ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES
DEPARTEMENT OF EMERGENCY MEDICINE AND CRITICAL CARE

A STUDY ON THE ASSESSMENT OF PATTERN AND PREDISPOSING CONDITIONS OF CHILD SEXUAL ABUSE AMONG FEMALE CHILDREN SEEN IN GANDHI MEMORIAL HOSPITAL ADDIS ABABA, ETHIOPIA 2017

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Acronyms

AAU- Addis Ababa University

AIDS - Acquired Immunodeficiency syndrome

CSA- Child sexual abuse

CDC - Centre for Disease Control

CI – Confidence Interval

FMOH- Federal Ministry of Health

GMH- Gandhi Memorial Hospital

HIV- Human Immunodeficiency Virus

IRB-Institutional Research review Board

TASH-Tikur Anbesa Specialized Hospital

WHO- World Health Organization

NDUTH -Niger Delta University Teaching Hospital

NPSS-National Society for the Prevention of Cruelty to Children

SSA- Sub-Saharan Africa

STI-- Sexually Transmitted Infection

PSRC- Paediatrics Surgical Referral Clinic

PTSD-Post Traumatic Stress Disorder

Abstract

Background: Child sexual abuse remains a silent crime which occurs in different settings and cuts across varying social classes. Child sexual abuse is a serious breach of basic human rights and is responsible for numerous adverse sequelae its wide-spread presence in both developing and developed countries is well documented. Child sexual abuse is a serious worldwide public health concern that requires collective, as well as individual, pro-active measures for safeguarding children's rights. Child sexual abuse is associated with a variety of problems in the short and the long term for both male and female victims.

Objective: To assess the pattern and predisposing conditions of child sexual abuse among female Children seen in Gandhi Memorial Hospital Addis Ababa, Ethiopia 2017

Methods: The research was conducted by collecting reported child sexual abuse cases from the records of patients who presented to Gandhi Memorial Hospital as a case of Child sexual abuse from March 2016 to February 2017 seen in Gandhi Memorial Hospital. Systematic random techniques were used to determine the sample size**.**

Results: Being a total of 292 selected samples of victim children was included from the one year period then completed a semi-structured questionnaire and data were analysed**.**Their peak age is adolescent age (12-18yr). Most of the victims (41.1%) live with their both parents, followed by single parent care taker. Nearly half of the cases were victimized at their own home followed by their neighbour home. Even though most of them have old hymen injury physical finding at presentation, minor laceration and major bleedings were also common. Almost all the perpetrators are male and majority of the perpetrators are known by the child and most of them use alcohol during the time of attack.

Conclusion: From the study it shows female children are at risk of sexual abuse irrespective of their age, socioeconomic status and degree of relationship between the perpetrators and victims.The proportion of child sexual abuse at Gandhi Memorial Hospital is estimated 73.3%, from the total victims of females, some came down with pregnancy.Presences of family problem were a predisposing factor for CSA.

Recommendations: As we observed CSA is becoming one of problem of the public health problem so it is important that effective preventive strategies must be developed and implemented.Establishment of child protection centre is mandatory. We should enhance CSA data documentation to utilize for the promotion of evidence based CSA policy & programming.

CHAPTER ONE

1. INTRODUCTION

1.1 Background of the Study

Child sexual abuse (CSA) is an important social problem worldwide which affects the physical, mental and psychological health of a child. (1)

It is defined as the involvement of a child in a sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared for and cannot give consent to, or that violates the laws or social taboos of society.(1)

It may include physical contact (fondling a child's genitals, masturbation, oral-genital contact, and digital penetration, vaginal and anal intercourse) or noncontact abuse (exhibitionism, voyeurism, and child pornography). It usually involves coercion of the unsuspecting victim through trickery or bribery or it could be forceful; with acts ranging from rape to unwanted fondling. (1)

Child sexual abuse remains a silent crime which occurs in different settings and cuts across varying social classes. Due to the stigma associated with it, the victims rarely disclose the act thus leading to underreporting of cases, with even fewer victims eventually presenting for medical care(1)

Child sexual abuse is a serious breach of basic human rights and is responsible for numerous adverse sequelae its wide-spread presence in both developing and developed countries is well documented. CSA is a serious worldwide public health concern that requires collective, as well as individual, pro-active measures for safeguarding children’s rights. CSA is associated with a variety of problems in the short and the long term for both male and female victims(1, 2)

The sexual abuse of children occurs throughout Europe, from the Inuit in Greenland, the Council of Europe published Child sexual abuse in Europe containing chapters on sexual abuse in particular countries (Romania, Germany, Poland, England), and chapters focusing on legal

obstacles to rehabilitation, therapeutic help for victims, working with perpetrators, and telephone helplines (3).

In recent years, concern has been expressed about the rising incidence of reported crimes targeting women and girls. Police records in Kenya documented 1,987 cases of rape in 2001 compared with 2,908 reported cases in 2004. This represented a 46.4% increase. The actual figure is thought to be higher considering that not all violations are reported. The World Health Organization (WHO) estimates that 36-62% of all sexual assault victims are aged below 15 years.(4)

The devastating long- and short-term consequences of CSA on the lives of the victims are reflected in the high public and scientific interest on this topic. The need for reliable overall prevalence estimates of CSA is crucial for health research worldwide, especially for allocating economic resources in health care and estimating the burden.(5).

In addition to the stigma associated with CSA, the victims also experience short and long term adverse health effects of the abuse such as transmission of HIV and other STIs, somatic and visceral injury, unwanted pregnancy, obstructed labour, vesico-vaginal and recto- vaginal fistulas. CSA is also associated with high risk behaviours such as prostitution, multiple sexual partners, substance abuse, delinquency in later life and psychological problems like feelings of vulnerability, shame, guilt, fear, poor self-esteem and depression.(1)

The sexual abuse of children is as pervasive in sub-Saharan Africa (SSA) as it is in other parts of the world. As elsewhere, it is most commonly perpetuated by family members, relatives, neighbours and others known to the child victim. The sexual victimization of children may also be commercialized in the form of juvenile prostitution, child pornography, trafficking of children for sexual purposes and child marriages. Public awareness of child sexual abuse in SSA is low(6)

There is growing recognition that children in sub-Saharan Africa (SSA) are vulnerable to HIV-transmission through sexual abuse and exploitation including incest, child rape, early (coerced) coitus, ‘sugar daddies’ and transactional sex. However, this awareness is relatively recent. For example, an early analysis of sexual behaviour in sub-Saharan Africa was Standing &Kisekka’s

annotated bibliography that was "intended as a contribution to basic research on AIDS transmission and to the formulation of appropriate prevention programmes"(6)

Victims of CSA carry psychological burdens of fear, blame, rage, guilt, and/or disbelief about their experiences. Many sexually abused children never disclose the abuse. When they do, it may be months or years, before the abuse is revealed. Sometimes, they are married adults with children of their own before the abuse is ever addressed. As a result, suffering often continues over long periods of time (7).

Child sexual abuse (CSA) is a widespread public health problem. Consequently, researchers have documented its short- and long-term effects in many studies. It has been reported in such endeavours that CSA has consistently been linked to a range of difficulties including depression, dissociation, post-traumatic stress disorder (PTSD), personality disorders, anxiety and fear, re victimization, and substance abuse (8).

1.2 Statement of the Problem

Child Sexual Abuse (CSA) has a negative effect on the child's entire family, and it creates a burden on both the health care system and on society. Most CSA research is based on adults' recall of their experiences. Recall biases during adulthood could hinder the identification of true CSA risk factors and might limit the understanding of this phenomenon(9).

