COLLEGE OF HEALTH SCIENCES

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MASTER OF PUBLIC HEALTH

Sexual Assault and Psychosocial Support among Survivors at Gandhi Memorial Hospital, Addis Ababa, Ethiopia

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Abbreviations and Acronyms

ANC	Antenatal care
ART	Antiretroviral
GAD – 7	Generalized Anxiety Disorder – 7
HBsAg	Hepatitis B surface antigen
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IRB	Institutional Review Board
KII	Key Informant Interview
NGOs	Non-Governmental Organization
OR	Operation Room
PC-PTSD – 5	Primary Care Post Traumatic Stress Disorder – 5
PHQ – 9	Patient Health Questionnaire – 9
PTSD	Post-Traumatic Stress Disorder
SNNPR	Southern Nations, Nationalities and Peoples Region
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infections
UK	United Kingdom
UNFPA	United Nations Population Fund
UTI	Urinary tract infection
VDRL	Venereal disease research laboratory
WHO	World Health Organization
WHOQOL	World Health Organization Quality of Life

Abstract

Background: In Ethiopia, the pooled prevalence of lifetime sexual violence was found to be 39.33% in 2018. Sexual assault survivors face medical and psychological problems after the assault. Relevant and reliable data on sexual assault is critical to inform the knowledge we have about the burden, risk factors, circumstances and consequences surrounding sexual assault.

Objectives: This study aims to assess the sexual assault experiences and psychosocial support of sexual assault survivors at Gandhi hospital Addis Ababa, Ethiopia.

Methods: The study used a mixed method approach including a facility based cross-sectional design and case study design. The study was conducted at Gandhi memorial hospital one-stop center in Addis Ababa, Ethiopia. A total of 176 survivors and 6 key informants were recruited. Quantitative data was analyzed using SPSS version 25 and qualitative data was coded using open code version 4.03 and analyzed using thematic analysis.

Results: A total of one hundred seventy-six (176) women sexual assault survivors participated in this study. From the 176 women, majority 76.7% of the women were between the ages of 14 to 19. Majority 91.5% of survivors reported vaginal rape. The perpetrator was a stranger in 55.1% of the cases and 44.9% of assaults were committed in the perpetrator's home. Among the respondents 98.3% disclosed the assault to at least one person. Majority 70.5% of the survivors received positive social reaction while 94.3% received some kind of support after the sexual assault. With respect to the consequences suffered by survivors after the assault, 9.7% had unwanted pregnancy, 45.5% had depression, 63.8% had anxiety and 63.1% had post-traumatic stress disorder. Regarding predictors of mental health consequences, social reaction was found to be a significant predictor of PTSD with ($p < 0.05$), for every unit increase in social reaction there is 0.442 times decrease in PTSD diagnosis with ($P < 0.05$, OR 0.442, 95% CI 0.222, 0.880). Service providers at the one-stop center mentioned that they provide medical, psychological, and legal services for survivors in their center. The service providers also stated that the reaction the survivors receive from their social groups is mostly negative. Some of the service providers mentioned that survivors not coming to hospital early is a challenge. Another challenge pointed out was the lack of timely training and short working period within the center. For this reason, service providers recommended that the length of time they work in the center be extended to gain more experience and that training should be provided to professionals before they start working in the center.

Conclusions: Most survivors in this study were aged between 14 and 19 implying that adolescent aged girls are most vulnerable for sexual assault. Majority of the survivors reported receiving positive social reaction and psychosocial support after the sexual assault. Survivors also reported consequences like unwanted pregnancy, depression, anxiety, and post-traumatic stress disorder. Social reaction was found to be a significant predictor of PTSD with every unit increase in social reaction having 0.442 times decrease in PTSD diagnosis. Thus, these findings can be used as input for future prevention strategies, health education programs and for improving service provision for sexual assault survivors.

1. Introduction

1.1 Background

Sexual assault and sexual violence are generally considered to be synonymous and are usually used interchangeably. According to the World Health Organization (WHO) sexual assault or sexual violence is defined as: 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work'(1). Globally, around one in three women above the age of fifteen have been subjected to physical and/or sexual violence whether by intimate partner or anyone else at least once in their lives (2). In Ethiopia, the pooled prevalence of lifetime sexual violence was found to be 39.33% in 2018 (3).

There are different types of sexual assault based on the relationship of the perpetrator to the victim. These include familial sexual assault, spousal or intimate partner sexual assault, acquaintance sexual assault and stranger sexual assault (4). The victims of sexual assault can come from all walks of life. Any person regardless of age, sex or other socioeconomic characteristics can be affected by sexual assault although some individuals may have a greater risk of encountering sexual assault than others. Children and young women are among the most affected groups. There are also other groups that are disproportionately more vulnerable to sexual assault like women living alone, women of rural residence, women who have a boyfriend, physically and mentally disabled people, people with substance abuse problems and people who have previous history of sexual assault (4,5). Sexual assault usually happens inside either the victim's home or the perpetrator's home (6).

Sexual assault in women results in numerous short-term and long-term health outcomes. The first is physical health outcomes which include physical injury, genital injury, urinary infection, sexually transmitted infections including HIV (7). The second outcome is psychological health outcomes in which the most commonly observed ones are depression, anxiety and post-traumatic stress disorder; although others like sleep disorder and substance use disorder can also occur (8). A third outcome is obstetric outcomes that include unwanted pregnancy, increased risk of prolonged labor maternal distress during labor and delivery, two fold risk of antepartum bleeding and emergency instrument delivery (9). A fourth outcome is societal outcomes like poor social

support, alienation from family and community, separation from spouse, loss of employment and economic instability (10,11).

Experiencing sexual assault is associated with reasonably low levels of social support for victims. Particularly, victims report decreased contacts with friends and relatives, and receive fewer emotional support from friends, relatives, and spouse (12). Sexual assault victims often expressed the likelihood of not receiving support leading to intensified effects of sexual assault. On the other hand, survivors described the benefits of receiving psychosocial support as vital to healing and recovery. Hence survivors recommend for improvements in access to formal support services, better access to information, enhanced training for support providers, and better resources for empowerment of survivors (13).

According to the Revised Criminal Code of the Federal Democratic Republic of Ethiopia, majority of violence against women and girls is illegal under the code, including rape that occurs outside of marriage, trafficking in women, and prostitution for financial gain, and physical abuse that occurs within marriage or in an irregular union. Abduction, female genital mutilation, and early marriage are all prohibited. Nevertheless, the rape clause expressly states that cases of marital rape are not covered. Men continue to rape their spouses because there are no legal penalties for rapes committed during marriage, which has serious physical and psychological effects on the victims (14). In Ethiopia, the rate of charge filing, and conviction were high. Unknown attackers attacking women sexually and direct microscope images of sperm have been found to affect conviction rates. The evidence also suggests that presence of trauma, severe injury, and positive spermatozoa, are all associated with a higher likelihood of conviction (15).

Emergency medical attention for the prevention of pregnancy and STIs including HIV infection, along with the gathering of forensic evidence and the recording of injuries, and provision psychosocial support has an impact on the victims' health and recovery after sexual assault (16). To maximize the advantages, preventive therapy is expected to be administered to victims within 72 hours following the sexual assault. Even though it jeopardizes necessary medical interventions, delays of victims of sexual assault in presenting to medical facilities frequently occurs. Determining the variables linked to sexual assault victims' delayed presentation for care is therefore crucial (17).

1.2 Statement of the problem

Sexual assault is an ever growing worldwide public health problem (18). There are regional and national differences in the occurrence of sexual assault. Consequently, the WHO report has provided estimates of the prevalence in various global regions, with the estimated prevalence being 36% in Africa, 33% in the Americas, 26% in Europe, and 34% in Southeast Asia (19). The prevalence of sexual assault varies by region in Ethiopia as well. In the last ten years, the rates of sexual assault were 8.7% in Wolaita sodo, 28.6% in Jarso district in the Oromia region, 54.9% in Debre Berhan, and 9.7% in Tigray (20–23).

Sexual assault survivors deal with a wide range of physical and mental health issues because of the assault. In Tigray, a community-based survey revealed that 28.3% of victims of sexual assault had suffered physical injuries including as bone fractures, joint dislocations, eye, ear, and tooth injuries. HIV infection, other STDs, and unintended pregnancy caused the greatest medical repercussions, with reported rates of 2.7%, 13.6%, and 9.5%, respectively (23). According to research done in the southwest of Ethiopia, PTSD was developed by 75% of adolescent age girls who had been sexually assaulted. While depression occurred in 25% of these victims. About 25% of the victims said they had trouble sleeping, and 46.6% of them had substance abuse problems. (24).

Most sexual assault survivors do not disclose their assault to anyone. Of those that do disclose, only 8% do so to the police and only 25% come forward to their family. These survivors gave several explanations for not coming forward, including feelings of guilt and humiliation, fear of the perpetrator's retaliation, fear of their families' reactions, fear of the public's reactions, and uncertainty about what to do (25). Women’s non-disclosure and not seeking help is associated with increased risk of developing negative mental health consequences. Furthermore, victims' hesitation to disclosure during the early stages of their recovery journey may be heightened by negative social reactions to the disclosure of the sexual assault. (26). Negative social reaction has also been found to be associated with enhanced self-blame, avoidance coping and PTSD symptomatology (27). Moreover, it has been demonstrated that a victim of sexual assault may experience cumulative health effects from not being believed by the police. This is because mistrust breeds victim re-victimization, which exacerbates the emotional trauma that sexual assault already causes. (28). The help seeking behavior of women who have been sexually assaulted has been liked to different socioeconomic factors. Women who have undergone a more serious form of sexual assault, are

older, work, are wealthier, and are employed are far more likely to seek assistance than their counterparts (29).

Many nations create action plans to address the social and health issues related to sexual assault. Despite the fact that these action plans do not have the necessary national survey data for planning and policy development (30). Countries need reliable data on the nature and extent of sexual assault as well as the risk factors and consequences of the sexual assault in order to develop well-informed policies, national action plan, programs and services to prevent and respond to sexual assault (30). Therefore, this study aims to provide data on the experience of sexual assault among women survivors, the overall psychosocial support they receive and the medical, social, and psychological consequences they encounter.

1.3 Significance of the study

Credible and reliable data on sexual assault is critical to inform the knowledge we have about the types, risk factors, circumstances, consequences, and psychosocial support surrounding sexual assault. It is also important to differentiate the variations of these findings in different groups. Conducting these studies is also an important input for the design of effective and sustainable policies, programs, and strategies to combat sexual assault which is a significant public health problem.

Therefore, the findings of this study will benefit policy makers, public health program designers, the health care system, social and behavioral communication experts, and the society by providing accurate information about the risk factors and circumstances of sexual assault that can be used by public health experts to design effective prevention strategies and programs. It will also provide important data on the consequences of sexual assault and the existing services available for survivors in health facilities including psychosocial support. This will help to guide the health care community improve their services and give input for social and behavioral communication experts in designing evidence-based health education programs directed at the public's knowledge regarding sexual assault and its associated factors to improve the reaction of the society towards survivors. This study will furthermore be input to the literature on the topic and guide researchers on future study areas for further research.

2. Literature Review

2.1 Prevalence of Sexual Assault

The trend of sexual assault prevalence in the world has been documented particularly in a study that looked at this trend from 1990 to 2017 in a total of 195 countries and territories. According to this study, sexual assault prevalence rate in women has seen a decline in all the countries and territories around the world. In general, the basic sexual assault prevalence rates were higher in women in both high and low-income countries (31). Findings from the WHO multi-country study on women's health and domestic violence analyzed from 15 different sites in ten countries stated that the lifetime prevalence of sexual assault of women by an intimate partner ranged from 6% in sites of Japan, Serbia, and Montenegro to 59% in Ethiopia. In Ethiopia, Bangladesh, and Thailand city, women reported experiencing more sexual violence than physical violence from their intimate partner at 31%, 33% and 44% respectively (32).

In Belgium, the lifetime prevalence of sexual assault is 64% (33). In Ireland, the magnitude of sexual assault in women was found to be as high as 50% (34). In the United States of America, approximately, 27.3% of women have experienced sexual assault (35). In India, 9% of all reproductive aged women experience sexual assault in their lifetime (36). The prevalence of sexual assault in Tanzania and Uganda, according to a study conducted in 2020 among the country's adolescents, is 26.7% and 27.6% respectively (37). Another study conducted in Kenya and Zambia, estimates the prevalence of sexual assault at 40% for both countries (38).

One meta-analysis conducted on workplace sexual assault in Ethiopia puts the pooled prevalence at 22%. The pooled prevalence for attempted rape was 14.1%, the prevalence for rape was 8%, and for sexual harassment 33.2%. The prevalence was the highest among female university staffs at 49%, and commercial sex workers at 28%. Based on study location, Tigray national regional state reported the highest pooled prevalence of workplace sexual assault at 36.1%, the second largest was Oromia national regional state at 24.1%, third was Amhara national regional state at 22.6%, fourth was Addis Ababa at 18.8%, and last was SNNPR at 18.2% (39). Another systematic review and meta-analysis reported that the pooled prevalence of lifetime sexual assault among housemaids in Ethiopia was 46.26%. It also stated that the pooled prevalence for sexual harassment was 55.43%, the prevalence for attempted rape was 39.03%, and the prevalence for rape 18.85% (40).

A study conducted among college students in Bahirdar reported the prevalence of any form of sexual assault was 37.3%. Among the students 35.8% reported sexual harassment and 6.3% reported being rape at least once in their life time (41). Another study conducted in Oromia region, Jarso district among high school students suggested that around 28.6% of the participants have experienced some form of sexual violence at some point in their lifetime (21). A community-based study on domestic violence in Gondor reported that 19.2% of the women have experienced intimate partner sexual assault. The study also stated that among the women who have experienced physical violence 14.8% of them claim to have been raped (42). In a study done in Harar town among high school students, it was revealed that 25.9% of the students had experienced rape at some point in their life (43).

2.2 Factors associated with sexual assault

When looking at the factors associated with the relationship of the victims to the perpetrators of sexual assault, we can see that perpetrators of sexual assault come from any segment of the community. In a study conducted among female university students, it was found that majority of the rapists, at around 85% were known to the victims. The perpetrators were intimate partners in 57.7% of cases, family members/other relatives came next at 22.5%, strangers and teachers each contributed to 5% of the cases, and students alone committed 5.6% of the rape cases (25). Similarly, another study conducted in Jimma university specialized hospital also found that the bulk of the perpetrators were known to the victims (76.8%). Regarding the number of perpetrators, while most victims (91%) were assaulted by one perpetrator, around 5.1% of the rape cases were committed by multiple perpetrators (6). Another study also conducted in Jimma university medical center identified that close to half of the perpetrators were known to the victims; with strangers accounting for 14.4%, acquaintances 80.7%, and family accounting for 5%. Regarding the methods of coercion used by the perpetrator; verbal threats accounted for 47.1%, while physical force accounted for 44.4%, and while 3.2% of perpetrators used a knife, 2.1% of them used a gun (44).

A health facility based study assessing cases managed at a referral hospital in western Ethiopia described that the occurrence of sexual assault based on gender affects females the most at a rate of 95.6% among all cases reporting to the hospital (45). A community-based study with a large sample size conducted in Tigray showed that among all the reproductive aged groups included in the study young women aged 15–24 was the age group that was most affected by sexually assault

at 29.2%. Out of the reproductive aged group women in the study those living in urban residence were more exposed to sexually assault at 48.6%. The study also reported that women who did not have formal education which includes both those unable to read and write and those able to read and write were the most affected by sexually assault (23). A one-year retrospective review done at a tertiary referral hospital in urban Ethiopia described that most victims of sexual assault were found to be single women at 99.4% and majority of them were students at the time of assault at 76.5% (46).

According to a meta-analysis conducted on predictors of sexual assault among female students in higher education institutions, factors predisposing female students to sexual assault included; alcohol drinking, rural residence and ever having had a boyfriend were associated with higher risks of exposure to sexual assault (5). One study evaluating the effect of victims' resistance on rape completion found that compared to those who did not resist, women who put up verbal resistance and physical resistance were more likely to successfully avoid rape completion compared to their counterparts (47). According to another study conducted in southwest Ethiopia assessing intimate partner violence against women, a substantial number of women indicated a range of reasons for the quarrel between them and their intimate partners. They point out economic reasons as the most recurrent while power relation and partner being drunk were other reasons also mentioned. Similarly, women in the workforce and women with controlling partners were found to be more likely to report sexual assault than their counterparts (48).

A study assessing the epidemiology of campus sexual assault in Eswatini found that having a child, losing both parents before the age of 21, high levels of food insecurity and hazardous drinking were factors found to be significantly associated with lifetime sexual assault. It was also reported that re-victimization risk was higher in women who were sexually assaulted before their 18th birthday (49). In another study conducted among college students in Columbia university in New York, the following factors were described in association with sexual assault; having difficulty paying for basic necessities, having multiple sexual partners, binge drinking, and experiencing sexual assault before college (50). And a study conducted in sub-Saharan Africa among women with and without disability showed that women with cognitive and visual disabilities had the greatest experience of sexual assault (51).

The importance of age factors in survivors' avoidance coping in sexual assault is substantial. The employment of avoidant coping mechanisms among adolescent age children was found to be associated with fewer behavioral issues, while it was also associated with more sexual anxiety, in contrast to findings with adult survivors. Most survivors employ adaptive coping skills such as, internalized coping, angry coping, avoidant coping, and active/social coping (52). There is a significant difference between age groups and distinct coping abilities in sexual assault survivors. Adults above the age of 18 demonstrate a higher rank score for active coping, venting, and positive reframing compared to their younger counterparts (53).

