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A TALE OF TWO CASES: INSTITUTIONAL RESPONSE TO SEXUAL VIOLENCE IN A NIGERIAN TEACHING HOSPITAL

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Abstract.

Sexual Violence (SV) is a severely traumatic experience that largely and disproportionately affects women and children. It is a global phenomenon that is grossly under reported as most assailants are known to the survivors. In Nigeria, the issue is made worse because of the culture of silence around the phenomenon, worsening underreporting and care. This report highlights some of the issues in the management of such cases in a Nigerian Teaching Hospital and emphasizes the need for a formal guideline to govern the care of survivors.

Background

Sexual Violence (SV) is a major public health problem with attending short and or long term physical and psychological consequences. Sexual violence is any act or attempt to obtain a sexual act by violence or coercion, acts to traffic a person or acts directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work[1]. SV encompasses a lot of other related concepts, including but not restricted to rape, sexual assault, harassment and exploitation, coercion and incest. Incest is sexual activity between family members or close relatives. Various types exist depending on the degree of blood relationship between those involved, however that between first degree relatives is almost universally unaccepted.SV can occur to anyone at any age, including men and boys, however, women and children are the commonest victims[2]. The occurrence of SV is not limited to armed conflict situations alone, it is also high in times of peace[3]. SV is perpetuated not for sexual gratification but to impose or exercise power and dominance over victim[4].

Sexual Violence is an act with far reaching consequences. The prevalence of SV varies due to gross under reporting especially in a developing nation like Nigeria. This under reporting has been attributed to the enduring culture of male dominance, female social and economic disempowerment and poor or non-prosecution of sex offenders[5]. World Health Organization (WHO) stated that 1 in 3 women throughout the world would experience physical and or sexual violence by a partner or sexual violence by a non- partner with prevalence in the African region being 36.6%[6]. In Nigeria, as well as the global scene, there is a dearth of information on the prevalence of sexual violence as data is usually infered from reports in the media, various non-governmental organizations (NGOs), medicolegal clinics and the police. However, in most cases, this is just the tip of the iceberg[7].In a 5-year retrospective study in Lagos by Akinlusi and colleagues (2014) put the prevalence of SV at 8% which was lower than the prevalence in Ibadan (15%) and Maiduguri (13.8%)[8-10]. Badejoko and colleagues (2014) found a prevalence of 69% in a 5-year retrospective study in Ile-Ife[11]. Adeleke and colleagues (2012) found much lower figures in their study where they reported a steady rise in annual cases from 0.72% in 2003 to 3.6% in 2009 in Osun State[12]. The wide discrepancy in the prevalence between locations in the country might have more to do with the measurement of the concept of SV than actual differences in various populations.

Several factors influence the gross under reporting, hence under prosecution of SV cases. The case in Nigeria is not different from what happens in most developing countries. The role of culture in defining the concept of sexual act and sexual violence has been identified as a factor, for example in patriarchal society where the male is seen as superior and masculinity is closely associated with dominance, SV is sometimes tolerated[13]. Stigmatization about being referred to as 'damaged goods' and the need to preserve the family integrity have continued to encourage the culture of silence in reporting SV[14]. Myths surrounding rape is another factor for under reporting cases of SV, the victim is often blamed for various infarction (including but not limited to indecent dressing, being out late at night, being out alone and visiting an individual of the opposite sex alone) instead of the perpetuator. Other factors include the erroneous belief that inability of the survivor to provide evidence of injury or struggle during the attack means that the survivor eventually enjoyed the act therefore it could not have been an assault[15]. This also translates to the barrage of questions asked by the law enforcement agents and the need to provide evidence beyond reasonable doubt[16].

Case studies

Case 1: Miss PE is a 15-year-old native of Cross river State. On the 8th of August, 2017, she was brought to the adult accident and emergency unit of Hospital A by 2 police men for medico-legal examination. At the time she was a pre-menarcheal girl in senior secondary school who hailed from Akpe, Cross- River state. She had travelled to her maternal uncle in Ile-Ife to learn a skill about 6 months prior to presentation. Her uncle, a married man with 2 children and a pregnant wife put her to work at his shop frying potatoes. He did not enroll her in any training nor did he talk about her education. He attempted to have sex with her on the 3rd day after her arrival without success. However, 2 days after this, he had unprotected penetrative sex with her and threatened to physically assault her if she reported to any person. He continued to have unprotected sex with her on the average of two times a week until presentation. He used the withdrawal method for contraception. She complained to the wife who claimed it was a false accusation. P.E noticed recurrent lower abdominal pains with copious foul smelling vaginal discharge and again informed the wife who took her to a nearby clinic and threatened to tell her family she was promiscuous if she accused her husband (P.E's uncle). She denied previous sexual experience. On one occasion when she refused to consent to sex with the uncle, he threatened to beat her and she left the house, fearing for her life. She was found by a gateman to a radio station who heard her story and took her in to meet some of the staff. The staff of the radio station then took her to the police station from where she was brought to the hospital.

