EVALUATING THE MEDICAL CARE OF CHILD SEXUAL ABUSE VICTIMS IN A GENERAL HOSPITAL IN IBADAN, NIGERIA

O.K. IGE[1] and O. I. FAWOLE[2]
[1]Department of Community Medicine, University College Hospital, Ibadan, Oyo 20001, Nigeria and [2]University of Ibadan, Ibadan, Oyo, Nigeria

Corresponding Author: *Dr. O.K. Ige* ***E-mail:*** *drsimbo@yahoo.co.uk*

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SUMMARY

Objectives: Evaluation of the medical care provided to victims of Child Sexual Abuse (CSA).

Design: A retrospective cross sectional study.

Setting: The general outpatient clinic of a 150 bed secondary health care facility in Ibadan, Nigeria

Participants: Children < 18 years who were treated as Victim's sexual assault.

Main Outcome measure: Investigations and treatment prescribed for CSA victims.

Results: The median age of victims was 12 years (range 3-17 years). All were females and 33.3% had attained menarche. Many (68.1%) had torn hymen; of these, 16.3 % also had vaginal lacerations and bleeding. Children>10 years more often had torn hymen (P<0.001). Vaginal swab microscopy was done in 84.0% of those with torn hymen. About 60% of victims had retroviral screening done (all were non reactive) the retroviral screening of the perpetrator was requested in only case. None of the patients received post exposure prophylaxis for HIV. Of those with signs of vaginal penetration who had also attained menarche 12.2% had emergency contraceptives prescribed. Treatment of victims consisted mostly of antibiotics - 47.2% and analgesics- 37.5% with only 15.3% of patients proffered any form of counselling.

Conclusions: There is a still a huge gap between the health care needs of victims of CSA and the medical services provided for victims of CSA. The use of a treatment protocol and additional training for health care providers in the management of CSA victims is encouraged.

Keywords: child sexual abuse, medical care, evaluation, Nigeria

INTRODUCTION

Childhood sexual abuse (CSA) is a major public health problem affecting thousands of children and adolescents globally.[1] A growing number of studies, particularly from sub-Saharan Africa, indicate that the first sexual experience of girls is sometimes unwanted and forced.[2]

There is increased interest in CSA internationally because of the increasing evidence that sexual violence can have a profound impact on the physical, psychological, and social wellbeing of survivors.[3,4] In addition to immediate genital and bodily injuries, other risks include HIV and other sexually transmitted infections, unwanted pregnancy, urinary tract infection, depression and post-traumatic stress disorder.[5]

Many of the programs developed to respond to the needs of females who have been assaulted sexually are based in health care settings, including hospital emergency departments and gynaecological clinics.[6, 7] This is because healthcare providers play a critical role in the identification, treatment, and prevention of sexual violence.[8] The health sector thus plays the central role in providing comprehensive clinical care after sexual assault.[9] Child sexual abuse (CSA) victims require comprehensive health care to cope with the physical and mental health consequences of their experience. The evaluation of the health service delivery to victims of CSA is crucial because several important aspects of care after sexual assault are time dependent, such as emergency contraception, post exposure prophylaxis for HIV and collection of forensic evidence.[8] To date, few health sector interventions for sexual assault have been evaluated in Nigeria. The findings from this survey would have implications for guiding policies on the development of a viable treatment program for children and adults who have been victims of CSA in Nigeria.

SUBJECTS AND METHODS

This study was conducted at a general hospital in the city of Ibadan. Ibadan is situated in the south-western part of Nigeria and is the commercial, educational and administrative centre of Oyo State. The general hospital is a 150-bed hospital which functions as a referral centre for surrounding primary care facilities. Rape cases are treated within the hospital's outpatient department, which is staffed by a team of four doctors and six nurses on the average. A review of the records of all patients less than 18 years age, seen over a 12 month period (June 2008-May 2009) was conducted.

Ethical approval was obtained from the University College Hospital Institutional Review Board before the study was commenced.

Cases were identified based on a diagnosis of rape or sexual assault from the outpatient register of the hospital. Information was extracted from the medical records of eligible patients using a pretested 30-item structured chart review form. The form documented clinical care received, including history, physical examination, laboratory investigations, drug treatment, referrals and police notification. A total of 90 records were retrieved, of which 72 had enough information to be included in the analysis. Data was entered and analysed with SPSS version 15 software. Associations between variables were tested with the chi square test at a level of statistical significance of 5%.

RESULTS

Socio-demographic characteristics of CSA patients

Table 1 shows the patients' socio-demographic characteristics. The ages of children ranged from three to 17years; median age was 12 years while the modal age was 5 years. All the patients were females.

