Original

Comparative Retrospective Review of Survivor and Perpetrator Profiles in Two Nigerian Sexual Assault Referral Centres: Implications for Policy and Protection

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ABSTRACT

Background: There is increased awareness about sexual assault in Nigeria however there are gaps in the description of sexual assault survivors and perpetrators. The comparison of two sexual assault referral centers (SARC's) can help drive policy formulation in tackling sexual assault in Nigeria.

Method: A comparison was carried out of the (SARC) – Mirabel Centre, LASUTH, Lagos State, and Nana Khadijah Centre, Sokoto. Case files from the Mirabel center, Lagos and Nana Khadijah center, Sokoto were assessed. SPSS version 26 was used for statistical analysis. All categorical variables were summarized using percentages and proportions. Chi-square was used to determine differences between the variables between both centers. P-value less than 0.05 at 95% Confidence interval was assumed to be significant.

Results: A total of 10,158 cases were analyzed. Both centers had a majority of survivors aged 0-17 years old. There were significantly higher proportion in Nana Khadijah center, for age group 30-39 (p-<0.0001), multiple perpetrators (p-<0.001), and sources of referral (<0.001). The Mirabel center had significantly higher proportions for ages 14-17 years (p<0.01), 23-29 years (p<0.001), female gender (p-<0.001), unknown perpetrators (p- <0.001) and type of assault (<0.001).

Conclusion: There are many similarities among the survivors and perpetrators of sexual assault in Lagos and Sokoto. The gender disparity of survivors noted indicates the need to treatment modalities that encompass male and female survivors. There must be local policies that focus on sensitization, prevention and funding support for treatment of sexual assault in Nigeria.

Keywords: Sexual Assault, SARC, Survivors, Mirabel Centre, Nana-Khadijah Centre.

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INTRODUCTION

According to World Health Organization (WHO), at least one in three women are forced to have sexual relations, one-fifth was sexually abused before the age of 15 years old.[1,2] The victims of this devastating crime suffer short and long term consequences which include physical and mental psychological.[2],[3]

Sexual assault is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion, by any person, regardless of their relationship to the survivor, in any setting, including but not limited to home and work.[4]

Approximately 6% of women globally and in sub-Saharan Africa (SSA) have experienced some non-partner sexual violence at least once in their lifetime.[5] A wide variation in the prevalence of CSA in Nigeria was reported ranging between 2.1-77.7% .[6]

The rising number of cases of sexual violence in Nigeria has become disturbing despite several widespread condemnation and punitive measures.[3] The increase in reportage of rape cases could however be attributed to an increased awareness, total increase in number of rape cases or both.[7] It is assumed that the reported cases represent the tip of the iceberg; however; the advent of SARC could be a factor in the reporting of cases. [8] A study in a SARC in Enugu reported that children less than 13 years had the highest proportion of sexual assault cases.[8] This might be due to their vulnerability and inability to report cases. A study by Sodipo et al, reported that the mean age of survivors was 13. with more than a third being less than 10 years age.

Being young has been generally accepted as a risk factor for sexual assault, though it might just be a reflection of those who are reporting. [5] Most studies have reported a higher prevalence of sexual assault in females .[6] Sexual violence against males is difficult to discuss, hence could be under-reported. In conflict regions, male sexual assault is postulated to be a source of spiritual and financial gain for the perpetrators [9] There is a general agreement that sexual violence against women is rooted in gender power inequalities prevalent in society and in hierarchical gender relations.[10]
This is a retrospective review of the survivor and perpetrator characteristics of two sexual assault referral centers in Northern and Southern Nigeria with a view to understanding possible differences and formulating specific policies that would improve the management of victims of sexual assault.

METHODOLOGY

Study Area: The locations of the Mirabel Centre of the Lagos State University Teaching Hospital (LASUTH), Ikeja and the Nana Khadijah Centre, Sokoto.

The Partnership for justice is a non-governmental organization that set up two sexual assault referral centres, the Mirabel Centre, Lagos and the Nana Khadijah Centre, Sokoto. The Mirabel Centre was opened on, July 1st 2013, in Lagos State, Nigeria, situated at the Lagos State University Teaching Hospital as the first sexual assault referral centre in Nigeria, while the Nana Khadijah Centre, Sokoto, was set up in 2020. They provide comprehensive care at no cost to all survivors of sexual assault.

