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Prevalence and pattern of rape in children and young persons in a Specialist Hospital in Benin City, South-South, Nigeria.

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Abstract: *Rape- a form of sexual violence is an important clinical and public health problem worldwide. It is associated with physical, psychological and social consequences that can lead to increased morbidity and mortality. However, data on rape is scanty especially in developing Countries like Nigeria where it is underreported. This study was conducted to determine the prevalence and pattern of rape among females ≤ 24years managed in Central Hospital, Benin City, South-South Nigeria. We conducted a case control study using researcher administered questionnaire. Mean age was 13.73 (±6.46) years, 60.2% of victims resided in tenement houses. 71.8% occurred during the day, 35.9% in the victim's residence, 26.9% had extra-genital injuries and 71.8% had genital trauma. Family function was associated (test statistic 35.58, p<0.001) with rape. Family structure was associated (test statistic 10.60, p=0.014) with rape. Only 37.2% reported to police. Rape is high in this environment and mainly perpetrated by neighbours in the residence of the victim. Individuals with educated mothers were less likely to be raped and majority belonged to families that tended towards poverty. Rape was found to be significantly associated with family structure and function.*

Keywords: *Prevalence, pattern, rape, children, young person, CHB.*

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I. Introduction

The United Nations (UN) states that sexual violence is not a small problem that occurs in some pockets of society but rather occurs globally in epidemic proportions requiring immediate action.[1] Rape; a most severe form of sexual violence is a health problem of substantial proportion and regarded as a significant heinous crime with enormous impact that spans generations on the victim, family and community.[2]

Rape was defined by World Health Organisation as 'physically forced or otherwise coerced penetration –even if slight- of the vulva or anus using a penis, other body parts or an object'.[2] Rape is defined in Nigeria as; unlawful carnal knowledge (carnal connection which takes place other than between husband and wife) of a woman or girl without her consent, or with her consent, if consent is obtained by force, threat, intimidation, fear or fraud or in the case of a married woman, by personating her husband.[3]

Though rape can affect both males and females but for the purpose of this study, it is used in reference to the female gender as the victim. Violent crimes like rape with its antecedent health problems are assuming such great proportions that are comparable to epidemics in developing countries such as Nigeria.[4] A survey on the percentage of women aged 16years or older that have been sexually assaulted was discovered to range from 0.8% in Botswana,1.4% in Bolivia, 5.8% in Argentina to 8% in Brazil.[2] No differentiation was made in these surveys between rape by strangers and acquaintances (someone known to the victim e.g. family member, teacher, authority figure, date).[2] Surveys that fail to make this differentiation or those that evaluate rape by strangers only usually underestimate substantially the prevalence of rape.[2] The true incidence rates of rape of children cannot be established largely because many are unreported or rarely reported at the time it occurred and most data come from adults who report about their past experiences.[5] According to population-based studies conducted in Cameroun, the Caribbean, Peru, New Zealand, South Africa and Tanzania, high rates of forced sexual initiation have been reported with between 9% and 37% of adolescent females reporting rape at the hands of family members, teachers, friends or strangers.[5] Worldwide, it is widely accepted that more persons are raped by people that they know such as; family members, intimate partners, neighbours, friends, casual acquaintances, authority figures (pastors, teachers, landlords) in their lives than they are raped by strangers.[6-8]

Rape results in illness of the whole body with psychological, physical, social consequences that can lead to chronic problems with significant burden spanning generations in the society.[9,10] Studies have shown that rape contributes significantly to depression, alcohol and drug use and dependence, panic disorder, post-traumatic stress disorder (PTSD) and suicide attempts.[10]

Majority of rape events occur in a location that is familiar to the victim: either the residence of the victim or that of the perpetrator.[11] Hidden places like farm, footpaths and open places like streets have also been documented.[11,12]The time of the day when rape occurs is closely associated with the age of the victim. Rape in children are usually perpetrated during the day while older victims are more likely to be raped at night.[6, 12]

Though previous studies on rape in Benin City exist but none to characterize the family of victims currently exist. This study was therefore conducted to fill this gap in knowledge and updating current knowledge with a view to making recommendations towards addressing the problem in the study area.

II. Methods

This was a hospital based case control study carried out in Central Hospital Benin City (CHB), Edo State, South-south Nigeria, between March 1st 2014 and May 31st 2014. Central Hospital, Benin is a referral centre for the 34 health facilities under the State Hospitals Management Board that serves patients from Edo State and nearby states. CHB provides specialized services in the major areas of medicine. The subjects were females aged 24 years and below. All rape cases were recruited for this study and matched with controls based on age and sex visiting CHB for care.

The Smithklein APGAR questionnaire was used to assess family function and relevant data obtained using rape kit. Data analysis was performed using SPSS version 20. Ethical approval was obtained from the Ethical Committee of the hospital.

III. Results

Prevalence of rape and demographic profile of patients

There were 3440 children and young persons seen during the period of study out of which 78 were cases of rape, giving a prevalence of 2.27% (approximately 2.3%). The mean age for both groups was 13.73 (±6.46) years and majority of the respondents were in the age group 11 – 15 years. More respondents in the case group had primary level and no formal education. More respondents in the case group were found to be 2nd birth position while the control group had more respondents to be ≥5th birth position in the birth order (Table I).