CSA is highly prevalent worldwide. Females have a two or threefold risk compared to males to be sexually abused during childhood and about one in ten women is confronted with this experience. Similar gender- specific differences were reported in previous reviews for overall prevalence estimates (5)

Child sexual abuse is likely the most prevalent health problem children face with the most serious array of consequences. These consequences may be Individual (psychological and physical) or social consequences (7, 32)

Public awareness of child sexual abuse in sub-Saharan Africa is low. Whilst newspapers and other media have given this issue increasing attention in the last five years or so, most countries in the region have not had the clinical studies, sample surveys or nationwide polls of childhood

abuse experiences that we see in wealthier regions. This is largely the function of a poorly resourced academic/research sector, where such work is typically conducted elsewhere. (9)

Child sexual abuse is a disturbingly prevalent problem that has received increased attention from researchers, clinicians, and the general public during recent decades. Incidence studies from the 1990s provide the best estimate of the numbers of children and families affected by this problem, but even the advancement in comprehensive and methodologically sophisticated efforts are believed to underestimate the problem. (10)

Child sexual abuse, using children for sexual gratification of adult, is a criminal act committed against children which probably is one of the least acknowledged and least explored forms of child abuse in Ethiopia **(11).** There are too little reports on child sexual abuse as seen in health facilities in our communities, particularly at Gandhi Memorial Hospital, which is number one rape case referral hospital where no such previous study has been undertaken. This study is designed to determine the pattern and predisposing conditions of CSA in female children attending in Gandhi Memorial Hospital over one year period of time, March 2016 _ February 2017.

1.3. Significance of the Study

This study would be help full to have knowledge on the pattern of female child sexual abuse and its associated consequence. It would help to develop different strategic measures that could reduce the pattern of female child sexual abuse. In addition, the study may provide base line information to carry out further research on CSA and associated consequence among female children. The data obtained in this study, would be used by concerned bodies for planning and evaluating CSA. The recommendations given if considered are going to benefit the public, Nurses, Physician's, hospital administrators and policy makers at large on CSA.

CHAPTER TWO

2. LITERATURE REVIEW

Before the late 1970s, CSA was regarded as rare. In the following decades, the incidence—based on official statistics increased dramatically (12). Although much of this apparent increase probably reflected a growing awareness among the public and professionals, some studies suggest that the overall incidence of child abuse and neglect increased.

In U.S, the risk of sexual abuse towards girls is two times greater than boys, for instance a study conducted on 796 college students indicated that 19% of women and 9% of men had experienced some form of sexual abuse as children (13). When we see some of the National Statistics of U.S on the Prevalence of Child Sexual Abuse: a telephone survey, conducted by the Gallup Poll, indicated that as many as 19 per 1,000 children have suffered sexual abuse. The results indicate that more children are abused (all types of abuse) and neglected than are found in Child Protective Services reports (13).

Studies of both the incidence and the prevalence of sexual abuse of children in the United States began emerging in the 1960s and gained greater urgency after the cluster of day care centre child abuse cases in the 1980s made the issue one of acute public interest. Although we do not have data reflecting the prevalence of abusers, there are data from several studies reporting the prevalence of victimization (14).

In north-west England, a survey of 2, 420 children found that 19% reported that they had been the victims of attempted or completed sexual abuse or an abduction incident away from home, consisting of "indecent exposure (40.8% of victims), touching (25.8% of victims), and abduction (23.1% of victims), each occurring on their own; and incidents involving multiple types of act (10.2%)"(3).

When we come to Africa, the magnitude of CSA in Sub-Saharan Africa, (SSA) is unknown. The difficulties in establishing the extent of the problem are largely related to the measurement issue and also related to the fact that CSA is seriously under-reported, as noted by a number of authors (16). The fact that few researches being conducted; negative societal attitude of reporting the

incidence and limited access to health facilitates created difficulty in presenting accurate estimation of child sexual abuse in developing countries including sub-Saharan Africa (15).

The earliest study of CSA in Africa was by Westcott (1984), who described 18 cases of CSA at

Cape Town hospital victims range 2-12yr and 80% were female. In over half of the case the offender was a relative, a neighbour or others known by the child. 11In SSA prevalence levels are comparable with studies reported from other regions. The high prevalence level of HIV/AIDS in the region exposes sexually abuse children to high risk of infections (16).

A study in Tanzania, Respondents were asked to indicate whether they had experienced an unwanted sexual experience before the age of 18. To constitute child sexual abuse the perpetrator had to be five or more years older than the respondent. A total of 135 respondents (27.7%) reported having experienced at least one type of abusive sexual experience before the age of 18 (many respondents had more than one experience; this information is revealed in the individual analysis of abuse).Unwanted sexual intercourse was high, especially for woman (11.2%). The corresponding figure for men (8.8%) relates to experiences young males (<18 years) had with women at least five years their senior. It indicates that many early adolescent boys were involved in unwanted sexual relationships with older women (17).

A study in Zimbabwe Over 1 year, 1194 new clients (90% female) aged 7 weeks to 16 years were assessed, with 93% of boys and 59% of girls classified clinically as pre pubertal. 94% of clients reported penetrative sexual abuse, occurring most often in the child's home. Most perpetrators were identified as relatives or neighbors by children under 12 years, and 'boyfriends' by adolescent girls. At presentation, 31/520 (6%) clients tested were HIV-positive. Where recorded, 39 (6%) clients presented within 3 days of abuse, and 36 were given post exposure prophylaxis for HIV (PEP). Among female clients, orphan prevalence was higher than in theDemographic and Health Survey (DHS) and neighboring community (17).

Countries in East Africa like Tanzania CSA are widely perceived that it may be increasing as a result of AIDS sufferers' attempts to "cleanse" them. In addition there is also breakdown of traditional childcare systems; foreign influences, poverty, and the lowly position of girls in society are implicated(17).

A review literature from 1980 to 2003 on CSA and medical consequences of child sexual abuse

(CSA) include sexually transmitted infection (STI) and human immune virus (HIV) infection in

SSA shows the mean age of the child victims was 8 years. The incidence of penetrative sex in the studies ranged from 70 to 97%. Physical signs of CSA included genital or anal injuries, perineal trauma, and vesico-vaginal or recto-vaginal fistula (18).

The incidence of STD varied according to whether the study was retrospective or prospective.

Ten percent to 67% of children with STD had been sexually abused while 15 to 30% of sexual abuse incidents were associated with STD. The prevalence of HIV ranged from 3% in Togo to

37.5% in Cameroon. Most alleged child abusers were adult males known by the child, i.e., family members (30-60%), instructors or teachers, household personnel or neighbours. Some of the acts were motivated by traditional practices such as early, forced marriage and beliefs such as presumed benefits of sex with virgin children (cure for STI/HIV/STD, magic powers or wealth). This study shows that CSA is widespread throughout sub-Saharan Africa (18).

There is a tendency for under-reporting of sexual abuse. The reasons for non-reporting are complex and multi-faceted. These reasons may include a number of factors such as the age of the abused child at the time of the event, the relationship between the perpetrator and the abused, the gender of the abused, the severity of the abuse, developmental and cognitive variables related to the abused, and the likely consequences of the disclosure. Girls are more likely to report sexual abuse than boys and more importantly when the perpetrator is a relative, there is fewer tendencies to report abuse. Others may choose not to report due to fear of negative consequence of the disclosure, which may range from more abuse and injury to fear of retribution or ridicule, stigmatization and a lack of confidence in investigators, police and health workers (19).

A research on the Child Sexual Abuse Epidemic in Addis Ababa was conducted by collecting reported child sexual cases from child protection units of Addis Ababa police commission between July 2005 & 2006G.C of the total reported cases 23% of them were sexual victimization, where majority of them were committed against female children (20, 21).

There are a host of determining factors combine and inter-connect, leading to increased risk for children and persistent child sexual exploitation. These factors are grounded in the social context in which the child lives and develops, and relate to certain social norms (perceptions, practices, traditions and behaviour); Endemic and structural poverty, humanitarian crises created by conflicts and natural disasters; and the global development of the sex industry (22).

Another comparative study of the socioeconomic factors associated with childhood sexual abuse in sub- Saharan Africa. Demographic and Health Surveys in six sub-Saharan African countries conducted between 2003 and 2007 were used to access the relationship between CSA and socio economic status using multiple logistic regression models. The result shows there was no association between CSA and education, wealth and area of settlement. However, there was contrasting association between CSA and working status of women. This study agrees with other western studies which indicate that CSA transcends across all socio economic group. It is therefore important that effective preventive strategies are developed and implemented that will cross across all socio-economic groups (23).