2.3 Consequences of sexual assault

Sexual assault has been linked to causing different physical, medical, mental, and social consequences on victims. A study in southwest Ethiopia confirmed that sexual assault has a number of consequences including unwanted pregnancy, social problems, physical trauma and psychological problems (54). The most reported consequences of sexual assault according to a systematic review conducted in 2016 are pregnancy, genital injuries, fistulae, and sexual dysfunction. The review found that most common mental health outcomes include post-traumatic stress disorder (PTSD), anxiety and depression. Whereas the most serious social consequences of sexual violence stated were stigmatization and rejection by family and community and abandonment by spouse (11).

Plenty of physical consequences were documented in a hospital-based study in western Ethiopia. Genital injuries at 75.4% was the most common physical injury found among participants. Meanwhile Only 17.2% of study participants had non-genital injuries. Among these bruises were the most common non-genital injuries reported (45). Another hospital-based study in two Ethiopian towns reported on the physical injuries of victims presenting to the hospitals and found that around 5.9% of cases reported injuries to external genital areas, such as lacerations, stab wounds, or bleeding. From these files, it was also found that 4.6% of them presented with general body trauma. Among the non-genital injuries, the most common were abrasions at 42.9%, next was bruising at 27.3%, and last was lacerations at 15.6% (55).

Consequences related to the medical health of victims have also been reported among victims in northeast Ethiopia. Among these medical outcomes Sexually Transmitted Infections, including chlamydia and HIV, and unwanted pregnancy were mentioned (7). In another study conducted

also in southwest Ethiopia, we can observe that 67.2% of the study participants had an unwanted pregnancy, 48.9% of the study participants developed an STI, 16.7% of the participants tested positive for syphilis and 14.9% and 10% of them tested positive for Hepatitis B virus and HIV infection respectively (56). The study conducted in two hospitals in Ethiopia also mentioned that 0.8% of the victims who presented to the hospitals tested positive for HIV, while 0.2% tested positive for syphilis, 2.2% tested positive for hepatitis B, and 11.8% tested positive for gonorrhea, while 9% of the all the cases had unwanted pregnancy (55).

The proportion of victims suffering from psychological symptoms after encountering sexual assault as described in a study conducted in the UK among adolescents were found to be very high at around 90% of participants showing symptoms of PTSD, 88% of participants having symptoms of depressive disorder and 71% of them showing symptoms of anxiety disorder (8). Substance use disorder and sleep disorders are also among the mental health outcome that have been found to affect victims of sexual assault. Some of these include alcohol use disorder, khat use disorder, nicotine use disorder, inhalant use disorder and cannabis use disorder as described by a study conducted among adolescent girls in southwest Ethiopia. Additionally the study also described that more than half of the adolescent girls had poor social support, and a fourth of them had poor sleep quality (24).

Social Complications arising from sexual assault described by a study conducted among female high school students in Wolaita sodo included being disowning by family, being isolated from friends, having a reduced academic performance, discontinuation of school, alcohol addiction, sexual promiscuity, and sexual addiction (57). Women who have experienced sexual assault also encounter a host of socioeconomic consequences like taking leave off from work, poor job performance, an inability to work and ultimately unemployment arising either from quitting or being fired from their jobs. The collective effect of these occupational consequences in the long run affect the earning capability of the women eventually causing economic instability and shifting the longstanding financial path of the victims (10).

2.4 Psychosocial support in sexual assault

Many survivors of sexual assault feel immensely distraught after the assault. Therefore, they usually tell someone about their experience to get help. Survivors disclose their assault experience to different social support groups, like a friend, family, health care professionals, police officials,

or religious leaders. While countless women claim they received support, a significant number of women disclosing their assault history report receiving negative reactions from their social groups (58). Because of fear of this negative reaction survivors will usually refrain from disclosing the assault to anyone. Women who survived sexual assault describe that nondisclosure or delayed disclosure can lead to continued and worsened impacts of sexual assault by creating feelings of shame, self-blame, self-directed anger, and overall emotional distress (13). Shame, self-blame, and negative social reactions have been found to be associated with negative consequences like; psychological and physical distress, depression, PTSD, affect dysregulation, and maladaptive coping and they become barriers to disclosure and predict future re-victimization for the survivors (59).

Positive reactions from formal and informal social groups are credited with helping survivors in their recovery from the trauma caused by the sexual assault they suffered. Whereas mainly informal negative reactions are found to aggravate specific posttraumatic distress suffered by the survivors. Therefore identifying and addressing the social support necessities of sexual assault survivors is important in the prevention and treatment of these emotional and psychological distresses (60). Negative social reactions like; controlling, distracting, and treating survivors differently have been found to aggravate psychopathology (61). Negative social reactions and avoidance coping have also been suggested as the strongest predictors of PTSD symptoms in sexual assault survivors. The association seen between victim self-blame and PTSD symptoms is also due to the effect of negative social reactions from others (27).

A study conducted in Congo, evaluating the psychological support sexual assault victims received stated that after at least two psychological consultations, the severity in impairment of their global functioning has significantly gone down from extreme/medium to mild severity for 71.4% of the women. This benefit of the psychological support after sexual assault was completely sustained when the women were followed up on around one to two years after the initial consultations (62). As suggested by an umbrella review conducted on the efficacy of psychosocial interventions for mental health outcomes in low and middle income countries, there is ample evidence for the effectiveness of psychosocial interventions in adults with depression, PTSD, schizophrenia and other common mental disorders in humanitarian settings and in the general population (63).

Over-all the incidence of social reactions received might depend on the number of people to which the victims disclose the assault. Hence, more people knowing means more positive and negative reactions will be received. Women reporting more negative reactions and more PTSD symptoms usually recover the least over the years. Thus, teaching the useful and harmful effects of different types of reactions to disclosure to the informal social groups and formal support systems could improve their capability in reacting in a helpful manner which in turn will advance the recovery process of the survivors (64).

2.5 Health care services provided for sexual assault survivors

There are a set of services provided for sexual assault victims when they present to a health facility after experiencing the assault. These include laboratory tests, preventive prophylaxes, and treatments for infections and trauma sustained because of the assault. There are a set of laboratory tests that need to be performed for victims of sexual assault. In this study conducted in Saint Paul's hospital all the recommended laboratory tests were performed for around 71% of the victims. Serology tests for HIV, Hepatitis B and Syphilis were done. A urine pregnancy test was performed (46). In another study conducted in the One-Stop Service Center for survivors of sexual assault in Wollega University Referral Hospital, it was found that victims presenting to the hospital did so within 72 hours in only 36.5% of the cases. Regarding laboratory investigations; pregnancy test, STI tests, HIV, syphilis, and hepatitis tests were performed and a wrist x-ray was done for all victims (45).

A study conducted in Jimma hospital also described that victim's time of presentation to the hospital for the first time after the occurrence of sexual assault extended from a few hours to several months and the mean presentation time was found to be 15 days. From these survivors 76.8% were provided a pregnancy test, 99% were given HIV test, and 93% were screened for any STIs (6). Another study also conducted in Jimma university medical center reported that only 2.7% of victims presented to the hospital within a day of the assault, while more than half of the victims reported to the hospital within 6 or more days after the assault. Of those that reported to the hospital 75.9% received a pregnancy test, 58.3% received VDRL test, 54.5% underwent HBsAg test and 96.8% underwent HIV test. These laboratory investigation came back positive for pregnancy in 3.2% of cases and for syphilis in 1% of all cases (44).

Regarding therapeutic interventions a study looking at post sexual assault services provided for victims in 38 different emergency departments stated that approximately one-third of hospitals used 72 hours after sexual assault as a deadline for providing prophylaxis for victims. From all the hospitals 35% of victims received the recommended prophylaxis for chlamydia, gonorrhea, and emergency contraception (65). The study conducted in Saint Paul's hospital reported that Emergency contraception was provided for 42% of victims, HIV Post Exposure Prophylaxis was provided for 45% and STI prophylaxis was provided to 61.7% of all cases, while social support/ counseling was provided to 61% of the victims. Abortion was done for five of the victims who were positive for pregnancy. Appointments for follow up visits were given to 50% of the victims (46).

The study conducted in Wollega university referral hospital also reported that among total cases HIV prophylaxis was given for 68.9%, and prophylaxis for other STIs was given to 94.6% of all cases. Although hepatitis virus prophylaxis was not given to any of the eligible victims, emergency contraception was provided for 50% of them. In addition, surgical procedures, and inpatient services for at least 24 hours were provided in 4.9% and 16.7% of the cases respectively. Finally majority of the victims, around 97%, received psychosocial support from the center (45). The study conducted in Jimma hospital also stated that from all the survivors of sexual assault presenting to the hospital within the first five days of the assault, about 40.5% were provided with emergency contraception, while 60.5% of the survivors presenting within 72 hour of the assault were provided with HIV post exposure prophylaxis, 63% of those who presented within 24 hours were provided with STIs prophylaxis and 91.9% of all survivors were given counseling and psychosocial support during their visit to the hospital (6).

2.6 Research Questions

1. What is the experience of survivors regarding the sexual assault they encountered?

2. What are the post sexual assault services and psychosocial support sexual assault survivors receive?

3. What consequences did survivors suffer because of the sexual assault they experienced?

2.7 Conceptual framework

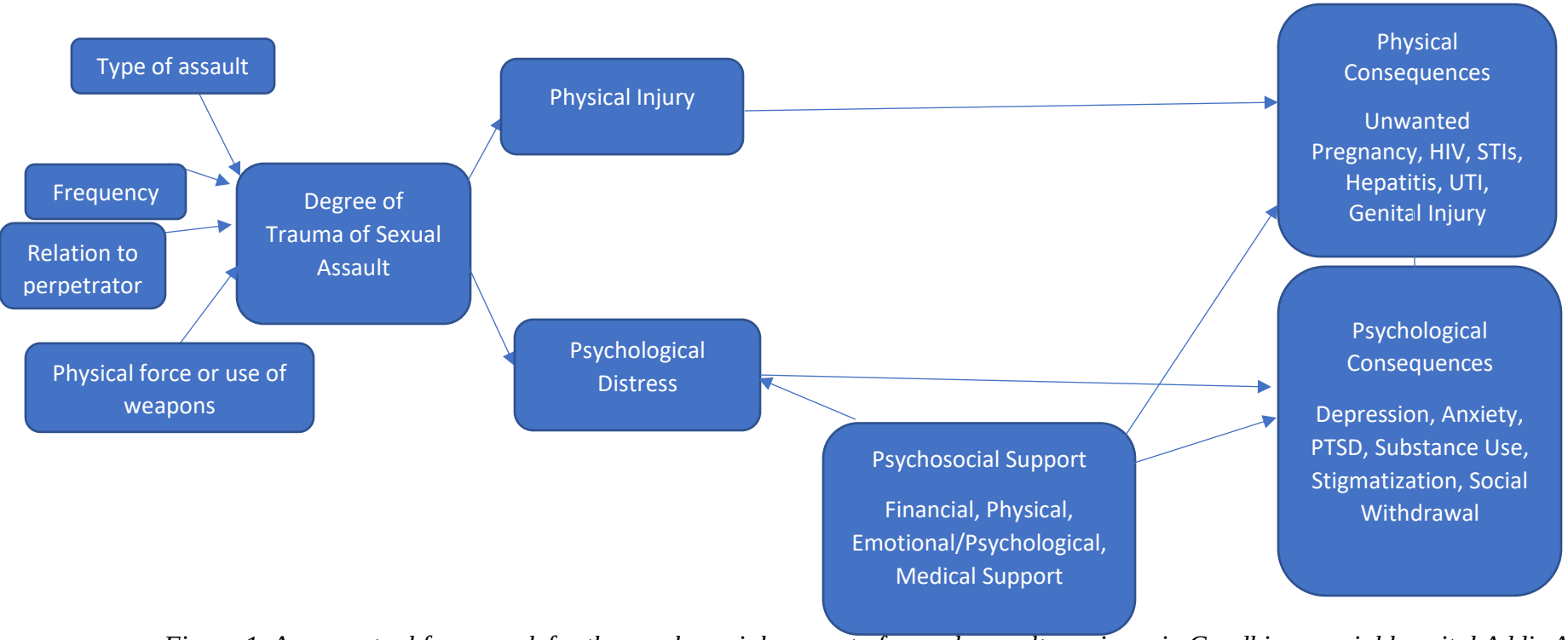

Figure 1. A conceptual framework for the psychosocial support of sexual assault survivors in Gandhi memorial hospital Addis Ababa Ethiopia adapted from Trickett et al.

3. Objectives

3.1 General Objectives

- To assess the sexual assault experiences and psychosocial support of sexual assault survivors at Gandhi hospital Addis Ababa, Ethiopia in 2023

3.2 Specific Objectives

- To describe the circumstances of sexual assault experienced by survivors at Gandhi hospital, Addis Ababa Ethiopia in 2023
- To assess the type of psychosocial support received by sexual assault survivors at Gandhi hospital Addis Ababa, Ethiopia in 2023
- To assess the consequences faced by sexual assault survivors at Gandhi hospital Addis Ababa, Ethiopia in 2023

4. Method and Materials

4.1. Study Area and Period

The study was conducted in Addis Ababa. Addis Ababa is the capital city of Ethiopia. It is also the largest city in Ethiopia. It hosts 30% of the population. An estimated 5.2 million people live in Addis Ababa (66). The study area, Gandhi hospital is in Addis Ababa city. Purposive sampling method was used while selecting the study area. The hospital was founded in 1958 GC. It has 350 beds. The hospital is operated under Addis Ababa Health Bureau. It has a total of 22 physicians, 140 nursing & 45 midwife staff. The hospital is primarily focused on reproductive, maternal, and neonatal health. The hospital has a one-stop integrated services center for gender-based violence survivors. It is where gender-based violence survivors including rape survivors are referred to and is the first of its kind in Ethiopia in providing integrated services for survivors of gender-based violence. The one-stop center within the hospital was piloted in 2008 to provide a comprehensive integrated response for survivors. The study was conducted from July 2023 to October 2023 at Gandhi memorial hospital one-stop center for gender-based violence.

4.2. Study Design

Convergent Parallel Mixed study design was used in which quantitative and qualitative data was collected at the same time and independently. Case study design was used for the qualitative study and an institution based descriptive cross-sectional study design for the quantitative study.

4.3. Population

4.3.1. Target Population

All women sexual assault survivors living in Addis Ababa and other parts of Ethiopia.

4.3.2 Source Population

All women that present to the one-stop center for sexual assault at Gandhi Hospital.

4.3.3 Study Population

All women above the age of 14 years that present to the one-stop center at Gandhi Hospital for sexual assault during the study period. Study population for qualitative study are service providers at Gandhi Hospital one-stop center.

4.3.4 Study Unit

An individual woman that presents to the one-stop center at Gandhi Hospital for sexual assault that fits the inclusion criteria.

4.4. Eligibility Criteria

4.4.1. Inclusion Criteria

Women who are above the age of 14 years

Women who are survivors of sexual assault presenting at the time of the study at Gandhi hospital one-stop center

Women who are willing to participate in the study

4.4.2. Exclusion Criteria

Women that are survivors of gender-based violence of a non-sexual nature.

Women who are unwilling to participate in the study

Women who are in acute, emergency state

Women under the age of 14 years

Men survivors that present to the center

4.5. Study Variables

4.5.1. Dependent variables

- Psychosocial support

4.5.2. Independent variables

- Age, residence, marital status, educational status, occupation, and social reaction

4.6. Sample Size Determination

For Quantitative Study

To calculate the number of study participants, a single population proportion formula is used with the following assumptions. Since the prevalence of rape in Ethiopia is 8 % (39) (P =0.08) is taken with 95% confidence interval and 4% margin of error. Then the sample size was calculated as follows.

$$n = \frac{(z \propto/2)^2 \, x \, P(1-P)}{d^2}$$

Thus, $n = \frac{(1.96)^2 \, x \, 0.08(1-0.08)}{(0.04)^2}$ = 176

For Qualitative Study

Saturation was reached at 6 service providers from the one-stop center who participated as key informants in this study.

4.7. Sampling procedure

4.7.1. For quantitative study

Consecutive sampling technique was used to recruit the women that present to the one-stop centre. Participants were chosen based on the apportioned sample size and the first one hundred and seventy-six (176) women who fit the inclusion criteria and presented to the one stop centre during the time of data collection were selected.

4.7.2. For qualitative study

Maximum variation purposive sampling was used to recruit service providers at the one-stop center for gender-based violence survivors at Gandhi hospital. The Key informant service providers were different from each other in terms of profession, educational status, and work experience to gain insight from as many viewpoints as possible.

4.8. Operational definition

Sexual Assault: any form of sexual contact without voluntary consent including sexual touching, forcing a victim to perform sexual acts, such as oral sex or penetrating the perpetrator's body and penetration of the victim's body orally, vaginally, or anally (1).

Rape: penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim (67).

Victim/Survivor: is a person who has experienced sexual assault. **Perpetrator:** is a person (or group of persons) who has committed an act of sexual assault.

Psychosocial Support: measured by adapting the WHOQOL tool with its components including emotional/psychological support, financial support, physical care and support, medial support, and

spiritual support from friends, family, non-government organization, community based organization, religious based organization, and government organization.

Depression: was measured by PHQ-9 tool having nine symptoms with a minimum symptom count of five qualifying for a diagnosis of depression.

