Addis Ababa University College of Health Sciences, School of Allied Health Sciences, Department of Nursing and Midwifery

Postgraduate program

Prevalence and associated factors of child sexual abuse among children treated at Addis Ababa Governmental Hospitals, 2018

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A THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES, SCHOOL OF ALLIED HEALTH "NURSING AND MIDWIFERY DEPARTMENT" IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTERS OF SCIENCE IN "PEDIATRICS AND CHILD HEALTH NURSING"

JUNE, 2018

ADDIS-ABABA, ETHIOPIA

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ACKNOWLEDGEMENT

First of all I would like to extend my appreciation to Addis Ababa University for giving me this opportunity to conduct this research.

My sincere gratitude goes to my advisors Mr.Tadesse Bedada and Mr.Leul Derebe who have helped me in accomplishing this thesis by giving me very important suggestions.

I would like to thank and appreciate the effort made by the participant children and their parents.

Thanks to the staffs of the institutions where the study was conducted for their unreserved assistance and also I would like to acknowledge the staff nurses who voluntarily assisted me in communicating with the participant children as well as in data collection with full effort.

ABBREVIATION AND ACRONYMS

CSA-Child sexual abuse

HIV-Human immunodeficiency virus

OPD- Out patient department

SRS- Simple random sampling

STI-Sexually transmitted infection

UK-United Kingdom

UNICEF-United Nations International Children Education Fund

WHO-World Health Organization

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ABSTRACT

Background: - Child sexual abuse, including sexual assault or rape, is a major global public health problem. It has a short term and long term effect. Even if child sexual abuse is prevalent, it is often hidden, unseen or under-reported. Its hidden nature is also well documented

Objective:-It was to assess the prevalence and associated factors of child sexual abuse among children treated at A.A. governmental hospitals from March1-31, 2018.

Method: An institutional based cross-sectional study was conducted. The sample size was calculated using single population proportion. Three hospitals were selected by simple random sampling then the numbers of participants were proportionally allocated. Descriptive statistics was done to identify the distribution of all the independent variables and binary and multiple logistic regressions were used to identify and examine the multiple determinant factors of child sexual abuse.

Result-From the total of 450 sampled children all participated in the study with a 100% response rate. Prevalence of child sexual abuse was found to be 48.2% and experience of child sexual abuse was significantly associated with age of the child, sex (being female) (AOR=2.915; 95% CI; 1.835-4.631) a habit of taking alcohol (AOR=2.525; 95% CI; 1.461-4.363).consuming chat (AOR=3.839; 95% CI; 1.684-8.752) and smoking (AOR=3.834; 95%CI; 1.669-8.807).

Conclusion-The prevalence of child sexual abuse among children treated at A.A. Governmental Hospitals was high and was significantly associated with age sex and use of substances (alcohol consumption, smoking and chewing chat)

Recommendations-Behavioral and sexual education is very essential and. measures should be taken to encourage abused children to report to legal bodies.

Key words-Child sexual abuse, prevalence, associated factors

CHAPTER ONE: INTRODUCTION

1.1 Background

A 'child' is a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger.(1)

The World Health Organization defines “Child sexual abuse” as “the involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society. (2)

Two types of child sexual abuse are often distinguished. These are contact and non-contact sexual abuse. The contact abuse includes activities by penetration (for example, rape and oral sex.).The non-contact activities include forcing children in looking at, or in the production of sexual image, watching of sexual activities, encouraging children to behave or act sexually inappropriate ways, or grooming a child in preparation of abuse (3)

Child sexual abuse can result in long term and short term effects. Effects of child sexual abuse can be physical psychological and emotional. Physical harm to victims range from sexually transmitted diseases to pregnancy. These physical harm consequences the significant emotional and psychological damage imposed by the abuse.(4)

It can also lead to post traumatic stress symptoms where the abuse is not disclosed or discovered or where the children do not receive adequate help and support following a disclosure. (5)

A number of risk factors exposed children to sexual abuse with most factors being related to socio-economic status and family adversity. For example, a lower family income, parental drug and alcohol abuse and parental discord are associated with a higher risk of CSA. Living arrangement of the child and parent’s educational status had statistically significant association with childhood sexual abuse (6)

Demographic factors of children and their parents, alcohol and drug misuse, going, missing, running away, a poor relationship with parents, and isolated position combined

with a setting in which a trusted relationship is formed were some of the risk factors that predisposed children to sexual abuse (7)

Children usually show us rather than tell us that something is upsetting them, so being aware of the signs is vital. However children may show vague things. Their information may not be clear and they may not have the words to explain what is bothering them. The way adults respond to this is vital to ensure child's safety. So every care giver should respond with care and urgency. Believe the child, be supportive, stay calm, be caring, face the problem, re-establish safety and get help.(8)

For children sexually abused medical care evaluation is necessary. Vaginal swab microscopy, retroviral screening, post exposure prophylaxis for HIV and emergency contraceptive should be prescribed. The diagnosis and management of sexually transmitted disease is also an important component. (9)

1.2. Statement of the problem

Sexual abuse, including sexual assault or rape, of children and adolescents, is a major global public health problem, a violation of human rights, and has many health consequences in the short and long term. A 2011 systematic review and meta-analysis of the prevalence of child sexual abuse around the world places the prevalence among girls at around 20% and among boys at around 8% (10)

Child sexual abuse is a common and worldwide serious problem. In Europe the prevalence of childhood sexual abuse was found to be 6% to 36% of girls and 1% to 15% of boys younger than 16 years. (11)

The prevalence of child sexual abuse in Mexico was 18.7% and it was more frequent in girls (58%) than boys (42%). In South Africa the prevalence of female sexual abuse was 14.61% and that of males was 9.99%. (12, 13)

Child sexual abuse alone is accountable for about one per cent of the global burden of disease. It is also accountable for several other conditions like alcohol consumption, illegal drug usage, development of mental disorders, and spread of sexually transmitted diseases, which when pooled, are accountable for over 20% of the global burden.(14)

The global economic impacts and costs that results from the consequences of physical, psychological and sexual violence against children can be as high as $7 trillion. This massive cost is higher than the investment required in preventing all forms of violence. This makes all forms of child abuse as a major global economic problem.(15)

The protection of children from all forms of violence including child sexual abuse is a fundamental rights guaranteed by the “Convention of The Rights of the Child” and other treaties and standards. Yet the problem remains the major one around the globe regardless of the child’s economic, social circumstances, culture, religion or ethnicity with immediate and long term consequences. In spite of its high prevalence, violence against children is often hidden, unrecognized and unseen or under-reported. Its hidden nature is well documented. (16)

Child sexual abuse has a negative psychosocial outcomes and a high risk sexual behavior in adults. This has an impact in leading of a positive relationship with others. Preventing child sexual abuse in advance is the only solution to prevent negative psychosocial outcomes.(17)

Some of the sexual behaviors developed later in life due to childhood sexual abuse are unprotected sex, multiple partners, and engagement in transactional sex, which increase the risk of HIV and other sexually transmitted infections (16)

Many research studies have asked adults about their life time experience of childhood sexual abuse rather than children themselves, though abuse can have an impact on memory and the ability to recall. Rather this study was conducted using cross-sectional method because being sexually abused can lead some victims to block out the abuse so that they do not remember and do not want to remember parts of their childhood.(5)

One of the adverse effects of CSA is mental illness. In a study on the effects of childhood adversity on adult mental health conducted in South Africa, 39.1% of women and 16.7% of men had experienced sexual abuse in childhood.(18)

1.3. Significance of the study

The study will provide a better understanding for governmental policy makers, in provision of data that is essential in forward planning, especially by prioritizing budgeting, facilities, staffing and training with the aim of preventing of childhood sexual abuse.

It helps organizations who work on child based violence in creating of safe environment for children at school, home and around their living environment.

The community should have an awareness of child sexual abuse, its long term and short term impact of and its preventive methods. So this study will show the need of health education for the society through social media.

Other researchers also may share concepts with this study for further investigation of the problem by identifying the gaps as well as the limitation of the study. It also will give a good understanding and an insight of the problem for beginner researchers like me to act more upon this issue in the future.

Community health nurses as well as pediatric nurses play a major role in the prevention, early detection, treatment, referral and rehabilitation of victims of sexual abuse. They also play a great roll in prevention of sexual abuse. This study will help professionals in assessing of their knowledge, attitude, practices and degree of confidence and skill regarding in identification, treatment and referral of victims of sexual abuse.

