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Child sexual abuse in Zaria, North-western Nigeria

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Abstract: *Background:* Child sexual abuse has been reported from all corners of the globe, and all age groups and both sexes are affected. Although the trauma of abuse heals with time, it leaves long term psychological and medical problems. This study was aimed at documenting the pattern of child sexual abuse in Zaria, Northern Nigeria.
Methods: Retrospective study of case notes of all patients seen with a history of sexual abuse, from August 2008 to October 2009, at a primary health centre in North-western Nigeria.
Results: A total of twenty cases were seen out of a total of 33, 313, which gave a prevalence rate of 0.06%. There were three boys and 17 girls, with a male: female ratio of 1: 5.7. The age range was 3-13 years, with a mode of 7years. Majority (19, 95%) were aged 12 years and below. Eleven cases (55%) attended school, while three (15%) were hawkers. Twelve (60%) of the children presented more than 72 hours after the assault. Twelve (60%) cases were abused more than once, and there was evidence of genital trauma in 60% of cases. The assailants were all males, and identified in 70% of the cases. Of those identified, 55% of them had previously been suspected of committing sexual abuse. In 55% of cases the assailants were either household members or neighbours. Only 12 (60%) of incidents were reported to the police. Legal outcome was not known in any of the cases. All the cases defaulted to follow-up.
Conclusion: Child sexual abuse is not an uncommon problem in Zaria. There is a need to ensure follow-up after treating immediate medical problems, in order to manage and prevent the long-term psychological problems of sexual abuse. The high default rate to follow-up needs to be further investigated. The legal outcome in all the cases was unknown.

Key words: child, sexual abuse, northern Nigeria

Introduction

The assumption that child sexual abuse is rare in the traditional African setting is being questioned.[1] Child sexual abuse has been reported from all corners of the globe,[2] although incidence rates vary depending on the methodology used to collect the data. What is common however, is that both sexes are affected,[1, 2] and the perpetrators of this crime are protean, ranging from family members,[3] other acquaintances,[4] to strangers.[5]

Child sexual abuse represents a current sociocultural issue in the African society.[6] It is associated with significant morbidity and mortality.[2, 7] Various types of injuries as a result of physical force such as multiple bruises in uncommon sites, burns wound in different stages of healing, vaginal and anal tears, serious injury leading to child's death have been reported.[11] The child is also exposed to sexually transmitted diseases and of course the psychological trauma of sexual abuse, which manifests as major stress and anxiety disorders, aggressive behavior, poor school performance and engagement in high-risk behaviours such as prostitution and higher rates of sexually transmitted diseases.[8] Although the trauma of abuse heals with time, it leaves long term psychological and medical problems behind.[2, 7] Therefore, physicians and other personnel who treat victims of abuse need to be skilled in addressing these issues. Unfortunately, there is little or no attention to child protection training given to physicians during the under-graduate or post-graduate training globally.[9]

A community survey in south-western Nigeria[10] showed that five percent of adults interviewed admitted to have been sexually abused as a child, and up to 35% admitted to have been sexually active in their adolescence, which highlights some of the consequences of child sexual abuse in later life.[10] This study was aimed at document-

ing the pattern of child sexual abuse in our environment, as there is paucity of relevant local documented data.

Methodology

This was a retrospective descriptive study, carried out between August 2008 and October 2009, at the Institute of Child Health (ICH), Banzazzau, Zaria City, Kaduna state, Nigeria. The ICH is a comprehensive primary health centre affiliated to the Ahmadu Bello University Teaching Hospital (ABUTH), Zaria. It is located in the heart of the ancient city of Zaria. During the study period, a total of 32,313 out-patients were attended to in the centre, mainly one-time attendees. As the numbers with multiple attendances were negligible the total number was used to calculate the prevalence rate.

Case notes of children with diagnoses of sexual abuse, rape or sexual assault during the 15 months period were manually retrieved. Information extracted included the bio-data, symptoms/ complaints and examination findings. Treatment received and any information obtained about the suspected assailants were also recorded. The data is presented as tables and text, and descriptive statistics employed to summarize.

Results

A total of 20 case notes fulfilled our search criteria, which gave a prevalence rate of 0.06%. All the patients were brought to hospital on suspicion of being, or witnessed to have been abused, except one case, which was an incidental finding. As shown in Table 1, there is a female preponderance, with a male: female ratio of 1:5.7.

The age range was 3 – 13years, with mode of 7years. Six (30%) of the victims were aged 3-5 years. Four children in the study shared the same address, with at least 2 of them (brothers aged three and seven years) suspected to be abused by the same assailant, living in the same extended family household. However, the exact relationship to the victims was not recorded. Among the three hawkers, only one attended school, as well as hawked after school hours, while (11, 55%) were attending school only. The mean interval between incident and presentation in the clinic was 14 days, however three cases presented within three to 21 hours after the incident.

