PREVALENCE OF SEXUAL ABUSE AMONG THE VISUALLY IMPAIRED YOUNG ADULTS AND ADULTS IN OYO STATE

BY

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Dedication

This work is dedicated to God, who by His mercies have sustained me and to my dearest mother Pastor Mrs. Stella Ayeni my prayer warrior and my loving husband HRH Oba Dominic Oluwagbenga Kolawole for been my teacher and pillar of achievement.

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ABSTRACT

Sexual abuse is any sexual act, attempt to obtain a sexual act, unwanted sexual comments, or acts to traffic or otherwise directed against a persons' sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. Previous studies show that disability is one of the major factors for vulnerability to sexual abuse; this study therefore assessed the prevalence of sexual abuse among visually impaired young adults and adults in Oyo state.

Three hundred and thirty five respondents were recruited in this study. Hence, the total population was used due to small sample size. A validated interviewer administered questionnaire was used to obtain information, descriptive and Chi-square statistics were used to analyze data obtained.

The participants' ages ranged from 16- 57 years with a mean age of males at 27.4±9.2 and females at 23.12±7.13 years. A greater proportion were Christians (65.7%) with majority been females (61.2%); 59.1% reported to have been sexually abused while 40.9 were not. Prevalence of sexual abuse among the participants by age group were as follows: 16-19 years (28.7%); 25-34 years (11.6%); 20-24years (10.1%);35-49 years (0.9%) and 50-64years(0.6%). Sexual abuse was found more among females (73.2%) than males (36.9)%($p< 0.05$). About a quarter (28.1%) reported to have been abused at school, 19.4% at home, 12.8% on the playground, at work (2.7%), in the church (2.1%) and mosque (1.2%). Majority of the females reported their perpetrator to be males (29.9%) while majority of the males reported their perpetrators to be females (11.0%). Majority of the survivors (76.6%) did not talk to anybody about the incident while(23.4%)did; of those who reported, the main people they talked to were; friend (6.9%); 0.6% an older person; family member(2.7%). Reasons for non-disclosure were lack of trust in the reporting process(31.9%); were fear of been badly treated(26.9%) ; not wanting to cause any trouble(22.7%);said they did not think it was serious enough to report(22.4%).

Incident of sexual abuse is high among the visually impaired in Oyo state and the level of disclosure is low. Therefore there is a need to provide educational programs with the core goals of increasing sexual abuse awareness, prevention, providing support for survivors and holding perpetrators responsible for their actions.

Keywords: Sexual abuse, visually impaired, young adults, adults, prevalence, disclosure.

Word count: 495

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CERTIFICATION

I certify that this project was carried out by Kolawole Bimbo Dominica Grace in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan, Ibadan, Nigeria.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the study

The World Health Organization(WHO) defines sexual abuse as: 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise directed against a persons' sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home or work (WHO, 2002).

The World Report on Violence and Health (Krug, 2002) defines sexual abuse as "*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work*''. Childhood sexual abuse (CSA) is defined as a sexual act between an adult and a child, in which the child is utilized for the sexual satisfaction of the perpetrator (Briere, 1992). Although the accuracy of statistics citing childhood sexual abuse are questionable due to the inability to assume complete disclosure from children , there is an underlying assumption that quoted prevalence figures of childhood sexual abuse experience is one out of three or four children (Briere and Elliot,2003).

Childhood sexual abuse is considered to be unique severe traumatic event since it includes violation of the child's body. Unlike other forms of abuse such as physical abuse in which the violation is on the body surface(whether or not internal injuries are caused), sexual abuse denotes oral,anal or genital penetration (Dilillo et al, 2006). The body, therefore, can no longer be perceived as a ''safe home.'' Escaping the abusive situation can often be possible only virtually in the victim's mind, whereas the body continues to endure suffering, (Silberg, 1998).

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Child sexual abuse often negatively affects long-term psychological and social well-being, although more than half of all sexual abuse survivors do not suffer the most extreme forms of psychiatric trauma.Factors that worsens the severity includes: younger age at first abuse, less developmental maturity, longer duration of abuse, occurrence of penetration, abuse by a parent figure or much older perpetrator, lack of support upon disclosure and absence of a caring non-abusing parent (Kaysen, Resick and Wise, 2003). Psychological and behavioral effects of child sexual abuse may include low self-esteem, depression, anxiety, fear, hostility, chronic tension, eating disorder, sexual dysfunction, self-destructive or suicidalbehavior, post-traumatic stress disorder, dissociation, multiple personality disorder, repeat victimization, running away, criminal behavior, academic problems, substance abuse and prostitution (Freshwater, Leach and Aldridge, 2001; Johnson, 2004).

Sexual abuse survivors are at higher risk of mental health and social functioning problems resulting from feeling of powerlessness, guilt, shame, stigmatization, and low self-esteem. Powerlessness damages coping skills and reduces ability to protect one's self from further abuse (Merrill, Thomsen, Gold and Milner, 2001). Victims may have a hard time knowing the boundaries of intimacy and may develop what psychiatrist call a ‘'disorder of hope'' in which they either idealize or despise new acquaintances. The result, in either case, is disappointment and a confirmation of their own helplessness in facing the rest of the world (Fleming, Mullen, Sibthorpe and Bammer, 1999; Simpson and Miller, 2002).

Disabilities are an umbrella term, covering impairments, activity limitations, and participation restrictions. Impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experience by an individual

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involvement in life situations. Disability is thus, not just a health problem it is a complex phenomenon, reflecting the interaction between features of a person's body and features of a society in which he or she lives (Howe, 1999). People with disabilities have the same health needs as non-disabled people for immunization, cancer screening etc. Therefore it is the societal perceptions and response to people with a disability that are more often responsible for the increased risk of victimization that such individuals experience. Consequently, certain factors place people with disabilities at risk of sexual violence. These factors include social and physical isolation, dependence on careers, a lack of knowledge that violence is criminal, and communication difficulties (Goodfellow and Camilleri, 2003).

Vulnerability is the characteristics and circumstances of a community, system or asset that make it susceptible to the damaging effects of a hazard (UNISDR, 2009). People with disability account for between 15% to 20% of the global community. This figure is higher in a developing country context (World Report on Disability, 2011).

Situations that people with disability consistently face include lower educational enrolment and attainment; limited employment opportunities; limited access to information, services and resources and an increased likelihood of a life in poverty. Disability is a cross-cutting concern; disability affects women, children and men alike and magnifies existing vulnerabilities among individuals, communities and nations. Women and children living with disability are even more likely to experience exclusion than their non-disabled peers. Consequently, their opportunities and security are further limited.

The most vulnerable of groups consist of those individuals living in poverty. A poor woman or child living with disability may face further exclusion and highly limited opportunities and security. This is the triple jeopardy; disability and risk of people with

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disability may be placed at increased disaster risk due to cognitive, intellectual or physical impairments. These factors may limit the ability of a person with disability to access information and/or to act on that information.

Research into the risk factors for abuse of disabled persons is very limited. However, a number of reasons for increased vulnerability are referred to in key or relevant publications (Brown, 2006). Societies devalue and disempowered persons with disabilities because in day or residential services may be exposed to higher risks due to the fact that there are no appropriate safe guards in place. They may be more isolated from friends and family, which render them more vulnerable to abuse and their impairment may be targeted as a focus of abuse.

Disabled persons dependency on an abusing career can create difficulties in avoiding or communicating about abuse especially if this is a key person through whom the child communicates, the disabled person learns from experience to be compliant and not to complain. Most importantly lack of effective sex education or safety and awareness is a driving force for the vulnerability of a disabled child (Dickman and Roux, 2005).

Abuse of the disabled person is on the increase due to their silent cries which most of the time go unheard because most of the times they receive intimate personal career, possibly from a number of careers, which may increase the risk of exposure to abusive behaviors (Bob McComack, et al, 2005).

Due to their impaired capacity to resist or avoid abuse and communication difficulties or lack of access to an appropriate vocabulary which may make it difficult to tell others what is happening. Disabled children are more vulnerable to abuse by their peers more than other children because most times they may not have someone to talk to or may lack the privacy they need to do this, or the person they turn to may not be receptive to the issue being communicated. They may also be inhibited about complaining because of

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fear of losing services thus these leads to poor data information on the level or extent of abuse of disabled persons.

1.2 Problem statement

Children and young people with disabilities are at risk in ordinary ways because they are children first and because they live in ordinary families, attend mainstream schools, attend local churches or faith groups, and engage in leisure pursuits in mainstream settings. But they are also at additional risk because of the increased likelihood that they will be separated from their families, accommodated in congregate settings where they encounter multiple caregivers, and are targeted on account of their vulnerability (Hopper, 2006).

A 2000 Nebraska school-based study found that children with disabilities were more than three times more likely to be sexually abused as children without disabilities. The sample included 40,211 children from 0-21 years using public school records from 1994 to 1995. The study found a 31% prevalence rate of maltreatment for children with disabilities vs. a 9% prevalence rate for children without disabilities (Sullivan and Knutson 2000).

Disabled persons and their families face many barriers to their full participation in society which limit their capacity both to contribute towards and access community resource and services, including preventive services. Lack of awareness among care givers, professionals and the general public on the vulnerability of disabled persons and indicators of abuse. A belief that disabled persons are not abused or beliefs that minimize the impact of abuse which most times leads to denial of, or failure to report abuse. General lack of communication and consultations with disabled persons over their experience, views, wishes, feelings, lack of choice and control they have over many aspects of their lives.

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Lack of appropriate or poorly co-ordinated support services can leave disabled persons and their families unsupported and physically and socially isolated. Isolation is widely considered to be a risk factor for abuse (Groce, and Trasi, 2004). Structural and skills gap between professionals working with disabled persons and those in child protection leading to barriers to an effective child protection system. Comprehensive and multi-agency assessments and planning in relation to indication of need at an early stage is lacking, leading to both failure to promote child welfare and failure to identify early indications of possible abuse. Most of the time assumptions are made about disabled children e.g. Their mood, injury or behavior which often times result in mistakenly attributing child's impairment to indicators of possible abuse.