Study design: A retrospective cohort observational study of case files of clients seen since inception was conducted to assess the age of clients presenting to the centre, gender, source of referral to the centre, multiplicity of perpetrators and relationship between the perpetrator and survivor.

Study Population: The study population was made up of clients of the Mirabel Centre, LASUTH, Ikeja and the Nana Khadijah Sexual Assault Referral Centre, Sokoto
Inclusion Criteria: All case files of clients of Mirabel (from July 2013- September 2023) and Nana Khadijah Centre (March 2020- September 2023) who had signed consent forms allowing the anonymous use of their information.

Exclusion Criteria: Case files with incomplete information and cases which did not involve sexual assault.
Sampling Technique: All case files that met the inclusion criteria were analyzed to avoid selection bias.

Operative Definitions:[4,11]

I. Survivor: Any person who was sexually assaulted, defiled or raped and was not killed in the process.
II. Perpetrator: Any person who commits sexual assault, rape or defilement.
III. Rape: Unlawful sexual intercourse with a woman or girl (≥ 18 years old) without consent.

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IV. Defilement: Penetration of the genitals of any person aged < 18 years of age.
V. Sexual Assault and Sexual Assault by penetration: Touching, sending sexually explicit images or making sexually explicit comments towards another person without his/her consent and Penetration sexually of the anus, vagina, mouth or any other opening in the body of another without consent respectively.
VI. Attempt to commit rape and sexual assault by penetration: Attempts to commit the offence of rape or sexual assault by penetration of a person with a part of his body or anything else without the consent of the person.

Data collection: The Mirabel and Nana Khadijah centers require that clients compulsorily sign consent forms allowing the anonymous use of their information and treatment. At the same time, minors and children have the consent forms signed on their behalf by parents or guardians. All case files of Mirabel and Nana Khadijah centers clients who had signed consent forms allowing anonymous use of their data were analysed. Case files with incomplete information (such as the age of the client and source of referral and details of the perpetrator) or those who were treated for physical assault/ battery were excluded.

A total of 8225 clients were treated at the Mirabel centre within the study period, all of whom met the inclusion criteria. The Nana Khadijah treated 1472 clients within the study period, of which 179 were excluded. The age of survivors presenting to the centre, their gender, source of referral to the centre, the multiplicity of perpetrators, clinical services rendered and the relationship between the perpetrator and the survivor were analysed

Ethical Consideration: Ethical clearance was obtained from the ethical committee of LASUTH, Ikeja (Registration number NHREC04/04/2008, Reference number LREC.06/10/793). Confidentiality was maintained as there was no patient identifiable information in the data.

Data collection and analysis: A proforma form containing the age group of survivors, gender of survivors, type of assault, reportage to the police, and characteristics of the perpetrator was used to extract the information Statistical Package for Social Sciences (IBM SPSS) version 26 was used for statistical analysis. The results obtained from socio-demographic characteristics of the respondents was summarized using frequency tables. Pie chart was used to represent variables graphically. All categorical variables were summarized using percentages and proportions. Chi-square was used to determine differences between the variables between both centers. P-value less than 0.05 at 95% Confidence interval was assumed to be significant.

