



Full Length Research Paper

Child sexual abuse: a review of cases presenting at the out patient clinic of a tertiary health centre in Bayelsa State, Nigeria

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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. Thus, this study was conducted to describe the pattern of sexual abuse among children presenting to the Children's Out-patient (CHOP) of the Niger Delta University Teaching Hospital Okolobiri, Bayelsa State, Nigeria by a retrospective analysis of case notes. Of the 12,229 children seen at the CHOP, 33 (32 females, 1 male) were reported to have been sexually abused accounting for 0.3% of the Paediatric out-patient visits. The mean age of the sexually abused children was 7.9 ± 4.0 years. Most of the sexual acts; 14 (70.0%) occurred in a residence and 7(21.2%) children reported it to be forceful. The perpetrators were mostly males (96.7%), adolescents (35.0%) and known to the abused children (66.7%). Nine (27.3%) of the children reported to the hospital within 72 hours of the abuse. The mode of sexual abuse in the majority (87.9%) of cases was genital-genital contact. Common presenting complaints included vaginal bleeding, vaginal/perineal pain, vaginal discharge and changes in behaviour. HIV screening was requested in 29 (87.9%) of the affected children and was reported to be negative in all the 18 children who were eventually tested. None of the children were referred for counselling and majority were lost to follow-up. In this sample of sexually abused children, the victims were mainly vulnerable premenarchial females who were abused at home by trusted males. Increased public awareness, accessibility to child social services and training of health care workers on appropriate management of cases is advocated.

Keywords: Child, sexual abuse, pattern, hospital, Bayelsa, Nigeria.

INTRODUCTION

Child sexual abuse (CSA) is an important social problem worldwide which affects the physical, mental and psychological health of a child. 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 (World Health Organisation, 1999). It may include physical contact (fondling a child's genitals, masturbation, oral-genital contact, digital penetration, vaginal and anal intercourse) or noncontact abuse (exhibitionism, voyeurism, and child pornography) (Child sexual abuse, 2014). It usually

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involves coercion of the unsuspecting victim through trickery or bribery or it could be forceful; with acts ranging from rape to unwanted fondling (World Health Organisation, 2003). Despite the adoption of the Childs Right Act by Nigeria in 2003, which protects children against sexual abuse and exploitation, (A bill for an act to provide and protect the right of the Nigerian child and other related matters 2003) it remains a crime that occurs not just in Nigeria but also throughout the world, in different settings, across various socioeconomic backgrounds and is punishable under the law (World Health Organisation, 2003; Yahaya et al., 2012; United Nations Convention on the Rights of the child, 1989).

The prevalence of CSA has been difficult to ascertain due to many factors such as differing definitions and perceptions on what constitutes sexual abuse in children (Child sexual abuse, 2014), under reporting of the crime (Johnson, 2006) and different settings where studies have been conducted thus making comparisons difficult (Jemal, 2012). Some studies use a narrow definition of CSA to include contact abuse and intercourse only (Andrews et al.). Other authors classify some sociocultural practices like child marriage and female genital cutting as forms of CSA (Lalor, 2004; Olusanya et al., 1986). The definition of CSA also differs with the age cut-off used to define childhood (Andrews et al.), though 18 years is generally used in most countries (A bill for an act to provide and protect the right of the Nigerian child and other related matters 2003). CSA is generally under reported due to lack of or delayed disclosure by the victims (World Health Organisation, 2003) which may be as a result of the inability of the child to understand that the behaviour is inappropriate or harmful, poor communication skills especially in the very young or disabled, feelings of guilt and shame by the victims or fear of the perpetrator (Do children sexually abuse other children? Preventing sexual abuse among children and youth 2014).

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 labor, vesico-vaginal and recto-vaginal fistulas (Lalor, 2008). CSA is also associated with high risk behaviours such as prostitution, multiple sexual partners, substance abuse, delinquency in later life (Ogunyemi, 2000; Watts and Zimmerman, 2002; Olley, 2008) and psychological problems like feelings of vulnerability, shame, guilt, fear, poor self-esteem and depression (Andrews et al.; Ogunyemi, 2000).