1.3 Justification for the study

Based on extensive search for literature on the topic i.e. child sexual abuse in Nigeria; it was discovered that there has been more research on sexual abuse done on the normal child, hence, there is paucity of research on sexual abuse of the disabled child. In Nigeria there has been an upsurge in the rate of sexual abuse of disabled children (Aderemi and Pillay 2012). These sexual crimes are mostly perpetuated against them by persons close to them and who attend the same institutions or are constantly in close proximity with them (Hopper, 2009).

It has been observed that persons with disabilities are at higher risk of been sexually abused and the Nigerian society or justice system is making it almost impossible to have justice prevail over the assailant and this is one the major reasons the incident goes unreported and the assailant not punished (Aderemi and Pillay 2012).

In Nigeria there are very few research work done on sexual abuse on the disabled persons, therefore, extensive search for literature on Nigerian based studies did not yield

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any meaningful results. Hence, when the research was conceived, it was targeted towards the visually impaired, which are possibly the group at the highest risk of been sexually abused due to their inability to effectively describe the perpetrator.

This study is justified for the following reasons; first, the study will bring to the awareness of the general public that sexual abuse is perpetrated among the visually impaired and almost nothing is done about it. Second, this study has potentials to identify reasons why there is underreporting and assailants not been punished. Thirdly, this study has potentials to provide possible design of interventions directed at preventive actions that can be taken by the visually impaired to protect themselves from been sexually abused.

However, globally the baseline information available during the literature review of this study reveals that most work has been concentrated on other disabilities neglecting those with visual impairment. People with disabilities are in a position of care dependency and may find it difficult to disclose abuse thus leading to under reporting. Therefore, a research aimed at investigating this could be valuable to the public health discipline.

1.4 Research questions

1) What is the prevalence of sexual abuse among visually impaired persons?

2) Who are the perpetrators of sexual abuse on persons with visual impairments?

3) What are the perceived causes of sexual abuse in this population?

4) What percentage of survivors seek help?

1.5 Broad Objective of the study

To investigate the prevalence of sexual abuse among visually impaired persons in Oyo State.

1.6 Specific objectives of the study

The specific objectives were to

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1) Determine the prevalence of sexual abuse on the visually impaired.

2) Identify perpetrators of sexual abuse of visually impaired persons.

3) Identify factors influencing sexual abuse of visually impaired persons.

4) determine health seeking practices among those who have experienced sexual abuse

1.7 Hypotheses

The hypotheses that were tested in this study were as follows;

1. There is no association between gender and sexual abuse

2. There is no association between age and prevalence of sexual abuse

1.8 Definition of terms

Rape: rape is usually defined as virginal, oral, or anal sex by force or against a person's will. Iowa law uses the term ''sexual abuse''

Sexual Assault: Sexual contact and touching in a non-consensual manner that is offensive to that person. Sexual contact is any touching of the sexual or intimate parts of the body

Child sexual abuse: the sexual exploitation or victimization of a child by an adult, adolescent, or older child. The difference in age and sexual knowledge between a child and an older person makes consent impossible. This includes a range of behaviors including vaginal, anal or oral penetration, fondling, exhibitionism, prostitution and photographing a child for phonographic. The sexual activity does not have to involve force; children are often bribed or threatened into sexual act.

Incest: When a person sexually abuses a member of a family.

Acquaintance Rape: When a victim knows the person who raped him/her.

Date Rape: A rape that occurs on a date or similar social events.

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Sexual Harassment: Any unwanted sexual advances, requests for favors and other verbal or physical contact of a sexual nature that makes an individual uncomfortable/intimidated. This can include sexual assault and rape.

Domestic Violence: An incident or pattern of behaviours (may include; physical, emotional, economic, verbal and/or sexual abuse) that a person uses to gain power and control within an intimate relationship. ''domestic'' usually refers to line in-partners, former live in-partners, or adult relatives who live in the same household.

Dating Violence: Physical, emotional, economic, verbal, or sexual abuse committed by one dating partner against another.

Stalking: Legally defined as ''a repeated course of conduct intended to cause fear of bodily injury or death.'' This is commonly used to include following and/or repeated harassment, regardless of intent (Thomas Weiss, 2012).

Visual Impairment: The World Health Organization recognizes three level of visual capacity as normal vision, low vision and blindness. For educational purposes, a person is visually impaired if he or she is blind and thus prefers reading in Braille or other means that do not involve sight (Iroegbu, 2006). Therefore, a visually impaired person is someone who has functional limitations in orientation and mobility skills, daily living activities and visual tasks resulting from his/her defective visual condition.

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CHAPTER TWO

LITERATURE REVIEW

2.1 Definition of disability

A disability is a condition or function judged to be significantly impaired relative to the usual standard of an individual or group. The term is used to refer to individual functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness and various types of chronic diseases. The most commonly cited definition is that of the World Health Organization in 1769, which draws a three-fold distinction between impairment, disability and handicap, defined as follows. An impairment is any loss or abnormality of psychological, physiological or anatomical structure or function; a disability is any restriction or lack (Resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being; a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that prevents the fulfillment of a role that is considered normal (depending on age, sex and social and cultural factors) for that individual (Thomas Weiss, 2012).

A person is visually impaired if he or she is blind and thus prefers reading in Braille or other means that do not involve sight (Iroegbu, 2006). Therefore, a visually impaired person is someone who has functional limitation in orientation and mobility skills, daily living activities and visual tasks resulting from his or her defective visual condition.

2.2 Definition of sexual abuse

The World report on Violence and Health (Krug, 2002) defines sexual abuse as ‘‘any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by

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any person regardless of relationship to the victim, in any setting, including but not limited to home and work''

2.2.1 Disability and sexual abuse

There are many reasons to suspect that children with disabilities will be more susceptible to sexual abuse than are other children. Firstly, children with disabilities are often under the care of, and in contact with, several adult caregivers among who may be potential abusers. In addition, some potential abusers will seek a child who appears vulnerable and uncertain, who demonstrates a need for contact, and who either will not tell of the actor who would likely not be believed should they tell (Conte et al, 1989).

Disability is a factor that contributes to a person's vulnerability to assault in, 'The Ultimate Guide to Sex and Disability, 'it states, in general, little information is available on the risks for people living with disability. The studies that have been conducted make it clear that there is a much higher than average risk of sexual abuse for people living with disabilities. The number form different studies vary, but the risk of children with disabilities (internationally) is anywhere from two to ten times greater than that found in the general population (Thomas Weiss, 2012).

2.3 Global, Regional, and National Burden of sexual abuse

Child abuse, but specifically sexual abuse, has been an important public policy issue over the last two decades in many European countries. Physical and emotional abuse is more likely to be condoned or excused whereas sexual abuse of children is almost universally condemned. There is a growing consensus about the prevalence and dynamics of such abuse. For example, in Ireland two studies were commissioned that provide background information about the abuse of all children (McGee et al, 2002; Good, McGee and O'Boyle, 2003).

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McGee et al suggested in Ireland on the SAVI report in Dublin that 20% of all women had been sexually abused with physical contacts as girls and that 16% of men had been similarly abused as boys. A further 10% of girls and 7% of boys had been abused in non-contact ways. A total of 40% of these incidents were ongoing and not a single occurrences. Of these 5.6%of girls and 2.7% of boys had been raped as children or adolescents and most shockingly 40% had told no one about it.

These figures are of a similar order to those emerging in other countries and broadly in line with Kinsey's initial estimate in the United States in Canada (1953) that 1 in 4 girls and 1 in 9 boys were victims of child sexual abuse. US figures from a congressionally mandated series of incidence studies, (National Centre on Child Abuse and Neglect (NCCAN, 1996) suggested that girls are three times more likely than boys to be sexually abused.

2.4 Factors influencing sexual abuse of disabled persons

Children who are blind or have low vision may not be fully aware of their surroundings, especially on public transportation or within the community. This can make them vulnerable to exploitation by others. Many persons who are blind or deaf/blind are taught mobility and Braille by guided physical contact. An individual may be conditioned to touch due to ongoing personal care or other disability or medical-related services. Being touched, often without permission, can provide confusing messages about space, boundaries and physical contact with others.

A range of international studies cited by Goode et al (2003) arrive at estimates of sexual victimization of between 6% and 54% of girls(depending on the definition of the abuse and the method of study) and 6-6% of boys children with disabilities may also be abused by their peer and by strangers in public places.

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According to meta-analysis of findings from studies of victimization of people with disabilities, children with disabilities are 2.9 times more likely than children without disabilities to be sexually abused. Children with intellectual and mental health disabilities appear to be the most at risk, with 4.6 times the risk of sexual abuse as their peers without disabilities (Lund, Emily, and Vaughn-Jensen, 2012).

According to the 2010 Administration on Children Youth and Families (ACYF) report, more than three million reports of child maltreatment were made in 2009, with 10% of cases involving sexual abuse. Victims (11%) who reported having a disability, including 3% with behavior problems, over 2% with an emotional disturbance, and over 3% with an additional medical condition (ACYF, 2010).

A 2000 Nebraska school-based study found that children with disabilities were more than three times more likely to be sexually abused as children without disabilities. The sample included 40,211 children from 0-21 years using public school records from 1994 to 1995. The study found a 31% prevalence rate of maltreatment for children with disabilities vs. a 9% prevalence rate for children without disabilities (Sullivan and Knutson 2000).

A 1998 Boys Town National Research Hospital study found that children with disabilities were 2.2 times more likely to be sexually abused than children without disabilities. The increased rate extended beyond sexual abuse to all forms of mal-treatment, with 64% prevalence rate of maltreatment for children with disabilities vs. a 32% prevalence rate for children without disabilities. The sample included more than 39,000 hospital records from 1982 to 1992 (Sullivan and Knutson, 1998).

In another study comparing sexual practices of 12-19 year old students with or without moderate intellectual disabilities in schools done in Oyo State, it was discovered that 68.3% of the sexually experienced intellectually disabled females reported history of

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rape victimization compared to the 2.9% of the sexually experienced non-disabled females shows that many women with intellectual disabilities are being raped constantly and the Nigerian society or justice system has made it almost impossible desire to have justice prevail over the assailant. This goes to show that rape is a crime that often goes unreported and unpunished in the Nigerian society due to the way such cases are treated (Aderemi and Pillay 2012).