CHAPTER TWO: LITERATURE REVIEW

2.1 Magnitude of child sexual abuse

According to the journal of " Family Medicine and Primary Care" the highest prevalence rate of CSA was seen in Africa (34.4%).Europe, America, and Asia had prevalence rate of 9.2%, 10.1%, and 23.9%, respectively. (2)

Cross sectional population based study conducted in Southern Brazil on "Child sexual abuse in southern Brazil and associated factors" show that the prevalence of reported sexual abuse in the sample was 3.9%; higher among girls (5.6%) than boys .Over 80%of all reported sexual abuse episodes took place before reaching 19 years of age, 63% happened before 15 years of age, 49%before 13 year, 27% before the children were 8years old, and 6%before reaching 4 years of age.(19)

A survey by United Nations International Children Education Fund (UNICEF) on demographic and health was conducted in India from 2005 to 2013, which reported that ten per cent of Indian girls have experienced sexual violence when they were 10–14 years of age and 30% during 15–19 years of age. Overall, nearly 42% of Indian girls have gone through the trauma of sexual violence before their teenage.(20)

A cohort study done by the Norwegian Institute of Public Health based on prevalence of sexual, physical and emotional abuse the Norwegian mother and child reported that 19% of the study participants had an experience of any type of childhood sexual abuse among women reporting any child abuse, 37% reported sexual abuse and women reporting any child abuse, 31% reported two or more types of child abuse. (21)

A study by Song et al. in China, found that about 33% of the participants reported sexual abuse. The lifetime burden of which was 41% for girls and 29.5% for boys (22)

Within Africa, studies consistently report high rates of child abuse, with prevalence as high as 64%. This review identified 23 quantitative studies, all of which showed high levels of child abuse in varying samples of children and adults. (23)

Lifetime exposure to sexual violence was reported by an average of 23% (9-33%) 13-15 year old school children from Namibia, Swaziland, Uganda, Zambia, and Zimbabwe.(24)

One school survey was done in Tanzania under the title of "Child sexual abuse in urban Tanzania: Possibilities and barriers for prevention" to assess the perceptions of key professionals and their experiences of handling cases of child sexual abuse and also to capture parents' experiences of legal reporting of child sexual abuse incidents. Qualitative and quantitative research design was used. The study reported that 56% (boys=30%, girls=26%) of the students were exposed to child sexual abuse, with boys more often affected than girls. 26% of boys and 19% of girls reported being forced to look at pornography. Forced sexual intercourse was experienced by 9.8% of boys and 8.7% of girls. (25)

A study was conducted in Swaziland, a land-locked country in southern Africa on "Risk factors associated with sexual violence towards girls in Swaziland" by using a two –stage cluster survey design to collect the sample. Data were collected in Swaziland from a nationally-representative sample of females ranging in age from 13-24 years. Information was collected from 1244 of 1292 eligible females for an overall response rate of 96%. 8.2% of females aged 13-14years, 14.4% of females aged 15-16 years, 12.7% of females aged 17-18 years, 22.1%of females aged 19-20 years, 13.1% of females aged 21-22years of age, 10.2%of females aged 23-24 years of age experienced sexual violence. (26)

In Ethiopia, A.A. one study was conducted in two tertiary hospitals Tikur Anbessa specialized hospital (TASH) and Yekatit 12 Hospital (Y12H) on topic "Time to presentation, pattern and immediate health effects alleged child sexual abuse: "from January 2011 to December 2012 by reviewing the chart of children less than 18 years old. They represented children who visited the OPD of the two hospitals during the study period. A total of 267(97.3%) cases visited the OPDs with alleged sexual abuse during the study period. The age range of sexual abuse was between 6 months and 18 years (median 9 years). The forms of sexual abuse included forced vaginal sex, 104(39.00%) ; forced anal sex, 3(1.10%); and finger vaginal penetration, 8 (3.00%).(27)

A Journal article under the title “The Child Sexual Abuse Epidemic in Addis Ababa: Some Reflections on Reported Incidents, Psychosocial Consequences and Implications” was published on March 2012. The study was conducted by collecting reported cases of childhood sexual abuse from Child Protection Units of Addis Ababa Police Commission and three selected non-governmental organizations working for the welfare of sexually abused children in Addis Ababa. Crime victim children 64 in number were included from the three organizations and they completed a semi-structured questionnaire and data were analyzed. Out of the 64 reported crime cases committed against children (between July 2005 and December 2006), 23% of them were child sexual victimization.(28)

A research titled “Prevalence of sexual abuse of male high school students in Addis Ababa, Ethiopia” was done using a cross-sectional descriptive method. 884 randomly selected students of nine high schools in Addis Ababa were involved. This study reported that life time prevalence of rape of male children was 4.3% and that of rape attempt was 8.7%. (29)

Another study conducted in Arbaminch town on “Childhood sexual abuse experiences and its associated factors among adolescent female high school students in Arbaminch town, Gammos Goff zone, Southern Ethiopia” used a mixed method of qualitative and quantitative study. The study was school based and cross-sectional. Among the total respondents, 11 % reported that they had experienced forceful sexual intercourse (rape) in their lifetime. Caressing breasts or genitals was reported by 28.7% of the students. Similarly, 29.3 % reported that they experienced unwelcome kissing. (30)

A cross sectional study was conducted in Bahir Dar private college students under the title “Prevalence and associated factors of sexual violence among private college female students in Bahir Dar city, North Western Ethiopia”. A total of 541 private college female students were involved in the study. Among the total respondents 37.3% of the participants reported any form of sexual violence. 35.8% sexual harassment was reported and 6.3% of them reported forceful intercourse (rape) in their life time.(31)

2.2. Risk factors associated with child sexual abuse

Child-level factors

Physical disabilities like deafness, blindness, and mental retardation were said to be associated with increased risk of being sexually abused. Children belonging to the lower socio-economic status were at higher risk. The absence of one or both biological parents, marital conflicts, and/or parental substance abuse increased the vulnerability. Children under the influence of alcohol/drugs were more susceptible.(32)

Delinquent behaviors during childhood (i.e., alcohol use, smoking, running away from home, and school maladjustment), lower economic status, those who lived in high-crime communities and living in major metropolitan areas were considered as the risk factors for child sexual abuse. (33)

The risk of experiencing sexual violence in childhood was higher among those who had no relationship with their biological mothers or parents as children. Childhood sexual violence was positively associated with the number of people the child lived with Also a child who lived with three or more families was significantly more likely to have experienced sexual violence before the age of 18 years. From violence–related risk factors studied, those considerably associated with sexual violence in childhood were having been physically or emotionally abused by an adult before they reach the age of 13 and knowing of another child who had been sexually assaulted. (34)

The risk of experiencing childhood sexual abuse was higher among children who lived alone and children who lived with others. Difference in school type, age, father or mother's education, family size and monthly household income of the students' parents were not considered as risk factors. (35)

Risk factors associated with child sexual abuse were found to be rural child hood residence, having a friend who drink alcohol (be male or female friends), no chance of discussion with parents. Substance use (chat chewing, drinking of alcohol), educational level of the child, marital status of their parents', current living condition of the child, and educational status of father were also found to be risk factors of sexual abuse. (36)

Parental and community-level factors

Risk factors were those characteristics associated with child abuse and neglect, of which may or may not be direct cause. A combination of individual, relational, community and social factors contributed to the risk of child abuse. Even though children are not responsible for the harm inflicted upon them, certain characteristics have been found to increase the risk of being maltreated. Age of the child, substance abuse and/mental health issues including depression in the family, parental low education, no biological transient caregivers in the home, social isolation, family disorganization and intimate partner violence, high poverty and residential instability were some of the risk factors. (37)

The majority of unwanted experiences were involved with older men in positions of authority, who approached participants when they were younger and the participant had little if any knowledge of sex. Family members, who had access to younger relatives, perpetrated instanced of abuse at younger ages.(38)

The identified key associated factors that were potential foci of child sexual and physical abuse were community-level factors (exposure to bullying, sexual violence, and rural/urban location), household-level factors (poverty, household violence and abuse, and non-nuclear family), caregiver-level factors (caregiver illness in especially AIDS and mental health problems, caregiver changes, family functioning, parenting, caregiver-child relationship, and substance abuse), and child-level factors (age, disability, physical health, behavior, and gender).(23)

Living configuration, parent's educational status, ever having a discussion with parents or guardians on sexuality and reproductive health, and monthly income had statistically significant association with CSA. (30)

The determinant of childhood sexual abuse were found to be marital status of the respondents' parents, living arrangement of the child, shortage of sexual education in the school, gender (being female),the presence of maladaptive behavior of student in the school. (39)

2.3. Conceptual framework.

This conceptual framework is developed from different literatures to assess the risk factors that predispose children to sexua abuse.(23, 30, 32, 40)