Anxiety: was measured by GAD-7 tool with its six symptoms with a minimum of three symptom counts qualifying for a diagnosis of anxiety disorder.

PTSD: was measured by using PC-PTSD-5 having five symptoms with a minimum of three symptom counts qualifying for a diagnosis of PTSD (post-traumatic stress disorder).

4.9. Method of data collection and tools

4.9.1. Quantitative data collection tool

A structured interviewer-administered questionnaire with closed-ended questions will be used for collecting the data. The questionnaire was adapted from sexual assault assessment literatures for data on socio –demographic characteristics, sexual assault circumstances and consequences, the WHOQOL tool for psychosocial support, and PHQ-9 depression assessment tool, GAD-7 anxiety assessment tool and PC-PTSD-5 post-traumatic stress disorder screening tools for mental health consequence assessment were used which have all been validated in an Ethiopian context and sub-Saharan African country setting and were found to be reliable. The questionnaire was pretested on about 5% of the sample size and appropriate modifications were done based on the pretest. The questionnaire was used to collect data on socio-demographic and circumstances of sexual assault, psychosocial support experiences of participants and consequences suffered because of sexual assault. The questionnaire was prepared in English and then translated into Amharic and was administered in Amharic since it is the local language.

4.9.2. Qualitative data collection tool

A Semi – structured key informant interview guide was used for this study. The interview guide is prepared to explore the sexual assault services provided for survivors, the psychosocial support experiences of survivors through the eyes of the health care providers, the resources available for providers and challenges faced in service provision. The interview guide was prepared in English and include open ended questions and then translated into Amharic. The participants' voices were recorded after receiving required consent from participants. During the interview additional

explanation and probing of questions was made to direct the participants for further exploration. Field notes and memos were taken by the researcher during collection of the data for personal reflections and observations. The other method used during data collection was observation, to capture essential nonverbal cues from participants while conducting interviews. The interview guide was edited based on observations from previous interviews during the data collection.

4.10. Data collection procedure

4.10.1. For Quantitative data

Four nurses working in the one-stop center were recruited as data collectors. They collected the data with a face-to-face interview. The data collectors were trained before the data collection period on the objective of the study, contents of data collection tools and procedures. Data collectors received informed consent from each respondent before data collection began. The confidentiality of the participants was assured. The data was collected from July to October 2023.

4.10.2. For Qualitative data

The qualitative data was collected at the same time as the quantitative data. All interviews were conducted by the primary investigator in Amharic language using the key informant interview guide after obtaining informed consent from the participants. All interviews were recorded using a voice-recorder with the consent of the participant, after which the audios were transcribed verbatim in Amharic language and later translated into English.

4.11 Data quality control

For quantitative data

Data quality was assured all throughout the data collection process. Training was given to data collectors on objectives, contents of the questionnaires, keeping confidentiality and privacy of the participants. The questionnaire was prepared initially in English then translated into Amharic by an individual who has experience in translation and again translated back to English by different person to ensure its consistency. The questionnaire was pretested before data collection to ensure that it's understandable. The data collected was reviewed by the investigator for its completeness, clarity and consistency before data analysis began. The data was entered into SPSS version 25 by the principal investigator to ensure quality of data entered.

Trustworthiness of qualitative data

Interview guides were prepared initially in English then translated into Amharic by an individual who has experience in translation and again translated back to English by different person to ensure its consistency. Trustworthiness was assured throughout the study. Credibility was maintained by prolonged engagement, peer debriefing and member checking. Dependability was enhanced by taking field notes, using recording devices, transcribing the digital files verbatim and keeping an audit trail of each step in the research process. Conformability was assured by conducting peer audit of field notes, transcriptions, and result. Transferability was assured by using a thick description of time, place, context, culture in the research process.

4.12. Data processing and analysis

4.12.1. Quantitative data

The completeness of the data was checked then entered and cleaned on SPSS version 25. After that the analysis was performed on SPSS version 25. Descriptive statistics were used to describe frequency, proportion, measures of central tendency and dispersion. The data was presented using texts, tables, and figures.

4.12.2. Qualitative study

The data analysis process started at the same time as data collection. The audio-recorded interviews were transcribed in Amharic verbatim and translated to English by the investigator. The transcribed data was carefully kept in a password protected personal computer that only the researcher can access. A back-up of the transcribed data was saved in a memory drive and kept in a place that can only be accessed by the researcher. Thematic analysis method was used to analyze qualitative data. The researcher read and reread the transcriptions by putting aside their own opinions to be familiarized with the data. The code book was then developed, and the data was changed into plain text and was entered into open code version 4.03 then coded. Themes were identified from the coded text, then similar ideas from the coded text get categorized into identified themes. Accordingly, the responses of participants were described under each thematic area.

4.13. Ethical Consideration

Ethical clearance and approval were obtained from Addis Ababa University, College of Heath Sciences, school of public health, Research and ethics committee (REC), Addis Ababa Health Bureau and Gandhi Memorial Hospital then letter of cooperation was written to the one-stop center of Gandhi hospital. The purpose and procedure of the study was explained briefly to the staff. Participants were informed about the voluntary nature of the study and rapport was built before

conducting the interviews. An information sheet on the purpose and procedures of the study, possible risks or discomforts during interview, benefits of the study, privacy and confidentiality issues, voluntary participation, and their right to withdraw from the study at any time were provided to the participants (See annex 1).

Prior to starting the interview, written informed consent was obtained from all study participants via their signature (See annex 2). To ensure confidentiality, all interviews were conducted in private rooms. While conducting the data collection the participants of the study will not be asked to state their names. In addition to this, all information recorded on the digital recorder will be deleted after the research document has been accepted and approved.

4.14. Dissemination of Result

The results of this study will be disseminated to Addis Ababa University, College of Health Science and School of public health, department of preventive medicine. It will also be shared with Addis Ababa Health Bureau, Gandhi memorial hospital and Ministry of health. In addition to that, the manuscript of the research will be prepared and submitted to suitable journals for possible publication.

5. Result

5.1. Quantitative Study Result

5.1.1. Socio-demographic characteristics of sexual assault survivors

A total of one hundred seventy-six (176) women sexual assault survivors participated in this study. From the 176 women, majority of them 124 (70.5%) resided in Addis Ababa and around 44 (25%) of them came from Oromia. While 143 (81.3%) were from urban residences, 33 (18.8%) were from rural residence. Majority 135 (76.7%) of the women were between the ages of 14 to 19, while 28 (15.9%) were in the age group 20 to 25. The mean age was 18 years old (SD = 5.139). Most 162 (92%) of the women were single, while 6 (3.4%) were married and 7 (4%) were divorced. Regarding educational status, 86 (48.9%) had completed primary school, 47 (26.7%) were of secondary school level, 17 (9.7%) were unable to read and write and 16 (9.1%) had a university level of education. When it comes to occupation, more than half of the women 102 (58%) were students, while 29 (16.5%) were private employees and 22 (12.5%) were daily laborers.

Table 1. Socio-demographic characteristics of sexual assault survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	Frequency (N=176)	Percentage (%)
Age (in years)		
14-19	135	76.7
20-25	28	15.9
26-35	10	5.7
36-45	3	1.7
Region of residence		
Addis Ababa	124	70.5
Oromia	44	25.0
Others[a]	8	4.5
Residence type		
Urban	143	81.2
Rural	33	18.8
Marital Status		
Single	162	92.0
Ever Married	14	8
Educational Status		
Primary school	86	48.9
Secondary school	47	26.7

Others[b]	43	24.4
Occupation		
Student	102	58.0
Private employee	29	16.5
Daily laborer	22	12.5
Others[c]	23	13

[a] Tigray/Amhara/SNNPR/Sidama

[b] Unable to Read & Write/Able to Read and write/University

[c] Unemployed/House Maid/Cleaner/Commercial Sex Worker/gov't employee/ merchant/ housewife

5.1.2. Substance use history

Among all the respondents 12 (6.8%) had history of substance use while most 164 (93.2%) did not have any history of substance use. Among the ever-married women only 1 (0.6%) had a husband with history of substance use.

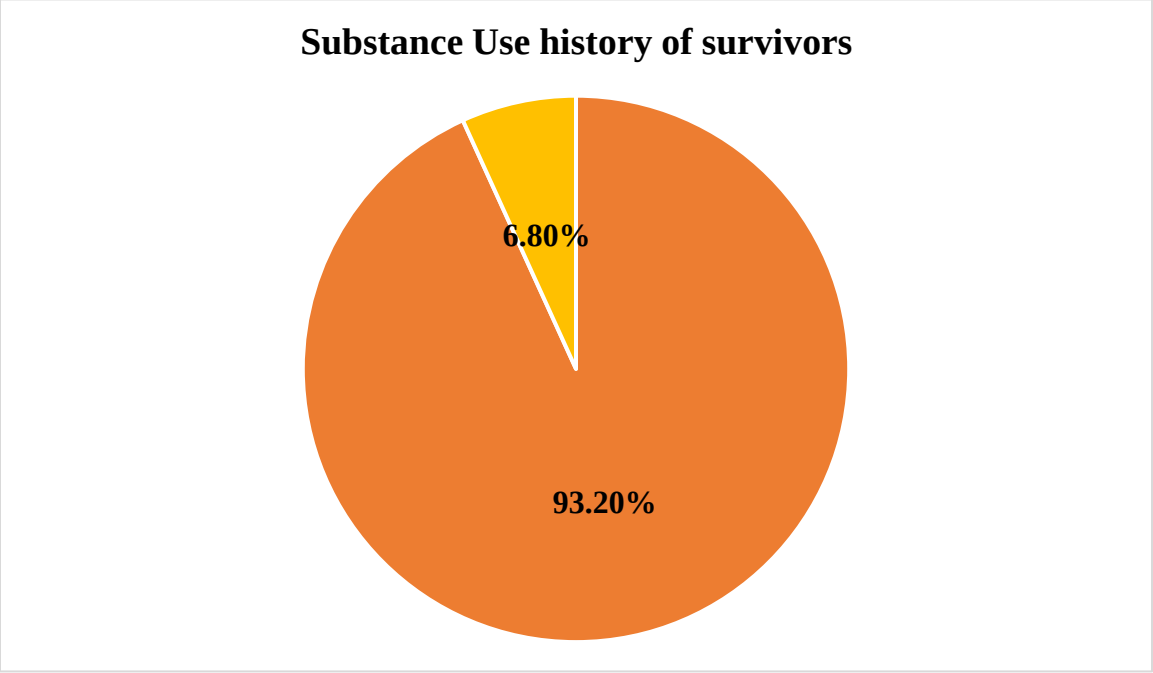

Figure 2. Substance use history of survivors of sexual assault at Gandhi hospital, Addis Ababa, Ethiopia, 2023

5.1.3. Circumstances of Sexual Assault

Looking at the type of sexual assault that survivors suffered, out of all the respondents, the majority 161 (91.5%) reported vaginal rape. Majority 80 (45.5%) of the women encountered the sexual assault within the three days prior to interview. The majority 79 (44.9%) of the assaults took place in the perpetrator's home. Among the survivors 21 (11.9%) have had previous history of sexual assault. Regarding the resistance survivors put up 62 (35.2%) didn't resist at all and stayed still or froze. When it comes to physical injury suffered during attack, 35 (19.9%) suffered physical injuries. Among these, most survivors 24 (68.6%) suffered bruises and scratches. Among the survivors 16 (9.1%) of them were using substances at the time of the attack, the majority of which were using alcohol 13 (81.3%). In terms of disclosure of the assault, 173 (98.3%) disclosed the assault to at least one person. While most of them 131 (74.4%) disclosed to their families, 11 (56.8%) of them disclosed to the police.

Table 2. Circumstances of sexual assault among survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	Frequency (N=176)	Percentage (%)
Types of sexual assault suffered		
Vaginal rape	161	91.5
Unwanted kissing	65	36.9
Fondling of sexual body parts	45	25.6
Others[a]	16	9.0
Time sexual assault occurred		
Within the past 3 days	80	45.5
More than 30 days ago	51	29.0
4 – 30 days ago	45	25.5
Place sexual assault took place		
Perpetrator's home	79	44.9
Survivor's home	26	14.8
In the street	20	11.4
Others[b]	51	28.9
Previous sexual assault history		
Yes	21	11.9
No	155	88.1
Resistance put up by survivor		
Physically Fight/Kick, Punch	72	40.9
Stay Still/Freeze	62	35.2
Reason/Plead	56	31.8
Cry/Sob	46	26.1

Others[c]	27	15.4
Disclose of sexual assault		
Yes	173	98.3
No	3	1.7

[a] Unwanted oral sex/ Experiencing anal sex

[b] Hotel/Car/Youth Center/School/ In the woods

[c] Scream for Help/ Run Away

Note: types of sexual assault suffered, and resistance put up by survivor have multiple options.

5.1.4. Perpetrators of sexual assault

Most of the respondents 97 (55.1%) were assaulted by a stranger. More than a quarter of the respondents 155 (88.1%) suffered single perpetrator sexual assault. Among all the respondents 26 (14.8%) reported that perpetrator use weapons during the assault. The most common types of weapons used were knife 11 (42.3%) and gun 8 (30.8%). The most common type of violence perpetrators used during the assault was threat of physical force in 71 (40.3%). Out of all the respondents 41 (23.3%) of them reported that the perpetrators were using some kind of substance. Out of those who were using substances, 37 (90.2%) were using alcohol. Among all the respondents 137 (77.8%) reported the assault to the police.

Table 3. Perpetrators of sexual assault suffered by survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	Frequency (N=176)	Percentage (%)
Perpetrator's relation with survivor		
Stranger	97	55.1
Acquaintance	63	35.8
Others[a]	16	9.1
Number of perpetrators		
One	155	88.1
Multiple	21	11.9
Type of violence used by perpetrator		
Threat of physical force	71	40.3
Insistence	57	32.4
Choking	53	30.1
Twisting arm & holding down	31	17.6
Others[b]	47	26.7

[a] Family/ Spouse

[b] Slapping/ Beating

Note: types of violence used by perpetrator have multiple options.

5.1.5. Psychosocial support of sexual assault survivors

Among the respondents 124 (70.5%) received positive reaction from their social groups, while 52 (29.5%) received negative reactions. Among those that received positive reactions, 123 (99.2%) received emotional support, while 14 (11.3%) received tangible support. From those that received negative reactions, survivors reported facing victim blaming 37 (71.2%), controlling behaviors from others 14 (26.9%), 12 (23.1%) reported their social groups trying to distract them from the attack, 11 (21.2%) endured not being believed and 8 (15.4%) reported being treated differently. Regarding psychosocial support among all the survivors, 166 (94.3%) received psychosocial support after the sexual assault. Of these majority 162 (92.0%) of the survivors received medical support, while 124 (70.5%) received emotional or psychological support, 28 (15.9%) received physical care and support like shelter, food, and clothing. Regarding where or from whom the survivors received support, most 150 (85.2%) of them received it from a government organization, followed by family 60 (34.1%). Most 128 (72.7%) of the survivors reported being brought to the health facility by family, followed by police 27 (15.3%) and 22 (12.5%) went to the health facility by themselves.

Table 4. Psychosocial support of sexual assault survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	Frequency (N=176)	Percentage (%)
Social reaction to disclosure		
Positive	124	70.5
Negative	52	29.5
Type of positive response		
Emotional Support	123	99.2
Tangible Support	14	11.3
Type of negative response		
Blaming	37	71.2
Controlling	14	26.9
Distracting the Survivor	12	23.1
Not Believing the Survivor	11	21.2
Treating the Survivor Differently	8	15.4
Support after sexual assault		
Yes	166	94.3
No	10	5.7
Type of support received		

Medical support	162	92.0
Emotional/Psychological support	124	70.5
Others[a]	63	35.8
Source of support received		
Government organization	150	85.2
From Family	60	34.1
Others[b]	29	16.4
Person who brought survivor to health facility		
Family	128	72.7
Police	27	15.3
Own Self	22	12.5
Other[c]	22	12.5

[a] Physical care and support/ Spiritual support/ Financial support

[b] from friends/ NGOs/ Community based organization/ Religious based organization

[c] Health Professional/My Employer/My Mother's Friend/an organization/ Friends/ Neighbors

Note: all have multiple options except for social reaction to disclosure and support after sexual assault.

5.1.6 Consequences of sexual assault

The findings from this study show that 80 (45.5%) survivors presented to the hospital within 72 hours and 96 (54.5%) of them presented to the hospital after 72 hours had passed. The majority, 155 (88.1%) of the respondents interviewed were on their first visit to the hospital. Among all the respondents, 13 (7.4%) reported having history of mental illness prior to sexual assault. Regarding health consequences suffered by sexual assault survivors, 17 (9.7%) had unwanted pregnancy, 2 (1.1%) had hepatitis b virus infection, 3 (1.7%) had genital injuries, 2 (1.1%) had urinary tract infection and 10 (5.7%) had started using substances after the assault. Regarding the social consequences of the sexual assault survivors, 17 (9.7%) suffered stigmatization and 2 (1.1%) experienced social withdrawal. When it comes to the mental health consequences suffered by sexual assault survivors, 80 (45.5%) of them met the required symptom criteria for depression diagnosis, while 114 (64.8%) of them met the required symptom criteria for a diagnosis of generalized anxiety disorder and 111 (63.1%) of them met the required symptom criteria for a diagnosis of post-traumatic stress disorder.