A retrospective analysis of case records of patients who presented to the Out Patient Department of General Hospital Suleja Niger State. The demographic features of individuals involved in sexual abuse and the pattern of presentation of cases were seen by a review of Child sexual abuse. All cases of sexual abuse seen over an 18 month period, a total of 81 cases of sexual abuse were recorded over the period of review where children (77 cases) accounted for 95.1% of the cases. There were 41 cases of sexual abuse seen in 2007, while 40 cases were documented within the first half of 2008. All the victims of sexual abuse were girls and all the perpetrators were males of whom six adolescent boys constituted 7.6%. There was no documentation on evaluation and management of sexually transmitted infections, HIV infection, emergency contraception, or scheduled follow up (24).

A cross-sectional study was conducted among Jirren high school female students in April 2005 on Child sexual abuse and its outcomes among high school students in southwest Ethiopia; CSA is a major contributing factor to the burden of disease among children and adolescents. The results revealed that the prevalence of CSA was 68.7%. Among the different forms of sexual abuses, verbal harassment was the most common (51.4%) followed by sexual intercourse, 18.0%

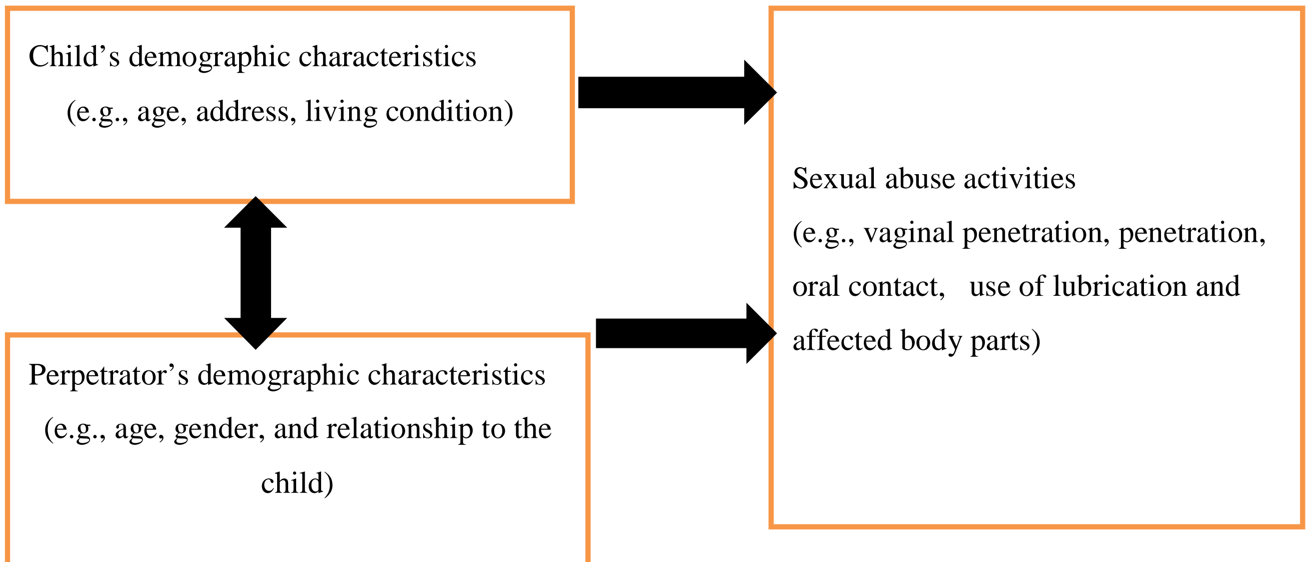
and unwelcome kissing, 17.1%. The commonly indicated abusers in this study were unknown persons (36%) followed by school-mates (31.5%). Among victims of sexual abuse, 7.2% had an unwanted pregnancy and 5.9% had sexually transmitted diseases. The rate of other psychological effects of CSA, such as suicide ideation, suicide attempt, and sexual dysfunction, was high. The overwhelming majority (86.4%) considered sexual abuse to be a major social problem. The study revealed that the prevalence of CSA is high (25).

Even though research evidence on child sexual abuse incidence in Ethiopia is scarce. Despite this, the rate of reports accentuates serious concern. A cross-sectional study conducted in Addis Ababa identified child sexual abuse prevalence rate of 38.5 % among the general public, out of which 29% were committed by victims' family members and 68% of them were victimized by adults the children knew (26).

Most perpetrators of child sexual abuse are relatives, the vast majority, 90%, are male adults and youth who are known to the child, in particular relatives and acquaintances. Although perpetrators are more likely than others to have experienced sexual abuse during their own childhood, most victims of sexual abuse do not go on to commit sexual abuse later in life. CSA most often comes to the attention of adults when children disclose. The impact of sexual abuse may not become evident for some individuals until later in adulthood (27).

In brief child sexual abuse is a universal phenomenon, factors and consequences of the incidences in developing countries like Ethiopia is scanty because of socio-cultural reasons. In general, the objectives of the study is to assess the pattern and predisposing conditions of CSAamong female children seen in Ghandi Memorial hospital from a period of March 2016 - February 2017

2.1 Conceptual Framework



This conceptual model was guided by Ecological Theory. It shows that the child's demographic characteristics and the perpetrator's demographic characteristics interact with each other to influence the occurrence of CSA. The focus of this study is on the child and perpetrator as part of the microsystem level. Hospital health records were used to assess the child's demographic characteristics, the perpetrator's demographic characteristics, and the history of sexual assault.(7)

CHAPTER THREE

3. OBJECTIVES

3.1. General Objective

- To assess the pattern and predisposing conditions of child sexual abuse among female Children seen in Gandhi Memorial Hospital Addis Ababa, Ethiopia from December 2016 to June 2017

3.2. Specific Objective

- To describe the pattern of female child sexual abuse in Gandhi Memorial Hospital from December 2016 to June 2017
- To identify the immediate associated consequence of female child sexual abuse
- To describe predisposing conditions for child sexual abuse

CHAPTER FOUR

4. Method and Materials

4.1. Study Area and Period

The study was conduct in Gandhi memorial hospital Addis Ababa from March 2016 to February 2017. Gandhi Memorial Hospital is one of the government hospital found in Addis Ababa. It was established by Mahatma Gandhi in 1948 E.C. and it gives primarily cares for women and babies. It gives service for 58,000 populations annually. Gandhi memorial hospitals have 384 total staffs. In this hospital there is an office that gives a law protection for women and female children. All raped female victims in Addis Ababa city administration and other regions are observed in this hospital.

The study was under taken from December 2016 to June 2017 in Gandhi Memorial Hospital.

4.2. Study Design

A retrospective institution based study design was conducted.

4.3. Population

4.3.1 Source Population

All cases of sexual abuse females seen at Ghandi Memorial Hospital over one year period (study period)

4.3.2 Study Population

All female children diagnosed and managed as cases of sexual abuse & who have full medical record like age, sex, socio-demography of perpetrator…etc. during the study period.

4.4. Sample Size and Sampling Techniques

The sample size was calculated using single population proportion with the following assumption

$$n = \frac{Z^2_{\alpha/2}\, p\,(1-p)}{d^2}$$

Where:

- $z_{\alpha/2}$ = critical value at 95% (CI) confidence interval (1.96)
- p = Prevalence of child sexual abuse 38.5% (previous study)
- d=marginal error that we can tolerate and,
- n=sample size

$$= \frac{1.96 \times 1.96 \times 0.385\,(1-0.38)}{0.05 \times 0.05}$$

= **364**

I use correction formula for final sample because the source population is less than10, 000 (i.e.1500 total females)

I.e. Nf = n/ (1+n/N) = 364/ (1+364/1500) = 292.9 = 293. By adding 10% non-respondent sample size (contingency) the final sample size may be as follows

Nf = 293 + 29.3 = 322.3 = **322**

After determine the sample size can use systematic simple random sampling by finding K value

I.e. k= 1100/322

k= 3.41…= **3**

4.5. Eligibility Criteria

4.5.1 Inclusion Criteria

- Age<18yrs (by UNCRC & African charter definition)
- CSA seen b/n march 2016 —February 2017 at GMH

4.5.2 Exclusion Criteria

- lost chart
- Chart’s with no documentation (incomplete charts)

4.6. Variables

4.6.1 Independent

- Age
- Gender
- Environment
- Disability

4.6.2 Dependent

- Sexual abuse

4.7. Operational Definitions

Child: - The UNCRC and the African Charter define a child as a person below the age of 18 (UNCRC Article 1 and African Charter Article 2)

Child maltreatment: is any act or failure to act by a parent, caregiver, or other person that results in serious physical, mental, psychological, and emotional harm and may lead to death.