Examination findings in the hospital revealed an anxious and unkempt girl. She had no evidence of recent or old injury on her skin. Secondary sexual characteristics where normal for age. Significant findings on abdominal examination was marked tenderness over the lower abdomen. Examination of the vagina revealed copious, foul smelling whitish discharge with a broken hymen.Samples for vaginal washout fluid and a high vaginal swab were taken. Other tests included a pregnancy test and a retroviral screen. She was started on various antibiotics and PEP. The results of the tests done indicated that multiple spermatozoa were found in both samples. The client was admitted. She had several counselling and therapy sessions with the mental health team. The hospital agreed to waive her hospital fees as she was a minor in a foreign land. A local NGO got information concerning the case and tried to coordinate activities around the case. They discussed with the police and found out that the accused was already in custody. They followed up on the results and started talking to specialists on possible DNA test. When the NGO went back to the laboratory to find out about the state of the samples, the samples were missing and nobody could tell who had taken them. This was

reported to the hospital management who called the technicians in charge but no one was brought to book over the missing samples. The mother of the client eventually showed up and pleaded that the case should be not be taken to court since it was a family matter. The police however declined. The client was eventually discharged to her mother who promised to bring her to court for the case to be heard. The assailant was let out on bail and the mother took the client back to Cross river.

Case 2: Miss N.O is a 4-year-old girl who lived with her parents in Ibadan but came to spend a few days with her maternal grandfather in Ife during her school holiday. On the 20th of August, 2017 she was brought to the children Emergency unit of hospital A by her mum following report of sexual assault by a 15-year-old male Togolese help who lived with the grandfather. The help had lived with him for many years and he was given the duty to care for the girl and her 6-year-old brother. On the day of the alleged assault, the help put the male child in front of the television and when he was distracted, he took the little girl into the room and had penetrative intercourse with her. The grandfather was in at the time but was asleep. The client kept touching her genital area for days after this and complaining of pain. The mother was called and when she arrived and asked the child, she narrated the history of the assault to the mother and she brought her to the hospital. Examination findings in the hospital revealed a cheerful girl. She played well until the doctor asked to see her genital area and she started crying. Minimal examination revealed no bruises or cuts, hymen was broken. No bleeding nor discharge. Tests done included a retroviral screen and the client was given antibiotics. Mother was counselled by the mental health team and the child had some sessions with the therapist but she was lost to follow up.

Discussion

Miss PE was sexually abused by her maternal uncle who was married with children. She was sent by her parents with the aim of learning a skill because of a decline in her academic performance and financial issues in the family. Sexual Violence is a major problem globally with women and female children mostly affected[3] as seen in both cases presented above. In most cases of SV, the assailant is known to the survivor as seen in both cases. Under reporting is the rule, especially because the victims are threatened. Badejoko and colleagues (2014) reported that the use of threat, either verbal or physical was common among their respondents who had experienced SV with 78.9% and 59.2% reporting the use of verbal threat and physical force respectively[11]. In the first case (P.E), verbal threat was used. P.E reported to the assailants' wife who accused her of fabricating lies and verbally threatened her also.

SV is associated with numerous complications. P.E was diagnosed of pelvic inflammatory disease as a result sexual abuse by her uncle. According to Moreno and colleagues (2013), the impact of SV on women results in them being twice as likely to develop depression, almost twice as likely to have alcohol use disorders, 16% more likely to deliver babies with low birthweight, 1.5 times more likely to contact HIV & other STIs and about 42% may suffer injury and death[6].