RESULTS

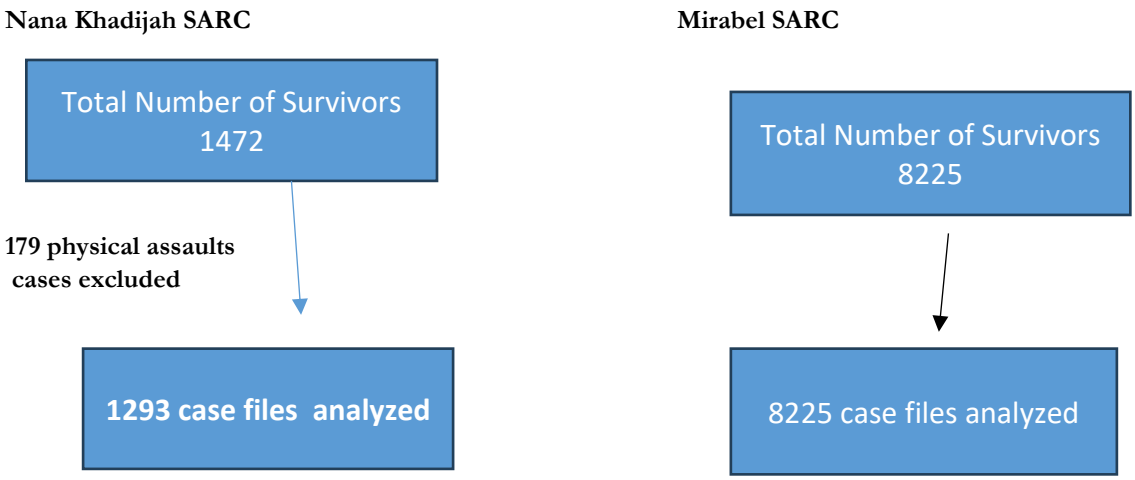

Figure 1 Flow Chart of Data Analysis

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The most affected age group for both centers was the 0-13 age groups most affected with 55.1% % and 58.4% %, respectively. The ≥ 40 age group were the least affected in both centers, having a proportion of < 1%, as shown in Figure 1.

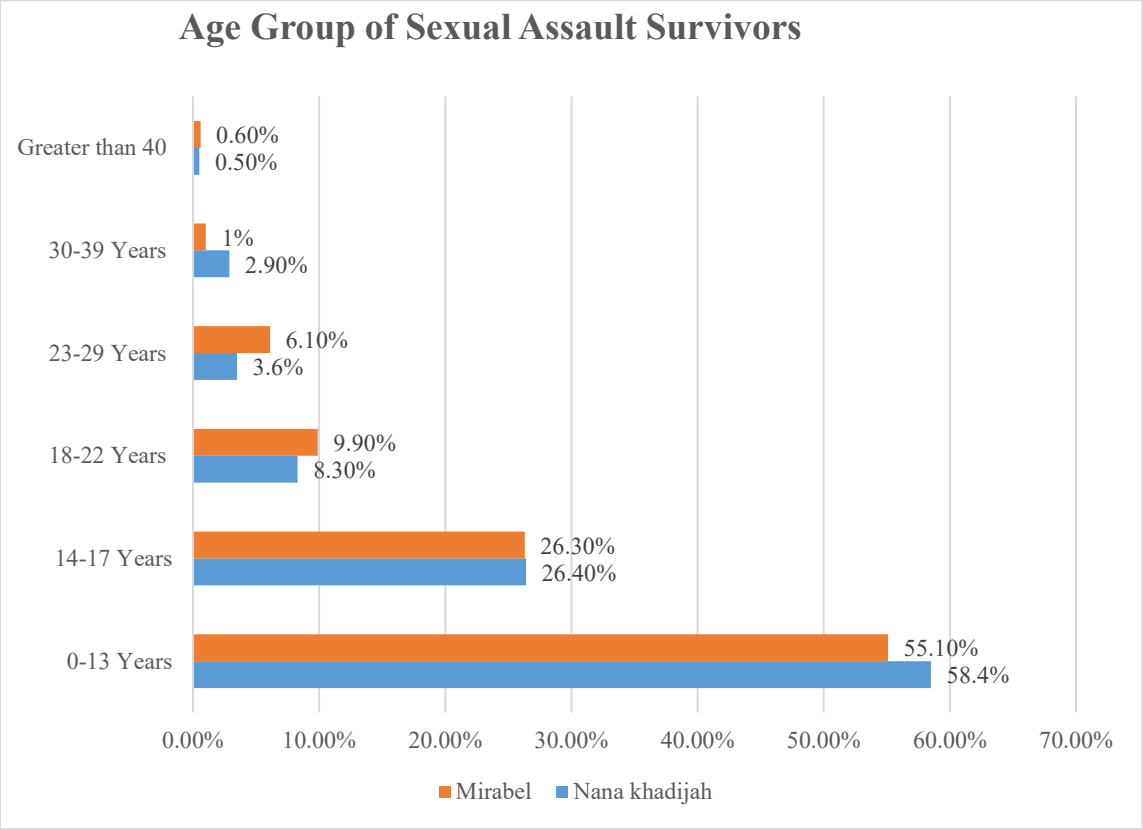

Figure 2: Bar Chart Showing the Age Group of Sexual Survivors in Mirabel and Nana Khadijah Centers

The comparison of the two centers shows key variations when odds ratios are considered. Survivors at Nana Khadijah center were more likely to be aged 30–39 (OR=2.708, p<0.001), multiple assailants (OR= 1.390, p<0.001), have referrals from Hospitals (OR=13.435, p<0.001) and NGO (OR= 19.176, p<0.001). Mirabel Centre survivors were more likely to be female (OR=0.048, p<0.001), known (non-family) perpetrators (OR= 0.661, p<0.001), defilement (OR =0.153, P<0.001) and rape (OR=0.088, p<0.001) as shown in table 1.