Sexual violence: any sexual act that is perpetrated against someone's will encompassing a range of offences, including a completed non-consensual sex act (i.e., rape), an attempted non-consensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment) (CDC)

Child sexual abuse: is any sexual contact or inappropriate sexual stimulation with the child.

Perpetrator: is an individual who has engaged in sexually abusive behaviour with a minor. These abusive activities could include vaginal and/or anal penetration, oral contact, ejaculation, and lubrication.

Sexual abuse activities: are those acts performed during a sexual assault. They can include:

a) sexually touching or fondling a child, or making the child touch the adult's sexual organs, penetrating the child's vagina or anus with a penis or any object;
b) showing sexually explicit material to the child, including exhibitionism, pornography, sexual intercourse or masturbation in front of a child; and
c) sexual exploitation that includes child prostitution or modelling for pornographic films or images

Trafficking for sexual exploitation: refers to the cross-border or internal recruitment, transportation, transfer and harbouring or receipt of children for sexual exploitation.

Exhibitionism: - a perversion in which sexual gratification is obtained from the indecent exposure of one's genitals.

Voyeurism: - is the practice of gaining sexual pleasure from watching others when they are necked or engaged in sexual activity.

Child pornography: - Any visual depiction of sexually explicit conduct a minor (less than 18 years)

Fondling: - to touch gently and in a loving way, or to touch a sexual way.

4.8 Data Collection Tools or Materials

The data was collected by using structured questioner from the Literature and medical records of the victims. The data includes study variables, which included the socio- demographic variables, the relationship between victim and perpetrator; time and place of the initial sexual abuse incidence were assessed.

Data was collected by trained nurses, trained by investigator, manually from the medical records of the hospitals after Consent for conducting the study was obtained from the department research and publication and Institutional research review board (IRB). Based on the inclusion and exclusion criteria sated data was collected from records of patients who presented to GMH as a case of sexual abuse from March2016 to February 2017.

Five female research assistants were carefully selected from the respective organizations. Each assistant met the minimum requirements of a diploma certificate, previous experience of data collection, and experience in working with abused children. One-day training on how to collect data and establish rapport with the respondents was provided at study area. The training focused on theoretical explanations, followed by practical demonstrations with each trainee afterward. Moreover, the principal investigator closely supervised the assistants on a daily basis throughout the data collection activities.

4.9. Data Quality Assurance

The data collection task was accomplished in the following two steps.

- The data were collected only by the staff members from the respective organizations, under the supervision of the principal investigator. In addition, strict confidentiality was assured through anonymous recording, and computer based coding of questionnaires, data analysis and kept in safe place.
- Data regarding the overall reported as cases of child sexual abuse was collected from medical registration based on the criteria.

Then start completing questionnaires by nurses after brief orientation on the purpose and method of completion was given.

4.10. Data Analysis Procedure

Data was enter into EPI data version 7.1 and exported to SPSS version 20. The data was transfer and analyse by SPSS software package. The descriptive analysis such as frequency, distribution, percentage and chi square or odds ratio was use.

4.11. Ethical Consideration

Ethical clearance was being obtained from Addis Ababa University department of Emergency Medicine and IRB before data collection period. Official letter was obtained and give for Gandhi Memorial Hospital managerial office.

4.12. Dissemination and Utilization of Results

The result was submitted in hard and soft copy to Addis Ababa University College of health science, department of Emergency medicine and Ghandi Memorial Hospital and Federal Ministry of Health. The result was available in the library of AAU for students as well as for other concerned readers or relevant bodies and published with reapited journals and efforts for presentation on scientific conferences and professional associations were considered.

CHAPTER FIVE

5. Results

5.1 General Characteristics of Sample Population

Overall a total of 1500 females were seen at GMH between March 2016 and February 2017. Out of these, 1100 cases were under 18 years children reported during the stated period. This is an average of 92 children sexually abused each month. The proportions were 73.3% from the total females seen in the hospital.

Among 322 samples, 292samples were participants in the study.

5.2. Socio Demographic Characteristics of the Victim

Data from 292 selected sample sizes of victim children was examined to see the demographic Variable of Age. The highest numbers were seen in age 12-18years which accounts (64.7%);

Address of the victim

Among the 292 selected cases 221 (75.69%) were from Addis Ababa & the rest 71 (24.31%) are from region

The most common residency place of the victims that came from Addis Ababa is the following based on kifle ketema.

Table 1: Age and address of sexual abused child visited in Gandhi Memorial Hospital from March 2016 to February 2017 (n=292)

Age			
	Age in years	Number	Percent
	2-3 years	17	5.8
	4-5 years	15	5.1
	6-11 years	71	24.3
	12-18 years	189	64.7
	Total	292	100
Address of the child			
	Adress by kiflketema	Number	Percent
	Addis ketema	14	4.8
	Yeka	27	9.2
	Akakikality	22	7.5
	Arada	10	3.4
	Bole	31	10.6
	Gulele	15	5.1
	Cherkose	16	5.5
	Kolfikeranio	34	11.6
	Lideta	24	8.2
	Nifas silk lafto	28	9.6
	Region	71	24.3
	Total	292	100

Educational status of the victims

Educational status of the victims from the data shows majority of the respondents 106(36.3%) were primary/elementary students, 40 (13.7%) were KG, 36 (12.3%) were secondary, 33(11.3%) were not started, 13(4.5%) the rest did not start school or has no formal education.

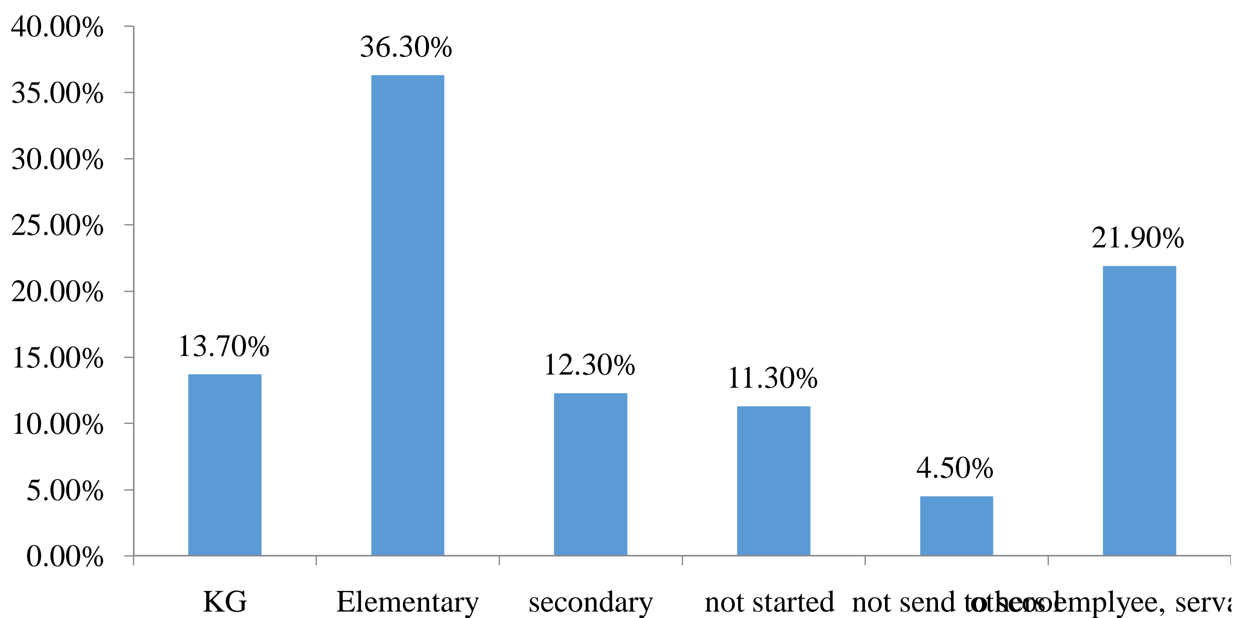


Figure 1: Shows educational status of the victims visited Gandhi Memorial hospital from March 2016 to February 2017.