Women are most frequently affected by domestic violence and abuse, but men with disabilities also are frequently abused. Children are sexually abused, beaten, humiliated and intimidated by adults mostly from the family or friends of the family. Disabled people are abused mostly by caregivers whether it is family or other disability service providers. Perpetrators of sexual abuse in the case of disabled people are e.g.:15-25% natural family members,15% acquaintances and neighbors,30% disability service providers,0-5% strangers.

If we compare the abuse and violence against disabled people with the abuse and violence against women and children the question arises whether there is a difference in the situation for disabled people is worse than for the other victims in at least 3 major points.

1) Disabled people are the highest risk group for abuse and violence and society isn't even aware of the problem;
2) Support for disabled victims is much less available than for non-disabled victims;
3) The abuse and violence against disabled people is much more commonly accepted and less frequently punished than for the other victims groups (Gregor Wolbring, 1994).

Sobsey and Varnhagen (1991) found that the risk of people with disabilities is at least one and a half times as high as for other people. When only more severe forms of

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abuse are considered that risk may be three or more times as high as the risk for people without disabilities. We now know that children with disabilities are more likely to be abused than other children and have strong evidence that adult's disabilities are more likely victims of violence. There is a long list of studies indicating the relative risk for children with and without disabilities.

Cross, Kaye, Ratnofsky (1993) provides the methodologically strongest evidence on sexual abuse, using a nationally representative American sample of 1,778 abused children in a prospective study. They found that children with disability were 1.67 times as likely to be abused as other children, based on all categories of abuse and neglect. They were 1.75 times as likely to be sexually abused and 2.09 as likely to be physically abused. The authors of this study suggest that their estimates are conservative, based on their models suggesting that suggested milder disabilities were probably under diagnosed in the sample and that institutional abuse was largely excluded because of the nature of the sample. In addition, the relative risk is not steady across ages. The risk for children with disabilities under age 1 is 1.20 times as great and the risk for other children, but for children between 14 and 17 years old, the relative risk has climbed to 2.77 times. This suggests that the risk of violence in adulthood may even be higher. Although there are fewer and less well-controlled studies of adults, the available data seem to bear this out.

Wilson and Brewer (1992) report an Australian study suggesting that violent crime victimization is 10 to 12 times more frequent for people with developmental disabilities than for other adults. They may be at risk within sporting networks (Brakenridge, 2008) and within the care system. Attempts to quantify the additional vulnerability of disabled children can only be guest mates due to the lack of available and comprehensive information.

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2.5 Consequences of sexual abuse

Abuse of disabled children is not often visible in the information gathered by mainstream child-care agencies or the criminal justice system (Cooke, 2000). The pattern of targeting and grooming is of particular importance in relation to disabled children and as mainstream services become more vigilant, perpetrators may move into other less attentive services, such as voluntary agencies that serve disabled children and young people, in order to access potential victims. Any visible disabilities might mark a child out as vulnerable, and if they are isolated from their peer group, have communication difficulties and less information about what to expect from adults and to whom they could report abuse, then they are more likely to be seen as targets. Disabled children and young people who have a negative self-image may also be particularly susceptible to grooming and deception, and to ''tricks or treats''

Sexual abuse of any child or young person or adult is a breach of trust that permeates their expectations of others, weather caregivers or future partners. Of course people recover and become strong, but they are left with scares on their souls and in their minds (Higgins and Swain, 2010). From analysis of over 40,000 children in America, Kansas City (Sullivan and Knutson, 2000) found that disabled children were 3.4 times more likely to be abused or neglected. They were 3.8 times more likely to be neglected; 3.8 times more likely to be physically abused; 3.1 times more likely to be sexually abused and 3.9 more likely to be emotionally abused. Overall, 31% of the total disabled children in this research had been abused.

Other research has found that disabled children and young adults are at increased risk of being abused or neglected (Sullivan et al, 1997) found that disabled children were 1.8 times more likely to be neglected; 1.6 times more likely to be physically abused

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and 2.2 times more likely to be sexually abused. Crosse et al (1993) found that disabled children were 1.8 times more likely to be sexually abused and 1.6 times more likely to be physically neglected. Overall they were 1.7 times more likely to be abused or neglected than non-disabled children. Stigma, fear, underreporting and society's failure to hold perpetrators accountable have led to a silent epidemic of child sexual abuse. When disability is added to this landscape, the silence is further compounded by a number by a number of factors.

Many of the people constituting the community of support for children and adults with disabilities are either unaware or unwilling to believe that these people are targeted for sexual violence. Parents and other family members may not report sexual abuse of a child in their care because they do not know who to turn to or are afraid that the child will be removed from their home. Professionals in disability organizations may lack training or education on the topic of sexual abuse and, therefore, miss indications of abuse of their clients. Meanwhile, because children with disabilities are segregated form larger society, victim services organization do not commonly see them in their base and, therefore, do not designate them as a priority population (Nancy Smith and Sandra Harell, 2013).

The majority of children and adults who are sexually abused will be moderately to severely symptomatic at some point in their life. Experiencing sexual abuse creates a feeling of powerlessness in the child and leaves the child with the perception of having little control over what happens (Dube et al, 2005). This lack of a sense of control acts as a stressor that has effects on the neurodevelopment of both male and female victims. Boys and girls cope differently with the stressor of sexual abuse. Girls are more likely to exhibit internalizing behaviors, such as depression and disordered eating (Anorexia, Bulimia, or Obesity).

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Externalizing behaviors such as delinquency and heavy drinking are more likely exhibited by boys. Understanding the underlying feelings of powerlessness and loss of control experienced by children who are sexually abused helps in understanding the behaviors and consequences that some sexual abuse victims exhibit.

All forms of child abuse have been linked with the development of a variety of behavioral problems in children. Sexualized behaviors in children have been linked most closely with child sexual abuse (Putham, 2003). Children who exhibit sexualized behavior tend to be younger and to have been sexually abused at a younger age (Muller's and Dowling, 2008; Putnam). Much sexual behavior exhibited by children are a apart of normal development; however, numerous studies have found that sexually abused children exhibit more sexualized behaviors when compared with other non-abused children (Friedrich et al, 2001, Paolucci et al, 2001). Sexual behavior in children can become a cause for concern due to particular aspects of the behavior such as frequency of the behavior, the child's demeanor while engaged in the behavior, or continuing to engage in the behavior after being asked to stop (Hornor, 2004). It is particularly alarming when a child demonstrates age-inappropriate sexual knowledge; for instance, when a 5-year-old child attempts to place his penis in the mouth, anus, or virginal of another child. Such behavior raises strong concern that the child has either observed explicit sexual behavior or has been sexually abused.

Child sexual abuse has been linked to the development of problematic behaviors, symptoms of attention deficit hyperactivity disorder (ADHD) can develop as a result of sexual abuse, and the child may be misdiagnosed as having ADHD (Mullers and Dowling, 2008). The symptoms are actually the result of the trauma of sexual abuse and are more accurately diagnosed as post-traumatic stress disorder (PSTD) or

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anxiety. Briscoe-Smith and Hanshaw (2006) reported that girls with ADHD were at increased risk of having been sexually abused. This is not to state that every child, male or female, diagnosed with ADHD has been sexually abused, but the possibility of sexual abuse should be explored in children, especially girls, diagnosed with ADHD.

Mullers and Dowling (2008) report a link between child sexual abuse and violent behavior, especially in adolescent males. The violent behaviors include the use of weapons and fighting. Violent behaviors are exhibited by male sexual victims more frequently than female victims and are an example of an externalizing behavior to cope with the stress of sexual abuse.

Child sexual abuse has been linked with a variety of psychiatric disorders in childhood and continuing into adult hood. Martin, Bargen and Richardson (2004) report that the incidence of psychiatric diagnoses occurring over a life time is 56% for women and 47% for men who have disclosed a history of child sexual abuse. However, when no history of child sexual abuse is reported, the rates of psychiatric disorders are much lower, at 32% for women and 34% for men. Depression, suicidal ideation, substance abuse and PTSD appear to be associated with sexual abuse and will be discussed more completely.

However, other psychiatric disorders also have been linked to sexual abuse such as borderline personality disorder, dissociative identity disorder, and bulimia nervosa (Putman, 2003). The development of pain disorders has also been found to be related to child sexual abuse (Sapp, 2005). Depression can be present in pre-adolescent children, adolescents, and adults who have been sexually abused (Mullers and Downing, 2008). Numerous studies have linked major depression and dysthymia with sexual abuse (Paolucci et al, 2001). Both boys and girls who have been sexually

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abused are at increased risk for the development of depression, and this risk continues into adulthood (Dube et al, 2005).

Putman (2008) suggests that a history of sexual abuse may change the clinical presentation of major depression, with reversal of neuron-vegetative signs such as increased appetite, weight gain, and hypersomnia when compared with depressed individuals without a history of sexual abuse. A history of sexual abuse has been associated with earlier onset of depressive episodes and an altered response to standard treatments for depression. The type of sexual abuse (touching vs. non-touching; penetration vs non-penetration) and relationship to the perpetrator (closer relative vs. non-related) appears to affect the development and severity of depression (Trickett, Noll, Reiffman and Putnam, 2001).

2.6 Interventions to protect persons with disability from abuse

Although some sexual assault prevention strategies are promising, very few have been evaluated (World Health Organization, 2002). These strategies include;

1) Skill –building through productive health promotions that include gender aspects and violence prevention.
2) Programs that work with families throughout child development
3) Work at the community level with men to change concept of masculinity, and work in school environment promoting equitable gender relations.
4) Abuse prevention education (NRCDV, 2002).
5) Increasing independent decision making skills of women with mental retardation in stimulated interpersonal situations of abuse examines individuals 'decision making skills by presenting them with audio stories that posed interpersonal psychological, physical and sexual abuse situations.

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An effective strategy based curriculum for abuse prevention and empowerment (ESCAPE) is a cognitive based decision making skills intervention expanding on the increasing independent decision making skills of women with mental retardation in stimulated interpersonal situations of abuse, including an abuse prevention curriculum for disability service providers (Khemka, Hickson and Reynolds, 2005).

The majority of preventive interventions focus on college students. Although college based rape prevention programs vary in their implementations strategies and measure of effectiveness, these programs commonly include component such as:

A) Providing information on the prevalence of sexual assault

B) Challenging rape myths and sex-role stereotypes'

C) Identifying risk related behaviors,

D) Increasing empathy for rape survivors

E) Providing information's on the effects of rape on victims and

F) Providing lists of victim resources (Brecklin and Forde, 2001).