Several community and school based studies on CSA have been conducted in Nigeria (Olusanya et al., 1986; Ogunyemi, 2000; Omorodion, 1994) and other parts of Africa (Pereda et al., 2009; Madu and Peltzer, 2001; Lalor,

2004) and these indicate that it is a growing concern in Africa. Thus, the aim of this study was to describe the pattern of sexual abuse among children presenting to the out-patient clinic of a tertiary hospital in Bayelsa State, South-South Nigeria with the aim of identifying mitigating factors underlying its occurrence and proffering solutions to curbing this heinous crime.

METHODOLOGY

Study centre

The Niger Delta University Teaching Hospital is a tertiary health centre located in Okolobiri, a sub urban community in Bayelsa State Nigeria. It was formerly a general hospital, but was converted to a Teaching hospital in September 2007. It is located about 10km from Yenagoa the state capital and serves as a referral hospital for the primary and secondary health centres surrounding it; as well as providing primary health care to the locals who live within the community and its environs.

The Paediatric Department comprises of the Children's outpatient clinics, Children's emergency ward and Children's medical and surgical wards and the Special Care Baby Unit. The Paediatric Outpatient clinics which run from 8am to 3pm from Monday to Friday and comprise of a daily general clinic and thrice weekly specialist clinics with approximately 200-300 children being seen on an outpatient basis each month.

Data collection

This was a descriptive retrospective review of the case records of children who had been sexually abused over a 4 year period (1st December 2009 to 30th November 2013). The register of the outpatient clinic was perused and diagnoses such as "sexual abuse", "sexual assault" or "rape" were used to identify the cases as a coding system is not used in the hospital. These case notes were subsequently retrieved from the Medical Records Department of the hospital and analysed. Information obtained from the case notes and entered in a proforma, included the child's age, sex, presenting complaints, and physical findings on examination. The interval between the time of the abuse and the victims presentation at the hospital was also noted. The relationship of the perpetrator to the affected child, the perpetrators' age and sex, mode of sexual abuse and the place the abuse occurred were also documented. The tests carried out on the child and/or perpetrators and their results were also noted. The identity of the sexually abused children was protected by not including their names in the proforma

Table 1. Age and sex of the sexually abused children and the perpetrators

Variable	Frequency	Percentage (%)
Sex of children	n=33	
Female	32	97.0
Male	1	3.0
Age of children (years)	n=33	100.0
1-5	10	30.3
6-10	14	42.4
11-15	9	27.3
16-20	0	0.0
Sex of perpetrators	n=33	100.0
Male	32	97.0
Female	1	3.0
Age of perpetrators (years)	n=20	100.0
13-18	7	35.0
19-24	4	20.0
25-30	1	5.0
31-36	0	0.0
37-42	6	30.0
>42	2	10.0

Ethical consideration

Ethical clearance was obtained from the Research and Ethics Committee of the Niger Delta University Teaching Hospital, Bayelsa.

Data analysis

Data was entered into a computer using Microsoft Excel and analysis comprised of calculation of ratios, means and standard deviation. Frequencies and proportions presented in tables.

RESULTS

Over the study period, a total of 12,229 children were seen at the Children's Outpatient (CHOP) clinic of the NDUTH. Out of these, 33 children (32 females and 1 male) had a diagnosis involving child sexual abuse accounting for 0.3% of the total out-patient visits over the study period.

The ages of the children ranged from 1 year 10 months to 15 years (mean age 7.9 ± 4.0 years) with 42.4% of the children aged between 6 and 10 years.

Of the 33 perpetrators, 32 were male and 1 was female. The ages of the perpetrators were known in 20 cases (60.6%) and ranged from 13 to 70 years; mean age was 27.7 ± 14.8 years. Seven (35.0%) of the

perpetrators were less than 18 years old. (See Table 1)

The perpetrators were known to the victim in 20 (66.7%) cases, out of which five were the child's relatives. Ten (33.3%) of the perpetrators were strangers. The relationship of the victim to the perpetrator was not documented in 3 cases.