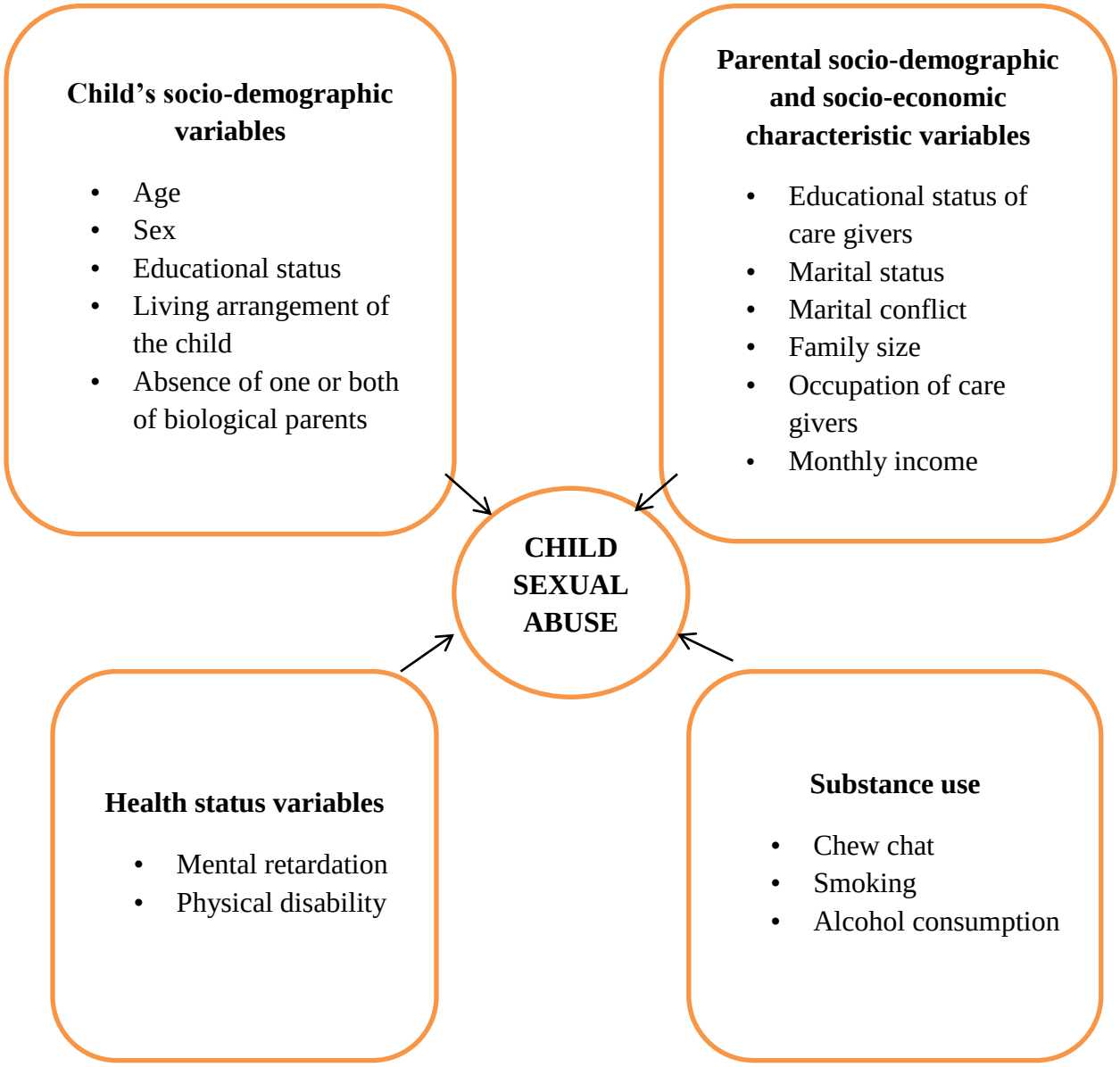

Figure 1- Conceptual framework indicating the association between the dependent and independent variable

CHAPTER THREE: OBJECTIVE OF THE STUDY

3.1. General objective

- To assess the prevalence and associated factors of child sexual abuse among children treated at A.A. governmental hospitals from March1-31, 2018.

3.2. Specific objectives

- To assess the prevalence of child sexual abuse among children treated at A.A. governmental hospitals from March1-31, 2018.
- To identify the factors associated with child sexual abuse among children treated at A.A. governmental hospitals from March1-31, 2018.

CHAPTER FOUR: METHODS

4.1. Study area and period

This study was conducted in Addis Ababa governmental hospitals, Ethiopia. Addis Ababa has more than 40 hospitals of which 11 are Government hospitals which give services to public. These are Tikur Anbessa Specialized Hospital, Menelik Hospital, Zewditu Hospital, Yekatit Hospital, Saint Paulos, St. Peter Hospital, Ras Desta Hospital, Alert Hospital, Tirunesh Beijing Hospital Ghandi Hospital and Amanuel Hospital.(41) However, in this study, only the government hospitals with pediatric departments were included except Gandhi Hospital and Amanuel Hospital which do not have pediatric units. So the study was conducted on the selected Governmental hospitals from January-June, 2018 and data collection period was from March1-31, 2018 to assess the prevalence and associated factors of child sexual abuse among children treated at A.A Governmental Hospitals, 2018.

4.2. Study design

An institutional based quantitative cross-sectional study design was employed to collect data from March1-31, 2018.

4.3. Population

4.3.1. Source population

The source population for this study was all children aged 7 years up to 18 years and who visited the governmental hospitals in seeking of medical care during the data collection period.

4.3.2. Study population

The study populations were all children aged 7 years up to 18years who visited the three selected governmental hospitals in seeking of medical care during the data collection period.

4.4. Inclusion and exclusion criteria.

4.4.1 .Inclusion criteria

Those children aged 7 years up to 18 years and who visited the selected institutions with their parents or guardians for any medical illness during the data collection period were included in the study. Orphans, street children and also those children who managed living by themselves were included in the study.

4.4.2. Exclusion criteria.

Those children below and above the age limits, who were very sick and were unable to communicate and children who have got parents or guardians and came alone were also excluded from the study.

4.5. Sample size and sampling techniques

The sample size was calculated using single population proportion formula with the following assumption. Prevalence of child sexual abuse obtained from previous study, which was done by collecting reported child sexual abuse cases from Child Protection Units of Addis Ababa Police Commission and three selected non-governmental organizations working for the welfare of sexually abused children in Addis Ababa with CI of 95% and 5% of margin of error between the sample and the underlying population was 23%. (42)

- 95% CI (z=1.96)
- Margin of error 5% (d)
- Prevalence of child sexual abuse 23% (42)

$n= z^2 p (1-P)/d^2$

n= (1.96×1.96) ×0.23(1- 0.23) / (0.05×0.05)

n=272

By adding 10% non-respondent sample size becomes 299.2 = 300. To minimize the variability across sampling to different OPDs in the three hospitals, design effect of 1.5 was used. So the sample size was 450. Then one third of the total number of governmental hospitals was taken and simple random sampling technique was used to select the hospitals. The selected hospitals are Yekatit 12 Hospital, Tikure Anbessa Specialized Hospital, and Zewditu Hospital.

4.5.1. Sampling procedure

For this study after the three hospitals were selected by simple random sampling, the numbers of the study populations were determined.

In the year 2017, from December 1 to February 28 a total of 21,735 children visited the selected three hospitals. Among these 950 children visited Zewditu Hospital, 4,907 children were treated at Yekatit 12 Hospital and 15,878 children were treated at Tikur Anbessa Specialized Hospital. Taking the average, children who came to Yekatit 12 hospital were 1,636 those who were treated at Zewditu Hospital were 317 and 5,293 children came to Tikur Anbessa Hospital in seeking of medical care per month. The total average children who visited the three institutions in seeking of medical care per month were 7,246.These numbers were proportionally allocated to the three selected hospitals.