Table 5. Consequences of sexual assault suffered by survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	Frequency (N=176)	Percentage (%)
Time of presentation to hospital		

After 72 hours	96	54.5
Within 72 hours	80	45.5
Visit to the hospital		
First Visit	155	88.1
Follow Up	21	11.9
History of mental illness prior to sexual assault		
No	163	92.6
Yes	13	7.4
Health consequences of sexual assault		
Unwanted Pregnancy	17	9.7
Substance abuse started after attack	10	5.7
Genital injuries	3	1.7
Hepatitis B Virus Infection	2	1.1
Urinary Tract Infection	2	1.1
Social consequences of sexual assault		
Stigmatization	17	9.7
Social withdrawal	2	1.1
Depression diagnosis criteria met		
Yes	80	45.5
No	96	54.5
Generalized anxiety disorder diagnosis criteria met		
Yes	114	64.8
No	62	35.2
Post-traumatic stress disorder diagnosis criteria met		
Yes	111	63.1
No	65	36.9

Note: health consequences of sexual assault and social consequences of sexual assault have multiple options.

5.1.8 Association of social reaction and psychosocial support with mental health consequences

To assess the association of social reaction and psychosocial support with mental health consequences (depression, anxiety, and PTSD), binary logistic regression was used. Social reaction and psychosocial support were found to be not significant in predicting depression and anxiety with ($p > 0.05$). While social reaction was a significant predictor of PTSD with ($p < 0.05$), psychosocial support was found to be not significant in predicting PTSD with ($p > 0.05$). For every unit increase in social reaction there is 0.442 times decrease in PTSD diagnosis with ($P < 0.05$, OR 0.442, 95% CI 0.222, 0.880).

Table 6: Predictors of depression diagnosis among survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	COR (95%CI)	P value	AOR (95%CI)	P value
Social Reaction				
Negative	1		1	
Positive	0.667 (0.344, 1.290)	0.229	0.582 (0.290, 1.171)	0.129
Psychosocial Support				
No	1		1	
Yes	1.865 (0.507, 6.854)	0.348	2.515 (0.640, 9.886)	0.187

Table 7: Predictors of anxiety diagnosis among survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	COR (95%CI)	P value	AOR (95%CI)	P value
Social Reaction				
Negative	1		1	
Positive	0.579 (0.297, 1.126)	0.107	0.572 (0.287, 1.142)	0.113
Psychosocial Support				
No	1		1	
Yes	0.806 (0.218, 2.970)	0.745	1.084 (0.277, 4.234)	0.908

Table 8: Predictors of PTSD diagnosis among survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Variables	COR (95%CI)	P value	AOR (95%CI)	P value
Social Reaction				
Negative	1		1	
Positive	0.409 (0.210, 0.795)	0.008	0.442 (0.222, 0.880)	0.020
Psychosocial Support				
No	1		1	
Yes	0.368 (0.100, 1.355)	0.133	0.556 (0.142, 2.178)	0.400

5.2 Qualitative Study Result

5.2.1 Background information of key informant interview participants

This section includes key informants working in Gandhi hospital one-stop center for gender-based violence interviewed about their experience on providing service to survivors of sexual assault presenting to the hospital. All participants were females. The participants include three nurses, two general practitioners and one counselor.

Table 9: Background information of key informant participants on service provision for survivors at Gandhi hospital, Addis Ababa, Ethiopia, 2023

Participant Characteristics		Number
Position in the Center	Nurse	3
	General Practitioner	2
	Counselor	1
Educational Background	Nursing	3
	Medical Doctor	2
	Psychology	1
Level of Education	Degree	5
	Master of public health	1
Work Experience in the Center	Ten months	1
	One year	3
	One and half year	1
	Four years	1

The findings are presented in five basic themes. These themes include post-rape service provided for survivors, available resources for service provision, and consequences of sexual assault, psychosocial support for survivors of sexual assault and challenges and recommendations. The themes are presented with numbering, under which sub- themes are presented unnumbered.

5.2.2 Post-rape services provided for survivors

Services

In this section, participants talked about the services they provide for survivors in their center. Most of the participants mentioned that they provide medical, psychological, and legal services for survivors in this center. Medical services include laboratory tests and medication treatment and prophylaxis. The laboratory tests include HIV tests, venereal diseases tests, hepatitis virus tests, pregnancy tests, urine tests, sperm test (whether sperm is present or not), gram-stain tests, and ultrasound tests. Medication treatments and prophylaxis are also provided for HIV, venereal diseases, hepatitis, and pregnancy. One participant mentioned that the service they provide is called one window service where survivors receive the medical, psychological, and legal services all together in one window. She also mentioned that after laboratory test are performed, the appropriate medications are provided depending upon the time of arrival which is categorized as within seventy-two hour of the assault and after seventy-two hours since the assault and only if they reach the hospital within seventy-two hours will they receive prophylaxis to prevent disease transmission. Here is an excerpt of how the participant described it in her own words.

"… There is medical service, there is police and a prosecutor and psychology. There are also different laboratory tests performed. The medical services we provide …If they reach us before 72 hours …. For example, HIV, venereal diseases, Hepatitis virus prophylaxis, pregnancy prevention medication will be given …." (KII 2: a nurse)

Another participant mentioned that these services are provided for the survivors immediately when they arrive at the hospital and the results come back within an hour.

"…These tests are done immediately when she comes here. The results also reach within one hour." (KII 3: a nurse)

Another participant who is a psychologist working as a counselor in the center mentioned that they usually see children coming to the hospital for services most of the time, therefore the room where they provide psychological counseling is prepared in a way that is child friendly with toys and puzzles. She also mentioned that they provide play therapy and art therapy for small children. And for the older survivors on the adolescent age group, they provide cognitive therapy, behavioral therapy, family/parent therapy, and trauma-informed therapy depending upon the age of the survivor and the type of sexual assault they have encountered.

"… it is usually small children that come here … so, positioning of the room, to provide play therapy/ art therapy, we have toys, puzzles…… for adolescence age… we have cognitive therapy, behavioral therapy, …… we also provide family/parent therapy. Trauma informed therapy for those that have suffered a trauma and have developed post-traumatic stress disorder…" (KII 6: a counselor)

As mentioned by the participants the above services are the baseline services that are provided for survivors. Other tests are performed based on the need of each case. After the medical and psychological services have been provided, the survivors will be sent to the legal system with medical certificate or evidence.

Documentation of services

Almost all participants mentioned that they document all the services they provide to the survivors. They mentioned that they have different records where they document the laboratory tests, genital injuries (if there are any), prophylaxis (for those that come within seventy-two hours of the assault), follow ups on the evaluation book, referrals separately.

"…we will document all the services we provide… We will document the laboratory tests, if there are injuries to genital area, we will document that… we have a document for follow up and in that we have an evaluation book, so we document on that also" (KII 1: a nurse)

One participant mentioned that they have a record keeping system called HMIS prepared by Addis Ababa health bureau where they document all the services they provide. She also mentioned that prophylaxis medications provided have their own separate record except for HIV prophylaxis which has its own separate record.

"…We will document all the services we provide on the HMIS record. …. treatments are recorded on a separate record like HIV prophylaxis and all other preventive medications. Especially the HIV prophylaxis has its own record…" (KII 3: a nurse)

Referrals

Almost all the participants stated that they refer different cases for different reasons either within the hospital to other wards or outside of the hospital to other hospitals. Within the hospital they refer cases in relation to pregnancy, abortion, big lacerations or bleedings for admission and inpatient care like suturing or IV medications, psychiatric problems, other medical disorder unrelated to sexual assault. Outside of the hospital they refer cases like anal rape of boys to Tikur Anbessa Hospital, since they don't possess the appropriate inspection device called anoscope for anal rape to be able to see inside the anus for evidence of rape. Additional referral to other hospitals like Zewditu or Minilik hospitals is done for victims that have additional medical cases or surgical injuries like head injury, eye injuries or fractures.

"…We refer them for abortions within this hospital… and, to start antenatal care. We send anal rape to other hospitals …We send them to Tikur Anbessa hospital. …medical problems; we send them to a medical hospital. … Surgical problems like fractures… we refer them to other hospitals." (KII 2: a nurse)

One participant explained that they link survivors that have become pregnant either to antenatal care or minor operation rooms within the hospital. They have a guideline on how to decide to send pregnant survivors either to antenatal care or minor operation rooms. They talk to the survivors and their parents and decide if she wants to go on follow up or terminate the pregnancy. But termination of pregnancy is done only if the pregnancy is under 12 weeks.

"…We have a guideline to decide whether to send to ANC (antenatal care) or minor OR... for pregnancy that is below 12 weeks, we will write up a referral for them to minor OR…" (KII 4: a general practitioner)

Another participant mentioned that they have a psychiatry department within the hospital, and they refer the survivor with severe mental illness to the psychiatry ward. She also mentioned that she has an assessment form called intake form to assess for mental illness. She also utilizes her observation and history that she gathers from the family about previous history of mental illness.

"We have a psychiatry department in this hospital. So, when we encounter victims with severe mental illness in the one stop center, we refer them to the psychiatric ward. …" (KII 6: a counselor)

Follow up

Most of the participants mentioned that the follow-up services they provide are one month and three months from the first visit. The participants mentioned that during the one-month appointment, pregnancy tests will be repeated because the pregnancy prophylaxis is not a hundred percent effective, just in case it has failed to prevent pregnancy or even if pregnancy has occurred to detect it early. At the three months appointment, the participants stated that the rest of the laboratory tests will be repeated like HIV tests, Venereal diseases tests, and hepatitis virus tests. In some cases, if an abortion was performed, they will be appointed for two weeks for an ultrasound after the abortion has been performed. Additional appointments are given if they have been exposed to HIV or have been found to be HIV positive, they will be linked to ART or if the test needs to be repeated, they will be appointed for six months.

"…Most of the time on our side we appoint them for one month and three months. For example, if their age makes them fit for pregnancy test … And on the third month they come for HIV, venereal diseases, and Hepatitis virus testing…" (KII 2: a nurse)

One participant also mentioned that the reason for repeating the tests is, for example, in HIV the first test only tells the status of the patient before the day of testing. Therefore, the test must be repeated after three months to get the status of the victims on the first day of testing.

"…The reason we repeat the tests is because for example HIV, the first test doesn't tell us the status of the patient on that day, it only tells us the status of the patient before that day. So, we must repeat the test to see the status of the patient for that day of initial test…" (KII 4: a general practitioner)

Another participant mentioned that regarding psychosocial follow-up, they appoint those that have special cases like those that are separated from family, those that don't have a good social life, and those that are not doing well in their schoolwork. She mentioned that the number of sessions they stay on follow up depends on their recovery but, it usually takes about one month or ten sessions till recovery.

"…follow up services …, I identify their problems and appoint those I think need follow up … The duration of time on the follow up and number of sessions depends on their problem and their recovery… It usually takes about one month or ten sessions till recovery in my experience so far." (KII 6: a counselor)

Rehabilitation and reintegration services

Almost all the participants stated that they don't provide rehabilitation and reintegration services. They also mentioned that those services are provided by an organization that has a shelter. They mentioned that the police that work with them after they finish their medical appointments will take the survivors that need it to shelter.

"… We have a room to be able to keep them here for up to seventy-two hours because if the assault was from a family member or if she doesn't know her home, has nowhere else to go, we can keep her here for seventy-two hours. After that our police will take them to sub city police and take them to an organization that has shelters. There they will get rehabilitation services…" (KII 1: a nurse)

5.2.1.2 Available Resources for Service Provision

Partners

All participants said that they have partners that provide support to the center. These partners include ministry of justice, ministry of women and children, Addis Ababa health bureau, Addis Ababa police department, UNFPA, local NGOs, Canadian government, Japan embassy, a German aid group, International medical corps, individual volunteers like "TikTok'ers". The types of support that these partners provide were also mentioned by the participants, which include material support, trainings, employing case managers, prosecutors, and police. The material supports include sanitary pads, soap, cloths, underwear, and the like. They also mentioned that they receive support in the form of material and not in money or financial support.

"There are plenty of individuals that gather and give us materials like sanitary pads, soaps, and the like. … Organization of Canadian government…UNFPA, Japan embassy. Ministry of justice. They mostly support us with materials and training. The Ministry of Justice employs the case managers and prosecutors. Addis Ababa police department employs the police…." (KII 2: a nurse)

Budget and payment

Most of the participants stated that the center operates on the hospital's budget and that survivors don't have to pay any fee to get service from the center. They mentioned that the hospital's budget is provided by Addis Ababa health bureau. They mentioned for the most part the budget is enough to stock up the center although there might be some shortages.

"Well health bureau and justice minister are I think the ones that provides the budget for us. But the hospital is supported by health bureau, so I think the budget comes from the health bureau…" (KII 5: a general practitioner)

Guidelines and trainings

All the participants mentioned that they have received a training guideline/manual. But most don't know if there is a national guideline on sexual assault or gender-based violence. All of them also mentioned that they have gotten training on gender-based violence. They mentioned that the training included psychosocial support, medical support, how to clerk and how to manage. One participant mentioned that the training was given to her by UNCHR and international medical corps.

"…I have gotten training on psychosocial support and case management. The training was given to me by UNCHR and international medical corps." (KII 6: a counselor)

Another participant also mentioned that after the basic training on sexual assault, other burn out trainings were provided like how to deal with the legal cases and how to write evidence for the legal case.

"…The training is called basic gender-based violence. After this basic training on sexual assault, other burn out trainings are there. Like how to deal with the legal cases, how to write evidence for the legal case." (KII 5: a general practitioner)

5.2.1.3 Consequences of sexual assault

Consequences

The participants mentioned consequences like pregnancy, depression, suspicious, fear, mistrust, sadness, self-isolation, self-blaming occur in survivors after the assault. Although some mentioned

that medical problems don't occur that often, one participant mentioned that she has seen women who developed medical conditions like STIs, HIV, and hepatitis. Another mentioned that she has personally encountered a woman who was found to be positive for hepatitis. One participant mentioned that she has not encountered diagnosed disorders, but she has seen the survivors be psychologically affected by the assault.

"…not diagnosed disorders but all of them would be psychologically affected. If you sit and talk to them deeply, you will understand that they have been affected psychologically… I have seen women who developed medical conditions after their assault. Like STIs, HIV, hepatitis…" (KII 4: a general practitioner)

Complications resulting from late presentation to hospital

All the participants stated that those survivors that present to the hospitals later than seventy-two hours face higher risk of exposure to transmissible diseases because they will not receive the prophylaxes available to prevent disease. Some participants also mentioned that the evidence of the injury they sustained will have disappeared and wounds would have healed by the time they present to the hospital which will affect their legal case because of lack of evidence for the police.

"…Because when they come early, they get preventive medications or prophylaxes. When they come late, we will not see the full extent of the injury … the evidence disappears with time… effect on the justice system because most of the injuries would be healed and disappear. So, it will be difficult to find evidence for the police." (KII 1: a nurse)

One participant mentioned that those survivors that come late will also suffer from depression because they keep their trauma to themselves without discussing it with anyone so that they don't receive psychosocial support. So, they will be more affected psychologically than physically.

"…Late comers won't get psychological support so they will come her more depressed because they will hold their trauma in all alone without discussing it with anyone, being stress all that time…" (KII 4: a general practitioner)

One participant mentioned that the survivors' psychological recovery journey will also be affected because of late presentation to the hospital. Those that come early will get psychological support which can give them a boost in their healing. But those that come later might have faced lots of

trauma by the time they get to the hospital. Therefore, those that present early to hospital have a better chance of recovery than those that present later. But this participant also notes that sometimes it's fluctuating, depends on the individual's personal endurance therefore early comers may take longer and late comers may recover earlier.

"*… those that come to us early have a better chance of recovering early compared to the ones that come to us later… but depends on the individual and it can also reverse early comers may take longer and late comers can also recover early…" (KII 6: a counselor)*

5.2.1.4 Psychosocial support for survivors of sexual assault

Social reaction

Most of the participants said that the survivors usually tell their families, two participants said that small children usually tell their mothers or a close family member. Adolescent age survivors usually tell their friends or if at school to their teachers then to neighbors. One participant said that they don't usually tell their family. The family might hear through their friends when they tell their friends.

"…Mostly they don't tell family, in my experience. Yes, they also tell their friends and through the friends the family might hear." (KII 1: a nurse)

Almost all the participants stated that the reaction from the survivors' social groups is mostly negative. They tend to reject the survivors, blame the survivors, friends might gossip about them, they get hit, told they did it on purpose. But participants also noted that there are those that have positive responses depending on the type of family the reaction might be split fifty/fifty between positive and negative reactions.

"…They tend to blame victims. "Why did you go there?" "It's your fault" type of comments happens… "You did it on purpose" type of comments happen" (KII 6: a counselor)

Emotional support

Most of the participants stated that survivors get care and compassion from families but not when it comes to society. On the other hand, two participants stated that there is more conflict that occurs more than care and compassion within families and even between neighbors. One participant stated

that it depends on the family but mostly the families care about whether she is still a virgin or not and don't care about her health or the trauma she suffered.

"It depends on the family by the way…they don't usually get care and compassion. They usually care about whether she is still a virgin or not. But in most families, they don't care about her health, the assault, or the trauma she suffered." (KII 3: a nurse)

Most of the participants stated that survivors don't get treated with respect and dignity. Two participants stated that survivors might get respect from family but that is not the case when it comes to the neighbors. They usually face discrimination from the neighbors.