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Table 1: Showing Comparative Analysis of the Nana Khadijah and Mirabel Centers

Type	*Nana Khadijah*	*Mirabel center*	*Odd ratio (95% CI)*	*P-value*
Age Group				
0-13	755(58.4)	4531(55.1)	1	
14-17	340 (26.4)	2171(26.3)	0.940(0.819-1.079)	0.378
18-22	1073(8.3)	814(9.9)	0.789(0.636-0.979)	0.031
23-29	47(3.6)	502 (6.1)	0.562(0.413-0.765)	<0.001*
30-39	37 (2.9)	82(1.0)	2.708(1.823-4.023)	<0.001*
>40	06(0.5)	49(0.6)	0.735(0.314-1.721)	0.478
Gender				
Male	483(37.3)	230(2.8)	1	
Female	810 (62.7)	7995(97.2)	0.048 (0.041-0.057)	<0.001
Number of Assailants				
Single	1121(86.7)	7271 (88.4)	1	
Multiple	150(11.6)	700 (8.5)	1.390 (1.153-1.676)	<0.001*
Unknown	22 (1.7)	254 (3.1)	0.562(0.362-0.872)	0.010*
Relationship				
Known (Family)	193 (15)	962 (11.7)	1	
Known (non-family)	815 (63)	6149(74.8)	0.661(0.557-0.784)	<0.001*
Not known	285 (22)	1114(13.5)	1.275 (1.042-1.561)	0.018
Type of Assault				
Attempted Rape	84 (5.7)	87 (1.1)	1	
Defilement	942 (64)	6376 (77.5)	0.153(0.062-0.185)	<0.001*
Rape	122 (8.3)	1434 (17.4)	0.088(0.083-0.224)	<0.001*
Sexual Assault	28 (1.8)	212 (2.6)	0.0137(0.083-0.224)	<0.001*
Sexual Assault by Penetration	117 (8.0)	107 (1.3)	1.133(0.760-1.687)	0.540
Services				
Counseling	1233 (40.4)	7279 (33.7)	1	
Medical	1256(41.2)	8109 (37.6)	0.915(0.844-0.990)	**0.03***
Forensic Medical Report	563 (18.4)	6201 (28.7)	0.536(0.488-0.591)	**<0.001***
Source of Referral				
Police	339 (26.3)	6145(74.7)	1	
Hospital	189 (14.6)	255 (3.1)	13.435(10.808-16.701)	<0.001*
NGO	128 (10)	121 (1.5)	19.176(14.616-25.157)	<0.001*
Self-Referral	261 (20.2)	1156 (14)	4.093(3.442-4.867)	<0.001*
Government Agency	342(24.1)	537 (6.5)	11.544(9.699-13.741)	<0.001*
Others	31(2.4)	11 (0.1)	51.085(25.457-102.513)	<0.001*

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DISCUSSION

The Sexual Assault Referral Centre (SARC) model aims to counter sexual assault health services' weaknesses and threats hampering integrated care for victims of sexual assault.[12] It provides valuable multidisciplinary services including medical treatment, forensic examination, police services, and psychological counselling to the sufferers of sexual abuse under one roof.[13] The establishment of SARC is in keeping with the WHO recommendations for sexual health services to integrate medical, psychosocial and forensic care for survivors of sexual assault.[14] It is important to realize that irrespective of reporting of a rape or sexual assault is done , survivors have a right to services that will help them recover and rebuild their lives; hence getting support and being believed is important.[15]

Nigeria currently has more than 22 SARCs, with the Mirabel centre being the first one in Nigeria. It is important to understand the peculiarities in the survivors and perpetrators that could reflect the difference between the North and South of the country.

Both centers had a majority of minors as majority of the survivors, which is keeping with studies which have identified young age as a risk factor for sexual assault.[16, 17, 18] This is likely due to a combination of factors, including younger survivors being more vulnerable to abuse, but could be due to underreporting among older survivors due to fear and stigma or shame,[4,] as demonstrated by the low numbers of survivors aged >40 years of age.