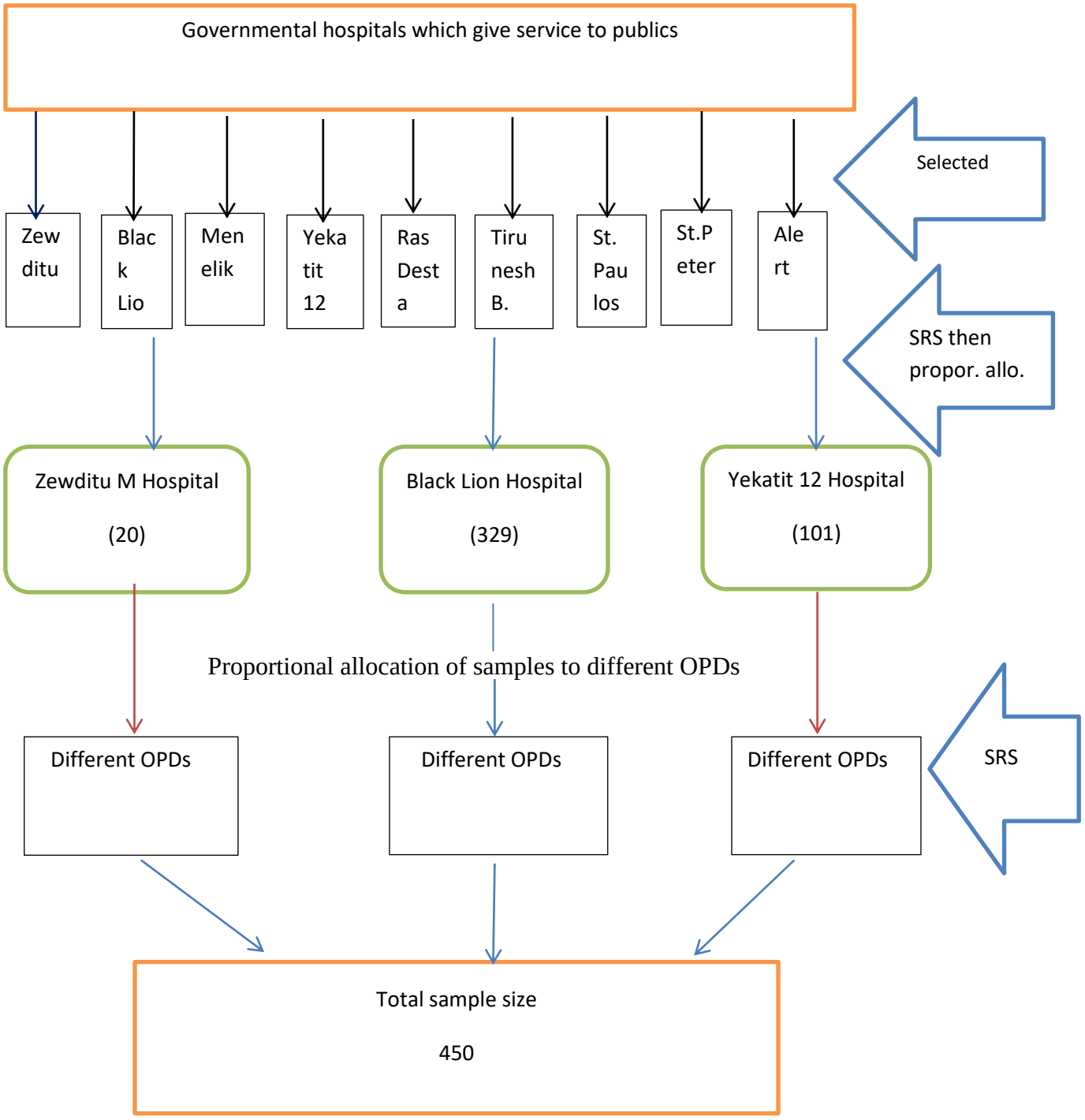

Figure 2. Proportional allocation of sample sizes to the three selected Hospitals which are selected using simple random sampling

N.B. SRS= simple random sampling

The allocated samples to each hospital were again proportionally allocated to different OPDs. Finally simple random sampling technique was employed to select the cards of the children before they were distributed to different departments.

4.6. Study variables

4.6.1. Dependent variables

Child sexual abuse

4.6.2. Independent variables

Child's socio-demographic variables

- Age
- Sex
- Educational status
- Living arrangement of the child
- Absence of one or both of biological parents

Parental socio-demographic and socio-economic characteristic variables

- Educational status of care giver
- Marital status
- Marital conflict
- Family size
- Parents' occupation
- Monthly income

Health status variables

- Mental retardation
- Physical disability

Substance use

- Chewing chat
- Smoking
- Alcohol consumption

4.7. Operational definition

Child sexual abuse-is a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation .It also includes sexual assault which is any act with a child without his or her consent through force or fraud.

Sexual contact:- The intentional touching of a victim's, defendant's, or any other person's intimate parts for the purpose of sexual arousal.

Rape: - to commit sex using force which the child does not want to and is not able to protect himself/herself.

Attempted rape:-: trial to have nonconsensual intercourse with a child where she was having a chance of escaping the attempt.

Life Time experience:-Any form of sexual abuse experienced by children during their childhood period as remembered. The forms of sexual abuse experiences can be contact and non- contact.

4.8. Data collection procedure and tool

Data was collected using an interview method. Child sexual abuse experience among children treated at Addis Ababa Governmental Hospitals was assessed by interviewing parents as well as children. The language that was used to assess the prevalence and associated factors of child sexual abuse was Amharic version and quality checkup was done immediately after collection of information from respondents. The tool was a validated one and is adopted from a previous study done on "Determinants of child sexual abuse among female high school students, Gondar, North West Ethiopia"(39) with some modifications. For its consistency pretest was done on 5% of the sample at Menelik

Hospital two weeks prior to the actual study and modification was made based on feedback from the pretest. The tool was used to collect data on socio demographic characteristics and other independent variables**.** It had four parts. Part one was used to assess the child's socio-demographic variables. Part two was used to assess parental socio-demographic and socio-economic characteristic variables. The last part was used to assess substance use history and the health status variables of the child. Part four assessed the types of child sexual abuse experiences.

4.9 Data quality assurance

Three BSc nurses received a 2 days intensive training on data collection techniques and were involved in the collection. Volunteer BSc staff nurses from the three hospitals also participated in data collection after training. Two MSc students were used as supervisors. General briefings on the objective of the study were given. The study participants were oriented about the purpose of the study and written assent was provided before data collection for those children who came with their parents or guardian. Written consent was also taken from orphans and children who managed themselves in their living and whose ages were in between the age limits. Data collection was supervised, and each interview technique was checked for appropriateness by the supervisor on a daily basis.

4.10. Data processing and analysis

After data collection was completed the variables was defined (coded). Before analysis, data was cleaned and edited. After that data was entered into Epi-data version 3.1 and analysis was done using SPSS version 21. Descriptive statistics was done to identify the distribution of socio-demographic characteristics and other independent variables of the study. Binary and multiple logistic regressions were used to identify and examine the multiple determinant factors of child sexual abuse. The association was declared significant at P value$\leq$0.05.

4.11. Ethical consideration

Ethical clearance letter was obtained from "Addis Ababa University, School of Allied Health Science Ethical Review Board" and an Ethical clearance letter was also obtained

from “Addis Ababa Regional Health Bureau- Ethical Review Committee” A permission letter was obtained from “Bureau of Ministry of Labor and Social Affair” to collect data from those children who did not have parents. Supportive letters were given to the hospitals where the study was conducted. Appropriate training was provided for data collectors and supervisors about the sensitivity of the issue. After a detail explanation of the purpose of the study, written consent and written assent was obtained accordingly from each study participants. Children who visited the hospitals for medical purposes had the right to participate and not to participate in the study. Participants who refused to participate in the study were not forced and they had the right to withdraw from the study at any time. Because of the sensitivity of the issue all the potential risks were assessed and participants’ privacy was secured while interviewing them. The actual victimized one child was linked to the appropriate place because it was the right of the participants to benefit from this study. All participants were treated equally with the same approach and without any incentive for their participation. Participants’ confidentiality was secured throughout the study period and data was secured safely so no other person can look at it.

4.12. Dissemination of the result

The final finding was defended as a master’s thesis at Addis Ababa University, School of Allied Health Science, Department of Nursing and Midwifery. The finding of the research was submitted to School of Allied Health Science and the result was also disseminated to Addis Ababa Health Bureau and to the institutions where the study was conducted.

The finding of this study could be used as a base line survey and provide as input for further studies on the subject, furthermore the finding may be published and disseminated through different journals and scientific publications.

CHAPTER 5: RESULT

5.1. Socio-demographic characteristics of the study participants

A total of 450 children participated in the study. Among the respondent children 226 (50.2%) were female children and 224 (49.8%) were male children. Among the participants 95 (21.1%) were under 10 years of age. 127 (28.2%) of the respondent' age were 10-14 years. The rest 228 (50.7%) participants' age were 15 and above. The minimum age of the participants was 7 and the greatest age was 18 and the mean age of the respondents was 13.67, with standard deviation 3.61.More than 38.9% of the respondents were below the mean age and 49.3% of the respondents were above the mean age.(Table 1)

In assessing the educational level of the study participants, among the 450 participants19 (4.2%) were uneducated, 248 (55.1%) were starting from grade 1 up to grade 8, those who were attending from grade 9 up to 12 were 136 (30.2%) and 47 (10.4%) of the study participants were above grade 12. Most of the study participants live with their parents.276 (61.3%) out 450 (100%) of them live with their parents. Those who live alone were 22 (4.9%), those who live with their father were 31 (6.9%). Out of the 450 children 46 (10.2%) live with their mother, 7 (1.6%) live with relatives and 12 (2.7%) live with person who has no relation at all. 315 (70%) participants' both or one of their parents were dead and 135 (30%) participants had one parent or both their parents were not alive. (Table.1)

Table 1 . Socio demographic characteristics of the study participants treated at Addis Ababa Governmental Hospitals, 2018, (n=450)

Characteristics	Number	%
Sex		
Male	224	49.8
Female	226	50.2
Age		
Under 10	95	21.1
10-14	127	28.2
15-18	228	50.7
Educational level		
Uneducated	19	4.2
1-8 grade	248	55.1
9-12 grade	136	30.2
Above 12 grade	47	10.4
Living arrangement		
Living alone	22	4.9
Living with both parents	276	61.3
Living with father	31	6.9
Living with mother	46	10.2
Living with friends	7	1.6
Living with relatives	56	12.4
Living with person who has no relation	12	2.7
Death of one or both parents		
Yes	315	30
No	135	70

The mean age of the participant was 13.6 years, with standard deviation 3.61 years.