"From their families yes, I think they are treated with dignity and respect. But from the neighbors, since it is usually thought that they would be discriminated they don't' tell their neighbors…" (KII 5: a general practitioner)

Most of the participants said that decision making is dependent upon the age of the survivor. For those that are underage or below 18 years of age, the family gets to decide, and survivors can't decide for themselves. For different tests that must be performed the parents' signature is required. But for the adult survivors, there are those that are influenced in their decision making and then there are others that get to decide on their own. One participant puts it like this:

"Again, it depends on the people, for example children that are underage, they can't decide for themselves.... even when they are above 18 after they encounter an assault, there are people that have difficulty making decisions. There are also those that are free to make their own decisions…" (KII 6: a counselor)

Most of the participants stated that psychological interventions are provided by psychologists. One participant stated that all survivors have a session with the psychologist unless it is nighttime or weekends.

"For the psychological support, there is a psychologist… All victims have a session with the psychologist unless it is nighttime or weekends. But any victim that come during office hours, they will go in for a session with her." (KII 3: a nurse)

The psychologist mentioned that she provides different types of psychological interventions for the survivors like group therapy for survivors with the same type of assault. She also mentioned

that she provides cognitive behavioral therapy, art therapy for small children and parent therapy for families together.

Material support

All the participants stated that they provide material support to the survivors. These materials include sanitary pads, cloths (pajamas), underwear, soap, detergent (omo, largo), shoes (slippers). These materials are provided by the aid organizations to the center to give to the survivors.

"Ones we give out for free are cloths (pajamas), underwear, sanitary pads, shoes (slippers), the medications are there…these materials are provided to us by the aid organizations…" (KII 4: a general practitioner)

5.2.1.5 Challenges and recommendations

Most of the participants mentioned survivors not coming to hospital early as one challenge. Another challenge mentioned by most participants is shortages in laboratory reagents and medication like hepatitis vaccine although they say the shortage is not that prominent. One participant mentioned training being given to the providers while nearing the end of their assignment at the center and being transferred to another ward as a challenge. Another mentioned that the work being associated with a lot of burnouts in relation to the heaviness of the topic as a challenge.

"The trainings come when you are about to be transferred out of the center… they trained us recently and now we will leave this center soon…" (KII 1: a nurse)

One participant mentioned that they receive clients that claim to have been sexually assaulted when they have not. Which creates an abuse of the center where it becomes an abortion center. The participant blames this problem, the difference in rules from the three sectors that run the center which are Addis Ababa Police Commission, Ministry of Justice, and Addis Ababa Health Bureau.

"…sometimes we encounter cases where for us as health sector their word is enough for us to give her medical support, we don't investigate further her claims according to our rules. When we get her, a card based on her words only, the police then investigate and might tell us that she is lying, and she hasn't been raped. Most of the time the center just becomes an abortion center…" (KII 1: a nurse)

One participant mentioned that in dealing with children who are disabled like those who have autism requires training to be able to give assessments or therapy to these survivors which is lacking in this center. Another challenge she mentioned is the language barriers for the psychological assessments and therapy sessions as the center gets survivors from different parts of the country with different languages.

"There are disabled people that come to us. … And we can't approach these victims like the other normal/typical victims. It is difficult to give therapies to them… the language barrier becomes difficult in those times. When we are using translators, it is not the same…" (KII 6: a counselor)

Most of the participants mentioned educating the public and awareness creation within the community as a recommendation. One participant suggested that the center should have its own budget separate from the hospital to overcome shortages. Other participants mentioned that the length of time they work in the center to be extended to gain more experience. She also suggested that training should be provided to professionals before they start working in the center.

"*I would say the professional giving the service here should get the training before they start working in the center……I think one person assigned here after being trained should work here for at least two to three years. You become more experienced with time and become better at your work…" (KII 2: a nurse)*

Two participants noted that the public should be educated about the importance of the first seventy-two hours after assault. Another participant recommended for the working space/ building to be improved and the center to have its own card room and pharmacy for the privacy of the survivors.

".... Also educating about the importance of the first seventy-two hours after the assault and that that time should not pass before they come to the health facility." (KII 3: a nurse)

6. Discussion

The aim of this study was to assess the sexual assault experiences, the psychosocial support and the services provided for survivors of sexual assault at Gandhi hospital, Addis Ababa in 2023. The results of this study showed that 81.3% of the survivors were from urban residence which is higher than a study conducted in Jimma University specialized hospital which reported that 68.7% of the survivors were from rural area (6). This discrepancy could be due to the study area of the current study being a metropolitan area leading to more urban residents presenting to the hospital than rural.

This study suggests that majority of the women were between the ages of 14 to 19 which is similar to a study conducted in Nigeria which stated that majority of the women ranged between the ages of 14 to 19 which implies that adolescent aged girls are more vulnerable to sexual assault (68). Regarding marital status 92% of the women in this study are single. This finding is supported by a study conducted in Jimma university medical center which reported that 99.5% of the survivors were single which indicate that being unmarried poses greater risk for sexual assault (44). The majority of the survivors in this study were found to be 58% students which is in line with the study from India which reported that 41% were students suggesting that schools might be hotbed for commission of sexual assault (69).

The most common type of sexual assault reported in this study at 91.5% was vaginal rape. A similar study conducted in Nigeria stated that 87.2% of all cases were raped through vaginal route which is consistent with the findings of the current study (70). In this study 45.5% of the survivors presented to the hospital within 72 hours of the assault. A similar study conducted in Wollega university referral hospital found that 36.5% of the survivors presented to the hospital within 72 hours (45). This difference in the findings might be due to the distance of the hospital from the population that it serves, making the presentation time longer for the survivors. This infers that distance of the health facility where post sexual assault services are provided from the community it serves is an important factor for survivors' timely presentation to health facility. It was mentioned in the qualitative study that survivors presenting to the hospital later than seventy-two hours face higher risk of exposure to transmissible diseases because they will not receive the prophylaxes available to prevent disease.

According to this study, the perpetrator of the assault was stranger in 55.1% of the cases. A similar study conducted in Egypt reported that 70.3% of the perpetrators were unknown to the survivors (71). However, this finding is contrary to general knowledge about sexual assault being commonly perpetrated by people known to the victims indicating the need for further investigation into the reasons for this finding. Regarding the place of assault, the findings of this study showed that 44.9% assaults were committed in the perpetrator's home. The study conducted in Jimma University medical center reported that 47.1% of the assaults were committed inside the perpetrator's home (44).

Findings of this study showed that 11.9% of the survivors had previous history of sexual assault and that 77.8% of them reported to the assault to the police. A similar study in Denmark also reported that 26.5% of the survivors has previous history of sexual assault and 69.3% of the survivors reported the assault to the police (72). The discrepancy in the findings of the two studies might be explained by the difference in denominator.

According to the findings of this study 88.1% of the respondents reported single perpetrator sexual assault meanwhile the type of violence used by perpetrator in 40.3% of respondents was threat of physical force and 19.9% of the respondents sustained physical injury. These findings are comparable to the study conducted in Nigeria where, it was reported that 70.9% of the assaults were committed by a single perpetrator and threat of violence was used in 31.1% of cases while the survivors sustained physical injury in 9.2% of the cases (70).

In this study, 14.8% respondents reported that perpetrator used weapon, and 23.3% perpetrators were using substances during the assault, while 7.4% of the survivors reported that they had previous history of mental illness. A similar study conducted in a tertiary referral hospital in urban Ethiopia also reported that perpetrators used weapon in 24.1% of cases and perpetrator was using substances in 5.3% of cases, while also reporting that 3.5% of survivors had previous history of mental illness (46).

Regarding disclosure of sexual assault, the findings of this study revealed that 98.3% of respondent disclosed the assault to at least one person. Of those that disclose their sexual assault history 74.4% do so to their family. The qualitative study also supports this finding with majority of the participants mentioning that the survivors usually disclose the assault to their families. In contrast

to a study conducted among university students in Ethiopia reporting that 19.7% of survivors disclosed the assault to their family, while the majority did not disclose to anyone at all (25).

According to the findings of this study, among the respondents, the majority 70.5% received positive social reaction, while 29.5% received negative social reactions. Although in the qualitative study, it was mentioned that social reaction towards the survivors is mostly negative. Other participants also mentioned that depending on the type of social group, their social reaction is split between positive and negative fifty/fifty.

Regarding psychosocial support, in the current study it was reported that among all the survivors, 94.3% received psychosocial support after the sexual assault. This finding is supported by the study conducted in Jimma University medical center which reported that 84.5% of survivors obtained counseling and psychosocial support during their visit to the clinic (44). Of those that get psychosocial support the majority 92.0% of the survivors received medical support, while 70.5% received emotional or psychological support, and 15.9% received material support like shelter, food, and clothing. This finding is supported by the qualitative study, in which almost all participants stated that survivors receive medical support like laboratory tests and prophylaxis treatments and material support like soap, clothing, shoes and the like from the one-stop center at Gandhi hospital. They also stated that psychological support is provided to the survivors from the psychologist at the center.

In this current study, findings regarding health consequences suffered by sexual assault survivors suggests that 9.7% had unwanted pregnancy. This finding is similar to a study conducted among survivors in northern Ethiopia which reported that 10.7% of survivors tested positive for pregnancy (7). In the qualitative study, participants also mentioned that survivors face consequences like pregnancy from the sexual assault.

This current study revealed that among the respondents, one survivor had tested positive for hepatitis b virus infection. The findings of the qualitative study also support this with one participant mentioning that she has personally encountered a woman who was found to be positive for hepatitis. A study conducted in a tertiary referral hospital in urban Ethiopia also supports this finding reporting that two cases were found to be positive for HBsAg (46).

According to the present study, 5.7% of survivors have started substance use after assault. In a similar study conducted among female high school students, it was found that 6.2% of survivors had developed alcohol dependency after encountering sexual assault (57).

In the current study, the proportion of survivors that showed symptoms of depression is 45.5%. One participant from the qualitative study also stated that those survivors that come late to the hospitals will suffer from depression because they keep their trauma to themselves without discussing it with anyone. A similar study conducted in Sweden reported that as many as 49% of those who had been subjected to penetrating sexual violence stated that they had been diagnosed with depression (73). This indicates that depression is one of the major consequences survivors suffer after encountering sexual assault.

Regarding survivors' history of anxiety after assault, the current study showed that 63.8% of them had symptoms of anxiety. A study done in the UK found that 71% of the survivors were at risk for anxiety disorder (8). The findings of this study stated that 63.1% of survivors reported having symptoms of post-traumatic stress disorder. In this study, social reaction was found to be a significant predictor of PTSD with ($p < 0.05$), for every unit increase in social reaction there is 0.442 times decrease in PTSD diagnosis with ($P < 0.05$, OR 0.442, 95% CI 0.222, 0.880). In a similar study conducted among adolescent girls showed that 72.7% of adolescent girls developed PTSD after exposure to sexual assault (24). This implies that anxiety and PTSD are among the most prevalent mental health problems faced by survivors of sexual assault.

7. Strength and Limitation

Strength

The strength of this study is that it can serve as a baseline for future research on psychosocial support of sexual assault survivors. Another strength of this study is that it utilizes mixed method to assess the sexual assault history of survivors in congruence with exploring the services provided for the survivors within the one-stop center for gender-based violence at Gandhi hospital.

Limitation

One limitation is because this study is a health facility-based study, it is limited to the survivors that seek medical help misses those survivors that did not seek health care services. Another limitation is that the study area is a one-stop center where medical psychosocial and legal services are provided in unison, therefore, the legal cases of the survivors does not allow for the survivors to talk to anyone outside of the service providers making conducting in depth interviews with the survivors difficult. In relation to the income of the survivors, it could not be used because the results for income were found to be meaningless as family income was not included. This study only included only one hospital as a study site due to limited budget and time. Service providers being used as data collectors could introduce bias and conflict of interest.

8. Conclusion

This study assessed the sexual assault circumstances, the psychosocial support, and the service provision for survivors of sexual assault at Gandhi hospital ones-stop center. The results of this study showed that 81.3% of the survivors were from urban residence and majority of them were between the ages of 14 to 19 which implies that adolescent aged girls are more vulnerable to sexual assault. The results also showed that most of the survivors were single and students implying that schools can be valuable areas for implementation of prevention projects on sexual assault.

The most common type of sexual assault reported by survivors in this study was vaginal rape 91.5% while the perpetrator of the assault was stranger in 55.1% of the cases and 44.9% assaults were committed in the perpetrator's home. Among the respondents, 7.4% of the survivors had previous history of mental illness and 19.9% of the survivors sustained physical injury. These findings give important insight that can be used in the prevention and management of sexual assault.

The findings of this study revealed that 98.3% of respondent disclosed the assault to at least one person. Majority of the survivors 74.4% disclosed the assault to their family. Regarding social reaction, the majority 70.5% received positive social reaction. Most of the survivors 94.3% received psychosocial support after the sexual assault. While 92.0% of the survivors received medical support, 70.5% received emotional or psychological support. In this study, consequences that were suffered by the survivors after the assault included unwanted pregnancy in 9.7%, depression in 45.5%, anxiety in 63.8%, and post-traumatic stress disorder in 63.1% of survivors. Social reaction was found to be a significant predictor of PTSD with every unit increase in social reaction having 0.442 times decrease in PTSD diagnosis.

Accordingly, the findings of this study provide useful input to consider in designing future prevention strategies against sexual assault and health education programs for awareness creation in the community. The results can also be used to improve the service provision for sexual assault survivors including psychosocial support.

9. Recommendation

Based on the findings of this study the following recommendations are suggested to the relevant stakeholders as follows:

For Federal ministry of health: it is recommended that a national guideline be prepared on the management of sexual assault cases so that survivors can receive consistent services from health facilities.

For Addis Ababa Health Bureau: it's recommended that trainings that are provided for health care professionals working in the one-stop center for gender-based violence at Gandhi memorial hospital be timely and given before the professionals begin their work with survivors. It's also recommended that evidence-based health education programs/projects be designed in order create awareness and educate the public about the different circumstances of sexual assault and services available for them so that the community can have the relevant information to protect itself from the adversities that arise from encountering sexual assault.

For Gandhi Memorial Hospital: it is recommended that the hospital assign professionals to the one-stop center for longer than one year so that the professionals can get the pertinent training and experience to deal with survivors in a productive manner. It is also recommended that the hospital gather the required resources to make the center self-sufficient for the sake of the survivors' privacy by making sure that all the service required be provided entirely within the center.

For Researchers: it's recommended that further research be conducted on the social reaction and psychosocial support of survivors including its impact on their health, healing, and recovery by doing a more in-depth assessment on survivors, their social groups and service providers in different institutions including shelters and non-governmental organizations that provide services for survivors of sexual assault.

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Annex One: Information Sheet English Version

Addis Ababa University

College of Health Science, School of Public Health

Department of Health Education and Promotion

Date _____

Consent Letter

My name is_____ I am a post-graduate student at Addis Ababa university department of behavioral health. This research is conducted to fulfill the requirements for the degree of master's in public health. This questionnaire is prepared to collect data from survivors of sexual assault.

The objective of this research is to explore the psychosocial support experiences of sexual assault survivors: to give input for professionals working with sexual assault survivors, to contribute to the work of relevant institutions in the area, and to share the findings for the betterment of the community.

Study procedures: The study involves a face-to-face interview. You will be asked a set of questions using a structured questionnaire. After signing the consent form, you will then be asked relevant questions, and your responses will be written on the questionnaire. The interview may take about thirty minutes.

Study benefits and harm: there will not be any incentives that will be given. But if you participate in this study, you will have long and short-term benefits. Short term, you will discuss pertinent issues about psychosocial support among sexual assault survivors, the result of the study will be used to expand and implement better psychosocial support interventions. There might be questions which might disturb you and make you uncomfortable.

Rights of Participants: You have full right either to participate or refuse as well as to quit in the middle of or at any time you want after you start your participation in this study. You may respond to all the questions, or you may refuse to answer questions you don't want to answer. You can ask any questions about things that are not clear to you.

Confidentiality: I would like to ensure that your identity will not be revealed and the information you provide will be kept secretly and the recorded data will be deleted as soon as the research has completed the study.

Data Sharing: During the study only, the principal investigator will have access to the study data including consent documents.

If you have any questions about all the above, you may now forward it before we proceed to the next step?

Are you willing to participate in the study?

1- Yes ⟶ (Take Informed Consent)

2- No, I don't want to participate in the study ⟶ (Thank You.)

Annex Two: Informed Consent

The objective, benefits, harms, procedures, and confidentiality of the study has been read and explained to me in the language I comprehend. I further understand that taking part in this study and withdrawing from participating at any time without having a reason is purely voluntary.

I agree to participate in this study.

What does your signature on this consent form mean?

Your signature on this form means:

- You have been informed about this study's purpose, procedures, and possible benefits.
- You have been given the chance to ask questions before you sign.
- You have voluntarily agreed to be in this study.

Participant:

Participant Signature (Signature or Thumb Print) Date

Name of interviewer Signature of Person Obtaining Consent Date

Annex Three: English Version of Questionnaire

Section A: Socio-demographic Characteristics of sexual assault survivors

Proceed for participants who are women above and including the age of 14 only!