The location of the abuse was noted in 20 (66.7%) of the cases and most (14 (70.0%)) occurred in a residence, either the child's or the perpetrators house (see Table 2 and 3).

Six (18.2%) of the children disclosed a prior sexual abuse; four of them by the same perpetrator. Twenty-three (69.7%) of the perpetrators were caught after the act by the parents or care givers of the abused children but only five (21.7%) of them were reported to the police.

All the affected children and/or their parents gave a positive history of sexual abuse. The sexual abuse was discovered after parents/care givers noted the presence of the symptoms in 9 (27.3%) children, 6 (18.1%) children disclosed the abuse to their parents, 2 (6.1%) were caught in the act while 1 (3.0%) was discovered to be pregnant. In 7 (21.2%) children, the sexual abuse was an incidental finding during investigations for other symptoms such as constipation and changes in behaviour.

At presentation in the hospital, 28 (84.8%) children had physical symptoms suggestive of sexual abuse and the most common physical presenting complaint was the presence of vaginal bleeding and pain (see Table 4). One of these children, a 15 year old female presented with features of post-abort sepsis and was subsequently

Table 2. Relationship between the victim and the perpetrator (n=30)

Relationship between the victim and perpetrator(n=30)	Frequency (%)
Stranger	10(33.3%)
Neighbour	10(33.3)
Uncle	3(10.0%)
Family friend	2(6.7%)
Classmate	2(6.7%)
Step brother	1(3.3%)
Cousin	1(3.3%)
Teacher	1(3.3%)

Table 3. Location of the sexual abuse

Location of the sexual abuse(n=20)	Frequency (%)
Child's house	8(40.0%)
Perpetuators house	6(30.0%)
In the bush	2(10.0%)
Uncompleted building	2(10.0%)
Behind the house in a shared compound	1(5.0%)
Classroom	1(5.0%)

Table 4. Presenting complaints and genital findings seen in the sexually abused children

★Presenting complaints	Frequency(%)
Vaginal bleeding	9(27.2%)
Vaginal/perineal pain	7(21.2%)
Vaginal discharge	6(18.2%)
Abdominal pain	5(15.5%)
Behavioural changes–withdrawal, fear, apprehension	5(15.5%)
Urinary and fecal incontinence (±vaginal prolapse)	3(9.1%)
Semen at vaginal orifice	2(6.1%)
Dysuria	2(6.1%)
Anal pains	2(6.1%)
Rectal bleeding	1(3.0%)
No symptoms; incidental finding	5(15.2%)
★Genital findings at presentation	
Ruptured hymen	18(54.5%)
Erythematous vaginal wall/vulva	10(30.3%)
Bruises around vaginal orifice	6(18.2%)
Supra-pubic/abdominal/cervical tenderness	3(9.1%)
Urethral prolapse	2(6.1%)
Anal tears± fissures	2(6.1%)

Some had more than one presenting complaint or genital finding

admitted into the gynaecology emergency ward and managed. The most common genital injuries noted at presentation were the presence of disrupted hymen and erythema of the vaginal wall. However ten (30.3%)

children presented with more than one genital injury.

The time interval between the occurrence of the sexual abuse and presentation at the hospital ranged from 3

hours to 4 months. Nineteen (57.6%) of the children presented to the hospital within a week of the assault. However, only 9 (27.3%) of the affected children presented to the hospital within 72 hours of the abuse out of which 6 (66.7%) of them presented within 24 hours.

The act was reported to be forceful in 7(21.2%) cases where it was associated with strangling, gagging or use of herbal concoctions to sedate the child while in the rest it was associated with various forms of coercion such as bribery with gifts and money. The mode of sexual abuse in the majority, 29(87.9%) involved genital-genital contact while digital-genital contact and anal-genital contact was reported in 7(21.2%) and 4(12.1%) of cases respectively. No case of oral-genital contact was reported. Seven (21.1%) children reported more than one mode of sexual abuse.

At presentation, 29 (87.9%) children and their parents were counselled for Human Immunodeficiency virus (HIV) screening but only 18 (62.1%) of them were tested and all were negative. Of these 18 children, 6 (33.3%) of them had presented within 24 hours of the sexual abuse and were all offered post exposure prophylaxis. Six (18.2%) children came for follow-up but for other illnesses; out of these only one child had a repeat retroviral screening test done six weeks later which was negative.