School based populations have been a focus of sexual violence prevention efforts. Middle and high school programs which are similar to college programs but are tailored for a younger audience commonly include component such as;

1) Identifying, clarifying and challenging societal portrayals of male and female roles;
2) Identifying and modulating intrapersonal and interpersonal stressors;
3) Promoting coping strategies that dissuade the use of alcohol and drugs;
4) Challenging the use of violence as a means of conflict resolution;
5) Recognizing the early warning signs of violence;

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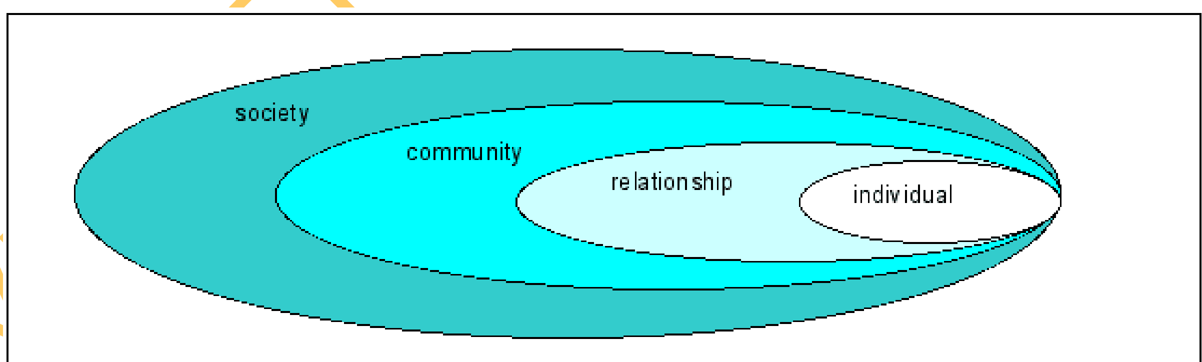
6) Correctly identifying and interpreting verbal, physical and sexual aggression as such as love; and

7) Developing strategies for disengagement from problematic relationships, including identifying and alerting a trusted adult (parent, relative, coach, religious leader, health professional) and options for legal recourse (Cohall, Bannister and Northbridge, 1999).

2.7 Conceptual frame work

The World Health Organization has proposed the use of an ecological model to provide a conceptual frame work for understanding the nature and causes of violence, including violence against women. Ecological models consider that behavior does not take place in a vacuum, and address the relationship of the individual to their environment, including interpersonal relationships, community and societal influences. The WHO report uses this model to explore risk factors for different types of violence, including violence by intimate partners and sexual violence (Krug et al, 2002).



The core of the model is the individual, and the personal characteristics which make them more or less at risk of violence. Around the individual are their close relationships, with partners, family members or others and how far these relationships might increase or decrease the risk of violence. The community in which the individual lives may

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contribute to their risk factors which might include the physical environment in which they live, but also issues of social inclusion or exclusion. The outer layer of the model represents the society in which an individual lives, and the pervasive influences of that society, including cultural norms and values, and the legislative and policy framework which supports them (Krug et al, 2002).

2.7.1 Application of Ecological Model to Sexual Abuse of Visually Impaired Persons

Society

This deals with eliciting factors to identify reasons for underreporting or non-disclosure of sexual abuse and also if factors influencing sexual abuse is related to location, stigmatization or non-enactment of sanction on perpetrators by law. This include questions like who they reported to after the incident, how soon did they report and reasons for report and non-report

Community

This deals with stigma and discrimination attached to the survivors which could be a factor for non-disclosure of the incident, limited access to information and education that sexual abuse is a crime, weak response and application of law against perpetrators of sexually abused. This includes knowing the level of peer discussions, relationship with family members and other individuals and type of help given.

Family

This deals with fear of been badly treated if report is made, lack of protection from abuse, isolated home environment, lack of trust in the reporting process and exposure to sexual abuse due to location. This also includes how safe the home environment is, and

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also by seeking for information to know the high risk location where sexual abuse can be perpetrated, who the perpetrators were and how much help was given.

Individual

Vulnerability due to impairment, sex, location and age, the above factors may have influence the high rate of sexual abuse among the visually impaired.

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Figure 2.1Application of Ecological Model to Sexual Abuse of Visually Impaired Persons

(Krug et al, 2002).

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CHAPTER THREE

METHODOLOGY

3.1 Study Design

This study was a descriptive cross sectional survey using interviewer administered questionnaire to obtain data on the prevalence of sexual abuse among visually impaired young adults and adults in Oyo State.

3.2 Description of Study Area

Oyo State is located in the south-western region of Nigeria and is one of the 36 states in the country. It consists of 33 local government areas and has a projected population of 6,596,392 million people (National Bereau of Statistics 2013). The major ethnic group is Yoruba, although other groups are also present in the state. Ibadan is the capital of Oyo State. Most of the people who reside in urban areas are civil servants, while those who reside in the suburban regions are civil servants, artisans, traders, farmers etc.

The first university in Nigeria is the University of Ibadan (established as a college of the University of London when it was founded in 1948, and later converted into autonomous university in 1962). It has the distinction of being one of the premiere educational institutions in West Africa.The other Universities in the state are: Lead City University, and LadokeAkintola University of Technology.

3.3 Study Population

The study population consisted of all male and female young adults and adults' persons with visual impairment in Oyo state. These persons were contacted through their official society called Nigeria Association of the Blind Oyo state chapter.

The State Association of the blind was formed in 1980 with about 15 members. Mr M.O Jimoh was the president of the state association, Around 1988 the association collapsed because of lack of cooperation and understanding among members for some years. It was

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dormant but in 1996 it was resuscitated under the leadership of Pastor Adeleke and he lead for about 4 years and in year 2000 Mr Job Oke took over and in 2006 Mr Obe Shola became the president. Shortly after about 2 years Mrs Sara Akinola took over then in 2011 Mr Lasisi Gerspaer became the chairman till date.

Under this new present leadership the association was zoned into 3 namely Ogbomosho/Oyo zone Okeogun/Ibarapa and Ibadan zone. Each zone is managed by a coordinator and organizes its meetings monthly while the state congress involving the three zones is held twice in a year. The state executives comprise of the chairman, vice-Chairman, The secretary, assistant secretary, treasurer, financial secretary, Public Relation Officer, Woman leader and Youth leader. The state government helps by giving some grants. The association helps to secure employments for its members. Meetings are held with the government from time to time to deliberate on certain matters, seminars and workshop are held to sensitize the public to give recognition to the association. For example last year the association of the blind organized white Cain day to let the public know the need and importance of the use of the white Cain. Below are the numbers of individuals in each zones of the association;

Ogbomosho/Oyo zone with a total number of 200 visually impaired persons

Okeogun/Ibarapa zone with a total number of 30 visually impaired persons

Ibadan zone with a total number of 120visually impaired persons.

3.4 Sample size calculation

The sample size was calculated using the formula

$$N = \frac{Z^2pq}{D^2}$$

Where N= sample size

D=degree of accuracy, 5% or 0.05

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Z=confidence level, 1.96

P=68% or 0.68(evidence from previous studies) (Aderemi and Pillay, 2012)

Q=1-p=1-0.68=0.32

$$N = \frac{1.96^2 \times 0.68^2 \times 0.32}{0.05^2} = 334.4$$

3.5 Inclusion criteria

The following conditions were ascertained before enrollment of study participant;

1. Persons with visual impairments ranging from partial to total blindness.
2. The participants were within the range of young adults and adults (16 years and above).
3. Participants were resident in any location within Oyo state.
4. Each participant was willing and interested to participate in the study.

3.6 Exclusion criteria

Non consenting individuals

3.7 Sampling technique

The total population was studied in this research due to small population size, thus, participants were recruited by using snowballing method this was done by contacting the state president and zone coordinators who gave information on how to get their members and the total number of members each zone has.

For those who were not active members of the association, links to contact them was provided by their peers. According to the President of the Association of the Blind in Oyo state the total number of visually impaired young adults and adults are approximately close to six hundred for both members and non-members but due to the sensitivity of the study and informed consent only 335 of the visually impaired person were interested in participating in the study.

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3.8 Validity and Reliability

Validly of the instrument was ensured by conducting a pre-test among 34 subjects (10% of sample size) utilizing a zone in the Association of the Blind Lagos state chapter. Reliability was ensured by using the findings of the pre-test to make necessary corrections for the main study after Cronbach Alpha statistical test on the pretest study has been done and the value gotten was 0.983. Revisions made included asking more specific questions to state exactly the type of unwanted sexual experience and ensuring it was exhaustive in order to get accurate results, separating questions on abuse that were asked together(anal or oral sex) and specifying the type of sexual act experienced.

3.9 Instrument for data collection

The instrument for data collection was a semi structured one hundred and forty three item questionnaire which contained both open ended and close ended questions designed to elicit information that gave empirical evidence to the objectives of the study(see Appendix 1).It comprised of five sections which are socio demographic characteristics of the subjects(section A)comprising of seven(7)questions. Section B comprises of eight(8) questions which elicited information on the prevalence and experience of sexual abuse. Section C is made up of four (4) questions to identify the perpetrators of sexual abuse,. Section D comprised of three (3) questions to identify influencing factors of sexual abuse ranging from location of abuse to number of persons present at the time of the abuse. Section E was to elicit information on health seeking practices and percentage of those who received help, which comprises of ten (10) questions which focused on level of disclosure and reasons for reporting or not reporting the incident.

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3.10 Data collection procedure

The data was collected through a detailed interviewer administered questionnaire which was administered to both male and female respondents in all the zones of the association of blind people Oyo state chapter. Ten trained research assistants were recruited for this study. Face to face interview was conducted since the respondents could not read. To ensure confidentiality due to the sensitive questions been asked each respondent was interviewed privately in order to get accurate and correct information.

3.11 Data management analysis

All copies of the questionnaire were returned to the researcher for data cleaning, coding of open ended questions and data entry. Double entry of questions was carried out to minimize errors. For this study, SPSS version 15.0 was used in the analysis of the collected data.

