are kept there in a comfortable atmosphere. Apart from the psychological trauma, sexually abused children are likely to suffer from early and unsafe sexual initiation. Hence, proper attention should be given to reverse these tragic consequences. There should be a team in hospitals to deal with child abuse management and related issues. The team ought to comprise at least a pediatrician, psychiatrist, social worker, and a nurse. The pediatrician should play a central role here and act as a team leader. When an abused child comes in, he/she should be provided with medical treatment, proper care, and counseling service. In the meantime, they can write a report as well. The job also requires an integrated effort with the police.

4. Apart from hospitals' other health institutions (health centres and clinics) are required to pave the ways to handle cases of child abuse properly. To this effect, they need to have at least the basic facilities. Organizing a series of seminars and workshops for the practitioners should be emphasized. Health centres and clinics should be well informed about child abuse management in order to reduce the huge burden on hospitals. Only severe cases of child abuse should be referred to hospitals. Otherwise General Practitioners (GPs) at the health centres can deal with the simple ones if they are given short-term training. Further, to relieve hospitals from their burdens, clinics and health centers should be strengthened to provide medical evidences. It is very helpful to create every possible means to upgrade the health professionals' capability, especially those found at the levels of clinic and health centre; because it is to these health institutions that many victims are brought at first. Thus, the first persons that come into contact with abused children should know how to handle everything effectively.
5. There is a need to separate the child from the abuser for some time after completing treatment at the hospital or any other health institution. In view of this, the establishment of child-friendly clinic which can provide victims with some sort of psychological support and handle other related matters is so essential.

6. Due to the prolonged age determination, a child stays for two to three months with the police. There, the child interacts with adult criminals and arrives at the remand home acquiring dangerous characters/behavior; and that makes the rehabilitation process very problematic. Moreover, female offenders are exposed to risky circumstances like sexual abuse and harassment while staying under police custody for a long period of time. Dalliance of medical evidences/age determination results has been an obstacle in categorizing the offenders as juveniles or mature criminals, and in getting final court decisions for the alleged child offenders. It has also created difficulty for the police in persuading their bosses to release the detained children on bail. Such dalliance creates work overload upon the police since they spend a lot of time in taking child offenders to and fro the hospitals. Child offenders, especially those who do not have relatives, are forced to remain under police custody for a long period of time, and in the meantime they learn more serious offences from others; placing them in the remand home is not possible unless they are medically ascertained as under aged. Further delaying age determination results initiates the recidivists to be engaged in further offensive acts. Independent child-friendly clinic should be established to tackle such problems. Such child-friendly clinic should comprise trained police, health professionals, psychologists/psychiatrists, lawyers and other relevant professionals and has to have sufficient rooms and equipment for doing the job. Currently, age determination is carried out by volunteer physicians. In case there are no voluntary physicians, the activities will eventually be halted. Therefore, there is a need for a separate clinic to take up the activities in age determination. Therefore, an institution which can perform age determination and treat abused children should be established as a pilot scheme. Then, appropriate training ought to be given to those professionals who deal with these two issues in such a way that they do effectively at their work place. Such a special centre can help in getting complete evidences with good judicial relevance.

7. A clear protocol has to be developed and used for age determination, and the job needs to be handled in line with the established protocol. This is what usually creates delay of age determination results.

8. There could be suspected child offenders who have birth certificates or registered birth dates, hence, before sending children to a hospital, thorough assessment has to be made. Besides their own observations and the medical results, judges should be able to use evidences/clues like birth certificates, other documents, as well as witnesses who know the child very well to estimate his/her age. These help to make up for the questionable validity.

9. Juvenile delinquents should only be seen in the juvenile court. If possible, in a separate and comfortable premise that makes them feel at ease. Besides, the judges, prosecutors and professionals who work for the preservation of the rights of the child should get some training on how to deal with children. Special training should be given to the police, judges and prosecutors of the remand home in order to deal with children's cases properly.
10. The police should understand the law very well and act accordingly. They should take good care in assembling and keeping evidences, because intended or unintended destruction of evidences has been reported by some victims. Moreover, they need to take the detained children to the juvenile court within the acceptable time-frame.

11. With appropriate transformations and the provision of essential materials and human resources, CPUs should be replicated and adopted on a larger scale, with more committed efforts to reach more children in distress in the city. Furthermore, as much as possible, the police ought to ensure the preservation of children’s rights and their safety. Complementary to these, family supervision order needs to be established so that parents can be oriented on children's' rights as well as the types and content of care they need.