No	Questions	Responses
A1	Victim Identification Number	_____
A2	Hospital	_____
A3	Region of Residence	1. Tigray 2. AA 3. Amhara 4 Oromia 5. SNNP 6. Sidama 7. Other specify
A4	Residence type	1 Urban 2 Rural
A5	How old are you?	____Years
A6	Sex	1. Male 2. Female
A7	What is your Marital Status?	1. Single 2. Married 3. Divorced 4. Widowed
A8	What is your Educational Status?	1. Unable to Read & Write 2. Able to Read and write 3. Primary school 4. Secondary school 5. Technical 6. University
A9	What is your Occupation?	1. Government employee 2. Private employee 3. Merchant 4. Daily laborer 5. Housewife 6. Student 7. Other (specify) _____
A10	What is your monthly income? Write 0 if no income	_____birr
A11	Do you have history of substance use	1. Yes 2. No 98. No response
A12	If married, does your spouse have history of substance use	1. Yes 2. No 98. No response 99. Not applicable

Section B. Sexual attack history and psychosocial support of sexual assault survivors

B1	What were the types of sexual abuse you suffered? (Don't Prompt)	
B1.1	Fondling of sexual body parts	1. Yes 2. No
B1.2	Unwanted kissing	1. Yes 2. No
B1.3	Unwanted oral sex	1. Yes 2. No
B1.4	Experiencing anal sex	1. Yes 2. No
B1.5	Vaginal rape	1. Yes 2. No
B2.	When did sexual assault take place? (Don't Prompt)	1) Within past 3 days 2) 4 – 7 days ago 3) 8 – 15 days ago 4) 16 – 30 days ago 5) More than 30 days ago
B3	What is the perpetrator's relation with you? (Don't Prompt)	1) Stranger 2) Acquaintance 3) Spouse 4) Family 5) Other (Specify)
B4	How many perpetrators were there? (Don't Prompt)	1) One 2) Multiple
B5	Where did the attack take place? (Don't Prompt)	(1) Perpetrator's home (2) Survivor's home (3) In the street (4) In the woods (5) Other (Specify)
B6	Did you encounter any sexual assault before this one?	1. Yes 2. No
B7	If yes to B6, how many times have you encountered sexual assault before this?	_____Times
B8	Have you reported the assault to the police? If yes skip to B10	1. Yes 2. No
B9	If No, do you have the intention to report to the police?	1. Yes 2. No
B10	Did the perpetrator use weapons? If No skip to B12	1. Yes 2. No
B11	If yes to B10, What kind of weapon did perpetrator/s use? (Don't Prompt)	
B11.1	Gun	1. Yes 2. No
B11.2	Knife	1. Yes 2. No
B11.3	Stick	1. Yes 2. No
B11.4	Stone	1. Yes 2. No
B11.5	Other (Specify)	_____
B12	What was the type of violence perpetrator used? (Don't Prompt)	
B12.1	Insistence	1. Yes 2. No
B12.2	Threat of physical force	1. Yes 2. No

B12.3	Twisting arm & holding down	1. Yes 2. No
B12.4	Slapping	1. Yes 2. No
B12.5	Choking	1. Yes 2. No
B12.6	Beating	1. Yes 2. No
B13	Was the perpetrator/s using substances at the time of the attack? If No skip to B15	1) Yes 2) No 97) I don't know
B14	If yes to B13, which substance was the perpetrator on?	1) Alcohol 2) Drugs 3) Both
B15	Were you using substances at the time of the attack? If No skip to B17	1) Yes 2) No 98) No response
B16	If yes to B15, which substance were you on?	1) Alcohol 2) Drugs 3) Both
B17	What type of resistance did you put up? (Don't Prompt)	
B17.1	Stay Still/Freeze	1. Yes 2. No
B17.2	Reason/Plead	1. Yes 2. No
B17.3	Cry/Sob	1. Yes 2. No
B17.4	Scream for Help	1. Yes 2. No
B17.5	Run Away	1. Yes 2. No
B17.6	Physically Fight/Kick, Punch	1. Yes 2. No
B18	Did you receive any physical injury during the assault? If No skip to B20	1. Yes 2. No
B19	If yes to B18, What kind of physical injury did you receive? (Don't Prompt)	
B19.1	Soreness	1. Yes 2. No
B19.2	Bruises/Scratches	1. Yes 2. No
B19.3	Cuts	1. Yes 2. No
B19.4	Broken Bones	1. Yes 2. No
B19.5	Knife/Gun Shot Wound	1. Yes 2. No
B20	Did you disclose the assault to anyone? If no skip to B22	1. Yes 2. No
B21	If yes to B20, to whom did you disclose? (Don't Prompt)	
B21.1	Family	1. Yes 2. No
B21.2	Friends	1. Yes 2. No
B21.3	Neighbors	1. Yes 2. No
B21.4	Police	1. Yes 2. No
B21.5	Other (Specify)	
B22	Did you think your life was in danger during the attack?	1. Yes 2. No
B23	What was the social reaction you received when you disclosed the attack? If negative skip to B25	1. Positive 2. Negative
B24	If response to B23 was positive, which response did you receive? (Don't Prompt)	
B24.1	Emotional Support	1. Yes 2. No
B24.2	Tangible Support	1. Yes 2. No

B25	If response to B23 was Negative, Which response did you receive? (Don't Prompt)	
B25.1	Controlling	1. Yes 2. No
B25.2	Blaming	1. Yes 2. No
B25.3	Not Believing the Survivor	1. Yes 2. No
B25.4	Distracting the Survivor	1. Yes 2. No
B25.5	Treating the Survivor Differently	1. Yes 2. No
B26	Did you get any kind of support after the attack? If No skip to B29	1. Yes 2. No
B27	If yes to B26, what kind of support did you get?	
B27.1	Financial support	1. Yes 2. No
B27.2	Physical care and support (food, shelter, and clothing)	1. Yes 2. No
B27.3	Emotional/Psychological (care, affection, acceptance)	1. Yes 2. No
B27.4	Medical support (pregnancy, injury, HIV, STIs)	1. Yes 2. No
B27.5	Spiritual (Religious support, Prayer)	1. Yes 2. No
B28	If yes to B26, from where do you get support?	
B28.1	From friends	1. Yes 2. No
B28.2	Non-governmental organization	1. Yes 2. No
B28.3	Religious based organization	1. Yes 2. No
B28.4	Government organization	1. Yes 2. No
B28.5	From Family	1. Yes 2. No
B28.6	Community based organization	1. Yes 2. No
B29	Who brought you to the health facility? (Don't Prompt)	
B29.1	Own Self	1. Yes 2. No
B29.2	Family	1. Yes 2. No
B29.3	Friends	1. Yes 2. No
B29.4	Neighbors	1. Yes 2. No
B29.5	Police	1. Yes 2. No
B29.6	Other, (Specify)	
B30	Is this your first visit to the center or are you on follow up	1. First visit 2. Follow up

Section C. Medical, Psychological, and Gynecological Problems after attack

C1	Do you have any history of mental illness prior to sexual assault	1. Yes 2. No
C2	What kind of health problems did you encounter because of the sexual assault	
C2.1	Unwanted Pregnancy	1. Yes 2. No 3. Not tested
C2.2	HIV Infection	1. Yes 2. No 3. Not tested
C2.3	Hepatitis B Virus Infection	1. Yes 2. No 3. Not tested
C2.4	Genital injuries	1. Yes 2. No
C2.5	Urinary Tract Infection	1. Yes 2. No
C2.6	Sexually transmitted diseases (STDs)	1. Yes 2. No
C2.7	Social withdrawal	1. Yes 2. No

C2.8	Substance abuse started after attack (drug, alcohol etc.)	1. Yes 2. No
C2.9	Stigmatization	1. Yes 2. No
C3	Depression like symptoms	
C3.1	In the past 2 weeks, have you had little interest or pleasure in doing things?	1. Yes 2. No
C3.2	In the past 2 weeks, have you been Feeling down, depressed or hopeless?	1. Yes 2. No
C3.3	In the past 2 weeks, have you had Trouble falling asleep, staying asleep, or sleeping too much?	1. Yes 2. No
C3.4	In the past 2 weeks, have you been Feeling tired or having little energy?	1. Yes 2. No
C3.5	In the past 2 weeks, have you had Poor appetite or overeating?	1. Yes 2. No
C3.6	In the past 2 weeks, have you been feeling bad about yourself, that you are a failure and let yourself and family down?	1. Yes 2. No
C3.7	In the past 2 weeks, have you had Trouble concentrating on things like reading, or watching TV?	1. Yes 2. No
C3.8	In the past 2 weeks, have you been moving or speaking slowly, or opposite restless and moving around a lot?	1. Yes 2. No
C3.9	In the past 2 weeks, have you had Thoughts of being better off dead or hurting yourself in some way?	1. Yes 2. No
C4	Anxiety like symptoms	
C4.1	Feeling nervous or anxious	1. Yes 2. No
C4.2	Worrying too much about different things, not being able to stop or control worrying?	1. Yes 2. No
C4.3	Trouble relaxing	1. Yes 2. No
C4.4	Being so restless that it's hard to stay still	1. Yes 2. No
C4.5	Becoming easily annoyed or irritable	1. Yes 2. No
C4.6	Being afraid as if something awful might happen	1. Yes 2. No
C5	Post-Traumatic Stress Disorder like symptoms	
C5.1	In the past month, have you had nightmares about the assault?	1. Yes 2. No
C5.2	In the past month, have you tried hard not to think about the assault or went out of your way to avoid situations that remind you of the assault?	1. Yes 2. No
C5.3	In the past month have you been constantly on guard, watchful or easily startled?	1. Yes 2. No
C5.4	In the past month have you felt numb or detached from people, activities or your surroundings?	1. Yes 2. No
C5.5	In the past month have you felt guilty or unable to stop blaming yourself or others for the assault or problems caused by the assault?	1. Yes 2. No

Annex Four: English Version of Key Informant Interview Guide

I. Background Information

1. Name of Informant _____
2. Name of Center_____
3. Position in the Center_____
4. Level of Education _____
5. Educational Background _____
6. Work Experience in the Center _____

II. Interview Guide on Service Provision

1. On average how many sexual assault victims do you serve per month?
2. What activities and services do you give to sexual assault victims? Please list them.
3. What services do you keep documented? Please list all the records you keep.

   Probe: services, referral and follow up records? Do you think the records you keep are adequate to identify victim's history?
4. What does the referral system look like?

   Probe: do they ever get referred to specialist care? Given mental health assessment? Put on medication? HIV? Medical? Surgical? Psychosocial intervention?
5. Do the victims get follow up services? What services do the victims receive during follow up?

   Probe: How long do they stay on follow up? How frequent is the follow up? Do you do home visits/shelter visits? How many sessions of counseling did you usually give during follow up?
6. What rehabilitation and reintegration services do the victims receive?

   Probe: do they get skill training? Job securing support? Income generating programs? Support groups with other survivors? Do you link to (work with) Community centers? Formal/informal education?
7. In your experience, what types of medical, psychosocial, and mental problems do victims usually face after their assault?

Probe: Medical disorders (HIV, Unwanted Pregnancy, HBV, Anemia, Tetanus, STIs, UTI, Physical Injuries)? Mental disorders? Psychosocial problems?

8. Do you have partners (other organizations) that give support? If yes list the names of organizations? What kind of support did they give you (financial, material, professional support, training etc.?
9. Are the services in this center given free of charge for the victims of sexual assault?
10. Do you have enough budget allocated from the government for the services?
11. In your experience, do victims who come to health facility late after the attack suffer from more complications as compared to those who come to health facility earlier?

    Probe: Psychosocial trauma? Physical symptoms? Medical complications? Mental health complications?

12. In your observation, is the flow of patients/victims coming to health facility increasing or decreasing?

    Probe: what are the reasons for decrease or increase (are you working on community awareness and putting out information for potential victims on how to get access to your services?)

III. Psychosocial Support of Survivors

13. What types of psychological and social interventions do victims receive in this center?

    Probe: Counselling? Group therapy? Cognitive behavioral therapy? Trauma based approach. Art therapy/Play therapy? Psychodynamic psychotherapy? Client Centered/humanistic/ supportive psychotherapy? Family therapy? How many sessions are usually given**?**

14. Is there an assigned professional for the psychosocial support given? Or does any provider that gives the other services give psychosocial support?
15. What is the material support they receive from the center? Please list them.

    Probe: Financial Support? Medical Support?

16. In your experience who do sexual assault survivors usually tell of their assault?

    Probe: To family, friends, or neighbors?

17. What kind of response do they commonly receive when they tell their situation to their social groups?

    Probe: how do they respond to the victims? Positively or negatively? How does the response affect the survivors?

18. In your experience, do sexual assault survivors receive spiritual support?

    Probe: what kind of spiritual support? From whom?

19. In your experience, do survivors usually feel like they are being treated with dignity and respect from their social groups (family, friends, and neighbors)?
20. In your experience, do survivors usually receive care and compassion from their social groups (family, friends, and neighbors)?
21. In your experience, are they usually able to think clearly and make their own decisions without being influenced by someone else?

    Probe: have they been coerced or influenced into doing something they didn't want to do? Do they ever get told by anyone to say something or not say anything? Decision (to go home, to report to police/health facility, on pregnancy, HIV status disclosure and taking medication)

IV. Challenges and Recommendation for Improvement on Service Provision

22. What challenges have you faced while caring for sexual assault victims?

    Probe: delayed reporting (regarding distance, rural vs. urban victims (hiding information /shyness)? Fear and stigma, Cultural (female beliefs on male rights to abuse women) and religion influences, drop out of patients from follow up? Threats to providers? Lack of resources (Shortage of medications, laboratory services)? Lack of training, (shortage of trained professionals)?

23. Do you know of any national guideline for management of sexual assault that you use in your service provision?

    Probe: If yes what is the name of the document? Do you use the guideline?

24. Have you gotten any training on providing care for victims of sexual assault?

Probe: Training on psychosocial support of victims? From where? Was it helpful in your work with sexual assault victims?

25. What do you recommend being done to improve the services provided to sexual assault victims in this center?

Annex Five: Amharic Version of Information Sheet

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የሕብረተሠብ ጤና አጠባበቅ

ከ ጤና ትምህርት ና ማዳበር ትምህርት ክፍል ቀን_____

_____

መግቢያ

ሰላማዊት መንግስቱ እባላለሁ።

በአዲስ አበባ ዩኒቨርስቲ የድህረ ምረቃ ተማሪ ነኝ። ይህን ጥናት የምሰራው ማስተርስ ዲግሪ መመረቂይ ማሟያ ስለሆነ ነው ። ይህ ቃለ መጠይቅ የተዘጋጀው ወሲባዊ ጥቃት ለደረሰባቸው ሰቶች ነው ።

የዚህ ጥናት አላማ ከፆታዊ ጥቃት የተረፉ ሰዎችን ስነ ልቦናዊ ድጋፍ ማሰስ፡ ከፆታዊ ጥቃት የተረፉ ሰዎችን ለሚያገለግሉ ባለሙያዎች ግብአትን መስጠት፣ በአካባቢው አግባብነት ባላቸው ተቋማት ስራ ላይ የበኩሉን አስተዋፅአ ማድረግ እና ግኝቶቹን ለህብረተሰቡ ማካፈል ነው።

የጥናት ሂደቶች፡ ጥናቱ የፊት ለፊት ቃለ መጠይቅን ያካትታል። የተዋቀረ መጠይቅን በመጠቀም የጥያቄዎች ስብስብ ይጠየቃሉ። የስምምነት ቅጹን ከፈረሙ በኋላ ተዛማጅ ጥያቄዎች ይጠየቃሉ እና ምላሾችዎ በመጠይቁ ላይ ይፃፋሉ። ቃለ መጠይቁ ሠላሳ ደቂቃ ያህል ሊወስድ ይችላል።

ከጥናት የሚገኙ ጥቅም እና ጉዳት፡ የሚደረጉ ማበረታቻዎች አይኖሩም። ነገር ግን በዚህ ጥናት ውስጥ ሲሳተፉ የረጅም እና የአጭር ጊዜ ጥቅሞችን ያገኛሉ። ለአጭር ጊዜ፣ ከጾታዊ ጥቃት የተረፉ ሰዎች መካከል የስነ-ልቦና-ማህበራዊ ድጋፍን በተመለከተ አግባብነት ባላቸው ጉዳዮች ላይ ይነጋገራሉ፣ የጥናቱ ውጤት የተሻሉ የስነ-ልቦና-ማህበራዊ ድጋፍ ጣልቃገብነቶችን ለማስፋት እና ተግባራዊ ለማድረግ ይጠቅማል። እርስዎን የሚረብሹ እና የማይመቹዎት ጥያቄዎች ሊኖሩ ይችላሉ።

የተሣታፊዎች መብቶች፡ በዚህ ጥናት ውስጥ መሳተፍ ከጀመሩ በኋላ ለመሳተፍ ወይም ላለመሳተፍ እንዲሁም በፈለከው መሃል ወይም በማንኛውም ጊዜ የማቋረጥ ሙሉ መብት አለህ። ለሁሉም ጥያቄዎች ምላሽ መስጠት ወይም መመለስ የማትፈልጋቸውን ጥያቄዎች ላለመመለስ እምቢ ማለት ትችላለህ። ለእርስዎ ግልጽ ባልሆኑ ነገሮች ላይ ማንኛውንም ጥያቄ መጠየቅ ይችላሉ።

ሚስጥራዊነት፡- ጥናቱ እንደጨረሰ ማንነትዎ እንደማይገለጥ እና ያቀረቡት መረጃ በሚስጥር እንደሚቀመጥ እና የተቀዳው መረጃ እንደሚጠፋ ማረጋገጥ እፈልጋለሁ።

ዳታ መጋራት፡ በጥናቱ ወቅት ዋናው መርማሪ ብቻ የስምምነት ሰነዶችን ጨምሮ የጥናት መረጃውን ማግኘት ይችላል።

ከላይ ስላሉት ሁሉም ጥያቄዎች ካሉዎት ወደ ቀጣዩ ደረጃ ከመቀጠላችን በፊት አሁን ሊያስተላልፉት ይችላሉ?