Table 1: Bio-data characteristics of the studied population of 20 children

Characteristic (n=20)		Number	(%)
Age group (yrs)			
	1 – 5	6	30
	6 – 12	13	65
	13-18	1	5
Sex	Male	3	15
	Female	17	85
Child attending school			
	Yes	11	55
	No	2	10
	Not stated	7	35
Time interval between incident and presentation			
Less than three (3) days		6	30
Greater or = three (3) days		12	60
Not stated		2	10
Past history of been abused			
	Nil	8	40
	Once	4	20
	More than once	8	40
Assailant identified			
	Yes	14	70
	No	6	30

Table 2 shows that the most frequent presenting features were related to genital trauma or infection. None of the victims had any physical or mental handicap. Fourteen children presented on account of disclosure, suspicion or rape. Many had multiple clinical features on presentation.

Peri-anal findings were seen only in males, multiple peri-anal bruises and fissures. The main findings in females were absent hymen and vaginal discharge. Only one girl aged six years had sexualized behavior. A patient had burn wounds on both arms and legs, suggesting concurrent physical abuse, although such history was not obtained.

Human immunodeficiency virus (HIV) screening tests were done in 19(95%) using antibody based method. All those tested for HIV were non-reactive, although the tests were not repeated for confirmation. Other investigations done included vaginal swab in 13(65%), pregnancy test three(15%), urine culture six(30%), abdominal ultrasound in one (5%), and serology for hepatitis C antibody in two (10%).

Vaginal swab culture grew *Staphylococcus aureus* in two patients, *Pseudomonas* species in another two and *Candida* species was isolated in one patient. Spermatozoa were not documented in the vaginal or rectal swabs in the three patients who presented within 24 hours after the incident. All investigations were ordered for on presentation but as patients pay for services most were delayed due to financial constrains. The exact interval was not documented in the records.

In 50% (10/20) of the children, antibiotic treatment was given for the prevention and or treatment of sexually

transmitted infections. Five (25%) children were referred to the gynaecologist, while only nine (45%) presented just once for follow up visit. No patient was referred/received psychotherapy or psychiatric evaluation/psychologic intervention.

There was scanty information obtained about the assailants, although all those identified were males. At least two of the assailants were known to be married, while two were said to be recently divorced, and they all had children of their own. The age range of the assailants was 20-60years with a mean of 49 years. In all the cases that the suspected assailant was identified, they were neighbours or household members (houseboys, guardman/ security guard, and live-in relatives), with the exception of one case that involved a total stranger. Eleven (55%) of the assailants had been previously suspected of committing abuse in the past, but it was not documented whether any of them had been convicted before.

Four (20%) of the victims had just one assailant and just one event, 12 (60%) had one assailant on several occasions, while two (10%) had more than one assailant on several occasions. None of the victims had more than one assailant on a single event. The number of assailants and events were not recorded in two (10%) cases. The legal outcome was not documented in any of the cases, although in 12 (60%) of the cases the police were involved.

Table 2: Presenting clinical features

Presenting features (n=20)	Number	(%)
Trauma	5	(25)
Genitourinary findings	16	(80)
Absent hymen	12	(60)
Miscellaneous	3	(15)
Normal genital findings	4	(20)

Many had multiple presenting features

Discussion

This study has shown that child sexual abuse is not as uncommon as previously thought. The prevalence rate of 0.06% is low compared to a similar hospital based study in Dakar, Senegal where a rate of 0.4%[6] was obtained. The study setting, design and period may account for the observed difference. While our study was in children Faye et al's[6] study was prospective and involved mainly adolescents. Although, prevalence rates of child sexual abuse as high as 69.9%[11] and 77%[4] have been reported in studies from some parts of Nigeria, these figures were from vulnerable groups consisting of street hawkers and girls in paid employment. The difference between hospital based and community based studies may not be surprising as non-penetrative forms of sexual abuse are not likely to be reported to hospital for various reasons such as taboo, protection of family name and family influence. In addition, inadequate training of health personnel in the detection, inadequate support system and channels for reporting may account for the low prevalence.

Most of the children were aged 10 years and below and attending school. The reason for this is not clear though previous studies[4,12,13] have shown similar trend. It may be speculated that young children are less likely to report such attacks due to fear. The low number of adolescents in this study is due to the fact that the institute caters specifically for children under 15years of age.