Being female is a well-established risk factor for sexual assault, and both centers had a higher proportion of females as survivors There was a large proportion of male survivors in Nana Kadijah centre, Sokoto. This is similar to a study in Northwest Nigeria, which reported a prevalence of 22.8 % for male sexual assault survicors,[19] There appears to be more awareness about sexual orientation, such as homosexuality and bisexuality, presently .[19]

Nigeria also has strong laws against men having sex with men, which could impact reporting. The conflict of male victimization with the stereotypical perception of men being the sex-dominant gender is considered an essential sociocultural barrier preventing disclosure in male victims.[20] These barriers to disclosure are believed to increase the risk of psychological symptoms, post-traumatic stress disorder and other trauma-related disorders in male compared to female victims.[20]
Both centers reported that perpetrators were more likely to be known to the survivors, which is in keeping with various studies in Nigeria. These studies have highlighted the increasing patten of family members becoming perpetrators, hence emphasizing the need for strengthened home service visits by social services, and even awareness by health professionals to detect cases during hospital visits.[6] The Nana Khadijah center had a higher proportion of unknown perpetrators, similar to a study in Northwest Nigeria,[19] highlighting the need for vigilance.

The cases mostly involved one perpetrator, which is in keeping with available literature,[4] and is in keeping with the reports of persons known to the perpetrator being responsible.[4,19] The psychological complications of sexual assault carried out by perpetrators known to survivors could result in more psychologically damaging outcomes than being assaulted by a stranger and destroy the ability of survivors to trust people.[21] However , the reported number of multiple perpetrators in both centers needs to be monitored with the growing influence of cult related activities and gang rape.

Most of the referrals to both centers were from the police and law enforcement officers, is in keeping with other studies, including in the UK, where 84% of referrals to SARCs in England were made by police .[22] This may not be unconnected with the fact that most sexual assault survivors are children and adolescents, hence, their parents or guardians would decide to report the incident to the police first. There is however need to train police officers on how to provide psychological first aid, while allowing for proper collaboration such that the medical treatment can be accessed within the 72-hour period. The significant proportion of referrals from non-governmental organizations in Sokoto emphasize their importance in supporting the treatment of sexual assault survivors.

Insufficient funding for sexual assault support is a well-documented barrier.[22,23] This hinders staff training and specialization. This is a potential challenge in Nigeria as most SARC's are funded by donors, and therefore at risk of funding challenges

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Limitations

There are challenges with retrospective observational study, as recall bias from survivors and observational bias could occur. There could also be challenges with missing data , measurement of outcomes and selection of the reported result. These were avoided by ensuring ethical standards and using recognized outcomes.

Implications of the findings

Some implications of the findings from this study include:

1) The domestication of the child rights act in all states of Nigeria.
2) The creation of a national data base of perpetrators of sexual assault, which could act as a deterrent.
3) Coordination of sensitizations efforts among stakeholders including Nongovernmental organizations, police, National orientation agency, Ministries of Youth and women Affairs, information, Health and Justice at federal and state levels with a view to educating the populace on implications of rape and defilement.
4) Every state should have a Domestic and Sexual Violence Agency which would be tasked with coordinating efforts in tacking sexual assault in the various states of Nigeria.
5) There should be setting up of more SARC in Nigeria with funding support which will help in providing holistic treatment while also providing data which drives policy.

CONCLUSION

There are many similarities among the survivors and perpetrators of sexual assault in the SARC located in Lagos and Sokoto. The gender disparity noted indicates the need to treatment modalities that encompass male and female survivors. There must be local policies that focus on sensitization, prevention and funding support for treatment of sexual assault in Nigeria.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Declarations

Ethical Consideration: Ethical clearance was obtained from the ethical committee of LASUTH, Ikeja (Registration number NHREC04/04/2008, Reference number LREC.06/10/793). Confidentiality was maintained as there was no patient identifiable information in the data.

Authors' Contribution: Sodipo OO conceptualized the study, analysis and final writeup. Odunaye-Badmus S was involved in writing up the introduction, methodology and in the final writeup
Adejumo O was involved in review of the final writeup

Conflict of interest: There is no conflict of interest from the authors

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