12. The mass media ought to take on new roles, including local and national advocacy. So far, the media's contribution in this country has been somewhat depressive, still remaining extremely influential. The mass media should dedicate ample network time to children's issues.
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<td>Police woman (CPU)</td>
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<td>8. Getnet Zeleke</td>
<td>Policeman (Investigator)</td>
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<td>9. Ketema Sirma</td>
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<td>11. Yidnekatchew Tesfaye</td>
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<td>12. Solomon Alemu</td>
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<td>14. Asalef Asfaw</td>
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<td>17. Solomon Sima</td>
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<td>20. Yigremachew Tadesse</td>
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<td>22. Sisay Kebede</td>
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<td>23. Ewnetu Demile</td>
<td>&quot; (investigator)</td>
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<td>24. Tezeru W/Yohannes</td>
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<td>30. Meaza Tadesse</td>
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<td>31. Hamere Asefa</td>
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<td>32. Genet Hailu</td>
<td>Policewoman (investigator)</td>
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<td>33. Sisay Gessesse</td>
<td>Para-social Worker</td>
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Appendix A

Scheduled Interviews with Health Workers (Nurses/Physicians)

1. Name_____________________________________________________
2. Age_______________________________________________________
3. Sex M_______F_________
4. Field of Training: (a) Nurse___; (b) Health Officer____; (c)MD____; (d) Others, specify___________
5. Field of specialization (if you are a medical doctor)
   (a) Pediatrician___; (b)surgeon___; (c)Orthopedist___; (d)Internist___; (e)Others, specify___________
6. Work experience (in months/years) ______
7. Are you familiar with the term child abuse? Yes ___; No___
8. If your answer to the above question is 'Yes', how have you developed knowledge about child abuse?
   (a) Through participation in workshops/seminars held on child abuse
   (b) Through reading research papers and/or articles written on child abuse
   (c) Through the electronic media (TV, Radio, etc.)
   (d) Through the print media (Newspaper, Magazine, etc.)
   (e) Others, specify_____________________
9. As a health professional, have you ever been involved in child abuse management? Yes_____; No_____
10. What kind of child abuse cases have you ever handled so far?
    (a) Physical abuse (beating, whipping, burning, etc.)
    (b) Sexual abuse (rape or other forms of sexual abuse)
    (c) Emotional (psychological) abuse
    (d) Others, specify________________________________
11. What type of help do you usually give to abused children?
    (a) Physical examination
    (b) Medical or surgical treatment
    (c) Counseling
    (d) Others, specify___________________________
12. What kind of physical (bodily) and behavioral (psychological) symptoms did the children mostly exhibit when you examined them?
    ______________________________________________________
    ______________________________________________________
13. Who brings abused children to the hospital in most cases?
    (a) Parents (d) The Police
    (b) relatives (e) Others, specify____________________
    (c) neighbors
14. Do parents (alleged abusers), in most cases, be honest in telling you the true causes of their children's injury, while bringing them to the emergency room of the hospital?
Yes___ ; No___

15. If your answer to the above question is ‘No’, how do you know (suspect) as to whether child abuse has really taken place or not?

________________________________________________________________________
________________________________________________________________________

16. In instances when you come across child abuse cases, what measure(s) will you take?

(a) report the case to the police
(b) report the case to the social worker
(c) Others, specify______________________

17. Do you refer the abused child and/or parents (abusers) to a psychologist or psychiatrist for counseling? Yes___ ; No___

18. If ‘No’, why____________________________

19. Do you handle an abused child in a team? Yes____________ ; No________________

20. If ‘yes’, who are the team members? ________________________________

21. If your response to question number 19 is ‘No’, why not?

_____________________________________________________________________

22. What type of help do you offer to the abused child on the time of discharge from the hospital?

(a) Send him/her back to the parents (abusers)
(b) Separate him/her from the abuser
(c) Send the parents for counseling or psychiatric therapy
(d) Others, specify__________________________

23. How could you be sure that further abuses would not take place upon sending the child back to the parents (abusers) or what would you do to avert further abuses

_____________________________________________________________________

24. What are the conditions or under what circumstances do you rescue the child from the abuser (parents/guardians)?

_____________________________________________________________________

25. Upon separating (rescuing) the children from the abusers, who will take responsibility for their future life, or where do you usually place them?