3.12 Ethical Considerations

All respondents that were invited in this study were fully informed about the study and consent was obtained from interested subjects. Participation in the study was voluntary and participants were free to withdraw at any point in time without any consequence, confidentiality of the respondents was ensured and this was achieved by avoiding the use of names and address. Strict confidentiality of all information collected from the study participant was maintained by ensuring a restricted accessibility to the data. The data was handled by the researcher; the supervisor and the data analyst, while these individuals were aware of utmost confidentiality of the data collected. This was reinforced by non-disclosure of identity of the study participants

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3.13 Limitation of the study

The study described has the following constraints;

1. Some of the information that was requested from the respondents was of a private and personal nature, coupled with the fact that it could have some "stigma potentials", and some of the respondents could not give accurate answers/withheld information to some specific questions asked, so it would be considered by the researcher to assume that information given by respondents would not be hundred percent accurate.
2. Some of the individuals in the study population refused bluntly to participate in the research because they were not comfortable with the sensitivity of question that will be asked by drawing conclusion when the topic is mentioned to them.

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CHAPTER FOUR

RESULTS

4.1 Demographic Characteristics

The ages of the respondents ranged from 16-57 years with a mean age of males at 27.4±9.2 and females at 23.1±7.1. Majority of respondents, (30.4%) were between 16-19 years age group (late adolescent), the second largest age-group(33.7%) was those in the 20-34 years old (early adults), followed by the third group(21.2%) which was those in the 35-49(adults). The respondents in the 50-64 years age-group had the lowest number they were just six in number accounting for just 1.8% of the respondents.

The gender distribution of the respondents' shows that more females, 205(61.2%), than males, 130(38.8%), participated in the study. With regards to religion the majority of the respondents were Christians 220(65.7%) and 115 (34.3%) were Muslims and none for other religion.

The ethnic group with the largest number of participants 288(86.0%) was the Yoruba ethnic group. They were followed by the Hausa ethnic group who numbered 37(11.0%) and the Igbo ethnic group were just 10(10.0%) in number.

Ranging from highest to lowest the confidants of the respondents were GOD 81(24.2%) – Sister71(21.2%)- father 61(18.2%)- Friend 57(17.0%) – Parent 30(9.0%) –Wife 21(6.3%)-Pastor 4(1.2)- Teacher 2(0.6%)- Son 1(0.3%) – none 1(0.3%), a total of five respondents did not respond accounting for 1.5% and one was not applicable accounting for another 0.3%

Majority of the respondents were students 226(67.5%), 45(13.4%) were into business, 35(10.4) were teachers,5(1.5%) are preachers,11(3.3) were into nursing, those into banking, civil servants and engineering were 3(0.9%) each and ICT consultants were 2(0.6%) two were unemployed which accounts for another 0.6%.

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258(77.6%) respondents were singles while 72(21.5%) were married and a total of five respondents did not respond accounting for 1.5%. results are presented in table 4.1.1 below

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Table 4.1.1;Socio Demographic Characteristics

N = 335

Age in years	Number	Percent%
16-19	102	30.4
20-24	113	33.7
25-34	71	21.2
35-49	43	12.8
50-64	6	1.8
Marital Status		
Single	263	78.5
Married	72	21.5
Religion		
Christian	220	65.7
Islam	115	34.3
Ethnicity		
Yoruba	288	86.0
Igbo	10	3.0
Hausa	37	11.0
Occupation		
Student	226	67.5
Banking	3	0.9
Civil servant	3	0.9
Teaching	35	10.4
ICT consultant	2	0.6
Business	45	13.4
Preaching	5	1.5
Unemployed	2	0.6
Engineering	3	0.9
Nursing	11	3.3

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4.2 PREVALENCE OF SEXUAL ABUSE

When respondents were asked generalized questions on the type of abuse they have been exposed to, slightly above a quarter of the respondents 53 (22.7%) reported to have experienced sexual contacts without their consent. Someone else has made 33(14.2%) of the respondents to have sexual contact with another person without their consent; 34 (14.6%) reported to have been engaged in either oral or anal sex without their consent, Those who have experienced an attempt to engage them in oral or anal sex but were not successful were 26(11.2%) 34(14.6%) of the respondents respectively has been made to engage in a sex act without their consent. Results shown in figure 4.2.1 presents slightly higher responses when respondents were asked if "someone has ever attempted to make them engage in a sex act but was not successful; 53 (22.7%) of the respondents that said yes to unwanted sexual experience.

When respondents were asked the specific type of unwanted sexual contact they have experience, majority of the respondents198 (59.1%) said they had been touched on sensitive parts of their body which includes **breast, penis, virginal and buttocks.**146(43.6%) had experienced attempted touch on sensitive parts,25(7.5%) had experienced oral sex without consent,22(6.6%) had experienced anal sex without consent,34(10.1%) had experienced attempted anal sex without consent,32(9.6%) experienced attempted oral sex without consent, 65(19.4%) had been kissed without consent,100(29.9%) had experienced attempted kiss without consent; 61(18.2%) had been continuously harassed to be forcefully engaged in a sex act.

A large number 107(31.9%) had also been touched on their genitals without consent, 113(33.7%) had be subjected to listening to sexual words about their body against their will, 36(10.7%) had experience full sexual intercourse against their will,36(10.7%) had

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been forced to stay where sexual intercourse is been committed against their will,101(30.1%) had been hugged against their wish

A little above quarter 45(13.4%) had been forced to touch another person genital against their wish; 46 (13.7%) had experienced someone rubbing his/her genitals on their body against their wish and lastly 84(25.1%) had experienced an attempt to have sexual intercourse against their wish.

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4.2.1 Specific unwanted sexual experience which has occurred by sex

Specific unwanted sexual experience	Male (%)	Female (%)	Total N
Touch on sensitive parts without consent	24.2	75.8	198
Attempted sexual contact without consent	17.1	82.9	146
Oral sex without consent	36	64	25
Anal sex without consent	22.7	77.3	22
Attempted oral sex without consent	29.4	70.6	34
Attempted anal sex without consent	28.1	71.9	32
Kiss without consent	30.8	69.2	65
Attempted kiss without consent	22	78	100
Continuous harassments to forcefully engage in any sex act	29.5	70.5	61
Touch of genitals without consent	31.8	68.2	107
listening to sexual words about your body against your will	19.5	80.5	113
Full sexual intercourse without consent	33.3	66.7	36
forcing you to stay where sexual intercourse is been committed against your wish	30.6	69.4	36
hug against your wish	22.8	77.2	101
forcing you to touch his/her genitals against your will	33.3	66.7	45
Rubbing his/her genitals on your body against your will	32.6	67.4	46
Someone attempted to have sexual intercourse with you against your will	27.4	72.6	84

N = 335
n=198
Multiple responses were given*
Respondents who gave no response or not applicable were not included

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TABLE 4.2.2 Reasons why sexual abuse was not successful

Reasons why the act was not successful	Frequency/n	Percent%
he grabbed me but was not successful because i forced myself out of his hands	4	8.5
I ran out of the house	8	17.0
he tried to deceive me to his house	5	10.6
I kicked him away from me	8	17.0
I screamed for others to come and help me	8	17.0
I bite him	1	2.1
because it was not intentional	1	2.1
its confidential i cannot answer	1	2.1
I did not like the person that is why i did not do it	11	23.4

n = 198

Respondents who gave no response or not applicable were excluded

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4.3 Timing of Encountered Sexual abuse

A large number of respondents 87(43.5%) had encountered unwanted sexual experience two times, slightly below half of the respondents 40(20.0%) had encountered unwanted sexual experience three or more times while almost a quarter of the respondents20(10.0%) had sexual encounter once.53(26.5%) of the respondents did not recall how many times they had encountered unwanted sexual experience. The result is shown below in table 4.2.4 to show the distribution between gender according to how many times either male or female had encountered unwanted sexual experience.

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Table 4.3.1 Frequency of sexual abuse

Frequency	Male	Female	Total
	No %	No %	No %
Once	7(11.1%)	13(9.5%)	20(10%)
Two times	20(31.7%)	67(48.9%)	87(43.5%)
Three or more times	15(23.8%)	25(12.5%)	40 (20%)
Do not recall	21(33.3%)	32(23.6%)	53 (26.5%)
Total	63(100%)	137(100%)	200 (100%)

Respondents who gave no response or not applicable were excluded

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The bulk of sexual abuse experienced by the respondents took place within the past 30 days 59(17.6%) prior to the commencement of the research and closely followed by 37(11.5%) which occurred six months to less than one year,18(5.4%) occurred ten or more years ago while 15(4.5%) occurred one month to less than six months ago,12(3.6%) occurred one year to less than two years ago and 8(2.4%) occurred five years to more than ten years ago.15(4.5%) respondents do not recall how long ago the sexual abuse occurred and 128(38.2%) preferred not to answer; a total of 28(8.4%) gave no response.

Majority 0f the respondents 96(48.2%) who were within the age range of 16 through 19 carried the highest number of abuse closely followed by 25-34 years 39(19.6%), 34(17.1%) fell within the age range of 20-24 years while few of the respondents 3(1.5%) were in the age range 35-49 closely followed by the age range 50-64 who were just 2(1.1%) respondents.

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Table 4.3.2 Age and sex of those who experienced sexual abuse

Age during sexual abuse (years)	Male No %	Female No %	Total No %
16-19	13 (22.3)	83 (59.3)	96(48.2%)
20-24	12 (20.3)	22 (15.7)	34(17.1%)
25-34	23 (39.0)	16 (11.4)	39(19.6%)
35-49	1 (1.7)	2 (1.4)	3(1.5%)
50-64	0	2 (1.4)	2(1.1%)
Do not recall	5 (8.5)	6 (4.3)	11(5.5%)
Prefer not to answer	5 (8.5)	9 (6.4)	14(7%)
Total	59 (100)	140 (100)	199(100%)

Respondents who gave no response or not applicable were excluded

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4.4 PERPETRATORS OF SEXUAL ABUSE

Majority of the perpetrators were not related 125(81.2%) to the respondents who have experienced sexual abuse while 15(9.7%) were related to the respondents; results shown in table 4.3.1. More than half of the perpetrators were strangers 88(42.9%) closely followed by peers 49(23.9%); then Neighbor 18(8.8%); instructor 11 (5.4%); family friend 10(4.9%); uncle or aunt 7(3.4%); driver 7(3.4%); mother or fathers friend 5(2.4%); step father/mother 4(1.9%); brother or sister 3(1.5%); and lastly grandparents 1(0.5%). From the gender disposition majority of the perpetrators were males 118(35.22%) while female perpetrators were 60(17.9%); this results is shown in table 4.3.2 below. Nearly all the women are reporting that their perpetrator was a man 100(81.3%) while the majority of men who have been sexually abused say their perpetrators were females 37(67.3%).reports on same sex abuse: For men 18(32.7%) say their perpetrators was male and for women 23(18.7%) say their perpetrators was females.