According to an analysis by Grossin et al,[5] in Paris, victims of abuse younger than 15 years are more likely to present to hospital after 72 hours of the assault. This corroborates our own findings, but may just be a reflection of the fact that children depend on others to make their health decisions. It may also be probably due to their being too scared to inform parents until they develop obvious disturbing features such as painful gait, discomforting sensations at the external genitalia or foul smelling discharge. Three boys were victims of sexual abuse in this study, all under 10years and two had obvious peri-anal trauma. Holmes and Slap[8] in USA reported that boys at risk of abuse are less than 13 years, of low socio-economic background, assailants known but frequently unrelated to the victim and abuse typically involves penetration. Although the number is too small, it highlights the existence of male sexual abuse in the community which has hitherto been considered to occur mainly in developed countries. Thus sexual abuse of boys may not be uncommon, but perhaps under recognized and therefore under reported.

In this study we found a very high proportion of repetitive child sexual abuse in contrast to other reports that documented single abuse in most of their cases.[5,12] The study from Maiduguri however, also showed that 48% of the victims suffered two or more episodes of sexual abuse.[4] It may be postulated that lack of reporting, and lack of punitive/rehabilitative/protective mechanisms could be contributory.

We found 60% of patients with evidence of genital trauma in this study, which mirrors the high percentage obtained by Omorodion[12] in Benin-city, Chesshyre and Molyneux[14] in Blantyre, Malawi. This contrasts the 19.5% documented by Grossin et al,[5] in Paris and 31% by Santos et al,[13] in Lisbon, Portugal, although the latter studies had much larger sample sizes. The incidence of trauma could also be related to the degree of resistance put up by the victim, which in turn could be determined by a variety of factors, such as physical force in trying to keep the child quiet or threat to avoid disclosures.[7] In some assailant, the association of sexual arousal with aggression coupled with the need to maintain the level of arousal through escalating violence, results in serious injury or death of the victim.[7]

A study from Zaria suggested that accidental trauma, either from road traffic accidents or falls on a sharp

object was responsible for anorectal injuries seen in children.[15] Our study however, shows that sexual abuse is a possible differential of such injuries.

Body trauma may also be noticeable in older children who offer resistance.[5] However; our study only found one documented case with evidence of trauma (burns) outside the perineum. Although this suggests physical abuse, it may as well be associated with the sexual abuse.[7]

A study on paediatric HIV infection from Sokoto showed that 0.2% of infections resulted from sexual abuse.[16] The initial antibody HIV test in all those tested was negative. However, due to the short follow up period, it was not possible to determine those who may have sero-converted, although antibody testing is not the most sensitive method. The use of DNA PCR test may have been more informative. The lack of facilities for forensic examinations and tests also meant that proving a particular assailant was responsible for a suspected offence became difficult.

Besides the trauma and medical sequelae of sexual abuse, for example sexually transmitted disease and HIV,[2,6,14] there is substantial evidence to suggest psychological sequelae like anxiety, depression, runaway, substance abuse, suicide, sexual abuse offences or marital problems in later years.[2,17,18] History of child sexual abuse is also a significant risk factor for girls to engage in unsafe sexual practices in later adolescence or young adulthood.[3] Despite the aforementioned evidence, our patients received only medical treatment, partly because of the high follow-up default rate, and the limited access to psychological therapy. However, the fact that none of the patients was referred for such services further buttresses the assertion that doctors are exposed to little or no child protection training during either the undergraduate or post-graduate curricula in Nigeria as in many countries around the world.[9] The normal genital findings in four victims could be due to healing of minor bruises when interval between abuse and presentation is prolonged, or may suggest non-penetrative abuse, oral penetration or penetration with a foreign object.[8,13]

The preponderance of male assailants in our study corresponds to what Santos et al,[13] in Lisbon, Portugal, Hobbs and Wynne[7] in Leeds United Kingdom documented. It is noteworthy though that Olley[3] in Nigeria documented 36% of housemaids were suspected to be responsible for child sexual abuse in his study.

The use of force,[12] and threats[5] has also been documented by others. These were also the group that had multiple assailants. A fact which was attested by Morhason-Bello et al,[19] that most adolescents who are sexually exposed, have more than one partner.

The victims' homes were the most frequent places of assault in the study by Grossin et al,[5] in Paris and quite a number of assailants were previously acquainted with their victims including family members, family friends, relatives, housemaids and neighbours.[3,5,7,12,13,20] There was scanty documentation of the place the abuse was suspected to have been carried out in our study, but majority of the assailants could be classified as acquaintances.

Conclusion

This study is limited by the small sample size and incomplete documentation, thus could not allow for comprehensive analysis. However, despite its limitation it provides a documented report of child sexual abuse in Zaria. The management of child sexual abuse extends far beyond making a diagnosis. There is a need for thorough documentation of cases, and follow-up should be ensured after treating immediate medical problems, in order to manage and prevent the long-term psychological effect. There is also the need for forensic evidence in our environment to assist law-enforcement to protect or remove victims of child sexual abuse in our environment. Also advocacies, legislations, establishment and empowerment of functional social and welfare department to facilitate follow-up of cases is essential.

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