_____________________________________________________________________

26. What are your suggestions to improve child abuse management in the future?

(a) Seminars and workshops to practitioners
(b) Creating public awareness on the issue
(c) The law enforcing bodies should work hand in glove with medical professionals
(d) Orientations to the police on how to handle cases of child maltreatment
(e) Establishment of child protective agencies
(f) Opening child abuse management clinics
(g) Others, specify________________________________________

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27. What are the problems faced (if you have one) in producing medical evidences or proofs that would facilitate the prosecution of alleged perpetrators of child abuse? ______________________________________________________________

28. Overall comments: ____________________________________________________________
Appendix B

A Questionnaire for Interviews with Physicians (Radiologists, Pediatricians, Internists, and Orthopedists) Regarding Age Determination

Code No_______

1. Name of the Physician____________________
2. Age_______
3. Sex_______
4. Educational level:
   (a) General Practitioner (d) Internist
   (b) Radiologist (e) Orthopedist
   (c) Pediatrician (f) Others, specify
5. Work Experience (in months/years):
   (a) As a physician____________________
   (b) In the practice of age determination____________________
6. What types of age determination methods do you apply? ________________________
7. What are the major differences between the types of age determination methods employed; and which one of them do you think is most effective? __________________________________________
8. Is it only a single medical doctor who does age determination of a particular child offender, or is it done on a team basis? If it is done on a team basis, how do you reach upon consensus (agreement)? __________________________________________
9. How many physicians are there (other than you) to do age determination in the hospital? _________________
10. Do you have adequate time to do age determination? ________________________
11. How often do you see cases of age determination for young offenders? _________________
12. How long does it take to issue age determination result for an alleged child offender? _________________
13. Have you taken a special course/training on age determination? Yes____; No___
    If ‘yes’, what type of training have you received? ________________________
14. Do you have a clear protocol? Yes____; No___
15. If ‘yes’, what type of protocol do you use? ________________________
16. Do you have adequate facility (room, equipment) to do the job? Yes____; No___
17. How many cases of offenders do you evaluate every week? ________________________
18. Do you write and sign the board decision on the same day of evaluation of cases? Yes____; No___

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19. Do you have clients requesting for age determination other than the alleged child offenders? Yes____; No____
   If yes, for what other purpose(s) do you perform age determination? ______________

20. What type of problems (if any), do you usually face in determining the ages of child offenders in your hospital?

21. How much reliable are the techniques you follow and the results you arrive at in determining the actual age of a child offender (how accurate is age determination in most of the cases)?

22. What recommendations do you forward for better handling of age determination cases?

23. Any additional comments you would like to make:
Appendix C

A Questionnaire for Interviews with The Police

Code No_____________

1. Name of the policeman/Policewoman
2. Age
3. Sex-
4. Educational level-
5. Work experience (in months/years)-
6. Experience in handling child abuse cases and child offenders? (in months/years)_____
7. Have you received special training(s) on how to deal with child abuse and/or child offenders? Yes _____; No_____
8. If ‘yes’, who organized them and for how long have you been given the training? ____________________________________________
   If ‘no’, what do you suggest regarding such a training? ____________________________
9. Does your police station have a recording system for the incidence and prevalence of child abuse and child offenders? Yes _____; No_____
10. If ‘yes’, based on the statistical data you have, how severe are the problems of child abuse and child offenders?
11. On average, how many cases of child abuse do you come across per day/week/month?
12. How many child offenders are currently in your custody? What special care do you give them?
13. Are there parents/guardians or others who have been imprisoned due to their violent acts committed against children? Yes _____; No_____
14. What are the most common types of child abuse cases so far reported to you?
15. Would you give an account of the reporting system about child abuse?
16. Are there laws that state reporting of child abuse cases to be mandatory? Yes __; No___
17. If such laws exist, do people really know that it is their duty to report when they come across abused child/abusers? Yes _____; No_____
18. In most instances, who reports child abuse cases to you?
   (a) The general public ____________________________________________
   (b) Parents _____________________________________________________
   (c) Children themselves __________________________________________
   (d) Others, specify _____________________________________________
19. Is there any increase or decrease in the trend of reporting the case to the police station? ________________________________
20. Do you have special/separate room(s) in which you keep abused children and child offenders? Yes _____; No_____
21. How many of the abused children and child offenders are sent to the hospital for treatment and/or medical evidence purposes? ____________________________
22. How long does it usually take to get treatments and/or medical evidences/?
23. To which hospitals do you usually send abused children/child offenders? ____________________________________________
25. Mention some of the problems you face in sending them to the hospital.