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት?

Annex Six: Amharic Version of Informed Consent

የፈቃደኝነት ማረጋገጫ ሰነድ

የጥናቱ ዓላማ፣ ጥቅሞች፣ ጉዳቶች፣ ሂደቶች እና በሚስጥር ተነቦልኝ በተረዳሁት ቋንቋ ተብራርቶልኛል። በተጨማሪም በዚህ ጥናት መሳተፍ እና ምክንያት ሳይኖር በማንኛውም ጊዜ ከመሳተፍ መውጣት በፈቃደኝነት ብቻ እንደሆነ ተረድቻለሁ።

በዚህ ጥናት ለመሳተፍ ተስማምቻለሁ።

በዚህ የፍቃድ ቅጽ ላይ ፊርማዎ ምን ማለት ነው?

በዚህ ቅጽ ላይ ፊርማዎ ማለት፡-

- ስለ ጥናቱ ዓላማ፣ ሂደቶች እና ሊኖሩ ስለሚችሉ ጥቅሞች ተነግሮዎታል።
- ከመፈረምዎ በፊት ጥያቄዎችን እንዲጠይቁ እድል ተሰጥቶዎታል።
- በዚህ ጥናት ውስጥ ለመሳተፍ በፈቃደኝነት ተስማምተዋል።

ተሳታፊ፡-

_____

የተሳታፊ ፊርማ (ፊርማ ወይም አውራ ጣት ህትመት) ቀን

_____

የቃለ መጠይቅ አድራጊ ስም የፈቃድ ማግኘቱ ፊርማ ቀን

Annex Seven: Amharic Version of Questionnaire

ክፍል አንድ መጠይቅ ፡ በወሲባዊ ጥቃት የተጠቁ ሰዎች የሶሺዮ-ዲሞግራፊክ ባህሪያት

እድሜያቸው 14 እና ከዚያ በላይ ለሆኑ ሴቶች ብቻ መጠይቁን ይሙሉ

ተ.ቁ	ጥያቄዎች	ምላሾች
A1	የተሳታፊ መለያ ቁጥር	_____
A2	ሆስፒታል	_____
A3	የሚኖሩበት ክልል	1. ትግራይ 2. አዲስ አበባ 3. አማራ 4. ኦሮሚያ 5. ደቡብ 6. ሲዳማ 7. ሌላ (ይግለጹ)_____
A4	መኖሪያ አይነት	1. ከተማ 2. ገጠር
A5	ዕድሜሽ ስንት ነው?	_____ ዓመት
A6	ፆታ	1. ወንድ 2. ሴት
A7	የጋብቻ ሁኔታ	1. ያላገባ 2. ያገባ 3. የተፋታ 4. የሞተበት
A8	የትምህርት ደረጃ	1. ማንበብ እና መጻፍ አልችልም 2. ማንበብ እና መጻፍ የሚችል 3. የመጀመሪያ ደረጃ ትምህርት 4. ሁለተኛ ደረጃ ትምህርት 5. ቴክኒክ 6. ዩኒቨርሲቲ
A9	ሥራሽ ምንድን ነው?	1. የመንግስት ሰራተኛ 2. የግል ሰራተኛ 3. ነጋዴ 4. የቀን ሰራተኛ 5. የቤት እመቤት 6. ተማሪ 7. ሌላ (ይግለጹ)_____
A10	ወርሃዊ ገቢዎ ስንት ነው? ገቢ ከሌለ ዜሮ ይጻፉ	_____ብር
A11	እርስዎ የአደንዛዥ እጽ ሱስ አለብዎት	1. አዎ 2. አይ 98. መልስ የለም
A12	ባለ ትዳር ከሆኑ፣ የትዳር አጋርዎ የአደንዛዥ እጽ ሱስ አለባቸው?	1. አዎ 2. አይ 99. አይመለከትም

ክፍል ሁለት፡ የወሲባዊ ጥቃት ሁኔታ እና የወሲባዊ ጥቃት ተጎጂዎች ስነ ልቦናዊ እና ማህበራዊ ድጋፍ

B1	የደረሰብሽ የወሲብ ጥቃት ምን አይነት ነበር? (ፍንጭ አትስጥ)	
B1.1	የወሲብ አካል ክፍሎችን መነካካት	1) አዎ 2) አይ
B1.2	የማይፈለግ ከንፈር መሳም	1) አዎ 2) አይ
B1.3	ያልተፈለገ የአፍ ወሲብ	1) አዎ 2) አይ
B1.4	በፊንጢጣ የግብረ ሥጋ ግንኙነት ማድረግ	1) አዎ 2) አይ
B1.5	የሴት ብልት መድፈር	1) አዎ 2) አይ
B2	ወሲባዊ ጥቃት መቼ ተፈጸመ? (ፍንጭ አትስጥ)	1) ባለፉት 3 ቀናት ውስጥ 2) ከ 4 - 7 ቀናት በፊት 3) 8-15 ቀናት በፊት 4) 16-30 ቀናት በፊት 5) ከ 30 ቀናት በፊት
B3	ጥቃት አድራጊው ከእርስዎ ጋር ያለው ግንኙነት ምንድን ነው? (ፍንጭ አትስጥ)	1) የማላውቀው ሰው 2) የማውቀው ሰው 3) የትዳር አጋር 4) የስጋ ዘመድ 5) ሌላ (ይግለጹ)_____
B4	የጥቃት ፈጻሚዎቹ ምን ያህል ነበሩ? (ፍንጭ አትስጥ)	1) አንድ 2) ብዙ
B5	ጥቃቱ የተፈጸመበት ቦታ (ፍንጭ አትስጥ)	1) የጥቃት አድራጊው ቤት ውስጥ 2) የተጠቂው ቤት 3) በመንገድ ላይ 4) በጫካ ውስጥ 5) ሌላ (ይግለጹ
B6	ከዚህ ጥቃት በፊት ሌላ ወሲባዊ ጥቃት ደርሶቦታል?	1) አዎ **2)** አይ
B7	ለ B6 አዎ ከሆነ፣ ከዚህ በፊት ምን ያህል ጊዜ ወሲባዊ ጥቃት አጋጥሞዎታል?	_____ ጊዜ
B8	ጥቃት የተፈጸመበት መሆኑን ለፖሊስ አሳውቀዋል? አዎ ከሆነ ወደ B10 ይዝለሉ	1) አዎ **2)** አይ
B9	ለ B8 መልሱ አይደለም ከሆነ፣ ጥቃት የተፈጸመበት መሆኑን ለፖሊስ ለማሳወቅ ፍላጎት አለዎት?	1) አዎ **2)** አይ
B10	ጥቃት አድራጊው መሳሪያ ተጠቅሟል? አይደለም ከሆነ ወደ B12 ዝለል	1) አዎ **2)** አይ
B11	ለ B10 አዎ ከሆነ፣ ጥቃት አድራጊው ምን አይነት መሳሪያ ተጠቅሞዋል? (ፍንጭ አትስጥ)	
B11.1	ሽጉጥ	1) አዎ **2**) አይ
B11.2	ቢላዋ	1) አዎ **2)** አይ
B11.3	ዱላ	1) አዎ **2)** አይ

B11.4	ድንጋይ	1) አዎ **2)** አይ
B11.5	ሌላ (ጥቀስ)	
B12	የጥቃት ፈጻሚው ምን ዓይነት ጥቃት አደረሰብሽ? (ፍንጭ አትስጥ)	
B12.1	በንግግር መገፋፋት	1) አዎ **2)** አይ
B12.2	ማስፈራራት	1) አዎ **2)** አይ
B12.3	እጅ መጠምዘዝ እና መሬት ላይ መጣል	1) አዎ **2)** አይ
B12.4	በጥፊ መምታት	1) አዎ **2)** አይ
B12.5	ማነቅ/ማፈን	1) አዎ **2)** አይ
B12.6	መደብደብ	1) አዎ **2)** አይ
B13	ጥቃቱ በተፈፀመበት ጊዜ አጥቂው/ዎቹ የተጠቀሙት አደንዛዥ እጽ ነበር ውይ? (ፍንጭ አትስጥ) ፣ አይደለም ከሆነ ወደ B15 ይዝለሉ፣	1) አዎ 2) አይ 97) አላውቅም
B14	ለ B13 አዎ ከሆነ፣ ጥቃት ፈጻሚው የትኛውን ንጥረ ነገር ተጠቅመዋል?	1) አልኮል መጠጥ 2) አደንዛዥ እጽ 3) ሁለቱም
B15	ጥቃት በደረሰብሽ ጊዜ አደንዛዥ ንጥረ ነገር ተጠቅመሽ ነበር ወይ? (ፍንጭ አትስጥ) ፣ አይደለም ከሆነ ወደ B17 ይዝለሉ፣	1) አዎ 2) አይ 97) ምላሽ የለም
B16	ለ B15 አዎ ከሆነ፣ የትኛውን ንጥረ ነገር ተጠቅመሽ ነበር?	1) አልኮል 2) አደንዛዥ እጽ 3) ሁለቱም
B17	በጥቃቱ ወቅት ምን ዓይነት የመከላከል ጥረት አደረግሽ? (ፍንጭ አትስጥ)	
B17.1	መደንገጥ እና መፍዘዝ	1) አዎ **2)** አይ
B17.2	ምክንያት መፍጠር/ መማጸን	1) አዎ **2)** አይ
B17.3	ማልቀስ	1) አዎ **2)** አይ
B17.4	ለእርዳታ መጮህ	1) አዎ **2)** አይ
B17.5	መሸሽ/መሮጥ	1) አዎ **2)** አይ
B17.6	መታገል/መማታት	1) አዎ **2)** አይ
B18	በጥቃቱ ወቅት አካላዊ ጉዳት ደርሶብሻል? አይደለም ከሆነ ወደ B20 ዝለል	1) አዎ **2)** አይ
B19	ለ B18 አዎ ከሆነ፣ ምን ዓይነት የአካል ጉዳት ደርሶብሻል? (ፍንጭ አትስጥ)	
B19.1	የመቀጥቀጥ ሀመም	1) አዎ **2)** አይ
B19.2	መብለዝ/መጫጫር	1) አዎ **2)** አይ
B19.3	የቆዳ መሰንጠቅ/መፈንከት	1) አዎ **2)** አይ
B19.4	የአጥንት መሰበር	1) አዎ **2)** አይ
B19.5	በቢላዋ መወጋት/በጥይት መመታት/መቁሰል	1) አዎ **2)** አይ
B20	ስለ ጥቃቱ ለሌሎች ሰዎች ተናግረሻል?	1) አዎ **2)** አይ
B21	ለ B20 አዎ ከሆነ፣ ለማን ተናግረሻል አይደለም ከሆነ ወደ B22 ዝለል	
B21.1	ለቤተሰብ	1) አዎ **2)** አይ
B21.2	ለጓደኛ	1) አዎ **2)** አይ

B21.3	ለጎረቤት	1) አዎ **2)** አይ
B21.4	ለፖሊስ	1) አዎ **2)** አይ
B21.5	ሌላ (ጥቀስ)	
B22	በጥቃቱ ወቅት ህይወቴ አደጋ ላይ ነው ብለው አስበው ነበር?	1) አዎ **2)** አይ
B23	ጥቃቱን ሲያሳውቁ ከማህበረሰብዎ የተሰጥዎት ምላሽ ምን ነበር? አሉታዊ ከሆነ ወደ B26 ዝለል	1. አዎንታዊ 2. አሉታዊ
B24	ለ B23 ምላሽ አዎንታዊ ከሆነ ምን ምላሽ አግኝተዋል? (ፍንጭ አትስጥ)	
B24.1	ማበረታታት	1) አዎ **2)** አይ
B24.2	ተጨባጭ/ቁሳዊ ድጋፍ	1) አዎ **2)** አይ
B25	ለ B23 ምላሽ አሉታዊ ከሆነ፣ የትኛውን ምላሽ አግኝተዋል? (ፍንጭ አትስጥ)	
B25.1	መቆጣጠር	1) አዎ **2)** አይ
B25.2	መውቀስ	1) አዎ **2)** አይ
B25.3	አለማመን	1) አዎ **2)** አይ
B25.4	እንድረሳው መገፋፋት	1) አዎ **2)** አይ
B25.5	ከበፊቱ የተለየ ባህርይ ማሳየት	1) አዎ **2)** አይ
B26	ከጥቃቱ በኋላ ማንኛውንም አይነት ድጋፍ አግኝተዋል? አይደለም ከሆነ ወደ B29 ይዝለሉ	1) አዎ **2)** አይ
B27	ለ ጥያቄ B26 መልስዎ አዎ ከሆነ ፣ ምን አይነት ድጋፍ አግኝተዋል?	
B27.1	የገንዘብ ድጋፍ	1) አዎ **2)** አይ
B27.2	ቁሳዊ ድጋፍ (ምግብ፣ መጠለያ እና ልብስ)	1) አዎ **2)** አይ
B27.3	ስነ-ልቦናዊ ድጋፍ (እንክብካቤ እና ፍቅር፣ ማበረታታት፣ ማረጋጋት)	1) አዎ **2)** አይ
B27.4	የሕክምና ድጋፍ (ለእርግዝና፣ ለአካላዊ ጉዳት፣ ለኤችአይቪ፣ ለአባላዘር በሽታ)	1) አዎ **2)** አይ
B27.5	መንፈሳዊ ድጋፍ (የሃይማኖት ድጋፍ፣ ጸሎት)	1) አዎ **2)** አይ
B28	ለ ጥያቄ B26 አዎ ከሆነ ፣ ድጋፍ ከማን ያገኛሉ?	
B28.1	ከጓደኞች	1) አዎ 2)አይ
B28.2	ከመንግሥታዊ ያልሆነ (እርዳታ) ድርጅት	1) አዎ **2)** አይ
B28.3	ከሃይማኖታዊ ድርጅት	1) አዎ **2)** አይ
B28.4	ከመንግስት ድርጅት	1) አዎ **2)** አይ
B28.5	ከስጋ ዘመድ (ቤተሰብ)	1) አዎ **2)** አይ
B28.6	ከማህበረሰባዊ ድርጅት	1) አዎ **2)** አይ
B29	ወደ ጤና ተቋም ማን አመጣሽ? (ፍንጭ አትስጥ)	
B29.1	በእራሴ	1) አዎ **2)** አይ
B29.2	የስጋ ዘመድ (ቤተሰብ)	1) አዎ **2)** አይ
B29.3	ጓደኞች	1) አዎ **2)** አይ
B29.4	ጎረቤቶች	1) አዎ **2)** አይ

B29.5	ፖሊስ	1) አዎ **2)** አይ
B29.6	ሌላ፣ (ይግለጹ)	
B30	ወደ ማዕከሉ የመጡት ለመጀመሪያ ጊዜ ነው ወይስ በማዕከሉ በክትትል ላይ ቆይተሻል?	1. የመጀመሪያ ጊዜ ነው 2. ክትትል ላይ ነኝ

ክፍል ሶስት፡ ከጥቃት በኋላ ያጋጠሙ የህክምና፣ የስነ-ልቦና እና የማህጸን ችግሮች

C1	ከፆታዊ ጥቃት በፊት የአእምሮ ህመም ነበረብዎት?	1) አዎ **2)** አይ
C2	በወሲባዊ ጥቃቱ ምክንያት ምን ዓይነት የጤና ችግሮች ገጥሞዎታል?	
C2.1	ያልተፈለገ እርግዝና	1) አዎ **2)** አይ 3) አልተመረመርኩም
C2.2	ኤችአይቪ	1) አዎ **2)** አይ 3) አልተመረመርኩም
C2.3	የሄፓታይተስ ቢ ቫይረስ ኢንፌክሽን (የጉበት በሽታ)	1) አዎ **2)** አይ 3) አልተመረመርኩም
C2.4	የብልት ጉዳት	1) አዎ **2)** አይ
C2.5	የሽንት ቧንቧ ኢንፌክሽን	1) አዎ **2)** አይ
C2.6	የአባላዘር በሽታዎች	1) አዎ **2)** አይ
C2.7	እራስን ማግለል	1) አዎ **2)** አይ
C2.8	ከጥቃቱ በኋላ የአደንዛዥ እፅ አላግባብ መጠቀም ደንዛዥ እጽ፣ አልኮል፣ ወዘተ)	1) አዎ **2)** አይ
C2.9	መገለል	1) አዎ **2)** አይ
C3	የድባቴ አይነት ምልክቶች	
C3.1	ባለፉት 2 ሳምንታት ውስጥ፣ ነገሮችን ለመስራት ፍላጎት ማጣት ወይም ደስታ ማነስ?	1) አዎ **2)** አይ
C3.2	ባለፉት 2 ሳምንታት ውስጥ፣ እርስዎ የሀዘን ስሜት ወይም የተስፋ መቁረጥ ስሜት ነበሮት?	1) አዎ **2)** አይ
C3.3	ባለፉት 2 ሳምንታት ውስጥ እንቅልፍ ያለመውሰድ ችግር፣ በቂ እንቅልፍ አለመተኛት፣ ወይም ለብዙ ሰአታት መተኛት አጋጥሞዎታል?	1) አዎ **2)** አይ
C3.4	ባለፉት 2 ሳምንታት ውስጥ የድካም ስሜት መሰማት ወይስ አቅም ማነስ አለዎት?	1) አዎ **2)** አይ
C3.5	ባለፉት 2 ሳምንታት ውስጥ የምግብ ፍላጎት መቀነስ ወይም ከልክ በላይ መብላት አለብሽ?	1) አዎ **2)** አይ
C3.6	ባለፉት 2 ሳምንታት ውስጥ ስለራስሽ መጥፎ ስሜት መሰማት፣ ዋጋቢስ ነኝ ብሎ ማሰብ፣ እራሴን እና	1) አዎ **2)** አይ

