

SHORT REPORT

Implications of Silence in the Face of Child Sexual Abuse: Observations from Yenagoa, Nigeria

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Abstract

Child sexual abuse (CSA) is common globally but underreported. It has far-reaching physical, social, and mental health effects and often the victims suffer in silence because of the shame and stigma associated with the experience. Despite international and country specific legislation to protect children and punish offenders, CSA thrives and sometimes leads to the death of victims. We report two cases of children aged 7 and 8 who presented at Niger Delta University Teaching Hospital Bayelsa, Nigeria. In both cases, the offender was known to the victim's parents who did not only refuse to report the cases to law enforcement agents but also discontinued medical follow-up for the children. These cases highlight that in cases of CSA, parents and families often prefer silence rather than confronting offenders or reporting incidents to law enforcement agencies. This choice of inaction only promotes the ill. It is essential that laws and regulations meant to protect children locally and internationally are implemented to end the scourge of CSA and its many effects. (*Afr J Reprod Health 2018; 22[2]: 83-87*).

Keywords: Children, sexual abuse, implications of silence, parents

Résumé

Les sévices sexuels infligés aux enfants (SSAE) sont communs partout dans le monde mais elles sont sous-déclarées. Elles ont des effets physiques, sociaux et mentaux profonds et souvent les victimes souffrent en silence à cause de la honte et de la stigmatisation associées à l'expérience. Malgré la législation nationale et internationale visant à protéger les enfants et à punir les contrevenants, les SSAE se développent et entraînent parfois la mort des victimes. Nous rapportons deux cas d'enfants âgés de 7 et 8 ans qui se sont présentés au Centre Hospitalier Universitaire de Niger Delta University, à Bayelsa, dans l'Etat de Delta, au Nigeria. Dans les deux cas, le contrevenant était connu des parents des victimes qui, non seulement refusaient de signaler les cas aux agents de la force publique, mais interrompaient également le suivi médical des enfants. Ces cas soulignent le fait que dans les cas de SSAE, les parents et les familles préfèrent souvent le silence plutôt que de confronter les délinquants ou de signaler les incidents aux organismes d'application de la loi. Ce choix d'inaction ne fait que favoriser les malades. Il est essentiel que les lois et les règlements destinés à protéger les enfants aux niveaux local et international soient mis en œuvre pour mettre fin au fléau de SSAE et à ses nombreux effets. (*Afr J Reprod Health 2018; 22[2]: 83-87*).

Mots-clés: Enfants, sévices sexuels, implications du silence, parents

Introduction

Child sexual abuse (CSA) is a global phenomenon with dire immediate and long-term implications for the child^{1,2}. The World Health Organization defines CSA as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or that violates the laws or social taboos

of society”³. This is supported by the Convention on Rights of a Child (CRC) which was adopted by the General Assembly of the United Nations in 1989⁴.

In spite of the wide acceptance of CRC, CSA persists in both low, middle, and high income countries^{5,6}. The true prevalence is not known because it thrives in silence and rarely receives the attention it deserves^{7,9}. According to WHO, about 73 and 150 million boys and girls respectively

experience various forms of CSA, and one in five women and one in 13 men were sexually abused as children¹. In the United States, the Center for Disease Control and Prevention noted a CSA prevalence of 4% and 11% for boys and girls respectively⁶. In a four-year retrospective study of the outpatient records in a pediatrics facility in Nigeria, 33 cases (32 girls and one boy) of CSA were noted out of 12,229¹⁰. This result seems to point to low prevalence, but also tells of the gross underreporting of CSA on account of the culture of silence about CSA which cuts across geographical lines^{2, 8}. The WHO guidelines for medico-legal care of victims of sexual violence suggest a significant undersreporting of sexual violence³. Often, victims suffer in silence in their homes or communities where the predisposing factors still exist.