26. What are the most common types of offences committed by child offenders?

27. What types of abuse are committed against children?

28. What are the major difficulties you frequently face (if any) in determining the ages of physically mature child offenders?

29. How many of the child offenders who were sent to the hospitals were actually examined by the physicians?

30. How long does it take to get age determination results?

31. What do you think are the reasons for delay in issuing medical evidences/age determination results?

32. How reliable and valid are the medical evidences?

33. Child abuse usually occurs behind the scenes; what are the attempts you make to trace the perpetrators and put them before the law?

34. What attempts are being made to prevent child abuse, and child offence? What do you suggest in this regard?

35. Do you see any connection or relationship between abusive acts of parents/guardians and their psycho-social conditions (loneliness, depression, stress, and lack of support from their social groups)? Yes____; No____

36. What do you think are some of the individual, family? community and cultural factors that cause child abuse and child offenders?

37. Is there any evidence which indicates that adults who inflict family violence against children have history of being abused during childhood? Yes_____; No____

38. From the record of the incidents, how do you describe those family members who behave violently towards children, taking into account the following variables:
   (a) Age (b) Income (c) Marital status (d) Sex (e) Occupation

39. How do child abusers and child offenders perceive their deviant acts/behaviours?

40. What do you suggest to improve the handling of abused children/child offenders?

51. Any other points you would like to raise: ______________________________
Appendix D

A Structured Questionnaire for in-depth interviews with mature abused children

Code No. ______________ Place of Interview ______________ Date___________

1. Name________________________
2. Age________________________
3. Sex________________________
4. Place of birth_______________
5. Marital status of parents:
   (a) Live together   (d) Widowed
   (b) Divorced       (e) Others, specify
   (c) Separated
6. With whom were you living before/up to the incident of abuse?
   (a) With both parents  (c) With father only
   (b) With mother only  (d) Others, specify
7. What was your family size or the number of siblings and other dependent family
   members you have at home?
   (a) brother   (b) Sister  (c) Others, specify
8. What do your parents do for a living?
   Father________________________
   Mother________________________
   others, specify_________________
9. What is your family’s estimated monthly income? _________________________
10. What is the type of abuse (maltreatment) inflicted upon you? _____________
    (a) physical  (b) Sexual  (c) Emotional  (d) Others, specify___
11. When have you been abused? __________________________________________
12. Who has abused you? What is your relationship with the abuser?
    (a) Father   (c) Step-parent
    (b) Mother   (f) Neighbor
    (c) Sibling   (g) Others, specify______________________________
    (d) Friend
13. What are the causes of violent treatments committed against you? ____________
14. Who brought you to the hospital for treatment?
    (a) Parent (c) Police (b) relative  (d) Others, specify__________
15. In which hospital were you treated?
   __________________________________________
16. What type of treatment were you given in the hospital? _____________________
    (a) Medical treatment   (b) Counseling (psychotherapy)
    (c) Others, specify_______________________________________
17. For how long did you get the treatment? _________________________________
18. Have you now totally recovered from the injuries (wounds, fractures, bruises, etc.) you
    suffered due to the abuse?  Yes______; No_______
    If ‘no’, what symptoms are still persisting? __________________________________
19. Did the hospital give you medical evidences that would enable the police to prosecute the
    abuser?____________
20. How long did it take to produce the medical evidences? ____________________
21. What other problems did you face (if any) in the process of receiving medical
22. If you were counseled in the hospital, who gave you such form of treatment?
_____________________________________________________________________
23. For how long have you been counseled? Was it continuous or only given once?
_____________________________________________________________________
24. How much has the counseling helped you or what advantages did you get from it?
_____________________________________________________________________
25. Was there any other family member who has been abused or maltreated like you?
Yes______; No_______
26. If yes, who is he/she?
(a) brother (b) sister (c) Others, specify______________________________
27. If your response to question No. 23 is 'yes', who was the abuser?
(a) the same person who has abused you
(b) a different person, specify______________________________________
28. With whom are you living now?
(a) Parents
(b) In foster care
(c) In child welfare institution
(d) Others, specify_________________________________________________
29. What has been done to the abuser (perpetrator)?
(a) Prosecuted and jailed
(b) Have been given counseling (psychotherapy)
(c) Others, specify_________________________________________________
30. What do you feel after you have been abused? ________________________
31. Do you have any idea about children's rights (CRC)? Yes_____; No_______
32. If yes, what is the main source of information? _______________________
33. Do you believe that your parents/family members have the right to apply corporal
punishment against you (beat or flog you)? Yes______; No_______
34. Have you ever reported an abusive case you faced to the police? Yes_____; No_______
35. If 'yes', how did the police respond? ___________________________________
36. If you have never reported the abusive case to the police, why did you fail to do so?
_____________________________________________________________________
37. What do you intend to do in case of future abuse? _______________________
38. Do you know other children who have been abused by their parents/guardians?
Yes_____; No_______
39. If 'yes', how many are they? _________________________________________
40. Any other points you would like to add: ___________________________________
_____________________________________________________________________
_____________________________________________________________________