High Vaginal Swab (HVS) microscopy, culture and sensitivity was requested in 20 (60.6%) of the victims, but carried out in only 5(15.1%) and the cultures yielded *Escherichia coli* in 2 children, *Streptococcal pneumonia*, *Candida species* and *Proteus species* in 1 child each. No culture or testing was done for gonorrhoea or chlamydia. Other tests carried out on the affected children included screening for Syphilis in 9(27.3%) children and screening for Hepatitis B surface antigen and Hepatitis C virus in 4 (12.1%) children each. All the results were negative at presentation, but no repeat tests were done.

Only 4 (12.1%) children had attained menarche, of which only one presented to the hospital within 24 hours of the sexual assault and was given emergency contraception. In spite of the fact that 23(70.0%) perpetrators were caught, only one was present at the hospital and was tested for HIV and other STIs which were all negative, however no repeat tests were done.

DISCUSSION

Child sexual abuse accounted for 0.3% of the paediatric out-patient visits in the present study. This low number of cases seen in our hospital is similar to reports from other hospital based studies in Nigeria (Chinawa et al., 2013) and other parts of Africa (Girgira et al., 2004) but is not representative of the burden of CSA in Africa (Lalor, 2004; Madu and Peltzer, 2001; Omorodion, 1994; Ogunyemi, 2000; Jewkes et al., 2002). With the definition of CSA comprising of both contact and non contact abuse (Child sexual abuse, 2014), studies have found that

most cases of abuse remain underreported because they are done in secrecy and usually leave no physical symptoms (Kellogg, 2005). The lack of physical symptoms may have contributed to the low number who presented at the hospital. Underreporting of cases of CSA in the hospital has been attributed to be due to lack of knowledge of the appropriateness of obtaining medical care after CSA (Kellogg, 2005), lack of belief or support from the family of the victims (Do children sexually abuse other children? Preventing sexual abuse among children and youth 2014), poor access to the health facilities (Jemal, 2012) and the issue of "settling it within the family" in most African settings (The Second International Conference in Africa on Child sexual abuse, 2013). Another reason for under reporting of cases could be due to delay in disclosure of the abuse by affected children as seen in the present study where less than 20% of the victims reported the act to their parents. Disclosure is often delayed in children due to feelings of shame, fear of being blamed or the lack of understanding that the sexual behaviour is inappropriate or harmful (World Health Organisation, 2003; Do children sexually abuse other children? Preventing sexual abuse among children and youth 2014). Poor knowledge and perception of CSA has been reported among secondary school students in Ghana (Sika and Nnorom, 2013) and Nigeria (Eke et al., 2011). Eke *et al* (2011) in Nigeria, in a study of the perception of rape among secondary school children aged 10 to 20 years reported that only 4% of the children knew that sex between a child and an adult was rape. Also, in a study of 414 secondary school students in South Africa, 86.7% of the victims did not perceive themselves to have been sexually abused (Madu and Peltzer, 2001). Children have been shown to be targets of abuse because they are "trusting" and thus, easier to seduce and manipulate and have little or no knowledge about appropriate sexual behaviour (Johnson, 2006).

In this study, most of the affected children were females between the ages of 6 and 10 years old. This is similar to reports from other authors (Lalor, 2004; Chinawa et al., 2013; Girgira et al., 2014; Jewkes et al., 2002; Kellogg, 2005). Daru *et al* (2011) in a study of rape cases in Jos, Nigeria reported that 63.8% of the cases involved female children less than 16 years. Omorodion and Olusanya (1998) reported that 83% of 396 rape victims who reported to the police clinics were girls aged 13 to 19 years (Omorodion and Olusanya, 1998). In South Africa, more than a third of females have experienced some form of sexual abuse before the age of 18 years (Jewkes et al., 2002). The increased vulnerability of girls to sexual abuse in Africa has been attributed to a breakdown in the traditional child care system, poverty, the myth that sex with a virgin was a "cure" for HIV/AIDS and the lowly position of girls in the society (Lalor, 2004). The low reporting of male sexual abuse in this study has also been noted by other authors (Chinawa et al., 2013). However, male sexual abuse is believed to be more

common now than previously thought as boys may experience sexual abuse as often as girls but are less likely to disclose it (Kellogg, 2005). Some studies have shown as many as 31% of all male children less than 18 years in some settings are reported to have been sexually abused (Moody, 1999).