Religion of the victims

Almost half of the victims 144 (49.31%) cases documented as orthodox Christian the next highest wereMuslims account 67 cases.

5.3. Pattern of Child Sexual Abuse

Victim's previous history of sexual abuse

Majority ofthem 242cases (82.88%) has no previous history of sexual abuse, but the rest 50 cases (17.12%) has previous history of sexual abuse by the same or different perpetuator.

Time & place of attacks

Most of the attack occurs during day time 189 (64.7%) cases, and around 103 (35.3%) cases were during the night time. Most of the abuse 138 (47.3%) occurs in their house and neighbours 84 (28.8%).

Table 2: Place of attack Vs time of attack Cross tabulation Gandhi Memorial hospital from March 2016 to February 2017

place of attack		time of attack		Total
		day time	night time	
place of attack	own home	60	78	138
	Neighbour	80	4	84
	School	30	0	30
	Unknown	19	21	40
Total		189	103	292

Number of perpetrators

When we see the number of, perpetrators, to a victim: in about 269 (92.1%) of cases only one perpetrator was involved, 17 (5.8%) of cases two perpetrator are involved and the rest 6(2.1%) of cases three attackers were reported.

Type of sexual contact

The most common cause of sexual contact was vaginal which accounts 278 (95.2%).

The type of sexual contact is described in the following tables:

Table 3: Sexual contact visiting Gandhi Memorial hospital from March 2016 to February 2017

Type of contact	Number	Percent
Vaginal	278	95.2
vaginal and oral	13	4.5
Others	1	.3
Total	292	100.0

5.4. Immediate Associated Consequence of Sexual Abuse

Physical examination documented during time of arrival

The common findings are old torn hymen 131 (44.9%), Normal or suspected 82 (28.1) minor injury (injury involving only mucosal layer or skin) 30 (10.3%), major injury (new hymen injury) (injury beyond the mucosal layer) or those loss their virginity 42 (14.4%), only discharge 5 (1.7%) and skin change (bruise rash etc.) 2(.7%)

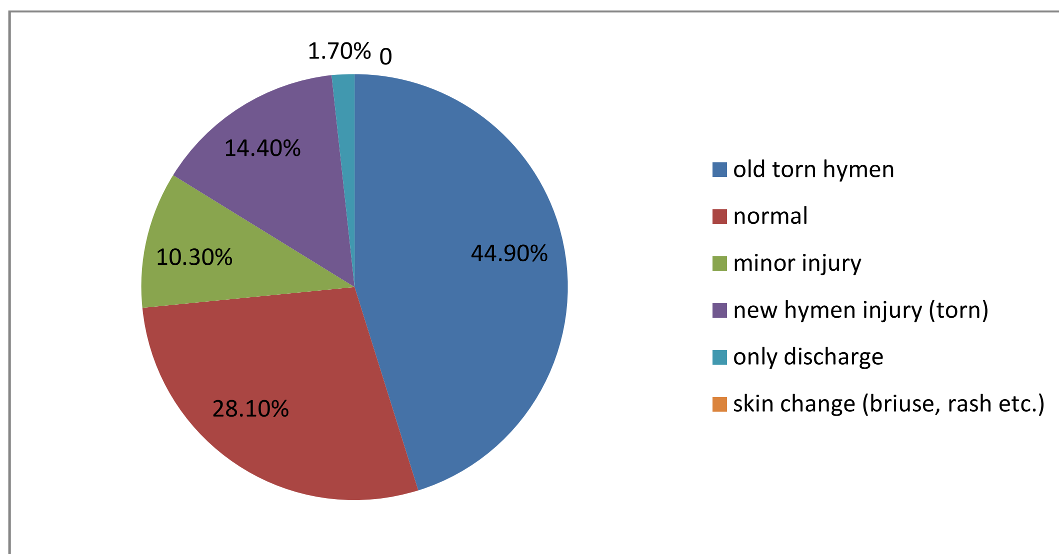


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Figure 2: Physical examination findings sexually abused victims Gandhi Memorial hospital from March 2016 to February 2017.

Laboratory investigation done

Almost above 3/4th of the victims were done laboratory investigations it accounts 244 (83.6%) and the rest 48 (16.4%) cases were no laboratory investigations done.

When we see the laboratory investigation of sexually abused child was: 280 (95.9%) cases are free (negative) from HIV, HBsAG, pregnancy the rest 12 (4.1%) cases are pregnancy test positive.

Table 4: Age and pregnancy test outcome of sexually abused victims presented at Gandhi Memorial hospital from March 2016 to February 2017

Variable		Pregnancy test done	
		Negative	Positive
Age	2-3 years	17(5.8%)	0
	4-5 years	15(5.1%)	0
	6-11 years	71(24.3%)	0
	12-18 years	177(60.6%)	12(4.1%)

Who brought the victims and time of presentation to the health centre?

Most of the victims199 (68.2%) brought by family (i.e. father, mother or sister, brother), 64 (21.9%) by police, 16 (5.5%) herself, 11 (3.8%) by care giver, 1 (0.3%) by aunt and 1 (0.3%) others. the highest present (45.2%) of victims presents to health unit within 24-48 hours.The minimum was after 1 day and the maximum was 1 year

Table 5: Time of presentation of the victim to the hospital or health centre

Time	Number	Percent
within 24 hour	35	12
24-48 hours	132	45.2
48 hours- 7 days	81	27.7
8- 30 days	27	9.2
>30 days	7	2.4
Others	10	3.4
Total	292	100

Age & sex of the perpetuator

Out of 292 the age was documented only in 131 of the perpetrators the rest of the perpetrator age were not indicated in the document. The majority of sexual abuse was done by males it accounts 285 (97.6%) the rest 7 (2.4%) was by females

Table 6: Socio demographic characteristics of the perpetrator

Age Vs. sex Cross tabulation of perpetrator				
Variable		sex		Total
		male	Female	
Age	13-18 years	19	0	19
	19 - 24 years	30	1	31
	25 - 30 years	64	1	65
	31 -35 years	1	0	1
	36- 41 years	15	0	15
	not indicated	156	5	161

5.5. Predisposing Condition of Child Sexual Abuse

Living Condition of victims

Most victims 120 (41.1%) were living with their both parents

Table 7: Living condition of the victims presented at Gandhi Memorial hospital from March 2016 to February 2017.

Care taker	Number	Percent
Both parents	120	41.1
Adopted	5	1.7
Relatives	39	13.4
only father	24	8.2
only mother	42	14.4
no care taker	61	20.9
Unknown	1	.3
Total	292	100.0

**no documentation about care takers on the chart*+ Living lonely (lives alone)

Working condition of the parents / care takers

When we were evaluated the working condition of the family /care taker:

About 88 (30.13%) of the family/care takers were working in government, 50 (17.12%) were private employed, 91(31.16%) labour worker and 63 (21.57%) were unknown

Family problem

The victims which accounts the highest person were in parents has no problem and divorced parents which is depicted on pie chart