	ቤተሰቤን የሀዘን ስሜት ውስጥ እንድንገባ አርጌያለሁ የሚል ስሜት አለዎት?	
C3.7	ባለፉት 2 ሳምንታት ውስጥ እንደ ማንበብ, ቲቪ መመልከት እና የመሳሰሉት ነገሮች ላይ ትኩረት የማጣት ችግር አጋጥሞዎታል?	1) አዎ **2)** አይ
C3.8	ባለፉት 2 ሳምንታት ውስጥ እነቅስቃሴዎ ወይም ንግግርዎ ዘገምተኛ ሆኗል ወይም በተቃራኒው መቅበጥበጥ እና ብዙ መንቀሳቀስ አብዝተዋል?	1) አዎ **2)** አይ
C3.9	ባለፉት 2 ሳምንታት ውስጥ፣ ብሞት ይሻለኛል ብሎ ማሰብ ወይም በሆነ መንገድ እራስዎን ለመጉዳት ማሰብ አለዎት?	1) አዎ **2)** አይ
C4	የጭንቀት አይነት ምልክቶች	
C4.1	የመረበሽ ወይም የመጨነቅ ስሜት አለዎት?	1) አዎ **2)** አይ
C4.2	ስለተለያዩ ነገሮች በጣም አብዝቶ ማሰብ እና አብዝቶ ማሰብን ማቆም ወይም መቆጣጠር አለመቻል?	1) አዎ **2)** አይ
C4.3	ዘና ማለት አለመቻል	1) አዎ **2)** አይ
C4.4	መቅበጥበጥ እና ተረጋግቶ መቀመጥ አለመቻል?	1) አዎ **2)** አይ
C4.5	በቀላሉ መበሳጨት ወይም መነጫነጭ	1) አዎ **2)** አይ
C4.6	አንድ መጥፎ ወይም አስከፊ ነገር ይደርስብኛል ብሎ መፍራት	1) አዎ **2)** አይ
C5	ከአደጋ በኋላ የሚመጣ የጭንቀት መታወክ አይነት ምልክቶች	
C5.1	ባለፈው ወር ውስጥ ስለ ጥቃቱ ቅዠቶች ነበሩዎት?	1) አዎ **2)** አይ
C5.2	ባለፈው ወር ስለ ጥቃቱ ላለማሰብ ብዙ ሞክረዋል ወይንስ ጥቃቱን የሚያስታውሱ ሁኔታዎችን ለማስወገድ ጥረት አርገዋል?	1) አዎ **2)** አይ
C5.3	ባለፈው ወር ውስጥ እራስሽን መከላከል ዝግጁ ሆኖ መቆየት፣ አካባቢሽን በንቃት መጠበቅ ወይም በቀላሉ መደንገጥ አለብሽ	1) አዎ **2)** አይ
C5.4	ባለፈው ወር ውስጥ ስሜት አልባ መሆን ወይም ከሰዎች፣ ከአንዳንድ እንቅስቃሴዎች ወይም ከአካባቢዎ እራስን ማግለል?	1) አዎ **2)** አይ
C5.5	ባለፈው ወር ውስጥ የጥፋተኝነት ስሜት ተሰምቶሻል ወይም በጥቃቱ ለተፈጠሩ ችግሮች እራስሽን ወይም ሌሎችን መውቀስ ማቆም አልቻልሽም?	1) አዎ **2)** አይ

Annex Eight: Amharic Version of Key Informant Interview Guide

I. የባለሞያው ግላዊ መረጃዎች

1. የመረጃ ሰጪው ስም _____

_____

2. የትምህርት ደረጃ_____

3. የትምህርት አይነት_____

4. የህክምና ማእከሉ ስም_____

5. በማዕከሉ ውስጥ ያልዎት የስራ ድርሻ _____

6. በማዕከሉ ውስጥ ያልዎት የሥራ ልምድ_____

II. በማእከሉ የሚሰጡ አገልግሎቶች ላይ ያተኮረ የቃለ መጠይቅ መመሪያ

1. በአማካይ በወር ምን ያህል የወሲባዊ ጥቃት ሰለባዎችን ታስተናግዳላችሁ?

2. ለወሲባዊ ጥቃት ሰለባዎች ምን ምን አይነት አገልግሎቶችን ይሰጣሉ? እባክዎን ይዘርዝሯቸው?

3. ምን ምን አይነት አገልግሎቶችን በሰነድ መዝግበው ያስቀምጣሉ? እባክዎትን በሰነድ

የምታስቀምጧቸውን ሁሉንም መራጃዎች ይዘርዝሯቸው?

ምርመራ፡ አገልግሎቶች፣ ሪፈራሎች፣ የክትትል መረጃዎች? የሚይዟቸው መረጃዎች የተጎጂን

ታሪክ በአግባቡ ለምለየት በቂ ናቸው ብለው ያስባሉ?

4. የሪፈር አደራረግ ስርአታችሁ ምን ይመስላል?

ምርመራ፡ ወደ ልዩ ባለሙያተኛ ይላካሉ? (ለአይምሮ ጤና፣ ለውስጥ ደዌ፣ ለቀዶ ህክምና፣ ሳይኮሶሻል እርዳታ ይላካሉ)?

5. የወሲባዊ ጥቃት ተጎጂዎች የክትትል አገልግሎት ያገኛሉ?

ምርመራ፡ በክትትል ውስጥ ለምን ያህል ጊዜ ይቆያሉ? በአጠቃላይ ምን ያህል የክትትል(ምክክር) ግንኙነቶች ያገኛሉ? ክትትሉ በየስንት ጊዜ ነው? የቤት ለቤት/የመጠለያ ጉብኝት ታደርጋላችሁ?

6. ተጎጂዎች ምን አይንት የመልሶ - ማቋቋም እና መልሶ - ማዋሀድ አገልግሎቶችን ያገኛሉ?

ምርመራ፡ የክህሎት ስልጠና ያገኛሉ? የስራ ማስገኘት ድጋፍ? የገቢ ማስገኛ ፕሮግራሞች፣ ከሌሎች ተጠቂዎች ጋር ማህበር መፍጠር? መደበኛ/ኢ-መደበኛ ትምህርት መስጠት? ከማህበረሰባዊ ተቋማት ጋር ማገናኘት?

7. በእርሰዎ ተሞክሮ፣ ተጎጂዎች ከጥቃት በኋላ ምን አይነት የህክምና፣ የስነ-ልቦናዊ እና የአእምሮ ችግሮች ያጋጥሟቸዋል?

ምርመራ፡ የህክምና እክሎች (ኤች አይ ቪ፣ ያልተፈለገ እርግዝና፣ ሄፓታይተስ ቢ (የጉበት በሽታ)፣ የደም ማነስ፣ ቴታነስ፣ የአባላዘር በሽታዎች፣ የሽንት ቧንቧ ኢንፌክሽን፣ የአካል ጉዳት)? የአእምሮ እክሎች፣ የስነ-ልቦና እና ማህበራዊ ችግሮች?

8. ድጋፍ የሚሰጧቹ አጋር ድርጅቶች አሉ? ካሉ የድርጅቶቹን ስም ዝርዝር ይንገሩኝ? ምን አይነት ድጋፍ ይሰጣሉ (የገንዘብ፣ የቁሳቁስ፣ የባለሙያ ድጋፍ፣ ስልጠና ውዘተ.)

9. በዚህ ማእከል ውስጥ ለወሲባዊ ጥቃት ሰለባዎች የሚሰጠው አገልግሎት ከክፍያ ነጻ ነው ወይስ አይደለም?

10. ለማእከሉ ከመንግስት የተመደበው በጀት በቂ ነው ወይስ አይደለም?

11. በእርስዎ ልምድ፣ ከጥቃቱ በኋላ ዘግይተው ወደ ጤና ተቋም የሚመጡ ሰለባዎች፤ ቀደም ብለው ወደ ጤና ተቋም ከሚመጡት ጋር ሲነጻጸሩ የከፉ የጤና ችግሮች ያጋጥሟቸዋል?

ምርመራ፡ ስነ-ልቦናዊ ጉዳት፣ አካላዊ ጉዳት፣ የህክምና ችግሮች፣ የአእምሮ ጤና ችግሮች?

12. በእርስዎ ምልከታ፣ ወደ ጤና ተቋም የሚመጡ የወሲባዊ ጥቃት ተጎጂዎች ፍሰት እየጨመረ ነው ወይስ እየቀነሰ ነው?

ምርመራ፡ የመጨመር ወይም የመቀነስ ምክንያቶች ምንድን ናቸው (በማህበረሰብ ግንዛቤ ላይ እየሰራችሁ ነው? አገልግሎታችሁን ለሚፈልጉ ተጎጂዎች፣ አገልግሎታችሁን እንዴት ማግኘት እንደሚችሉ ግንዛቤ ትሰጣላችሁ ወይ?

III. ለወሲባዊ ጥቃት ተጎጂዎች የሚሰጥ የስነ-ልቦና እና ማህበራዊ ድጋፍ ላይ ያተኮረ የቃለ መጠይቅ መምሪያ

13. ለወሲባዊ ጥቃት ተጎጂዎች በዚህ ማእከል ውስጥ ምን አይነት የስነ-ልቦና እና ማህበራዊ ድጋፍ (ኢንተርቬንሽኖች) ይሰጣቸዋል?

ምርመራ፡ ካውንስሊንግ፣ ግሩፕ ቴራፒ፣ ኮግኒቲቭ ቢሄቪየራል ቴራፒ፣ ትራውማ ቤዝድ አፕሮች፣ አርት ቴራፒ/የጨዋታ ቴራፒ፣ ሳይኮዳይናሚክ ሳይኮቴራፒ፣ ክላየንት ሴንተርድ/ሂውማኒስቲክ ሰፖርቲቭ ሳይኮቴራፒ፣ ፋሚሊ ቴራፒ?

14. ለሚሰጠው የስነ-ልቦና እና ማህበራዊ ድጋፍ የተመደበ ባለሞያ አለ? ወይንስ ሌሎች አገልግሎቶችን የሚሰጡት ባለሞያዎች ናቸው የሚሰጡት?

15. የወሲባዊ ጥቃት ተጎጂዎች ከማእከሉ የሚያገኙት ቁሳዊ ድጋፍ ምንድን ነው? እባክዎ ይዘርዝሯቸው?

ምርመራ፡ የገንዘብ ድጋፍ፣ የህክምና ድጋፍ?

16. በእርስዎ ልምድ፣ የወሲባዊ ጥቃት ተጎጂዎች ብዙውን ጊዜ ስለጥቃታቸው ለማን ይነግራሉ?

ምርመራ፡ ለቤተሰብ፣ ለጓደኞች ወይም ለጎረቤቶች

17. በእርስዎ ልምድ፣ ተጎጂዎች ሁኔታቸውን ለቤተሰብ፣ ለጓደኞች ወይም ለጎረቤቶች ሲነግሩ ብዙውን ጊዜ ምን አይነት ምላሽ ያገኛሉ?

ምርመራ፡ ተጎጂዎች የሚያገኙት ምላሽ ምንድን ነው? አዎንታዊ ወይስ አሉታዊ? ምላሹ ተጎጂዎች ላይ ምን አይነት ተጸኖ ያሳድርባቸዋል?

18. በእርስዎ ልምድ፣ የወሲባዊ ጥቃት ተጎጂዎች መንፈሳዊ ድጋፍ ያገኛሉ?

ምርመራ፡ ምን አይነት መንፈሳዊ ድጋፍ? ከማን?

19. በእርስዎ ልምድ፣ የወሲባዊ ጥቃት ተጎጂዎች ከቤተሰብ፣ ከጓደኞች ወይም ከጎረቤቶች አክብሮትን ያገኛሉ?

20. በእርስዎ ልምድ፣ የወሲባዊ ጥቃት ተጎጂዎች ከቤተሰብ፣ ከጓደኞች ወይም ከጎረቤቶች እንክብካቤ እና ሀዘኔታ ያገኛሉ?

21. በእርስዎ ልምድ፣ የወሲባዊ ጥቃት ተጎጂዎች ብዙውን ጊዜ በሌላ ሰው ተጽእኖ ሳይደረግባቸው በግልጽ ማሰብ እና የራሳቸውን ውሳኔ መወሰን ይችላሉ?

ምርመራ፡ ማድረግ የማይፈልጉትን ነገር እንዲያደርጉ ተገደዋል? መናገር የማይፈልጉትን እንዲናገሩ መገደድ? መናገር የሚፈልጉትን እንዳይናገሩ መደረግ? ወደ ቤት ለመመለስ መወሰን? ለፖሊስ ስለማሳወቅ? ወደ ህክምና ለመሄድ፣ ስለ እርግዝና ሁኔታ መወሰን፣ ስለ ኤች አይ ቪ ተጠቂነታቸው መግለጽ፣ መድሀኒት ለመውሰድ መወሰን)?

IV. አገልግሎት አቅርቦት ላይ ያሉ ተግዳሮቶች እና የማሻሻያ ሃሳቦች ላይ ያተኮረ የቃለ መጠይቅ መመሪያ

22. ለወሲባዊ ጥቃት ተጎጂዎች በምትሰጡት አገልግሎት ላይ ያጋጠምዎት ተግዳሮቶች (ተፈታታኝ ሁኔታዎች) አሉ? ምንድን ናቸው?

ምርመራ፡ ዘግይቶ ሪፖርት ማድረግ (ከርቀት ጋር በተያያዘ፣ የገጠር እና የከተማ ተጎጂዎች ልዩነት (መረጃ መደበቅ/አይናፋርነት)? ፍርሃት፣ መገለል፣ ባህል (ወንዶች ሴቶችን የማጥቃት መብት አላቸው ብለው ማመን)፣ የሃይማኖት ተጽእኖዎች፣ የታካሚዎች ክትትል ማቋረጥ፣ ባለሞያዎች ላይ ዛቻ መድረስ፣ የግብአት እጥረት (ላብራቶሪ፣ መድሃኒት)፣ የስልጠና እጦት (የሰለጠኑ ባለሞያዎች እጥረት)?

23. የወሲባዊ ጥቃት አገልግሎት አሰጣጥ ላይ የሚያውቁት አገርአቀፍ መመሪያ (ጋይድላይን) አለ?

ምርመራ፡ ካለ መመሪያው (ጋይድላይኑ) ምን ተብሎ ይጠራል? መመሪያውን ትጠቀማላችሁ?

24. ለወሲባዊ ጥቃት ተጎጂዎች አገልግሎት አሰጣጥ ላይ ምን አይነት ስልጠና ወስደዋል?

ምርመራ፡ ስለ ተጎጂዎች የስነ-ልቦና እና ማህበራዊ ድጋፍ ስልጠና አግኝተዋል? ከየት አገኙ? ለወሲባዊ ጥቃት ተጎጂዎች በምትሰጡት አገልግሎት ላይ ስልጠናው ጠቃሚ ነበር?

25. በዚህ ማእከል ውስጥ ለወሲባዊ ጥቃት ተጎጂዎች የሚሰጠውን አገልግሎት ለማሻሻል ምን ቢደረግ ብለው ይመክራሉ?

CURRICULUM VITAE

1. PERSONAL INFORMATION

Name: SELAMAWIT

Father's Name: MENGISTU

Last Name: WELDEHANNA

Date of birth: May 16, 1993, G.C

Place of birth: Harar, Ethiopia.

Nationality: Ethiopian

Marital Status: Single

Address: Mobile: +251920169022

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2. EDUCATIONAL BACKGROUND

Elementary school: Model School from 1999 – 2007 G.C

High school: SOS Hermann Gmeiner School from 2008 – 2011 G.C

University: Haramaya University from 2012 -2015 G.C (BSc. In Public Health)

Addis Ababa University enrolled in 2018/19 (candidate for MPH in Health promotion and education)

3. WORK EXPERIENCE

Rural Health Center as a public health officer from 2016 – 2018 G.C

Freelance Data Collector in 2018 G.C

Internship at Tikur Anbessa Specialized Hospital for 3 months (Aug 14- Oct 11, 2019)

4. HOBBY AND INTERESTS

- Socializing with family and friends

- Watching Documentaries, listening to music and watching movies

5. ADDITIONAL SKILLS

- Computer Skill

- Microsoft Packages (MS Word, Excel, PowerPoint...)

6. LANGUAGE

- Proficient in Spoken and Written English and Amharic

7. REFERENCE

-Mrs. Berhan Tassew (School of Public Health, Addis Ababa University) Phone: +251911365200

ASSURANCE OF PRINCIPAL INVESTIGATOR

I, the undersigned, agree to accept all responsibilities for the scientific and ethical conduct of the research project. I will provide a timely progress report to my advisor and seek the necessary advice and approval from my primary advisors during the research. I will communicate timely to my advisors and all stakeholders involved in the study including any source of funding for this research.

Name of the student: _____

Date: _____

Signature: _____

Approval of the primary Advisor

Name of the primary advisor: _____

Date: _____

Signature: _____