The characteristics of the perpetrators in this study are similar to reports from several studies, where about 20% of all cases of CSA are committed by male adolescents (Girgira et al., 2014; Kellogg, 2005). Females have been found to be perpetrators in 14% of cases reported against boys and 6% against girls (Child sexual abuse, 2014). The occurrence of cases of child abuse by known perpetrators has been reported by other authors (Yahaya et al., 2012; Jemal, 2012; Lalor, 2004; Lalor, 2004; Daru et al., 2011; Whealin, 2007). However, in the present study intra-familial cases accounted for 16.7% of cases, similar to the 13.4% reported by Girgira in Ethiopia (Girgira et al., 2014) but lower than the 30 to 40% reported by other authors (Child sexual abuse, 2014; Jemal, 2012; Whealin, 2007). The lower rate in this study could be due to the fact that in Africa most cases of incest are settled within the family (Johnson, 2006; Lalor, 2004). Parents have been found to be more likely to report the case to the authorities if the perpetrator was not a family member (Johnson, 2006). However, out of court settlements in CSA cases has been reported in some countries in Africa (The Second International Conference in Africa on Child sexual abuse, 2013) where the perpetrator compensates the parents of the child with money or marriage to avoid attracting public attention and shame to the family. The weak political will of the legislators to bring the perpetrators to justice is also an important mitigating factor affecting reporting of the cases, thus leading to continued abuse as the perpetrators go unpunished in most cases (Akinade et al., 2010).

In the present study, less than 30% of the children who had been sexually abused presented due to symptoms noted by their parents. This is not surprising as genital findings are often absent in victims of CSA even in the presence of a history of penetration of the child's genitals (Johnson, 2006). This is because mucosal injuries in children heal quickly and some forms of non-contact sexual abuse leave no physical evidence (Kellogg, 2005). Madu et al (2001) reported digital-genital contact as the most prevalent form of sexual abuse in their study on CSA among secondary school students in South Africa; with genital penetration occurring in less than 30% of cases. This differs from our own findings and those of other Nigerian studies (Chinawa et al., 2013) where genital penetration was more common. Sexual abuse in children is also usually associated with the use of manipulation rather than physical force (World Health Organisation, 2003) which agrees with our findings, where the minority reported the use of force. However, psychological and behavioural effects are usually more common than physical symptoms of CSA (Kellogg, 2005). It is possible

that the small number of children who presented with symptoms was due to the poor knowledge and perception of CSA by their parents leading to a low index of suspicion of abuse in their children (Ige and Fawole, 2011).

The retrospective nature of this study made it difficult to ascertain why only half of the victims were screened for HIV even though CSA has been identified as a risk factor for HIV transmission in Sub-Saharan Africa (Lalor, 2008). This may be due to the poor knowledge of the attending physicians about management of children who have been sexually abused, which probably affected the medical services offered to them, as has been reported by other authors (Ige and Fawole, 2012). In a study on CSA in a tertiary hospital in Abakiliki, Chinawa et al (2013) reported that less than half of the abused children were screened for HIV and 3% were found to be HIV positive at follow-up. Daru et al (2011) reported that only 64% of the rape cases seen in a tertiary hospital in Jos were screened for HIV. Girgira et al., (2014) attributed the reasons for the low provision of post exposure prophylaxis for HIV and other STIs in their study to the victims delay in presentation at the hospital. Early presentation of cases of CSA is important because forensic studies carried out within the first 72 hours of sexual abuse could be used to corroborate the abuse as well as providing evidence in civil or criminal court proceedings (Kellogg, 2005). Studies have shown that the presence of semen, sperm or acid phosphatase, a positive culture for gonorrhoea, a positive serologic test for syphilis or HIV (in the absence of prenatally acquired or transfusion acquired infection) makes the diagnosis of sexual abuse a certainty even in the absence of a positive history (Kellogg, 2005).