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Appendix E
A Structured Questionnaire for Interviews with Child Offenders

Code No____________; Place of interview________________________Date ____________

1. Name______________________________

2. Age______________________________

3. Sex___________________

4. place of birth____________

5. Address: Woreda________________________Kebele__________________

6. What was the reason you have been detained for? ________________________

7. When did you commit the offense? ________________________

8. How old were you at that time (at the time of the offence)? __________________

9. With whom (if any) did you commit the offense? __________________________

10. Did you tell the police your exact age at the time of detention? Yes______ ; No______

11. If ‘no’, why? ______________________________________________________

12. Have you been referred to a hospital for age determination? Yes______ ; No______

13. If ‘yes’, which hospital? ________________________________________________

14. How many other child offenders (if any) were referred to that hospital with you?

15. Through what type of examination have you passed in the hospital for determining your age?
   (a) Dental  (b) X-ray  (c) Genital examination
   (d) Others, specify____________________________________________________

16. How many physicians were there examining you? __________________________

17. What was your estimated age after the examination? __________________________

18. Were the physicians precise in determining your age? Yes______ ; No______

19. How long (how many days) did it take them to determine your age? _______________

20. What problems (if any) have you observed (faced) at the time of examination in the hospital? __________________________________________________________

21. What type of services or special care (if any) do you receive in the detention centre (remand home)? ____________________________________________________________

22. What type of problems (if any) have you faced so far?
   (a) Stayed for an extended period of time in police custody
   (b) Health problem
   (c) Food problem
   (d) Problem of accommodation
   (e) Harsh treatment by the police
   (f) Abused by adult prisoners
   (g) Others, specify____________________________________________________

23. Were there adults in the prison, detained with you?  Yes______ ; No______

24. If ‘yes’, how many were they, can you guess? ______________________________

25. Do you think your personalities (behaviors) have shown positive changes in the rehabilitation centre?  Yes______ ; No______

26. If yes, how can you justify that? __________________________________________

27. Any other issues you would like to raise: _____________________________________
Appendix F
A Structured Questionnaire for Interviews with Abusive Parents and Other Perpetrators

Code No. __________________ Place of Interview __________________ Date __________

1. Name____________________
2. Age____________
3. Sex____________
4. Place of birth____________
5. Address: Woreda__________________ Kebele ______________________________
6. Educational level
   (a) Illiterate  (d) High school
   (b) Read and write  (e) Others, specify________________________
   (c) Elementary
7. Marital status:
   (a) Married  (d) Widowed
   (b) Divorced  (e) Others, specify______________________________
   (c) Separated
8. Occupation:
   (a) Employed  (b) unemployed
9. If employed, how much was your total monthly income? _________________
10. How many children do you have?
    (a) Sons_____________  (b) Daughters_____________
11. Have you ever been imprisoned? Yes______; No______
12. If 'yes', what was the reason for your imprisonment?
13. How old was the victim?- 
14. What was your relationship with the victim?
    (a) Father  (b) Mother  (c) Others, specify_______________________
15. What type of injuries/maltreatment have you caused to the victim?
16. What do you feel now about the incident? ______________________________
17. What type of disciplinary methods do you usually follow when your children make mistakes?
    (a) Corporal punishment
    (b) Beating
    (c) Spanking
    (d) Whipping
    (e) Denying them food
    (f) Shouting at them
    (g) Others, specify_________________________________________________
18. From whom did you learn such disciplinary methods?
19. Have you ever been maltreated by your parents when you were a child? Yes____No____
20. If 'yes', what type of maltreatment did you face? __________________________
21. Would you describe the situation, and briefly state the major reasons that brought about such punishment?
22. Do you consume alcohol? Yes______; No______
23. If 'yes', how frequently? _____________________________________________
24. Do you take any stimulating or depressing substances (e.g. chat, other drugs)?
   Yes______;No______
25. If yes, to question No. 21 and 22, were you taking such substances just before the incidence of abuse? Yes______; No______
26. Have you been given counseling (psychotherapy) after the abusive act? Yes______; No______
27. If 'yes', where and by whom? __________________________
28. How long did it take to get medical evidence (was there a delay)? __________________________
29. If 'yes' to the above question, would you tell us all the problems you encountered due to delay of medical evidence?
   __________________________________________________________________________
30. What do you comment (think) that parents should do in order to prevent maltreatment (abuse) of children? __________________________
31. What type of misconduct do you usually observe from your child/children?
   __________________________________________________________________________
32. Do you follow up the way your children behave? __________________________
33. Please, could you tell us certain ways of child-rearing that you have learned from your parents? (If any) __________________________
34. In what conditions do you behave violently against your child/children? __________________________
35. Are there family members other than you who behave violently against children? Yes______; No______
36. If you have more than one child which of these children has/have often been punished or ridiculed? ________________________________
37. Why? ________________________________________________________________
38. Any other points you would like to raise: _________________________________
Appendix G
A Structured Questionnaire for Interviews with Judges, Prosecutors, Defense Lawyers, and Other Legal Experts