The predisposing factors of CSA include female sex, poverty, and physical and mental disability. It is also found to be higher in children in foster homes, adopted children, single parent homes and during wars or armed conflict^{1,3}. It is pertinent to note that it can exist in seemingly safe places and often thrives in deception and silence because families and victims prefer to save face rather than confront the many physical and psychological health implications^{1-3,5}. Child sexual abuse exposes victims to immediate physical trauma such as genital injury, anal fissures/bleeding, and death. Long term effects include sexually transmitted infection (STI), HIV, pregnancy, depression, post-traumatic stress disorder (PTSD) and psychosis^{1-3,9,11,12}. The relationship between childhood adversity and mental health problems have been well documented and sexual abuse has been noted as the most potent of all childhood adversities^{1,11,12}. A prospective study by Spataro and colleagues demonstrated an increased risk of adult mental disorder in sexually abused children compared to the general population (12.4% v. 3.6%)¹². Although CSA is commonly perpetrated against girls, a qualitative study by Sigurdard ottir and colleagues reported deep and intolerable psychological consequences for men who were victims of CSA⁹. Child sexual abuse distorts the social and sexual relationships of both men and women affected.

The effects of CSA persist because of silence^{7,9,10,13}. In Nigeria, the laws, parents, and victims are silent, which allows perpetrators to continue the abuse of more victims. Although the Child Rights Act in Nigeria recognizes 18 years as the age of consent, child marriage before this age persists in the country^{8,10,14}. Few states have implemented the CRA and in Bayelsa, the law is yet to become a working document¹³. The aim of this case presentation is to underline the attitude of silence on the part of parents and the laws on CSA and the effects on the lives of children who are unable to fight for themselves.

Methods

Case Presentations

This study utilized the case report method to highlight two cases of child sexual abuse that presented to Niger Delta University Teaching Hospital, Bayelsa, Nigeria in 2015.

Case 1

AE is an eight-year-old female who presented to the antiretroviral therapy (ART) unit of Niger Delta University Teaching Hospital with an internal referral from the Pediatrics Unit for Retroviral Screening and possible post exposure prophylaxis (PEP). She presented in company of her father and the school teacher who had noticed blood stains at the back of her uniform. Alarmed, the teacher had interrogated the child, who revealed that the father's friend had on several occasions had sexual intercourse with her. The teacher had then contacted the father and they brought the child to the pediatrics unit for care.

Examination at the pediatrics unit revealed absence of hymen and perineal lacerations. At the ART unit, RVS was nonreactive but PEP was not commenced because the child presented 72 hours after the incident. The teacher and the parent were advised to report the incident to the police and bring the child back for testing in six months' time. The father refused to confront the friend and subsequent attempts to contact them to repeat the test for the child failed. He is a single parent, unemployed, with a primary level of education.

Table 1: Demographics and Characteristics of Cases

Variable	Case 1	Case 2
Gender	Female	Female
Age	8	7
Presentation of Victim	Perineal lacerations, ruptured hymen, bleeding	Ruptured hymen, Sad
Gender of Offender	Male	Male
Relationship of Offender	Family Friend	Contracted transporter
Location of Abuse	Home	Bush
Outcome of Treatment	Lost to follow-up and refusal to involve law enforcement agents	Lost to follow-up and refusal to involve law enforcement agents

Case 2

BE is a seven-year-old female who presented with her mother to a rural health center outpost of the Community Medicine Department of Niger Delta University Teaching Hospital. A day prior to presentation, the mother had noticed that the child came back from school looking withdrawn and dirty. Her effort to elicit information from the child failed, so she decided to bathe her and change her clothes. However, on removing her clothes, she saw that the child's underwear had brownish stains which the child could not explain. A month prior to the incident, she had caught the child masturbating and had seriously warned her to desist from such acts. The index problem reminded her of that incident and she was worried because the child refused to talk to her despite threats and beatings. She took the child to a spiritual home where the female evangelist was able to persuade the child to talk.

The child revealed that the *Keke* (tricycle) driver who took her to and from school often stopped around a bushy path and inserted his hands in her vagina. She could not recount the number of times this had happened. The mother, unsatisfied, brought the child to the center for care. At the health center, the child was sad looking, and vaginal examination revealed absence of hymen and reddish particles inside her vagina. The particles the mother confirmed to be pepper that she inserted into the child's vagina as punishment for the act. The peppery particles were cleaned, and the mother warned to desist from such form of punishment. The family was advised to involve the police to bring the culprit to justice. RVS was negative and the mother was asked to bring the child back in six months for repeat test. However, further attempts to follow up on the child failed, as

both the husband and wife, who had achieved a tertiary level of education, asked the doctors to stop disturbing their family.