There was no documentation about any form of counselling given to the victims and/ or their parents at presentation despite the availability of Child Social services in the hospital. It is not surprising then, that majority were lost to follow-up. This may be due to the lack of training of the clinicians and hospital social workers on counselling of sexually abused children (Ige and Fawole, 2012). Emotional and psychological support should be offered to the abused children and their non-offending parents, as studies have found that less severe outcomes have been noted when the victims have positive support from their families (Andrews et al). Follow-up of a sexually abused child enables the managing physician, not just to monitor the child's physical and emotional healing, but also to ensure that the child is protected from further abuse (Johnson, 2006).

STUDY LIMITATIONS

The children seen at the hospital in this study were mainly those who presented with symptoms of sexual abuse or who disclosed the act to their parents /caregivers, which makes it difficult to use this data to

determine the burden of CSA in our community. From the case notes, there was poor documentation of these cases by the attending physicians and thus other relevant information such as reasons for delayed disclosure and reporting of the cases could not be obtained. Also, no parent was documented as a perpetrator in this study unlike other studies on CSA. This non-disclosure may have been influenced by the person who brought the child to the child; with the child unlikely to reveal this information for fear of repercussions. The lack of effective Child social /welfare services in Nigeria and the "out of court" settlements of cases of sexual abuse in most parts of Africa, means that many cases of CSA especially where perpetuated within the family, will remain undisclosed

CONCLUSION

Child sexual abuse is a long standing menace which is getting increased recognition in our society. It affects mainly vulnerable pre-pubertal females and most of the acts are perpetuated at home by trusted males. An increased public awareness and training of paediatricians, gynaecologists and other health care workers on the management of cases of child sexual abuse is advocated. There should be improved accessibility to child social services as well as training of social workers on appropriate counselling skills. Increased political will by the government to bring the perpetrators to justice and discouraging of "out of court" settlements for CSA cases at the community level would also help to mitigate this crime.