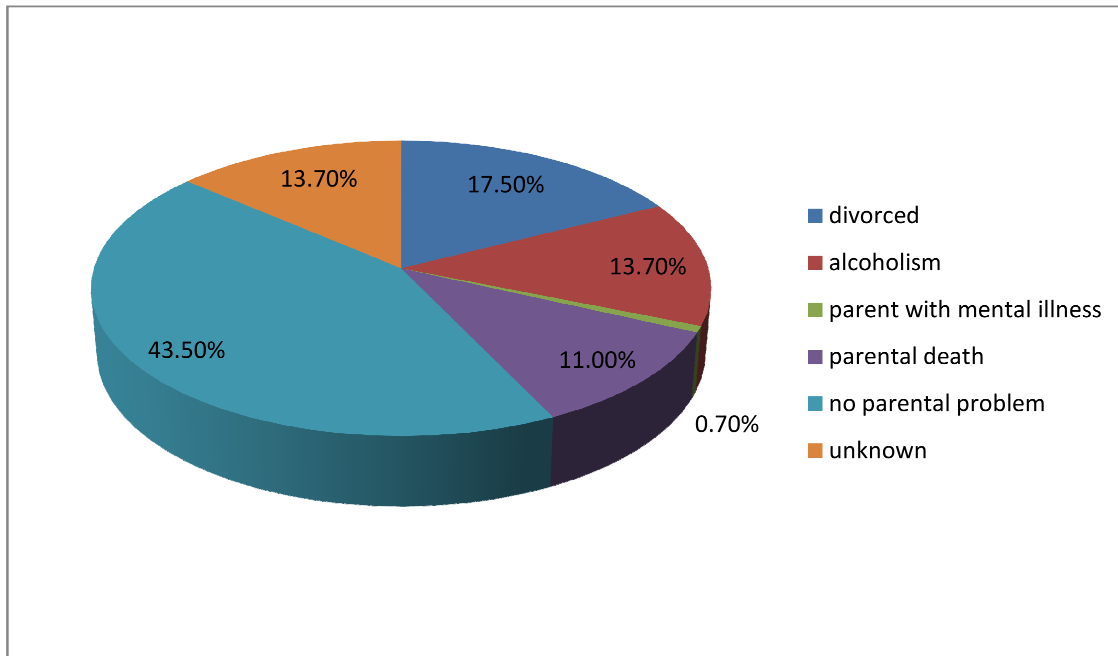

Figure 3: Common family problems of the victim presented at Gandhi Memorial hospital from March 2016 to February 2017.

Presence of underlying disabilities among the victims

To evaluate the presence of underlying disabilities among the victims like physical, cognitive, emotional… the result shows only 7 cases (2.39%) have disability majority are physical Disabilities (blind, prosthetic leg, hearing loss), 252(86.3%) cases have no disabilities and 33(11.3%) cases have no documentation about the disabilities.

Table 8: Underlying disabilities in sexually abuse children presented at Gandhi Memorial hospital from March 2016 to February 2017

Disability	Frequency	Percent
No	252	86.3
Yes	7	2.4
Unknown	33	11.3
Total	292	100.0

Relationship of the victim to the perpetuator

The relationship of the victims with the perpetuator is described as follows: The result shown in the following bar chart neighbour 84 (28.8%), family 69 (23.6%), friend 51 (17.5%), stranger 14(4.8%), employer 39 (13.4%), teacher 13 (4.5%) and the rest 22 (7.5%) are not known.

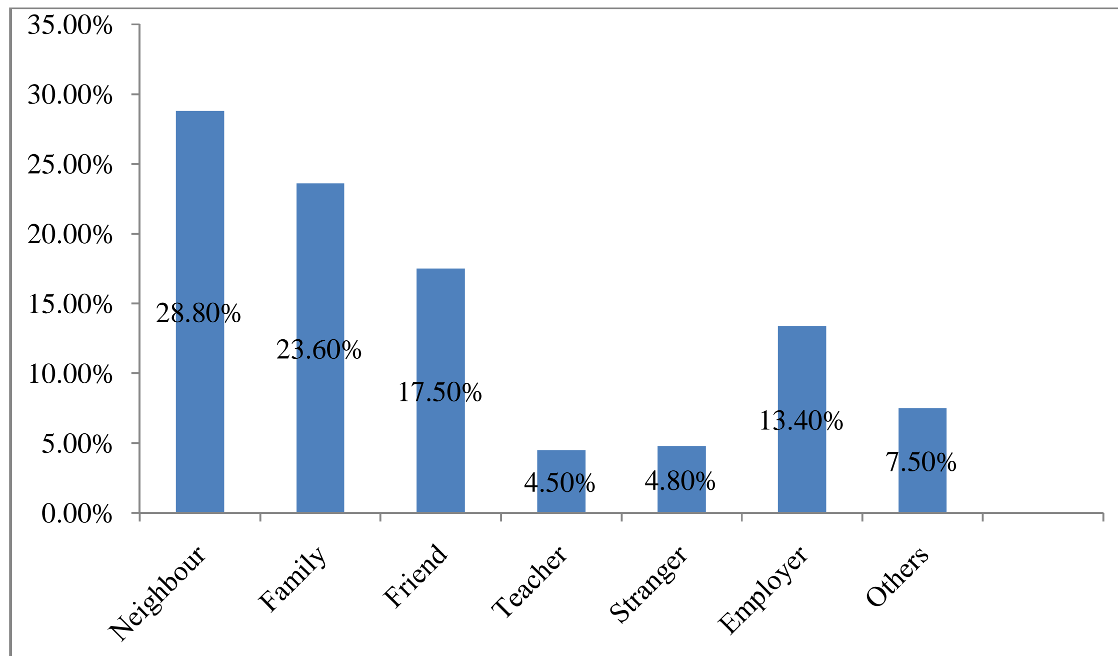

Figure 4: Relationship of victim to the perpetrator

Materials used by the perpetrator during attack

The majority uses alcohol or drugs during the attack; others will be described by the following table:

Table 9: Type of mechanisms used by the perpetrator

Mechanism or material used	Frequency	Percent
alcohol or drug	96	32.9
force (kick, hit, blow)	45	15.4
Cheating	85	29.1
Verbally abusing	66	22.6
Total	292	100.0

**cheat: calling to their home for help, for help but sexually abused*

**verbally abused: verbally disappointed, tend to fear to tell any one*

CHAPTER SIX

6. Discussion

As we observe from a one year result a total of 1100 cases of CSA were seen over a one year period this makes the proportion of female child sexual abuse at Gandhi Memorial Hospital to be 73.3%. The result is less than reported in other studies (Africa, Europe or North America). There is probably of under reporting of sexual abuse children due to multiple reason like age of abused child , relationship between attacker & child, severity of abused & consequence of disclosure, awareness of the care taker about reporting were observed in similar study (19)

Data from selected samples of victim children was examined to see the demographic variables of victim children, from the total of 292 children. This result is consistent with research done in UK by NSPCC ,which is the highest of sexual abuse were reported in teenage girls , CSA in Addis Ababa and in SSA by Westcott (1984) which reveals females vulnerability for CSA , 80% & 89% respectively (28,20). A study done in Nigeria also reveals this (1).

The peak age for CSA shows in adolescents' age (12-18yr) which accounts 64.71% followed by middle child hood age (6-11yr) accounts 24.3 %. This result is also similar (with a review of literature by Pitche P. Child sexual abuse and sexually transmitted infections in sub-Saharan Africa, Nov 2005 (18). In this age secondary sexual characteristics were developed due to this the perpetrator attract by the children.

The data shows most of the victims 75.7% came from Addis Ababa the rest 24.3% came from other regions. From these victims came from Addis Ababa kefleketema Kolfi Keranio is the leading (top) in female CSA which accounts 11.6%, followed by Bole 10.6%and Nifas silk lafto 9.6%. Why these area's account more CSA need further study.

According to figures obtained most of victims are elementary school students

Result also shows previous history of sexual abuse 17.1% has previous history and 82.9% has no previous history. A study done by Hassan M. (2014) In 37 hospital records, more than half of the children (56.8%) reported that this was their first episode of sexual abuse. When we assess disability there is poor documentation on disability, presence of underlying disabilities (2.4%),

mainly physical in our cases, are predisposing factors for CSA. This finding coincides with previous study by Maniglio, R. (2009). Severe mental illness associated with victimization. (22) US study also shows disabled children are at more risk than non-disabled peers.

Child sexual abuse can vary along a number of dimensions including time, place, type of contact, and time to present to the health centre. The majority attack (64.73%) takes place during day time & 35.27%% at night. A study in Western Reserve University (2014) reveals that(7). This time is working time most of the parents go to the work place due to this most of the children have no guardian, and also students go to school and recreational places.