5.2. Parental socio-demographic and socio-economic characteristics

The maximum number of the family members was 15 and the minimum was 1 with a mean of 4.9 and standard deviation of 2. Most of the study participants' family members ranged from 5 to 9. Out of the 450 participants 228 (50.7%) had 5-9 members. 211 (46.9%) of them have less than 4 family members and 11 (2.4%) of them had greater than 9 family members. (Table 3)

When we evaluated the educational level of their parents 112 (24.9%) female parents and 168 (37.3%) male parents were above grade 12.Out of the 450 study participants' parents 67 (14.9%) female parents and 91 (20.2%) male parents were educated 9-12 grade. 105 (23.3%) female parents and 72 (16%) male parents were educated up to grade eight.94 (20.9%) female parents and 31 (6.9%) were found to be uneducated. The rest 72 (16%) female parents and 31 (6.9%) male parents educational status were unidentified. (Table 3)

Most parents were married. That was 298 (66.2%) out of 450 (100%). Single parents were 13 (2.9%) and divorced parents were 25 (5.6%). One or both couples were not alive in 114 (25.3%) marriage. Parental conflict was reported in 186 (41.3%) marriages and 246 (58.7%) parents had no conflicts. (Table 3)

When evaluating the occupational status of participants' parents 156 (34.7%) male parents and 105 (23.3%) female parents worked at privately owned institutions or worked at their own private sector. 151 (33.6%) male parents and 115 (25.6%) female parents worked at governmental institutions. 18 (4%) of male parents and 6 (1.3%) of female parents retired from work. 50 (11.1%) of male parents and 159 (35.3%) of female parents did other tasks. 75 (16.7%) male parents and 65 (14.4%) female parents' occupation were unidentified. (Table 2)

The reported median monthly income was 3500 and the mode monthly income of the study participants' family was 2000 birr. The maximum monthly income of the participants' parents was 25,000 and the minimum was 400 birr. 85 (18.9%) of the family had an income <=1,600 birr. 126 (28%) of them had monthly income of 1651-3200 birr. Majority of them, that is 185 (41.1%) earned 3201-5200 birr per month. 36 (8%) of the family got

5251-7800 birr. Those whose income was 7801-10900 were 16 (3.6%) and 2 (4%) of the respondents' family had an income >10,900 birr. (Figure. 3)

Table 2- Parental socio-demographic and characteristics of the respondents' family among children treated at Addis Ababa. Governmental hospitals, 2018, (n=450)

Characteristics	Frequency	%
Family		
<=4	211	46.9
>4and<=9	228	50.7
>9	11	2.4
Parental or care givers' marital status		
Single	13	2.9
Married	298	66.2
Divorced	25	5.6
Partner not alive	114	25.3
Conflict between the respondent's parents or care givers		
Yes	186	41.3
No	264	58.7
Don't know	0	0
Male parent's or care giver's occupation		
Private and own	156	34.7
Governmental	151	33.6
Retired	18	4
Others	50	11.1
Don't know	75	16.7
Female parent's or care giver's occupation		
Private and own	105	23.3
Governmental	115	25.6
Retired	6	1.3
Others	159	35.3
Don't know	65	14.4

The median monthly income was 3500 and the mode monthly income of the study participants' family was 2000 birr

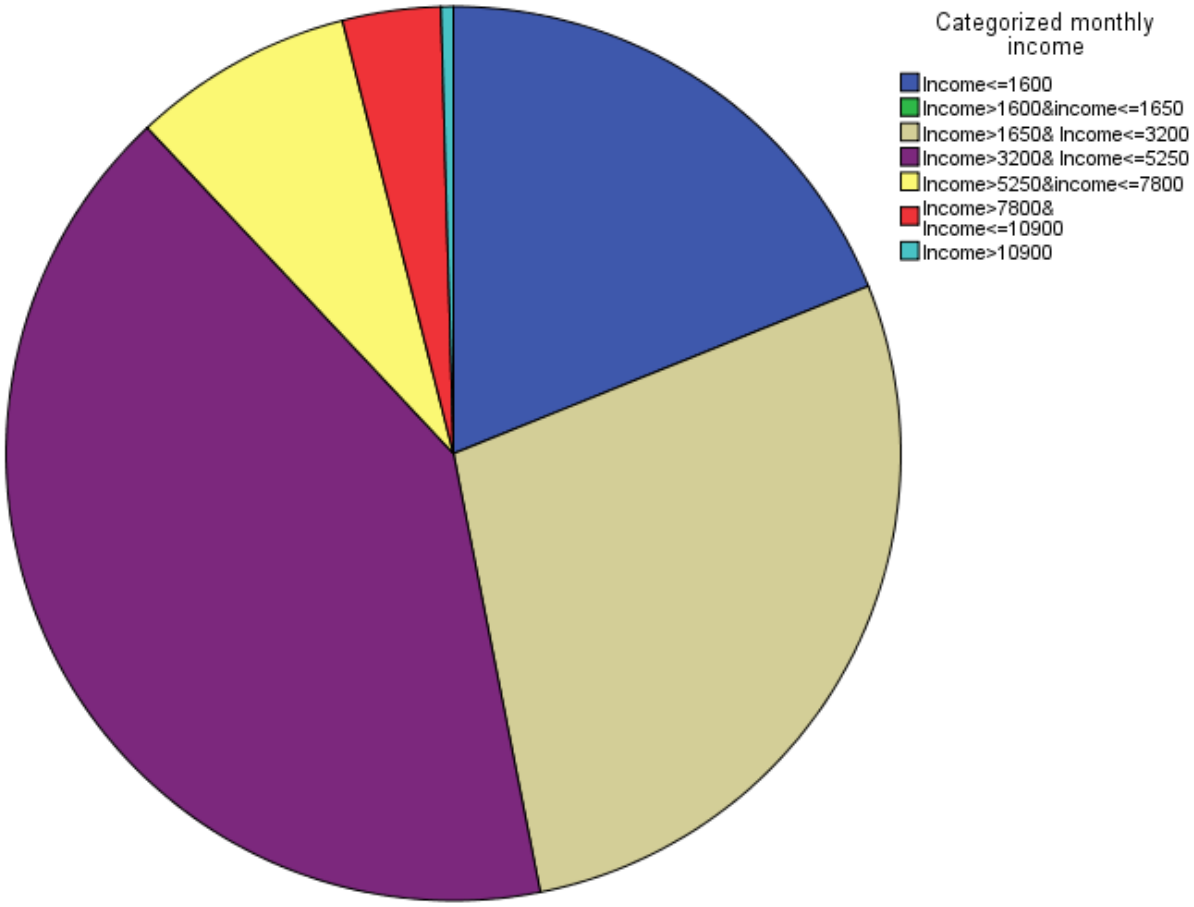

Figure 3: Monthly income of the Respondent's family among children treated at Addis Ababa Governmental Hospitals, 2018, (n=450)

5.3. History of substance use and health status of the respondents

Among the reported substance use history the most prevalent one was use of alcohol. Participant who reported that they used alcohol were 152 (33.8%).Among these 76 (16.9%) were males and 76 (16.9%) were females. The second prevalent reported substance use history was use of chat.83 (18.4 %) respondents reported that they consume chat. Among these 41 (9.1%) were males and 42 (9.3%) were females. 78 (17.3%) smoked.44 (9.8%) were males and 34 (7.6%) were females.(Table 4.)