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Table 4.4.1 Relationship between the perpetrator and the survivor

	Relationship	No	Percentage %
1	Stranger	88	42.9
2	Mother or father's friend	5	2.4
3	Brother or sister	3	1.5
4	Family friend	10	4.9
5	Half brother or sister	2	1.0
6	Neighbor	18	8.8
7	Uncle or aunt	7	3.4
8	Grandfather or mother	1	0.5
9	Instructor	11	5.4
10	Peer	49	23.9
11	Step mother or stepfather	4	1.9
12	Driver	7	3.4

N = 198

Respondents who gave no response or not applicable were excluded

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4.4.2 Frequency and percentage of perpetrator's gender on survivors by sex.

Perpetrators	**Victims**	
Sex	**Male n / %**	**Female n/%**
Male	18 (32.7%)	100(81.3%)
Female	37 (67.3%)	23(18.7%)
Total	55 (100%)	123 (100%)

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When respondents were asked how long they have known the person before the abuse majority 136(40.6%) said five years to less than ten years closely followed by 54(16.1%) who said one day to less than one month others said20(6.0%) 1 year to less than 2 years; 17(5.1%) 2 years to less than 5 years; 13(3.9%) I month to less than 6 months; 8(2.4%) said did not know the person at all; 7(2.1%) said less than one day and 10 years or more respectively while 4(1.2%) said I week to less than 1month.resluts are presented in table 4.4.3 below

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Table 4.4.3 Length of time perpetrator is known to victim

How long have you known the person at the time of the incident	Frequency/n	Percent%
Did not know the person at all	8	4.9
less than one day	7	4.3
One day to less than 1 week	54	33.1
1 week to less than 1 month	4	2.5
1 month to less than 6 months	13	8.0
month to less than 1 year	10	6.1
1 year to less than 2 years	20	12.3
2 years to less than 5 years	17	10.4
5 years to less than 10 years	23	14.1
10 years or more	7	4.3

N = 198
Respondents who gave no response or not applicable were excluded

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4.5 RESPONSES TO INFLUENCING FACTORS THAT AID THE OCCURRENCE OF SEXUAL ABUSE

Respondents were asked where they were abused and majority said at school 94(28.1%); closely followed by those who said at home 65(19.4%); some said on the play ground 43 (12.8%); others said at work 9(2.7%) and in the church 7(2.1%); only a few mentioned the mosque 4(1.2%). When asked if they were left in isolation majority of the respondents said yes 120(35.8%) while few of them said no 54(16.1%). Furthermore the respondents were asked how many persons committed the unwanted sexual act and majority of them said one person 104(31.1%) slightly above quarter said more than one person 46(13.7%) while 11(3.3%) do not recall how many persons has committed the unwanted act against them. A total of 20(6.0%) respondents preferred not to answer and 38(11.3%) gave no response while 116(34.6) of the respondents said it was not applicable to them. Results are presented in table 4.4.1 to 4.4.3

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Table 4.5.1 location of abuse

s/n	Location	Frequency	Percentage%
1	At home	65	29.3
2	At school	94	42.3
3	At church	7	3.2
4	At mosque	4	1.8
5	On the playground	43	19.4
6	At work	9	4.0

N = 198

Respondents who gave no response or not applicable were excluded

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Table 4.5.2 Survivors who were in isolation during the time of abuse

In isolation	Frequency/n	Percent%
Yes	120	62.8
No	54	28.3
Don't know	17	8.9
Total	191	100.0

Respondents who gave no response or not applicable were excluded

Table 4.5.3 Perpetrators who abused survivor

Number of persons	Frequency/n	Percent%
One person	104	57.5
More than one person	46	25.4
Do not recall	11	6.1
Prefer not to answer	20	11.0
Total	181	100

Respondents who gave no response or not applicable were excluded

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4.6 Health Seeking Practices

When asked the question "After the incident did you talk to anyone about it, regardless of whether you reported it'' responses are shown in the table below

Table 4.6.1 Respondents disclosure after the incident occurred

Response	**Frequency/n**	**Percent%**
Yes	39	11.6
No	128	38.2
Do not recall	2	.6
Prefer not to answer	19	5.7
Total	188	56.1

Respondents who gave no response or not applicable were excluded

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To those who said yes they talked about it further question was asked to probe more on who they talked with and 23(6.9%) said friend; 2(0.6%) said older person; 9(2.7%) said family member; 1(0.3) said crises counselor, health care professional, and law enforcement official respectively. Two said chaplain/religious leader accounting for 0.6% while 3(0.9%) did not recall who they talked with and 20 (6.0%) preferred not to answer. When asked if they talked to someone else about the incident apart from those mentioned above none answered yes. When asked "**How soon after the incident did you talk to someone about it"** 20(6.0%) said within 3 days of the incident; 9(2.7%) said within 4-30 days of the incident; 8(2.4%) said within 31-365 days of the incident; two (0.6%) reported longer than 365 days after the incident while 6(1.8%) did not recall and 27(8.1%) preferred not to answer. A total of 235(70.1) said not applicable while 28(8.4%) gave no response.

Another question was asked on the type of help gotten and 12(3.6%) said medical; 19(5.7%) said counseling and 5(1.5%) said legal services. Majority of the survivors did not formally file any report when asked; No had a total of 173(51.6%) and yes had only 14(4.2%); one person did not recall accounting for 0.3% and 112(33.4%) said it was not applicable to them while 27(8.1%) gave no response.

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4.7 Level of disclosure

To those who answered no they did not report formally further questions were asked to find out reasons why they decided not to report majority of the survivors 107(31.9%) said they did not trust the reporting process; 90(26.9%) said they were afraid of been treated badly; 76(22.7%) said they did not want to cause any trouble;75(22.4%) said they did not think it was serious enough to report; 72(21.5%) said they did not want family to know; 67(20.0%) said they were concerned over protecting their identity; 66(19.8%) said it was not clear that it was a serious crime or harm was intended; 64(19.1%) survivors said they did not want older people to know and 64(19.1%) said they did not want colleagues to know; 63(18.8%) said they did not know how to report;60(17.9%) said they lack proof the incident happened and below quarter 52(15.5%) said they were afraid of retaliation or that the incident will happen again.

Respondents were asked to state the reason that best describes why they decided to report for those who said yes to the question "did you formally report the incident". 12(3.6%) said to stop the person from committing other crimes against anyone;12 (3.6%) said because it was a crime; 6(1.8%) said they reported to get medical care after the incident while 5(1.5%) said they reported to get help; few3(0.9%) of those who reported said to punish the person and only two said to catch or find the person accounting for just 0.6% of the survivors who formally reported the incident.

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Respondents were asked if they had any other thing to share about the incident that was not covered in the questions above and their Reponses are as follows ; people always cheat the visually impaired 2 (0.6%); Nothing 16(4.8%); I was well protected at home it all began when I started secondary school 1(0.3%); she use to playfully touch sensitive parts of my body 1(0.3); Not applicable 272(81.2%); no response 43(12.8%).

Respondents were asked on recommendations they have for professionals handling the visually impaired as to response to unwanted sexual experience and 238(71.0%) said they needed more training; 237 (70.7%) said creation of sexual assault response team; 236(70.4%) said more prevention education be given; 228(68.1%) said more consequences for offenders and 184(54.9%) said more victim advocate should be provided.

Respondents were asked to give additional recommendations and the results are provided in table 4.7.1 below.

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Table 4.7.1Respondents Recommendations for preventing sexual abuse

Comments	Frequency /n	Percent%
teaching people not to engage in such act	14	4.2
teaching other people to abstain from sexual intercourse when they are young	4	1.2
sex education should be taught by parents and teachers extensively	64	19.1
religious talk	34	10.1
public awareness	4	1.2
visually impaired should be taught on how to freely express themselves when they are abused	3	0.9
visually impaired females should never be left alone with the opposite sex	5	1.5
improved policy to formulate law to protect the privacy of the visually impaired	4	1.2
promotion of gender equality	2	0.6
integration between the sighted and visually impaired	3	0.9
Teachers should be well interviewed and monitored before they are employed	2	0.6
provision of education for the visually impaired	4	1.2
more social amenities	10	3.0
empowerment should be given to the visually impaired	49	14.6
more training for teachers	1	0.3
No response	132	39.4

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4.8 TEST OF HYPOTHESIS

Hypothesis 1: There is no association between gender and sexual abuse;

Table 4.8.1 Prevalence of sexual abuse by gender

Sex	Sexual abuse				
	Yes	No	Not applicable	No response	Total
Male	48(36.9%)	79(60.8%)	0(0.0)	3(2.3%)	130
Female	150(73.2%)	52(25.4%)	1(0.5%)	2(1.0%)	205
Total	198(51.9%)	131(39.1%)	1(0.3)	2(1.0%)	335

	Value	Df	P value
Pearson Chi-Square	44.763[a]	3	.000

For hypothesis 1 (Ho1): the table shows that there is a significant association between gender and unwanted sexual experience (X^2 cal.=44.763, df=3, P= 0.000 which is less than 0.05) therefore the null hypothesis is rejected.

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Hypothesis II: There is no association between age and prevalence of sexual abuse;

Table 4.8.2 cross tabulation of age and sexual abuse

Age Range	**Sexual Abuse**		
	Yes	No	Total
16-19	110 (32.8%)	90(26.9%)	200 (59.7%)
20-24	50(14.9%)	23(6.9%)	73(21.8%)
25-34	35(10.4%)	22(6.6%)	57(16.1%)
35-49	2(0.5%)	1(0.3%)	3(0.8%)
50-64	1 (0.3%)	1(0.3%)	2(0.6%)
Total	198(59.1%)	137(40.9%)	335(100%)

Chi-Square Tests	Value	Df	P value
Pearson Chi-Square	2.649[a]	27	.000

For hypothesis 11 (Ho1): the table shows that there is a significant association between age and prevalence of sexual abuse (X^2 cal.=88.958, df=27, P= 0.000 which is less than 0.05) therefore the null hypothesis is rejected.