Most of the abuse 64.73% occurs in their house and neighbours 28.76. In most of the victims 92.1% attacked by a single perpetrator, the rest 7.9% cases caused by more than two attackers. These results were also similar with a study by Pitche P. Child sexual abuse and sexually transmitted infections in sub- Saharan Africa, Nov. 2005. (18).

The most common cause of sexual contact was vaginal which accounts (95.2%)(Anal cases were not seen in GMH).

The common physical findings were: most of the cases were present with old torn hymen 44.9% and 28.5% cases were normal or suspected. 14.45% cases were loss their virginity. The survey in USA Finkelhor and colleagues (2009), the majority of victims (70%) were physically injured. A study in urban Zimbabwe also saysmost girls (93%) described the type of abuse as vaginal penetration. (30)

When we came to laboratory investigation from the data 83.6% of the victims have laboratory investigations the rest 16.4% cases have no done or not documented. From these 95.9% cases were free (negative) from HIV, pregnancy, and HbSAg. 4.1% cases have positive result only pregnancy. This is one type of physical consequence of CSA. Gavin and colleagues (2009) and Trent and colleagues (2007) suggested that young child-victims of sexual abuse were at higher risk for early pregnancy and abortion. In this time the victim not use any type of family planning method due to afraid or may not knowing post pill to buy those medications or fair of the family or other reasons, and also most of the perpetrator uses alcohol or drugs during the time of abused (attack).

Among all victims 68.2% cases were brought to the health care (hospital) by the family members, 21.9% by police, 5.5% came themselves, 3.8% by their care givers and the rest were by aunt and others. The survey in USA Finkelhor and colleagues (2009) only 30% of these young victims contacted police about their abuse.

The highest present (45.2%) of victims presents to health unit within 24-48 hours. The minimum was after 1 day and the maximum was 1 year

Generally child sexual abuse can happen anywhere and anytime. It also shows clearly there is delay in presentation to healthcare, similar study was done by Lakew Z. There was significant delay in reporting to the health care (27).Major causes were fear of the offender & guardians and lack of awareness. Majority of the results are similar in a reviews of literature on CSA in SSA, physical sign of include genital & anal injury. A literature by Kurt Conklin, Child sexual , Advocates for Youth , February 2012 shows in most of CSA, there are no physical symptoms of harm to alert adults.(9)

Regarding the demographic variables of perpetrator and relationship of victim to perpetrator; almost all were males 97.6%, and the rest 2.4% were females. In 87.8 % of cases the perpetrators were known by the child, among them neighbours' accounts for 28.8%, family members 23.6%, friends 17.5%, employer 13.4% and teachers 4.5%.4.8% cases were by strangers and the rest was not documented. These results are consistent with a literature by Kurt Conklin, Child sexual abuse, February 2012 most perpetrators are known to the child(31) and also similar study SSA (1999-2003).(18) A study done by Hassan M. The majority of the perpetrators were males (96.8%); only 3 perpetrators were females (3.2%). (7)

Most of the perpetrators (32.9%) use alcohol or drug during the attack, 29.1% was cheated (mislead), 22.6% verbally abuse, & 15.4% use force.

When we assess the care taker (living condition) of the victim 41.1% of the victims live with their both parents, 13.4% with relatives, 14.4% with only mother and 8.2% with their fathers, the rest were no care taker. Therefore 22.6% of the cases live only with one parent, which is also associated factor for CSA. Among those living with one parent more predispose. This result is similar with a research done in USA which showed an increased risk of abuse in children with

only one parent particularly those living only with their mother. (29) Family in which CSA occurs tend to have common characteristics. These include limited involvement in recreational activities and restricted opportunity for personal growth and development. Diminished family cohesion and independence are also reported (Afifi& Macmillan, 2011). Many times, there are rules, functions, and responsibilities that are subliminal within the family unit. Absence of family authority figures and their protection may demand certain behaviours and attitudes from children that may influence the likelihood of CSA (Garrett, 2010). For instance, a lack of monitoring and protection by single parents and step-families increases the likelihood of victimization. (7)

Regarding the working condition of care takers the data shows that 31.2% labour workers, 30.1% government worker (employed), 17.1% private employed and the rest 21.6% work in other work conditions. From this incomplete documentation difficult to conclude the relationship of CSA and working condition but according to DHS report of 2007 in six SSA countries conducted between 2003-2007 to assess the relationship between economic status and CSA there was no association between CSA & economic status. This indicates that CSA transcends across all socioeconomic groups. (23)

According to the result presence of family problem is greater predisposing condition for CSA. Among all cases 42.9% has documented family problem (i.e. divorced=17.5%, alcoholic =13.7% parental death=11.0%, mental illness=0.7%), 13.7% of the cases no documentation & 43.5% documented as no problem. From this at least divorce and alcoholic are common predisposing condition of CSA.

6.1 Limitation of the study

- Incompleteness of the medical records of CSA may not give complete burden of the problem.
- under reporting of sexual abuse children due to multiple reason (age of abused child, relationship between attacker & child, severity of abused & consequence of disclosure, awareness of the care taker about reporting)
- psychological consequence of the child was not recorded

6.2 Conclusions

- From the study it shows female children were at risk of sexual abuse irrespective of their age, socioeconomic status and degree of relationship between the perpetrators and victims.
- The proportion of female child sexual abuse at Gandhi Memorial Hospital is estimated 73.3%, their peak age was adolescents age (12-18yr) 2/3rd of the victims live with their both parents, followed by single parent care taker.
- Generally child sexual abuse can happen anywhere and anytime
- Presence of family problem is one of the predisposing conditions identified for CSA.
- Some abused children come down with pregnancy this is a physical consequence of CSA. Parents and caregivers should be encouraged to report cases of sexual abuse promptly to the hospital.
- The most common cause of sexual contact was vaginal. Even though half of them have normal physical finding at presentation, minor laceration and major bleedings (new hymen injury) were also common.
- Majority of the perpetrator are males and they know by the child, neighbours followed by family members. Most of the perpetrators use alcohol or drug during the time of attack.

6.3 Recommendations

- As we observed CSA is becoming one of problem of the public health problem so it is important that effective preventive strategies must be developed and implemented.
- Establishment of child protection centre is mandatory.
- Further study need to be carried out to examine the multidimensional impact of CSA.
- Nationwide research on CSA gives the whole picture of the problem for prevention and policy makers.
- We should enhance CSA data documentation to utilize for the promotion of evidence based CSA policy & programming.

7. Reference

1. Duru C, Ederiane O, Akinbami F. Child sexualabuse: a review of cases presenting at the outpatient clinic of a tertiary health centre in Bayelsa state, Nigeria. Glo Adv Res J Med Med Sci. 2014;3(11):345-61
2. Stoltenborgh M, van IJzendoorn MH, Euser EM, Bakermans-Kranenburg MJ. A global perspective on child sexual abuse: meta-analysis of prevalence around the world. Child maltreatment. 2011;16(2):79-101.
3. Lalor K, McElvaney R. Overview of the nature and extent of child sexual abuse in Europe. 2010
4. Ruto SJ. Sexual abuse of school age children: Evidence from Kenya. Journal of International cooperation in Education. 2009;12(1):177-92.
5. Barth J, Bermetz L, Heim E, Trelle S, Tonia T. The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis. International journal of public health. 2013;58(3):469-83
6. Lalor K. Child sexual abuse and HIV transmission in sub-Saharan Africa. Child Abuse Review. 2008;17(2):94-107.
7. Hassan M. PATTERNS OF SEXUAL ABUSE AMONG CHILDREN WHO RECEIVED CARE IN AN EMERGENCY DEPARTMENT IN A MIDWESTERN CITY: Case Western Reserve University; 2014.
8. Wondie Y, Zemene W, Reschke K, Schröder H. Early marriage, rape, child prostitution, and related factors determining the psychosocial effects severity of child sexual abuse in Ethiopia. Journal of child sexual abuse. 2011;20(3):305-21.
9. Lalor K. Child sexual abuse in sub-Saharan Africa: child protection implications for development policy makers and practitioners. 2005.
10. Hsu E, Sedlar G, Flood MF, Hansen DJ. Child sexual abuse. Faculty Publications, Department of Psychology. 2002:138
11. Lakew z. Alleged cases of sexual assault reported to two Addis Ababa hospitals. East Africa Med J. 2001 Feb;78(2):80-3.
12. Putnam FW. Ten-year research update review: Child sexual abuse. Journal of the American Academy of Child & Adolescent Psychiatry. 2003;42(3):269-78.