Health status of the study participants was assessed and 22 (4.9%) of them had mental illness. Among these 14 (3.1%) of them were males and 8 (1.8%) were females.16 (3.6%) respondents had physical disability, 8 (1.8%) were males and 8 (1.8%) were females. (Table.3)

Table 3- Reported history of substance use and health status of the respondents among children treated at Addis Ababa Governmental Hospitals. (2018)

Characteristics	Male	Female	Total
	Frequency %	Frequency %	Frequency %
Use of Alcohol			
Yes	76 (16.9)	76 (16.9)	152 (33.8)
No	148 (32,9)	150 (33.3)	298 (66.2)
Use of Chat			
Yes	41 (9.1)	42 (9.3)	83 (18.4)
No	183 (40.7)	184 (40.9)	36 (81.6)
Habit of smoking			
Yes	44 (9.8)	34 (7.6)	78 (17.3)
No	180 (40)	192 (42.7)	372 (82.7)
Mental illness			
Yes	14 (3.1)	8 (1.8)	22 (4.9)
No	210 (46.7)	218 (48.4)	428 (95.1)
Physical disability			
Yes	8 (1.8)	8 (1.8)	16 (3.6)
No	216 (48)	218 (48.4)	434 (96.4)

5.4. Prevalence of sexual abuse

The overall prevalence of child sexual abuse was 48.2% and the frequency was 217, of which 84 (38.7%) males and 133 (61.3%) were females. The most prevalent type of sexual abuse was involuntary kissing with a frequency of 117 (26%), among these 17 (3.8%) were males and 100 (22.2%) were females. Those who were involuntarily touched and fondled were 105 (23.3%), males were 17 (3.8%) and females were 88(19.6%). The frequency of rape attempt was 94 (20.9%), 40 (8.9%) were males and 54 (12%) were females, and those who were raped were 54 (12%), males were 25 (5.6%) and females were 29 (6.4%). Among the study participants those who were encouraged to behave sexually were 29 (6.4%), 11 (2.4%) were males and 18 (4%) were females. Participants forced to look sexual activity were 66 (14.7%). Among these 25 (5.6%) were males and 41 (9.1%) were females. (Table.4)

Table 4- Prevalence of sexual abuse among children treated at Addis Ababa Governmental Hospitals, 2018 (n=450)

Characteristics	Male	Female	Total
	Frequency (%)	Frequency (%)	Frequency (%)
Kissed involuntarily			
Yes	17 (3.8)	100 (22.2)	117 (26)
No	207 (46)	126 (28)	333 (74)
Forced to look at sexual activities			
Yes	25 (5.6)	41 (9.1)	66 (14.7)
No	199 (44.2)	185 (41.1)	384 (85.3)
Encouraged to behave sexually			
Yes	11 (2.4)	18 (4)	29 (6.4)
No	213 (47.3)	208 (46.2)	421 (93.6)
Attempted rape			
Yes	40 (8.9)	54 (12)	94 (20.9)
No	184 (40.9)	172 (38.2)	356 (79.1)
Raped			
Yes	25 (5.6)	29 (6.4)	54 (12)
No	199 (44.2)	197 (43.6)	396 (88)
Touched and fondled			
Yes	17 (3.8)	88 (19.6)	105 (23.3)
No	207 (46)	138 (30.7)	345 (767)

5.5. Factors contributing to child sexual abuse

During the bivariate analysis factors which were associated with “Child sexual abuse” were assessed and variables like respondents’ age, sex, and educational level of the child and death of one or both parents were significantly with child sexual abuse. Other variables like consumption of alcohol, smoking and usage of chat were also significantly associated with the dependent variable. These variables were included in the final model to see the effect of individual variables on the dependent variable to control for potentially confounding variables.

At multivariate logistic regression respondents’ age, sex, usage of chat, smoking and consumption of alcohol were associated significantly. (Table 10)

The odds of experiencing child sexual abuse among children >9<=14 years old were higher than those children whose ages were <=9 (AOR=2.455; 95% CI; 1.216-4.959) and also the odds of experiencing child sexual abuse among children whose age were greater than 14 years were higher than those whose were <=9 (AOR=3.924; 95% CI; 1.704-9.039).

The odds of experiencing child sexual abuse were higher among females than male children (AOR=2.915; 95% CI; 1.835-4.631)

Respondents who consumed chat were 3.8 times more likely to be abused than those who did not consume chat (AOR=3.839; 95% CI; 1.684-8.752), the odds of experiencing child sexual abuse among children who smoked were higher than those children who did not smoke (AOR=3.834; 95%CI; 1.669-8.807). Children who drank alcohol were 2.5 times more likely to be abused sexually than those children who did not drink (AOR=2.525; 95% CI; 1.461-4.363). (Table 9)

Table 5--.Association of selected factors and child sexual abuse among children treated at Addis Ababa Governmental Hospitals, 2018, (n=450)

Variable categories	Sexually abused(n=212)		OR (95%CI for OR)	
	Yes	No	Crude OR	Adjusted OR
Age				
<=9	18	(8.3%)	1.00	1.00
>9<=14	52	(24.0%)	**2.966 (1.590-5.531)***	**2.455 (1.216-4.959)***
>14	147	(67.7%)	**7.763 (4.345-13.871)***	**3.924 (1.704-9.039)***
Sex				
Male	84	(38.7%)	1.00	1.00
Female	133	(61.3%)	**2.384 (1.632-3.481)***	**2.915(1.835-4.631)***
Educational level				
Uneducated	11	(5.1%)		
1-8 grade	93	(42.9%)	**.407 (.215-.770)***	
9-12 grade	85	(39.2%)		
Above grade 12	28	(12.9%)	1.00	
Death of one or both parents				
Yes	137	(63.1%)	**1.890 (1.255-2.846)***	
No	80	(36.9%)	1.00	
Use of chat				
Yes	72	(33.2%)	**10.021 (5.138-19.547)***	**3.839 (1.684-8.752)***
No	145	(66.8%)	1.00	1.00
Cigarette smoking				
Yes	68	(31.3%)	**10.177 (5.077-20.401)***	**3.834(1.669-8.807)***
No	149	(68.7%)	1.00	1.00
Alcohol consumption				
Yes	115	(53.0%)	**5.972 (3.843-9.283)***	**2.525 (1.461-4.363)***
No	102	(47.0%)	1.00	1.00

*** Statistically significant at P < .05**

CHAPTER 6: DISCUSSION

To the best of the author's knowledge, this is the first cross-sectional study done to estimate the prevalence and identify the risk factors of child sexual abuse among children treated at A. A. Governmental Hospitals and 450 sampled children were included in the study. From the total of 450 sampled children all participated in the study with a 100% response rate.

This finding, reported that prevalence of male sexual abuse was 38.7%. Those touched and fondled involuntarily were 3.8%, those who were involuntarily kissed were 3.8% and 5.6% of males were raped. This study also reported that children who had a habit of smoking and drinking alcohol were more likely to be sexually abused. Consistently a study done in South Korea reported that children who engaged in delinquency, such as alcohol use and smoking were more likely to be sexually abused. Contrarily the study done in South Korea reported that 13% of South Korean male children experienced one or more types of sexual abuse, 2.7% of male children were touched by or asked to touch the perpetrator's genitalia, 2.2% were kissed involuntarily and 1.7% of males were raped**(40)** which is a lower prevalence than this study. The difference in the prevalence of any form of sexual abuse between the two studies could be due to the difference in the study method used. The study done in South Korea in assessing of the prevalence and risk factors for male sexual abuse used a retrospective method by asking the respondents to recall their prior experiences of sexual victimization during childhood and it is obvious that child sexual abuse has an impact on memory and ability to recall theirs.

The finding of this report indicated that the most prevalent form of sexual abuse was unwanted kissing (26%) and any type of sexual abuse was 48.2%,(38.7%of boys vs 61.3% of girls) which was inconsistent with the study done in Tanzania which reported that the most prevalent form of sexual abuse experienced by children was being forced to watch pornographic materials (26%) and the prevalence of any type of sexual abuse was 56% (26%of female children vs 30% of male children).(25) This difference in the prevalence of any form of child sexual abuse could be because there is no single definition of child sexual abuse and most definitions take combination of factors into account, including

behaviors. Difference in advancement of technology could also determine which type of sexual abuse to be the most prevalent one.

This study's finding, reported that children who were under the influence of alcohol and substance use were highly vulnerable to child sexual abuse. Those who consumed chat were 3.8 times more likely to be sexually abused (AOR=3.839, 95%CI: 1.684-8.752). Physical disability, mental problem and marital conflict had no significant association with childhood sexual abuse consistently one study done in India reported that those children who were under the influence of substance use were 2.73 times at risk of child sexual abuse.(AOR=2.730,95%CI: 1.635-4.558) On the contrary, this study done in India reported that marital conflict, physical disability and mental illness had significant association with childhood sexual abuse **(32).**The possible explanation for the consistent report of the two findings could be because of the true association of child sexual abuse and a habit of substance use. On the contrary the inconsistent report of the two studies could be because of the difference in the knowledge and understanding of child protection and regular monitoring of their children.