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CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATION S

The findings obtained from this study were discussed using the information and data obtained the quantitative analysis. The implication of the findings as well as conclusion and recommendation were presented in this chapter.

5.1 Social Demographic Characteristics

Findings of the study showed that there were more females than males among the respondents. The ages 16-19 years were more in the study which might be due to the fact that there are more visually impaired young adults in the state.

The respondents were mainly Yoruba ethnic group. This might be due to the fact that the main language of communication in the state is Yoruba, especially in the traditional inner core areas. English and pidgin are spoken along with Yoruba in other areas because of the rich mixture of non-indigenes.

Majority of the respondents were Christians despite the fact that Islam and Christianity are two predominant religions in the state; there was no recognized traditional religionist among the respondents.

5.2 Prevalence of Sexual Abuse among the Visually Impaired

The prevalence of sexual abuse was measured by considering the type of unwanted sexual experience which includes; sexual contact, unwanted anal or oral sex, sex act and unwanted sexual experience which is encompassing of the former three mentioned.

The research findings indicated that more females were abused when compared to their male counterparts and this findings concurred with past studies that postulated that level of sexual abuse could be related to gender.(Powers et al, 2004; Hassouneh-Phillips and curry, 2002; Hughes et al, 2001; powers et al, 2002; Sobsey and Doe, 1991; Turk and Brown; 1993; Young et al 1997).

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The result indicated that less than quarter of the respondent had experienced sexual contact without their consent while some of the respondent has experience oral or anal sex without their consent, others reported to have been engaged in a sex act without their consent. This indicate that sexual abuse is been perpetrated among the visually impaired (NcGee et al, 2002).

Findings of the study showed that sexual abuse are been committed under the following circumstances ranging from the perpetrators committing the act under the use of drugs or other intoxicant, force, threat, causing of serious injuries etc. on their victims. The study also discovers that there is an apparent significance between gender and unwanted sexual experience which varies from touch on sensitive part, continuous harassment to forcefully engage in any sex act and full sexual intercourse without consent. Visually impaired females reported a high rate of unwanted sexual experience when it comes to touch on sensitive part of their body. A large number of respondents reported touches on their genitals without consent and above a quarter had been forced to touch other person genitals against their wish. Above half of the respondent had experienced an attempt to have sexual intercourse against their wish.

When the timing of unwanted sexual experience was tested, a large number of respondent had encountered unwanted sexual experience twice, slightly below half of the survivors had encountered unwanted sexual experience three or more times and a quarter of the survivors had unwanted sexual experience once.

Prior to the commencement of the research, the bulk of sexual abuse experienced by the survivors took place thirty days earlier and majority of the survivors fell within the age range of sixteen through nineteen indicating that more of the young adults are been assaulted, this falls in line with the findings of previous study by (Lund, Emily and

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Vaughl-Jenses, 2012). And this is also supported in another study by (Aderemi and Pillay 2012).

5.3 Perpetrators of sexual abuse

Nearly all female reported that the perpetrator was a male while the majority of men that have been sexually abuse reported that the perpetrators are female. Findings suggest that sexual assault are typically been committed by multiple perpetrators, though some are committed by individuals. Perpetrators relationship to victims and the length of time known ranges from short to long period. Reported relationship correlate highly with length of time victim knew there perpetrators, in this study victims tend to have known there perpetrators for either a long or short time before the incident occurred consistent with majority saying there perpetrator was a stranger. This finding is similar to findings from the study of (Cross, Kaye, Ratnofsky 1993).

Generally, from findings female are more prone to multiple sexual abuse and this finding is in agreement with earlier works of (Aderemi and Pillay 2012), (Sullivan and Knutson).

5.4 Influencing factors aiding the occurrence of sexual abuse

Sexual abuses are taking place at home, in the school, at church, at mosque, on the playground and at work. But majority of the sexual abuse that occurred in this study was in school closely followed by a large percentage that occurred at home and a bit less that occurred on the playground. A small percentage occurred at work, at church and in the mosque. This findings fall in line with study of (Cont et al, 1989) found out that children with disabilities are often under the care of, and in contact with, several adult caregivers among who may be potential abusers. In addition, some potential abusers will seek a child who appears vulnerable and uncertain, who demonstrates a need for contact, and who either will not tell of the actor who would likely not be believed should they tell. It

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was discovered that more of the sexual abuse was perpetuated when the victim was left in isolation and majority of the abuse was perpetrated by one person.

Self-disclosure by victims of abuse is very important to initiate legal and therapeutic intervention but findings from the study shows that non-disclosure of sexual abuse either formally or non-formally is common. Most of the victims wanted to report and also did not want to report because they were afraid of not being believed; being asked questions on their wellbeing; feeling ashamed of what happened and blaming themselves for the abuse and for the consequences of disclosure. For some victims, the barriers to reporting concerned the act itself and whether they think it is worthy of reporting their experience. As one of the respondent wrote in the open ended portion of the survey that ''people always cheat the visually impaired'''

Regardless of gender, the top reason for not reporting the incidence is because the survivor did not think the reporting process was okay. While formal reporting is low, survivors are talking to someone about what happened to them, and are typically having those conversations almost immediately after the incident occurred.

At the conclusion of the survey, all respondent regardless of their experience of sexual abuse where asked for recommendations on how professional could better respond to sexual abuse on the visually impaired. The top recommendation was to focus on the need for more training of professionals in their response to sexual abuse closely followed by the creation of a sexual abuse response team and more prevention education to reduce the prevalence of sexual abuse.

5.5 Implication of the findings for health promotion and education

The findings from this study have several implications for providing a curriculum for abuse prevention and empowerment. Health promotion is a Process to enable people have full control over their health and its determinant.

The combination of health educational and environmental supports for preventive actions aids the empowerment of the visually impaired in protecting themselves and also the

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provision of preventive health services through the improvement of the social, physical and economic environment.

5.6 CONCLUSION

It is very important to improve effort on sexual abuse prevention policy and support policy for survivors. The level of disclosure when tested in this study was below average and majority of the respondent who had encountered unwanted sexual contact will rather keep it to themselves than disclose debarring necessary steps from been taking. This is due to the Fact that majority of the survivor had a belief that nothing can be done even if they report and furthermore that reporting expose them to more harm than good. The silent cries of the survivors are going unheard because majority of the survivors place themselves in a state of self-denial thereby telling themselves that it has been done and nothing can be done to change the occurred incident.

Disability is a major factor that contribute to a person's vulnerability to assault, and the prevalence of sexual abuse among the visually impaired is relatively high because of their inability to effectively to describe their perpetrator due to their visually impairment and their constant need for care. And this findings is supported from the study of

Feelings of shame and fear, lack of understanding regarding the reporting process, perceived lack of seriousness of offence and fear of retaliation are deterring survivors from reporting. Therefore, it is very important to continue to improve medication about the type of services and resources available after sexual abuse and aim to reduce the stigma that may be associated with seeking help, be it medical, psychological or legal assistance. Reducing the stigma associated with sexual abuse is also helped by taking the emphasis of the victim and stressing that it is not the victim, but the offender who should feel the shame.

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5.7 **RECOMMENDATIONS**

The main aim of this study is to make parents, counselors, professionals to identify the important variables in prevalence of sexual abuse and the level of disclosure / reason for non-disclosure. The study also aim at assisting these groups to help all visually impaired in their care to be more protected and informed on the existence of sexual abuse. It is therefore recommended that;

(1) Policy makers and professionals should provide an environment that promotes educational programs, policies and procedures with the core goals of increasing sexual abuse awareness and prevention, providing support for survivors and holding perpetrators responsible for their actions.

(2) Effort should be made towards combating sexual abuse through cultural change by conducting a formal evaluation of training effectiveness which will help in eliminating attitudes and behaviors that lead to sexual abuse and creating an environment that provides support and justice to survivors.

(3) Parents should be encouraged to adopt the habit of educating their children on signs of sexual abuse and preventive measures they can take to protect themselves.

(4) Enhance and expand upon peer education. Training and education programs should be made for peers on the important role they can play in terms of advice and support provided to a survivor who may confide in a peer following a sexual assault. Peer training should provide guidance on how to respond when a survivor discloses an incident as well as promoting greater understanding of reporting options and various sources of support and care that may be available to victims.

(5) Law enforcement agencies should lay more emphasis on offenders been punished when caught and give assurance to survivors that they would be well protected.

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5.8 SUGGESTIONS FOR FURTHER RESEARCH

Majority of the respondent indicated that more training should be given to professionals and on how to teach sexual education to them. This desire for more information of sex education points to the need for further research to know the sexuality of the visually impaired.

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APPENDIX

QUESTIONNAIRE ON PREVALENCE OF SEXUAL ABUSE AMONG VISUALLY IMPAIRED YOUNG ADULTS AND ADULTS IN OYO STATE

Dear Respondents,

My name is Kolawole Bimbo Dominica Grace a post graduate students of the Department of Health Promotion and Education, Faculty of Public Health, Collage of Medicine, University of Ibadan. The purpose of this study is to **investigate the prevalence of sexual abuse among visually impaired young adults and adults in Oyo State.** The findings from this study will help in the design of intervention programs and formulate policies to address sexual abuse among the visually impaired.

Your identity, responses and opinion will be kept strictly confidential and will be used for the purpose of this research only. Your kind assistance is sought for you to answer the question accurately as possible to make the research a success. However, your participation is voluntary and you may request to withdraw at any time.

SECTION A Socio Demography

001. How old are you (as at last birthday) ? ______________________________

002. Sex: 1. Male [ ] 2. Female [ ]

003. Religion 1. Christian [ ] 2.Islam [ ] 3. Others (Specify) ____________

004. Ethnicity 1. Yoruba [ ] 2.Igbo [ ] 3.Hausa [ ] 4. Others (specify)_____________

005. Who is your confidant? ___________________________

006. What is your occupation? ____________________________

007. Marital status? __________________________

SECTION B Prevalence of sexual abuse

008. ***(Please tick (√) the appropriate response***

008a) Has someone ever had sexual contact with you without your consent?