Discussion

The two cases presented reveal an unwillingness of parents or guardians to involve law enforcement agents in cases of CSA. Studies suggest that most cases of CSA are not reported, especially not to law enforcement agencies⁷⁻⁹; and the few that present to hospitals are mainly interested in seeking immediate treatments for associated physical injuries and possible STIs¹⁰. These observations are seen in the two cases presented. The parents only came for the immediate treatments of their children and to know if they had been infected with HIV or other STIs. They were unwilling to report to the police or even attend follow up visits. Several reasons have been given for the low reporting of cases of child sexual abuse^{13,15}.

The child affected may not report the abuse to parents /guardians. The abuser could threaten the child not to report. The parent could also be the abuser in some cases. Sometimes, the parents may not believe the child or take such reports seriously when made. Also, cultural factors such as taboos on discussing sex - related issues, maintaining family honour/name, and avoiding possible social stigma and shame are some reasons why many cases are not reported. Also, the abuser could be a benefactor to the child's family or highly placed in the society making it difficult for the family to report such cases. We could not establish any reason for the reluctance to report to law enforcement agencies in the cases we have presented. The parents refused to tell us why they would not report to the police. It will be interesting

to systematically investigate reasons why people refuse to report cases of CSA to appropriate authorities in this environment. More importantly, it would be useful to create opportunities or enabling environment that encourages parents and victims to report CSA to law enforcement agencies. The lack of motivation to report cases of sexual abuse forces parents to be 'silent' and the helpless victims to suffer in silence.

Studies suggest that female children are more prone to sexual abuse^{10,16}. Pereda and colleagues reported global prevalence CSA rates of 19.7% and 7.9% among females and males respectively¹⁶. The two cases reported were also females. Single parenthood has also been associated with higher incidence of CSA. This was found in one of the cases presented here. Other predisposing factors to CSA could not be clearly established in both cases presented. Children are most vulnerable to sexual abuse between the ages of 7 and 13 years¹⁷. Both cases presented above fall within this age range. As previously documented, most sexual abusers are males. The abusers in the cases above were also males.

Most child sexual abusers are people the child knows very well or interacts with closely. Family members such as fathers, uncles and so on abuse children in 30% of cases. Other acquaintances such as family friends, neighbors, teachers and so on abuse children in 60% of cases. Only in 10% of cases are children abused by total strangers¹⁸. The abusers in the cases we reported were people well-known to the families and children involved. It is also known that most of the abuse takes place in familiar environments such as homes of victims or abusers. The abuse in the first case under discussion took place in the victim's home, while the second case was in a bush along the way to the victim's school.

Child sexual abuse has numerous negative effects on the physical and mental health of the affected children. These include injuries to the private parts, bleeding, pains, infection with HIV and other STIs, emotional and mental health problems amongst others. In significant number of cases, these effects may be lifelong. The children in the cases we presented had perineal injuries, bleeding and hymen rupture. Sad mood was reported in one of them. However, we could not

explore the mental health effects of abuse in the cases presented because there was no follow up. The parents of both children refused to attend follow up visits or give further information. However, it appears more cases of child sexual abuse are coming to limelight in recent times in Nigeria from reports in daily newspapers.

Conclusion

Most of cases of child sexual abuse are not reported to law enforcement agents. This may even be worse in Nigeria and other low-income countries where cultural factors prevent the reporting of such cases. As a result, many cases of sexual abuse go unpunished, leading to more and repeated abuses. In view of the negative consequences of sexual abuse on children, it is important that the public be better informed and motivated to report such cases. Also, law enforcement agencies need to collaborate with health care providers to ensure appropriate reporting and follow-up of CSA. More research is needed in our environment to enable better understanding of factors associated with child sexual abuse and how to adequately address the problem.

Ethics

Ethical approval was obtained from the Ethics committee of Niger Delta University Teaching Hospital with a waiver of consent.

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