Prevalence of completed rape of this study's finding was 12%, which was lower than that of study done in Addis Ababa, which was reported as 23%.**(28)** This high inconsistency could be because this study conducted in Addis Ababa was done by collecting reported child sexual abuse cases from Child Protection Units of Addis Ababa Police Commission and three selected non-governmental organizations working for the welfare of sexually abused children in Addis Ababa and all age groups who were under 18 years were included while this study participants' age were 7-18.

This study reported that completed rape of male children was 5.6% and that of rape attempt of male children was 8.9% and also in this finding parental educational level, family size monthly income of the family had no significant association with child sexual abuse which was consistent to the study done in Addis Ababa male high school students, which reported that rape attempt of male children was 8.7% and comparable to the report of completed rape of male children which was 4.3%. Considering risk factors, similarly to the study done in Addis Ababa male high school students parental educational level, family size and

monthly income of the family had no significant association with child sexual abuse **(29)** This consistency cold be due to similarity in the study area.

Report of completed rape of female children among children treated at Addis Ababa Governmental Hospitals was 6.4% and prevalence of unwanted kissing of female children was 22.2%. In addition, it was found that living configuration of children, parents' educational status and monthly income were found to have no association with childhood sexual abuse. On the contrary, a study done in Arbaminch town reported that living configuration of children, parents' educational status and monthly income were found to be risk factors of sexual abuse. Again, inconsistent to this report, the study done in Arbaminch reported that the prevalence of completed rape of female children was 11% and prevalence of unwanted kissing of female children was 29.3%. **(30).** The reason for lower prevalence of sexual abuse in this study and the reason why those factors did not associate with child sexual abuse could be due to awareness of the need of open discussion about sexual issue among family members even if parents were illiterate and had low income.

A study done in Gondar reported that marital status of participants' parents, living arrangement of children and sex of the child (being female) had association with child sexual abuse.**(39)** Unlike the report of the study done in Gondar, this study reported that marital status of participants' parents and living arrangement of children were not the determinant factors of child sexual abuse whereas consistently this study reported that sex (being female) had association with experience of child sexual abuse. The inconsistency in the risk factors could be explained as socio-cultural difference between the two study areas.

In this study the prevalence of completed rape of female children was 6.4%, consistent with that of the study done in Bahir Dar which was reported as 6.3% and also it reported that educational level and living arrangement of the child, substance use (chat chewing, drinking of alcohol), marital status of the child's parents, educational level of father were associated with child sexual abuse .On the other hand, this study done in Bahir Dar reported that the age of the child and monthly income of the family did not associate with experience of child sexual abuse.**(31)**. Consistently this study reported that monthly income of the family had no association with experience of childhood sexual abuse and a history of substance use had an association with experience of childhood sexual abuse. On the

contrary, this finding reported that the age of the child had association with experience of childhood sexual abuse whereas an educational level and living arrangement of the child, marital status of parents and educational level of the father did not associate with experience of childhood sexual abuse. The inconsistency could be due to the difference in study setting

CHAPTER 7: STRENGTH AND LIMITATION OF THE STUDY

7.1. Strengths

Most researches assessed lifetime prevalence of childhood sexual abuse. The strength of this study was that it didn't assess lifetime prevalence of sexual abuse so that those abused children will not have difficulty in recalling the incident.

7.2. Limitations

The method of this research was cross-sectional. This limited the interpretation of the estimated association because it may not explain the temporal relationship between the outcome variable and any explanatory independent variables. Under reporting of childhood sexual abuse is inevitable because the issue is very sensitive and some other reasons like age of the abused child, consequence of disclosure and also disclosure of childhood sexual abuse is limited due to the relationship between the abused child and the abuser. It was also difficult to assess some forms of child sexual abuse some among mentally ill children.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

8.1. Conclusions

The prevalence of child sexual abuse among children treated at A.A. Governmental Hospitals was high and experience of child sexual abuse was significantly associated with age and sex of the child Females were more likely to be sexually abused than males. The other risk factors identified were use of substances (alcohol consumption, smoking and chewing chat).

8.2. Recommendations

- Even though that all children need attention, based on the finding, it is recommended that sexual and behavioral education is very essential as children grows.
- Females are more at risk of sexual abuse than males. Due to this reason the necessary protection, education and monitoring of female children is very important.
- Measure should be taken to increase awareness about substance use and encourage abused children to report legal bodies.
- To protect children from sexual abuse is not only the responsibility of parents; rather it is the responsibility of teachers as well as the community members.

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ANNEXES.

Annex I- Information sheet

Addis Ababa University, College of Health Science, School of Allied Health Sciences

Information sheet and consent form in English

Information sheet

Dear participants ’

Hello my name is Sr. Messeret Takele I work for Addis Ababa University. We are conducting the survey in Addis Ababa Governmental Hospitals to learn about child sexual abuse and its associated factors. You have been chosen to participate in this study by chance.

We went to assure you that all answers will be kept strictly secret. The information you give us will be confidential and will be used only for study purpose. No names will be used if a report of the result is published; only summarized information of the total group will appear. No right and no wrong answer .If you are involuntary to be interviewed, you have the right not to participate. However, your participation could be very helpful to design appropriate intervention for identified problem. If there are things that require clarification you have the right to ask. If you have any question about this research project, please forward it to Sr. Messeret Takele, Addis Ababa University, A college Of Health Science, School of Allied Health Sciences. Phone number 0911622488

Assent form

In signing this document, I am giving my consent to allow my child to participate in the study and also to participate on behalf of my child which is entitled ‘Assessment of prevalence of child sexual abuse and its associated factors among children treated at Addis Ababa Governmental Hospitals”, Ethiopia

I have been informed that the purpose of this particular research project is to assess the prevalence and associated factors of child sexual abuse among children treated at Addis

Ababa Governmental Hospitals. I am also informed that the study will be done by conducting an interview. I am going to respond to this question by answering what I know concerning the issue. I am informed that the information I gave will be treated confidentially. I have also been informed that I can refuse to participate in the study or not to respond to question if I am not interested. Furthermore I have been informed that no money or incentives will be given for my participation in the study.. I understand that the results of this survey will have some input towards reducing the identified problem and Messeret Takele is the contact person if I have any question about the study and Messeret can be reached through a call at 0911622488.

I agree to participate _____ I disagree to participate_____

Signature_____ _____

Date _____

Thank you for spending your time.

Consent form

In signing this document, I am giving my consent to participate in the study entitled 'Assessment of prevalence of child sexual abuse and its associated factors among children treated at Addis Ababa Governmental Hospitals", Ethiopia

I have been informed that the purpose of this particular research project is to assess the prevalence and associated factors of child sexual abuse among children treated at Addis Ababa Governmental Hospitals. I am also informed that the study will be conducted through an interview I am going to respond to this question by answering what I know concerning the issue. I am also informed that the information I gave will be treated

confidentially. I have also been informed that I can refuse to participate in the study or not to respond to question if I am not interested. Furthermore I have been informed that no money or incentives will be given for my participation in the study. I understand that the results of this survey will have some input towards reducing the identified problem and Messeret Takele is the contact person if I have question about the study and Messeret can be reached through a call at 0911622488.

I agree to participate _____ I disagree to participate_____

Signature_____ Signature _____

Date _____

Thank you for spending your time.

Annex 2. Questionnaires

Questioners used in assessing of prevalence and factors that predispose children to sexual abuse

For each question, make a circle around a number that corresponds and for the answers fill the blank space.

Part 1.Socio-demografic characteristic of the child

No	Variable	Descriptive Categories
1.	Age	_____
2.	Sex	1. Male 2.No
3.	Level of education of the child	1. Do not go to school 3. 1-8 grade 4. 9-12 grade 5 12+
4.	Absence of one or both of biological parent	1. Yes 2.No
5.	Living arrangement of the child	1.Living alone 2,Father and mother 3Only with Father 4.Only with mother 5.With friends 6.With relatives 7.With person of no relation

Part 2 Parental socio economic and socio demographic characteristic variables

No	Variable	Descriptive Categories
1.	Educational status of the male care giver	1.Illetrate 2.Elementary 3.High School 4.12+ 5.I don't know
2	Educational status of the female care giver	1.Illetrate 2.Elementary 3.High School 4.12+ 5.I don't know
3.	Family size	_____
4.	Marital status	1.Single 2.Married 3.Divored 4.widowed
5.	Marital conflict between the child parents	1. Yes 2. No
6.	Male parent's occupation	1.Private 2.Government 3.Retired 4.Others 5.I don't know
7.	Female parent's occupation	1.Private 2.Government 3.Retired 4.Others 5.I don't know
8.	Monthly income	_____

Part 3.Substance use and child's health history

No	Variable	Descriptive Categories
1.	Alcohol use	1.Yes 2.No
2.	Smoking	1.Yes 2.No
3.	Chew chat	1.Yes 2.No
4.	Mental illness	1.Yes 2.No
5.	Physical disability	1.Yes 2.No