1.Yes [ ] 2.No [ ]

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008b) has anyone ever made you have sexual contact with another person without your consent? 1.Yes [ ] 2.No [ ]

008C) If yes to question**008A** please indicate whether or not each of the following describe how the person sexually contacted you or how he or she made you have sexual with another person without your consent

S/N	STATEMENT	YES	NO	DON'T KNOW
I	By ignoring your efforts to communicate that you did not want this to happen			
Ii	By not giving you the chance to express your willingness			
Iii	By committing the act while you were asleep or unconscious			
Iv	By committing the act after you used drugs or other intoxicants to the degree that a) you couldn't understand what you were doing b) you couldn't refuse to participate c) you couldn't communicate your unwillingness to participate			
V	By being given drugs or other intoxicants without your knowledge so that you couldn't understand or control what you were doing			
Vi	By being forced to use drugs or other intoxicants so that you couldn't understand or control what you were doing			
Vii	By threats that you would be killed, kidnapped, or seriously injured			
Viii	By other threats			
Ix	By causing serious injury			
X	By force			

008D) has someone ever made you engage in oral sex or anal sex without your consent?

1) Yes [ ] 2) No [ ]

008E) has someone ever attempted to make you engage in oral sex or anal sex without your consent, but was not successful?

1) Yes [ ] 2) No [ ]

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008F If yes to questions **008D** please indicate whether or not each of the following describes how the person attempted to make you engage in oral sex or anal sex without your consent

S/N	STATEMENT	YES	NO	DON'T KNOW
I	By ignoring your efforts to communicate that you did not want this to happen			
Ii	By not giving you the chance to express your willingness			
Iii	By committing the act while you were asleep or unconscious			
Iv	By committing the act after you used drugs or other intoxicants to the degree that a) you couldn't understand what you were doing b) you couldn't refuse to participate c) you couldn't communicate your unwillingness to participate			
V	By being given drugs or other intoxicants without your knowledge so that you couldn't understand or control what you were doing			
Vi	By being forced to use drugs or other intoxicants so that you couldn't understand or control what you were doing			
Vii	By threats that you would be killed, kidnapped, or seriously injured			
Viii	By other threats			
Ix	By causing serious injury			
X	By force			

009) have someone ever made you engage in a sex act without your consent?

1) Yes [ ] 2) No [ ]

010). has someone ever attempted to make you engage in a sex act without your consent, but was not successful?

1) Yes [ ] 2) No [ ]

010A) If yes to question **010** briefly describe how the attempt to engage in that sex act was not successful………………………………………………………………………………
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011) If yes to question **009** please indicate whether or not each of the following describes how the person attempted to make you engage in the sex act without your consent?

S/N	**STATEMENT**	**YES**	**NO**	**DON'T KNOW**
I	By ignoring your efforts to communicate that you did not want this to happen			
Ii	By not giving you the chance to express your willingness			
Iii	By committing the act while you were asleep or unconscious			
Iv	By committing the act after you used drugs or other intoxicants to the degree that a) you couldn't understand what you were doing b) you couldn't refuse to participate c) you couldn't communicate your unwillingness to participate			
V	By being given drugs or other intoxicants without your knowledge so that you couldn't understand or control what you were doing			
Vi	By being forced to use drugs or other intoxicants so that you couldn't understand or control what you were doing			
Vii	By threats that you would be killed, kidnapped, or seriously injured			
Viii	By other threats			
Ix	By causing serious injury			
X	By force			

012) Which of the following describe the type of unwanted sexual contact you have experienced?(Tick several answers possible)

Unwanted Sexual experience	Yes	N0	Don't know
(1) Touch on sensitive parts of the body without consent Breast Penis Virginal buttocks			
(2) Attempted touch on sensitive parts without consent			
(3) Oral sex without consent			
(4) Anal sex without consent			
(5) Attempted oral sex			
(6) attempted anal sex without consent			
(7) kiss without consent			

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(8) Attempted kiss without consent			
(9) continuous harassments to forcefully engage in any sex act			
(10)touch of genitals without consent			
(11) listening to sexual words about your body against your will			
(12) someone fully had sexual intercourse with you against your will			
(14) forcing you to stay where sexual intercourse is been committed against your wish			
(15) hug against your wish			
(16) forcing you to touch his/her genitals against your will			
(17) rubbing his/her genitals on your body against your will			
(18) someone attempted to have sexual intercourse with you against your will			
(19) prefer not to answer			

(If No to all the options skip to Q 31)

013) On how many different occasions have you encountered unwanted sexual experiences

1. One time [ ]

2. Two times [ ]

3. Three or more times [ ]

4. Do not recall [ ]

014 how long ago did this incident occur?

1.Within the past 30 days [ ] 2One month to less than 6 months ago [ ]
3. Six months to less than one year ago [ ] 4.One year to less than 2 years ago [ ]
5. Two years to less than 5 years ago [ ] 6.Five years to less than 10 years ago [ ]
7. Ten or more years ago [ ] 8. Do not recall [ ]
9. Prefer not to answer [ ]

015 what was your age at the time of the incident?

1. 16-19 [ ] 2. 20-24 [ ] 3. 25-34[ ] 4. 35-49 [ ] 5. 50-64 [ ]

6. 65 or older [ ] 7. Do not recall [ ] 8. Prefer not to answer [ ]

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SECTION C Perpetrators of sexual abuse

For the next set of questions, please think about the main person who committed the unwanted act(s) in this incident.

016 Was the person who committed the unwanted act(s):

1.Related [ ] 2. Not related [ ] 3. Do not recall [ ] 4. Prefer not to answer [ ]

017 which of the following describes your relationship to this person at the time? (***several answers possible***)

1. Stranger [ ] 2.Mother or father's friend [ ] 3.brother or sister [ ] 4.family friend [ ]

5.Half 5 brother/sister [ ] 6.Neighbor [ ] 7.uncle or aunt [ ] 8.teacher [ ]

9. grandfather/grandmother [ ] 10.Instructor [ ] 11.peer [ ] 12.mother/father [ ]

13. stepmother/stepfather [ ] 14. Others (specify without giving names)

……………………………………..

15. It never happened to me [ ]

018 was the person who committed the unwanted act a male or a female?

1. Male [ ] 2.female [ ] 3.prefer not to answer [ ]

019 how long had you known the person at the time of the incident?

1. Did not know the person at all [ ] 2. Less than one day [ ]

3.One day to less than 1 week [ ] 4. 1 week to less than 1 month [ ]

5. I month to less than 6 months [ ]

6. 6 months to less than 1 year [ ] 7. 1 year to less than 2 years [ ]

8. 2 years to less than 5 years [ ] 9. 5 years to less than 10 years [ ]

10. 10 years or more [ ] 11. Do not recall [ ] 12. Prefer not to answer[ ]

SECTION D influencing factors

020where were you abused**(tick all that applies)**

1. At home [ ] 2. At school [ ] 3.At church [ ] 4.At mosque [ ]

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5. On the playground[ ]   6.At work [ ]   7.Others (specify)…......................   8. It never happened to me [ ]

021 where you left in isolation

1.Yes [ ]   2.No [ ]   3. I don't know [ ]

022 Did one person or more than one person commit the unwanted act(s) in this incident?

1. One person [ ]   2. More than one person [ ]   3.Do not recall [ ]

4. Prefer not to answer [ ]

SECTION E Health seeking practices

023 After the incident occurred, did you talk to anyone about it, regardless of whether you reported it?

1. Yes [ ]   2.No [ ]   3. Do not recall [ ]   4. Prefer not to answer [ ]

024 which of the following describe who you talked to about the incident, not including those you may have talked to in order to make an official report? (Tick all that apply)

1. A colleagues at work [ ]   2.A friend [ ]   3.An older person [ ] 4.A family member [ ] 5.A crises counselor [ ]   6.A chaplain or religious leader [ ]   7.A health care professional [ ] 8. A law enforcement official [ ]

9. Someone else (specify without giving name)…………………………….

10. Do not recall [ ]   11. Prefer not to answer [ ]

025 How soon after the incident did you talk to someone about it?

1.Within 3 days of the incident [ ]   2.Within 4-30 days of the incident [ ]

3. Within 31-365 days of the incident [ ] 4. Longer than 365 days after the incident [ ]

6. Do not recall [ ]   7. Prefer not to answer [ ]

026 Did you receive any of the following types of help after the incident?

S/N	**Statement**	**Yes**	**No**	**Do not recall**	**Prefer not to answer**
I	Medical care				
Ii	counseling				
Iii	Legal services				

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027 Did you formally report the incident?

1. Yes [ ]   2. No [ ]   3. Do not recall [ ]   4. Prefer not to answer [ ]

028 If no to **Q027** please indicate whether or not each of the following was an important reason why you did not want to report the incident.**028**

S/N	Statement	Yes	No	do not recall	Prefer not to answer
I	Did not want older people to know				
Ii	Did not want colleagues to know				
Iii	Did not want to cause any trouble				
Iv	Did not want family to know				
V	Lack of proof that incident happened				
Vi	Fear of been treated badly if you report it				
Vii	Not clear it was a crime or that harm was intended				
Viii	Did not know how to report				
Ix	Afraid of retaliation or that the incident will happen again				
X	Did not think it was serious enough to report				
Xi	Did not trust the reporting process				
Xii	Concerned over protecting your identity				
Xiii	Other				

029 If YES to question **27** which of the following best describes the main reason why you decided to report the incident?

1.To get help after the incident [ ]   2.To get medical care after the incident [ ]

3. To prevent further crimes against you by the person [ ]

4. To stop this person from committing other crimes against anyone [ ]

5. To punish the person [ ]   6.To catch or find the person [ ]   7.Because it was a crime [ ]8. Other …………………………   9.Do not recall [ ]   10. Prefer not to answer [ ]

030 Is there anything else important to share about the incident that has not been covered in the questions asked above? (Please do not provide names of individuals or any specific details about the event that will allow it to be identified.……………....................

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031 What recommendations do you have for how the professionals handling the visually impaired persons could respond to unwanted sexual experience? (Tick all that apply)

1.More training [ ] 2.More prevention education [ ]

3. Creation of sexual assault response team [ ] 4.More victim advocate [ ]

5. More consequences for offenders [ ]

032 Please provide additional recommendations

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Thank you for you participation.

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