13. Karen J. Terry, Jennifer T. Child Sexual Abuse: a review of the literature, the joniay college research team. p. 3-5.
14. Child Protect: The Montgomery Area Children's Advocacy Center (1999). Child abuse statistics. From http://www.childprotect.org/statistics.htmaccessed February 2014
15. Darkness to Light (2001–2005) Statistics. From http://www.darkness2light.org/KnowAbout/statistics_2.asp Retrieved September,2013
16. Child Sexual Abuse in Sub-Saharan Africa :A Review of the Literature ,East, Central and Southern African Health Community July 2011.
17. McCrann D, Lalor K, Katabaro JK. Childhood sexual abuse among university students in Tanzania. Child abuse & neglect. 2006;30(12):1343-51.
18. Pitche P. Child sexual abuse and sexually transmitted infections in sub-saharan Africa. Med Trop (Mars). 2005 Nov;65(6):570-4. [PubMed]
19. Tallon J. Child sexual abuse: A review of the literature. Available from: http://www.usccb.org/nrb/johnjaystudy/litreview. accessed Aug,2014.
20. Jibril J. The Child Sexual Abuse Epidemic in Addis Ababa: Some Reflections on Reported Incidents, Psychosocial Consequences and Implication. Ethiop J Health Sci. 2012 March; 22(1): 59–66. [PubMed
21. Frank w. Ten-Year Research Update Review: Child Sexual Abuse J. AM. Acad.child adolesc.psychitry,42: 3,march 2003.
22. Dr Najat Maallam,jid . sexual abuse and exploitation of children in west and central Africa ,2008. P.11-13
23. Ismail Y, Joaquim S, Antonio P, Gloria M. A comparative study of the socioeconomic factors associated with childhood sexual abuse in sub-Saharan Africa, Pan African Medical Journal. 2012; 11:51 available online at: http://www.panafricanmedjournal. com/content/article/11/51/full/ accessed sep 2013.
24. Abdulkadir I, Umar LW, Musa HH, Musa S, Oyeniyi OA, Ayoola-Williams OM, et al. Child sexual abuse: A review of cases seen at General Hospital Suleja, Niger State. Ann Nigerian Med 2011;5:15-9.
25. Worku D, Gebremariam A, Jayalakshmi S. Child sexual abuse and its outcomes among high school students in southwest Ethiopia Jimma University, Medical School, Ethiopia. Trop Doct. 2006 Jul;36(3):137-40

26. Wondie Y, Zemene W, Tafesse B, Reschke K, Schröder H. The psychosocial consequences of child sexual abuse in Ethiopia: a case-control comparative analysis. JInterpers Violence. 2011 Jul;26(10):2025-41.
27. Meursing K, Vos T, Coutinho O, Moyo M, Mpofu S, OnekoO,et al Child sexual abuse in Matabeleland, Zimbabwe by Ministry of Health, Matabeleland AIDS Council, Bulawayo, Zimbabwe. SocSci Med. 1995 Dec;41(12):1693-704.
28. Radford, Lorraine, Corral, Susana, Bradley, Christine, et al. Child abuse and neglect in the UK today. London: NSPCC. 2011
29. Kurt Conklin, Child sexual, Advocates for Youth © February 2012.
30. Birdthistle IJ, Floyd S, Mwanasa S, Nyagadza A, Gwiza E, Glynn JR. Child sexual abuse and links to HIV and orphanhood in urban Zimbabwe. Journal of epidemiology and community health. 2011;65(12):1075-82.
31. . Kurt Conklin, Child sexual, Advocates for Youth © February 2012
32. Child Protect: The Montgomery Area Children's Advocacy Center (1999). Child abuse statistics. From http://www.childprotect.org/statistics.htmaccessed February 2014

8. Annex

English Questionnaires

Part I: Socio demographic characteristics of the child

1. Age
   - Under 1 year
   - 2-3 years
   - 4-5 years
   - 6-11 years
   - 12-18 years
2. Address(residence kefleketema) of the child
   - Addis Ketama
   - yeka
   - Akakykality
   - Arada
   - Bole
   - Gullele
   - kirkose
   - kolfekeranio
   - Lideta
   - Nifasilklafto
3. Educational status of the child
   - KG
   - Elementary
   - Secondary
   - College
   - Not started
   - Not send to school
4. Religion
   - Orthodox
   - Muslim
   - Catholic
   - Protestant
   - Other
5. Care taker (living condition) of the child
   - Both parents
   - Adopted
   - Relatives
   - Only father
   - Only mother
   - No care taker
   - Unknown

Part II. Socio demographic status of child family

6. Working condition of the family
   - Government employed
   - Private employed
   - Labor worker
   - Other Specify----------
7. Family problem
   - Divorced
   - Alcoholism

- Parent with mental illness
- Parental death
- No parental problem
- Unknown

Part III. General history of the child

8. Previous history of sexual abuse?
   - Yes
   - No
   - Unknown
9. Presence disability?
   - Yes
   - No
   - Unknown
10. Time of attack
    - Day time
    - Night time
    - Unknown
11. Place of attack
    - Own home
    - Neighbour
    - School
    - Unknown
12. Number of perpetrators to a child
    - One
    - Two
    - Three
    - Unknown
13. Type of sexual contact
    - Vaginal
    - Anal
    - Both (vaginal and anal)
    - Oral
    - Vaginal and oral
    - Others (specify -------------)
14. Physical examination documented during time of arrival
    - Normal
    - Minor injury
    - Newly hymen injury(torn)
    - Only discharge
    - Old torn hymen
    - Skin changes (bruise, rash etc)

- Anal laceration

15. Lab. Investigations done (indicate more than one if there)
    - Immediate HIV test done with result (Negative)
    - Immediate HIV test done with result (positive)
    - Pregnancy test done (negative)
    - Pregnancy test done (positive)
    - Victims HBsAg done (negative)
    - Victims HBsAg done (positive)
    - No investigation done
16. Who brought the child (victim) to the hospital (health centre)?
    - Family member (mother , father, sister, brother)
    - Police
    - Uncle
    - Aunt
    - Care giver
    - Her self
    - Others
17. Time of presentation of the victim to the hospital or health centre
    - Within 24 hrs
    - 24-48 hrs.
    - 48 hrs. - 7 days
    - 8 days - 30 days
    - >30 days
    - Others

Part IV: socio demographic characteristics of perpetrator

18. Sex
    - Male
    - Female
19. Age
    - 13-18 years
    - 19-24 years
    - 25-30 years
    - 31-35 years
    - 36-41 years
    - >42 years
    - not indicated

20. Relationship of the child or victim with perpetrator

- Family member (father, mother, brother, sister)
- Neighbour
- Friend
- Teacher
- Stranger
- Employer
- Other

21. type material used by the perpetrator during sexual attack

- Weapon
- Alcohol or drug
- Force (kick, hit, blow)
- Cheat (calling to their home to help for help but sexually abused)
- Verbally frustrated (verbally disappointed, tend to fear or not to tell to any one)

Declaration

The researcher, undersigned, declare that this is my original work and has not been presented in this or any other university and all sources of materials used for this thesis have been fully acknowledged.

Investigator Name: Getinet Assabu

Signature: ——————————

Date: ——————————

Place: Addis Ababa University, school of Health Sciences, Department of Emergency Medicine.

This thesis was submitted for examination with my approval as the university advisors.

Advisors:

1. Dr. Muluwork Tefera (MD, Associated professor)

   Signature:——————————

   Date:——————————

2. Mr Asmamaw Abebe (BSC, MEMCC)

   Signature: ——————————

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