Table1 Socio-demographic characteristics of CSA patients

Variable	N=72, n (%)
Age	
10 and below	31(43.1)
Older than 10	41(56.9)
Parents' Religion	
Christianity	34(47.2)
Islam	38(52.8)
Area lived	
High density	53(73.6)
Low density	19(26.4)
Caregivers	
Guardian	2 (2.8)
Parents	69(95.8)
Sister	1 (1.4)

Description of circumstances surrounding CSA incidence

The circumstances surrounding the abuse varied as shown in Table 2. Even though there was no documentation of the circumstances of the assault in 34(47.2%) of cases, 8(11.1%) of the victims were reported to have been assaulted by multiple assailants. Abuse most often occurred at the perpetrator's residence -21 (29.2%). In 44(61.1%) of cases, victims were assaulted in a residence while in 8 (11.1%) the assault occurred in school, street corners, bushes or uncompleted buildings. A familiar person was the perpetrator of CSA in 45 (62.5%) of cases.

Table 2 Description of the circumstances of the child sexual abuse incident.

Circumstances	n (%)
Multiple assailants	8(11.1)
Lured with money	6 (8.3)
Held at gunpoint	1(1.4)
Assaulted by an armed robber	1(1.4)
Beaten up	2(2.8)
Assaulted while on an errand	2(2.8)
Assaulted while hawking	5(6.9)
Attacked in a communal toilet	1(1.4)
Missing	34(47.2)
Place of abuse	
Victim's house	7 (9.7)
Perpetrator's house	21 (29.2)
School	6 (8.3)
Others(street corners, bushes and uncompleted buildings)	8 (11.1)
Missing	30 (41.7)
Identity of Perpetrator	
Familiar person (neighbours, friends)	45 (62.5)
Stranger	27 (37.5)

Table 3 Patients' history and findings on physical examination

Variable	N = 72, n(%)
Presenting complaint	
Sexual assault	68(94.4)
Vaginal discharge	2(2.8)
Pain on urination	1(1.4)
Nightmares	1(1.4)
Time to presentation	
Less than 72 hours	26(36.1)
More than 72 hours	46(63.9)
Menarche	
Pre-menarche	24(33.3)
Post- menarche	48(66.7)
Prior history of abuse	
Yes	6(8.3)
No	54(75.0)
Don't know	12(16.7)
Vaginal penetration	
Yes	49(68.1)
No	23(31.9)
Other physical examination findings	
Vaginal bleeding/cuts	8(11.1)
Others (bruises between thighs, sperm around introitus)	11(15.3)
None	53(73.6)

History and physical examination of the CSA victims

Table 3 shows the history and findings on physical examination of the abused children. The majority 68(94.4%) of children were brought because of a complaint of sexual assault. Time to presentation ranged between one hour and 30 days with a median time of 24 hours. Less than half - 26 (36.1%) presented within the critical 72 hours of the assault. On examination 49(68.1%) had signs of vaginal penetration.

Investigations and treatment

Table 4 shows the investigations prescribed for the victims. About three quarters 55(76.4%) had a vaginal swab for microscopy culture and sensitivity done and more than half 43(59.7%) had retroviral screening. However, only 1(1.4%) of all the patients had a request for the retroviral status of assailant. No further tests were done after the initial tests. Antibiotics were the most often prescribed medication 34(47.2%) followed by analgesics 27(37.5%). Just 11(15.3%) of the patients had some form of counselling. Of those with signs of vaginal penetration who had attained menarche 6 (12.2%) had emergency contraceptives prescribed. Four (5.6%) patients were referred for post exposure prophylaxis although the level of HIV risk was not documented for any of the patients. None of the patients had a follow up appointment.

Table 4 Investigations and treatment prescribed for CSA patients

Variable	**N (%)**
Investigations+	
High vaginal swab for MCS*	55(76.4)
Retroviral screening	43(59.7)
Full blood count	6 (8.3)
Treatment+	
Antibiotics	34(47.2)
Analgesics	27(37.5)
Vitamin supplements	18(25)
Counselling	11(15.3)
Oral contraceptives	6(8.3)
Tetanus toxoid	5(6.9)
Post exposure prophylaxis	4 (5.6)
Sedatives	3(4.2)
Suturing of lacerations	1 (1.4)

+ multiple responses

microscopy, culture and sensitivity

Police reports

Regarding statutory police notification, 17(23.6%) of the cases seen at the hospital were reported to the police. There was no significant association between case characteristics, relationship with the assailants or socio-demographic characteristics and police notification (P >0.05) Patient's characteristics, parameters and management of abuse and time to presentation. Children older than 10 years, those who had attained menarche, who lived in high density areas of town and those who had no history of previous sexual abuse were more likely to present within 72 hours of the assault (P< 0.05).