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REFERENCES

- A bill for an act to provide and protect the right of the Nigerian child and other related matters 2003. www.nigeriarights.gov.ng/files/.../40 assessed online February 2014
- Akinade EA, Adewuyi TDO, Sulaiman AA (2010). Sociolegal factors that influence the spread of rape in Nigeria. *Procedia Social and Behavioral Sciences* 5:1760-1764.
- Andrews G, Corry J, Slade T, Issa C, Swanston H. Child Sexual Abuse. Chapter 23. Comparative Quality of Health Risks; pages 1851-1941
- Child sexual abuse (2014). American Psychological Association www.apa.org/pi/.../child-sexual-abuse.asp assessed online
- Chinawa JM, Ibekwe RC, Ibekwe MU, Obi E, Mounkeke VU, Obi DC, Eke BC (2013). Practice and pattern of sexual abuse among children attending Ebonyi State University Teaching Hospital, Abakiliki, Ebonyi State. *Nig. J. Paed.* 40(3):227-231
- Daru PH, Osagie EO, Pam IC, Mutihu JT, Silas OA, Ekwempu CC (2011). Analysis of cases of rape as seen at the Jos University Teaching Hospital, Jos, North central Nigeria. *Niger. J. Clin. Pract.*; 14(1): 47-51.
- Do children sexually abuse other children? Preventing sexual abuse among children and youth. Available at www.stopitnow.org assessed on January 2014
- Eke GK, Opara PI, Tabansi PN (2011). Perception of rape amongst secondary school students in Port-harcourt. *The Niger. Health J.* 11(1):23-26.
- Girgira T, Tilahun B, Bacha J (2014). Time to presentation, pattern and immediate health effects of alleged child sexual abuse at two tertiary hospitals in Addis Abab, Ethiopia. *BMC Public Health* 14
- Ige OK, Fawole OI (2012). Evaluating the medical care of child sexual abuse victims in a general hospital in Ibadan, Nigeria. *Ghana Med. J.* 46(1)
- Ige OK, Fawole OI (2011) Preventing child sexual abuse: Parents perception and practices in Urban Nigeria, *J. Child Sexual Abuse.* 20(6):695-707
- Jemal J (2012). The Child sexual abuse epidemic in Addis Ababa: Some reflections on reported incidences, psychosocial consequences and implications. *Ethiop. J. health Sci.* 22(1): 59-66
- Jewkes R, Levin J, Mbananga N, Bradshaw D (2002). Rape of girls in South Africa. *The Lancet*, 359:319-321.
- Johnson CF (2006). Sexual abuse in children. *Paediatr. in rev.* 27(1):17
- Kellogg N (2005). The evaluation of sexual abuse in children. American Academy of Paediatric Consult on child abuse and neglect. *Pediatr.* 116(2): 506-512.
- Lalor K (2004). Child sexual abuse in Sub-saharan Africa: A literature review. *Child Abuse and Neglect.* 28: 439-460
- Lalor K (2004). Child sexual abuse in Tanzania and Kenya. *Child Abuse and Neglect.* 28(8): 833-844.
- Lalor K (2008). Child sexual abuse and HIV transmission in Sub-saharan Africa. *Child Abuse Rev.* 17(2): 94-107
- Madu SN, Peltzer K (2001). Prevalence and pattern of child sexual abuse and victim-perpetuator relationship among secondary school students in the Northern Province (South Africa). *Arch. Sex Behav.* 30(3): 311-21
- Moody CW (1999). Male child sexual abuse. *J. Pediatr. Health Care.* 13:112
- Ogunyemi O (2000). Knowledge and perception of Child sexual abuse in urban Nigeria: Some evidence from a community-based project *Reprod. Health.* 4(2): 44-53.
- Olley BO (2008). Child sexual abuse, harmful alcohol use and age as determinants of sexual risky behaviours among freshmen in a Nigerian University. *Afr. J. Reprod. Health.* 12(2): 75-88
- Olusanya O, Ogbemi S, Unikpe I, Oronsaye A (1986). The pattern of rape in Benin City, Nigeria. *Trop. Geog. Med.* 38
- Omorodion FI, Olusanya O (1998). The social context of reported rape in Benin-City, Nigeria. *Afr. J. Reprod. Health* 2(2):37-43
- Omorodion FI (1994). Child sexual abuse in Benin City, Nigeria. A sociological analysis. *Iss in Compr. Ped. Nur.* 17(1):29-36
- Pereda N, Guilera G, Forn M, Gomez-Benito J (2009). The prevalence of Child Sexual Abuse in community and student samples: A meta-analysis. *Clin. Psychol. Rev.* .doi: 10.1016/j.cpr.2009.02.007
- Sika Bright S, Nnorom C (2013). The perception of children on child sexual abuse: The case of children in some selected schools in the cape coast Metropolis, Ghana. *Advances in Applied Sociology*, 3,246752 doi 10.4236/aasoli.2013.36033.
- The Second International Conference in Africa on Child sexual abuse. African Network for Prevention and Protection against Child Abuse and Neglect (ANPPCAN) Regional Office 2012.
- United Nations Convention on the Rights of the child (1989). Office of the United Nation High Commissioner for human rights. <http://www.z.ohchr.org/English/law/cra.htm> assessed online February 2014
- Watts G, Zimmerman C (2002). Violence against women: global scope and magnitude. *LANCET.* 359:1232-1237

Whealin J (2007). Child Sexual Abuse. National Centre for PTSD Fact Sheet at www.ncptsd.org/facts/specific/fs_child_sexual_abuse.html Assessed January 2014.

World Health Organisation (1999). Report of the Consultation on Child Abuse Prevention (document WHO/HSC/PVI/99.1). Geneva: WHO

World Health Organisation (2003). Guidelines for the medico-legal care of victims of sexual violence. Chapter 7 pages 75-92.

Yahaya I, Soares J, Ponce De Leon A, Macassa G (2012). Comparative study of the socioeconomic factors associated with Child sexual abuse in Sub-saharan Africa. *Pan Afr. Med. J.* 11:51