Part 4.Types of sexual abuse experiences

No	Variable	Descriptive Categories
1.	Involuntarily kissed	1.Yes 2.No
2.	Forced to look at sexual activities	1.Yes 2.No
3.	Encouraged to behave sexually	1.Yes 2.No
4.	Attempted rape	1.Yes 2.No
5.	Raped	1.Yes 2.No
6.	Touched and fondled	1.Yes 2.No

የአባሪ መረጃ ቅጽ

አዲስ አበባ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ ተባባሪ ጤና ሳይንስ ትምህርት ቤት

የመረጃ ቅጽና የስምምነት ቅጽ

የመረጃ ቅጽ

ውድ ተሳታፊዎች

ጤና ይስጥልኝ ስሜ ሲ/ር መሰረት ታከለ ይባላል። የምሰራው አዲስ አበባ ዩኒቨርሲቲ ውስጥ ነው። በአዲስ አበባ የመንግስት ሆስፒታሎች ውስጥ ስለ ህፃናት የወሲባዊ ጥቃት እና ተያያዥ ምክንያቶች ጥናት እያካሄድን እንገኛለን። በዚህ ጥናት ውስጥ እንዲሳተፉ በአጋጣሚ ተመርጠዋል። ልጅዎን በተመለከተ የሚሰጡት መልስ በከፍተኛ ሚስጥር እንደሚጠበቁ ልናረጋግጥልዎት እንወዳለን። የሰጧቸው መረጃዎች በሙሉ በሚስጥር የሚጠበቁና ለጥናቱ አገለግሎት ብቻ ጥቅም ላይ እንደሚውሉ እንገልጽልዎታለን። በሪፖርቱ ላይ የሚታከሙ ከሆነ ምንም አይነት ስም ሳይጠቀስ ከጠቅላላው ቡድን የተገኘው ጭምቅ ውጤት ብቻ ይፋ ይሆናል። ምንም አይነት ትክክለኛ እና ስህተት መልስ የለም። ራስን የተመለከቱ ጥያቄዎች በፍቃደኝነት የሚመለሱ ሲሆን የመሳተፍ ወይም ያለመሳተፍ መብትዎ የተጠበቀ ነው። ሆኖም ግን የእርስዎ ተሳትፎ የተገኘውን ችግር ለመከላከል አመቺ የሆነውን ዘዴ ለመንደፍ በጣም ጠቃሚ ነው። ምንም አይነት ስለጥያቄዎቹ ተጨማሪ ማብራሪያ ካስፈለገዎት ማንኛውም ጥያቄ ማቅረብ የሚችሉ ሲሆን ማንኛውንም ጥያቄዎች ለሲስተር መሰረት ታከለ አዲስ አበባ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ የጤና ሳይንስ ትብብር ትምህርት ቤት ስልክ ቁጥር 0911622488 ይደውሉ።

የስምምነት ቅጽ

ይህንን ሰነድ በመፈረም “በአዲስ አበባ የመንግስት ሆስፒታሎች ኢትዮጵያ የታከሙና የወሲብ ጥቃት የደረሰባቸው ልጆች የወሲብ ጥቃት መጋለጥና ተያያዥ ምክንያቶች” በሚለው ጥናት ውስጥ ለመሳተፍ ስምምነቴን ገልጫለሁ። m

የጥናቱ ዓላማ በአዲስ አበባ የመንግስት ሆስፒታሎች ህክምና ያገኙና የተጋላጭነታቸውንና ተያያዥ ጉዳዮችን የተመለከተ እንደሆነ ተገልጾልኛል። በተጨማሪም ጥያቄው በራስ የሚመለስና ስለ ጉዳዩ ያለኝን እውቀት በተመለከተ መልስ መስጠት እንደምችል ተገልጾልኛል። በተጨማሪም የሰጠሁትን ምላሽ በሚስጥር እንደሚያዝ ተገልፆልኛል። በተጨማሪም በጥናቱ ውስጥ አለመሳተፍ እንደምችል ወይም ፍላጎቱ በሌለኝ ጥያቄ ላይ መልስ አለመስጠት እንደምችል ተገልጾልኛል። በተጨማሪም በዚህ ጥናት ውስጥ በመሳተፌ ምክንያት የሚከፈለኝ ምንም አይነት ክፍያ ወይም ማበረታቻ እንደሌለ ተነግሮኛል። የዚህ ጥናት ውጤት የተገለፀውን ወይም የተለየውን ችግር መቀነሻ ዘዴ ለማመንጨት የሚረዳ እንደሆነ ተረድቻለሁ እናም መሰረት ታከለ በጥናቱ ዙሪያ ጥያቄዎች ካሉኝ የማገኛቸውና በስልክ ቁጥር 0911622488 ደውዬ ላገኛት እንደምችል ገብቶኛል።

ለመሳተፍ ተስማምቻለሁ _____ ለመሳተፍ አልተስማማሁም

ፊርማ፡ _____ ፊርማ _____

ቀን _____ ቀን _____

ጊዜዎን ስለሰጡን እናመሰግናለን

አባሪ

ልጆች ላይ የወሲብ ጥቃት እንዲደርስባቸው የሚያጋልጡ ምክንያቶች ለመፈተሽ የቀረበ መጠይቅ

በእያንዳንዱ ጥያቄ በቁጥሩ ትክክል ያክብቡበት እንዲሁም ለመልሶች ባዶ ቦታዎችን ይሙሉ

ክፍል 1፡የልጁ የግል መረጃዎች

ቁጥር	አማራጮች	የመልስ ምድብ
1	እድሜ	_____
2	ፆታ	1 ወንድ 2 ሴት
3	የልጅ የትምህርት ደረጃ	1. ትምህርት ቤት አልገባም 2. 1-8ኛ ክፍል 3. 9-12ኛ ክፍል 4. 12+
4.	እናት ወይም አባት በህይወት አለመኖር	1. አዎ 2. አይ
5	የልጁ አኗኗር ሁኔታ	1. ብቻውን ይኖራል 2. ከእናትና አባቱ ጋር ይኖራል 3. ከአባት ጋር ብቻ 4. ከእናት ጋር ብቻ 5. ከጓደኞቹ ጋር ይኖራል 6. ከዘመድ ጋር ይኖራል 7. ከባዕድ ጋር

ክፍል 2፡ የወላጅ ማህበራዊ እና ኢኮኖሚያዊ ደረጃ አመልካች ምክንያቶች

ቁጥር	አማራጮች	የመልስ፡ ምድብ
1.	የጋብቻ ሁኔታ	1. ያላገባ 2. ያገባ 3. የፈታ 4. በሞት፡የተለየዉ
2.	የወንድ ተከባካቢው፡ የትምህርት፡ ደረጃ	1. ያልተማረ 2. 1-8 ክፍል 3. 9-12 ክፍል 4. ከ 12 በላይ 5. አላዉቅም
3.	የሴት ተከባካቢው የትምህርት ደረጃ	1. ያልተማረ 2. 1-8 ክፍል 3. 9-12 ክፍል 4. ከ 12 በላይ 5. አላዉቅም
4.	የቤተሰብ፡ አባላት ቁጥር	_____
5.	ግጭት በወላጆች ወይም በተከባካቢው መሃል	1. አለ 2. የለም
6..	የወንድ ተከባካቢው፡ የስራ፡አይነት	1. የግል 2.የመንግስት 3. ጡረተኛ 4. ሌላ 5. አላዉቅም
7.	የሴት ተከባካቢው የስራ፡አይነት	1. የግል 2. የመንግስት 3.ጡረተኛ 4. ሌላ 5. አላዉቅም
8.	የቤተሰቡ ወርሃዊ ገቢ	_____

ክፍል 3፡ የሱሰኝነትና የልጁ የጤና ታሪክ

ቁጥር	አማራጮች	መልስ
1	የአልኮል ተጠቃሚነት	----------
2.	ጫት መቃም	1. አዎ 2. የለም
3.	ማጨስ	3. አዎ 4. የለም
4.	የአእምሮ ህመም	1. አለ 2. የለም
5.	የአካል ጉዳት	1. አለ 2. የለም

ክፍል 4፡ የወሲብ ጥቃት ልምዶች አይነት

1.	ያለፈቃድ መሳም	1. አለ 2. የለም
2	በግድ የወሲብ እንቅስቃሴዎችን እንዲመለከቱ ማድረግ	1. አለ 2. የለም
3	በወሲባዊ ምልከታ እንዲታዩ ማበረታታት	1. አለ 2. የለም
4	የአስገድዶ መድፈር ሙከራ	1. አለ 2. የለም
5	አስገድዶ መድፈር	1. አለ 2. የለም
6	የወሲብ አካላትን መንካትና ማጥቃት	1. አለ 2. የለም