Regarding the patterns of abuse, children over 10 years and those who had attained menarche more often had signs of vaginal penetration (P<0.05). These children also had more requests for vaginal swabs for examination done (P<0.05). There was no association between the area in which child lived, the place of abuse or the relation with the assailant and signs of vaginal penetration (P>0.05). A significantly higher proportion of children with signs of vaginal penetration and also those who had attained menarche had retroviral screening done when compared with other children(P<0.05). With regards to treatment, antibiotics were more often prescribed for those who presented early (<72hours) following assault. There was no significant difference in the proportions of victims who had counselling with regards to age and time of presentation (P>0.05).

DISCUSSION

This study assessed the medical care provided to victims of CSA in a large city in South-Western Nigeria. Though this data was from a general hospital, which serves as a referral centre for other primary care providers, findings may not be entirely reflective of national practices. The peak ages of the victims were similar to those observed in the United States.[10] All the patients seen during the survey period were females as seen in other Nigerian studies [11] suggesting that the sexual assault of boys is either not a major public health problem or is not appreciated or reported. Vital information on the circumstances in which assault occurred was missing from the documentation in a lot of the cases reviewed in this study. The consensus on the minimum information required when documenting the history in CSA victims is that the date and time of the sexual assault, activities of patients following the assault, assault-related patient history, suspect information, methods employed by suspects and description of the sexual assault must be clearly stated in documentations of sexual assault victim.[10] This challenge of poor documentation is a major deterrent in conducting useful research on several reproductive health issues in the country especially in cases of sexual violence.[12] The incomplete documentation of findings seen in this study has been reported in other studies.[9,10.] About two thirds of the patients seen at this hospital had signs of vaginal penetration. This is at variance with a previous report that more than a quarter of physical examinations of children suspected of having been sexually abused are without definitive findings of sexual

abuse.[13] A possible reason for this may be that as opposed to other studies parents in this study brought their children as a result of complaints of assault by the children or discovery by the parents and not as result of a referral from a suspicious family physician.

The diagnosis and management of (STIs) is an important component of the treatment of assault victims.[14,8] About three quarters of patients in this study had investigations for sexually transmitted infections (STI) done but only a little over half were screened for HIV and none of the patients had any further tests done after the initial tests. Post assault care was also inadequate in this hospital, only about four out of every ten patients who had attained menarche and who presented within 72 hours of incidence had the required emergency contraception. This is consistent with reports from other sub Saharan studies which had reported that emergency contraception to prevent post rape pregnancy was not consistently offered to rape victims.[6] This oversight increases the chances of unwanted pregnancies with its mental and physical squealed.

A negligible number of patients were referred for post exposure prophylaxis and none had hepatitis B vaccine, most however had antibiotics prescribed as prophylaxis for other sexually transmitted infections. The recommendation is that prophylactic treatment for STI and HIV be provided to adolescent sexual assault victims. [15] This is especially important when there is mucosal exposure and in cases of repeated abuse or multiple perpetrators, or if the perpetrator is known to be HIV-positive and also in places with a high prevalence of HIV.[14] Only about a quarter of the cases reviewed in this study had any form of counselling. Although there was no specially trained counsellor for CSA in the health facility, none of the patients was referred for professional help. Psychotherapy has been a recognised way of moderating the negative effects of CSA on victims.[16-17]

Although health workers are required to report cases of CSA statutorily this was not always done.[18] This may be due to the reluctance for police involvement. This is might not be unconnected with the difficulties envisaged in seeking redress in sexual assault cases from the Nigerian legal system.[19] It may also be due to requests from parents who fear that the unwanted publicity that may ensue may cause more harm than good for their children.[20-21]

Similar to the findings from a baseline study on improving comprehensive care of sexual assault victim in South Africa[9] and other studies from the United states[22] the key problems identified in this study were substandard provision of clinical care; poor documentation, and lack of counselling and psychosocial referral. Obstacles were mainly due to provider barriers and patients' delays in seeking care.

CONCLUSION

There is a still a huge gap between the health care needs of victims of CSA and the medical services provided for victims of CSA. The use of a treatment protocol and additional training for health care providers in the management of CSA victims is encouraged. More research is encouraged in evaluating health care–based interventions for sexual violence survivors, especially studies on CSA, in Nigeria and other African countries.

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