Code No. ___________ Place of Interview _________________ Date ______________

1. Name________________________
2. Age________________________
3. Sex________________________
4. Educational level________________
5. Occupational status__________________
6. Is there any special court where only child abuse cases are separately handled?
   Yes_____ ; No______
7. On average, how many cases of child abuse cases are seen in the court per week/month?
   __________________________________________________
8. What are the most common types of child abuse cases frequently seen in the courts?
   (a) Physical abuse
   (b) Sexual abuse
   (c) Emotional (psychological) abuse
   (d) Others, specify ________________________________________________
9. Have you ever received any training on how to handle child abuse cases? Yes_____ ; No______
10. If yes, what type of training? __________________________________________
11. What type of problems do you face in the court procedures of child abuse cases?
    (a) Overloaded court rolls
    (b) Lengthy trials (long court delays)
    (c) Frequent postponement of trials
    (d) Intimidation by defense lawyers (councilors)
    (e) Delay of medical evidences
    (f) Validity of medical evidences
    (g) Others, specify________________________________________________
12. What types of special care are taken by the justice system in order to save children from further intimidation in courts from the alleged offenders or from the defense lawyers?
    ___________________________________________________________________
13. What is being done to alleviate the double trauma that children face in the court system?
    ___________________________________________________________________
14. On average, how long does a court trial take for a child abuse case?
    ___________________________________________________________________
15. Do all the complainants of child abuse pursue their case until they finally get the abuser convicted for the assault? Yes_____ ; No______
16. If 'no', how serious is the withdrawal rate of cases? How many of the complainants withdrew their cases this year? ________________________________
17. With what other professionals (if any) do you closely work during the trials of child abuse cases?
   (a) Physicians
   (b) Social workers
   (c) Others, specify________________________________________________
18. What are the problems (if any) in issuing medical evidences on child abuse cases?  

19. Are medical forensic evidences reliable in most of the trials of child abuse cases? Yes_____; No______

20. If 'no', what constraints are associated with them or what problems do these evidences have?  

21. In most cases, who are the perpetrators of child abuse cases?  
(a) parents (c) Friends  
(b) Relatives (d) Others, specify_________________________________

22. What type of court decisions are commonly passed against perpetrators of child abuse upon conviction?  
(a) Simple imprisonment  
(b) Rigorous imprisonment (not exceeding 5 years)  
(C) Fines  
(d) Others, specify________________________________________________

23. Any other points you want to add: ________________________________
Appendix H

Interview Guide Used for Interviews with Professionals Working in Child Abuse Management and Related Areas

1. Why do you think that parents or caretakers/the general public use violent acts against children?
2. What are the major factors that push children to develop delinquent behaviors/acts?
3. What do you suggest to solve the problem? What mechanisms do you suggest to educate the public in this regard?
4. Do you believe that the interventions of the agencies dealing with child abuse and child offenders are adequate? If ‘no’, what do you recommend for improvements?
5. What is your attitude towards those parents/caretakers, and other perpetrators that exercise violence against children? Do you believe that they have the right to do so?
6. Could you describe the impacts that child abuse will have on children?
7. Do you think society/government is doing everything it could to solve the problem?

   a. Family
   b. Government
   c. Church
   d. Society
   e. NGOs
   f. School

7. Give a brief sketch of the major events that you have encountered while working to help child abuse and child offenders
8. Any other points you would like to raise:

________________________________________________________________________________________