There is a huge deficit in the management of survivors of SV in Nigeria. This ranges from ignorance on the part of the general public and victims (most evidence is destroyed because of delay in seeking help) to ignorance on the part of the care givers and a general lack of coordination between and among the different departments that provide care. Within the hospital, lack of standard protocol in post rape care services to almost non-existent medico-legal linkage negatively impact on care given. In a retrospective study by Adeleke and colleagues (2012) it was noted that the vast majority of survivors that presented at the state hospital Asubiaro between 2003 and 2009 were not screened for STIs, had no PEP, no pregnancy prevention nor had follow up. Forensic evidence was taken only in

the latter years[12]. Akinlusi (2014) reported similar findings[8]. Although P.E presented about 3 days after the last sexual encounter, no rape kit was available to take forensic evidence. She however had PEP, emergency contraception and treatment of the PID. Both samples taken revealed spermatozoa however the chain of evidence was not kept thus the sample disappeared from the laboratory after the results got to the ward. Most cases of SV do not get to court in Nigeria for many reasons. In the Nigerian Law, the burden of proof is usually with the complainant and most times there is no viable evidence at presentation or there is a lack of facilities or resources to collect and keep the chain of evidence. Also, SV is still seen in cultural climes to be a shame not on the assailant but on the victim, thus, most families prefer to settle out of court or not to report at all.

Recommendation

The World Health Organization (WHO) has a guideline for health sector response to cases of women SV. This include: 1) Women centered care, 2) Identification and care for survivor intimate partner violence (IPV), 3) Clinical care of survivors of sexual violence (SV), 4) Training of health care providers on IPV and SV, 5) Health care policy and provision, 6) Mandatory reporting of IPV and SV[4]. There is a need to have an institutional protocol for the management of SV. These should include: a multidisciplinary approach, the availability of rape kit at both adult and children emergencies, provision of PEP, emergency contraception, treatment of STIs. Preservation of the chain of evidence by regular training of health workers, proper patient follow-up and strengthening of the medicolegal process are global best practices that need to be encouraged within the health facilities. While the institution has the capacity for a multidisciplinary approach, provision of PEP, emergency contraception and the treatment of STIs, it showed gross deficiency in bridging the gap between the client and the security/legal systems, maintaining the chain of evidence and follow up/referral to other services.

Conclusion

Sexual Violence (SV) is a global public health issue with devastating consequences to the survivor. It affects a significant proportion of the population even in Nigeria. It is generally under reported. But even when survivors show up in the hospital, they do not get the holistic care that promotes justice and overall wellbeing. Institutional protocols that encourage liaison services, promotes the overall health and wellbeing of the survivors should be implemented as a matter of urgency in the management of survivors of sexual violence in Nigeria.

References

Organization WH. World report on violence and health. 2002.

Cross ICotR. Advancement of Women: ICRC statement to the United Nations, 2013 2013.

Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. American journal of obstetrics and gynecology. 1996;175(2):320-4; discussion 4-5.

Organization WH. Guidelines for medico-legal care of victims of sexual violence. 2003.

Akinade E, Adewuyi T, Sulaiman A. Socio-legal factors that influence the perpetuation of rape in Nigeria. Procedia-social and behavioral sciences. 2010;5:1760-4.

García-Moreno C, Pallitto C, Devries K, Stöckl H, Watts C, Abrahams N. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence: World Health Organization; 2013.

Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. Social science & medicine. 2002;55(7):1231-44.

Akinlusi FM, Rabiu KA, Olawepo TA, Adewunmi AA, Ottun TA, Akinola OI. Sexual assault in Lagos, Nigeria: a five year retrospective review. BMC women's health. 2014;14(1):115.

Ajuwon A. Attitudes, norms and experiences of sexual coercion among young people in Ibadan, Nigeria. Sex without Consent: Young people in Developing Countries London and New York, Zed Books. 2005:96-104.

Kullima AA, Kawuwa MB, Audu BM, Mairiga AG, Bukar M. Sexual assault against female Nigerian students. African journal of reproductive health. 2010;14(3):189-93.

Badejoko OO, Anyabolu HC, Badejoko BO, Ijarotimi AO, Kuti O, Adejuyigbe EA. Sexual assault in Ile-Ife, Nigeria. Nigerian Medical Journal : Journal of the Nigeria Medical Association. 2014;55(3):254-9.

Adeleke NA, Olowookere A, Hassan M, Komolafe J, Asekun-Olarinmoye E. Sexual assault against women at Osogbo southwestern Nigeria. Nigerian journal of clinical practice. 2012;15(2):190-193.

Kalra G, Bhugra D. Sexual violence against women: Understanding cross-cultural intersections. Indian journal of psychiatry. 2013;55 (3):244.

Bimbolakemi O, Akinlabi FB, Olukoyaadewale O. Prevalence of violent sexual assault on South West Nigeria girls. European Scientific Journal, ESJ. 2014;10 (7).

Suarez E, Gadalla TM. Stop blaming the victim: A meta-analysis on rape myths. Journal of Interpersonal Violence. 2010;25(11): 35.

Awosusi A.O, Ogundana C.F. Culture of silence and wave of sexual violence in Nigeria. AASCIT Journal of Education. 2015;1(3):31-37.