Table I: Socio-demographic characteristics of respondents (N=156)

	Case group n=78 n (%)	Control group n=78 n (%)	Test statistic
Age (Years)			
2 – 5	13 (54.2)	11 (45.8)	χ^2=0.79 df=4
6 – 10	14 (50.0)	14 (50.0)	p=0.939
11 – 15	24 (53.3)	21 (46.7)	
16 – 20	15 (45.5)	18 (54.5)	
21 – 25	12 (46.2)	14 (53.8)	
Total	**78**	**78**	
Mean age		**13.73 (±6.46)yrs**	
Level of Education of respondent			
None	19 (63.3)	11 (36.7)	χ^2=12.87
Primary	34 (59.6)	23 (40.4)	df=3
Secondary	23 (41.8)	32 (58.2)	p=0.005
Tertiary	2 (14.3)	12 (85.7)	
Total	**78**	**78**	
Occupation of Father†			
Skilled	19 (45.2)	23 (54.8)	χ^2=0.46
Unskilled	56 (51.4)	53 (48.6)	df=2
Unemployed	2 (60.0)	2 (40.0)	p=0.718
Total	**77**	**78**	
Occupation of Mother			
Skilled	13 (38.2)	21 (61.8)	χ^2=20.16
Unskilled	64 (61.0)	41 (39.0)	df=2
Unemployed	1 (5.9)	16 (94.1)	p<0.001
Total	**78**	**78**	
Level of education of father			
Primary	34 (69.4)	15 (30.6)	χ^2=27.18
Secondary	20 (40.0)	30 (60.0)	df=3
Tertiary	5 (16.7)	25 (83.3)	P<0.001
None	19 (70.4)	8 (29.6)	
Total	**78**	**78**	
Level of education of mother			
Primary	30 (56.6)	23 (43.4)	χ^2=3.91
Secondary	26 (43.3)	34 (56.7)	df=3
Tertiary	9 (41.0)	13 (59.0)	p=0.271

None	13 (62.0)	8 (38.0)	
Total	**78**	**78**	
Birth Order			
1st	19 (47.5)	21 (52.5)	χ^2=4.90
2nd	21 (58.3)	15 (41.7)	df=4
3rd	10 (52.6)	9 (47.4)	p=0.298
4th	11 (64.7)	6 (35.3)	
≥5th	17 (38.6)	27 (61.4)	
Total	**78**	**78**	

†One father was deceased *Significant at p<0.05

Table II: Family income of respondents (N = 156)

Average monthly income (NGN)	Case group n=78 n (%)	Control group n=78 n (%)	Total	Test statistic
Low (<#6,000)	20 (51.3)	19 (48.7)	**39**	χ^2= 5.59
Middle(#6,000– 39,999)	40 (58.8)	28 (41.2)	**68**	df= 2
High (≥#40,000)	18 (36.7)	31 (63.3)	**49**	p=0.061
Total	**78**	**78**	**156**	

More victims were from low income families.

Location of rape event

Table III: Location of rape event (n=78)

Characteristic	Frequency	Percentage
Neighbor's house	22	28.2
Victim's house	28	35.9
Friend's house	3	3.8
Abandoned/uncompleted building	13	16.6
Bush path	9	11.5
Others	3	3.8
Total	**78**	**100**

Majority (35.9%) of the cases occurred in the house of the victim.

Table IV: Family and housing characteristics of respondents (N=156)

Characteristic	Case group n=78 n (%)	Control group n=78 n (%)	Test statistic
Family Structure			
Both Parents	31 (39.2)	48 (60.8)	χ^2= 10.60
Single Parents	21 (70.0)	9 (30.0)	df= 3
None	1 (25.0)	3 (75.0)	p=0.014*
Guardian	25 (58.1)	18 (41.9)	
Total	**78**	**78**	
Housing type			
Tenement	50 (60.2)	33 (39.8)	χ^2= 7.44
Non tenement	28(38.4)	45 (61.6)	df= 1
			p=0.006
Total	**78**	**78**	

*Fisher's exact test

There were more subjects (78.9%) in the case group from single parent family than the control group. 39.2% in the case group had family structure consisting of both parents and majority (60.2%) resided in tenement houses unlike the control group where majority (60.8%) lived with both parents and 61.6% resided in non-tenement houses.

Table V: Family function of respondents (N=156)

Family function	Case group n=78 n (%)	Control group n=78 n (%)	Total	Test statistic χ^2 df	p value
Dysfunctional	62 (71.3)	25 (28.7)	**87**	35.58 1	p<0.001*
Functional	16 (23.2)	53 (76.8)	**69**		
Total	**78**	**78**	**156**		

*Significant at p<0.05

Majority of the subjects (71.3%) from dysfunctional families were found to have been victimized while majority of the subjects (76.8%) in the control group were from functional families (76.8%).

Mode of presentation and type of injury sustained

Table VI: Extra-genital clinical examination findings in patients (N=78)

Clinical finding	Frequency (n)	Percentage (%)
Foreign material in body		
Present	9	11.5
Absent	69	88.5
Total	**78**	**100**
Extra-genital Injury		
Present	21	26.9
Absent	57	73.1
Total	**78**	**100**
Area of extra-genital injury* (n=21)		
Chest	4	19.0
Face + Eyes	10	47.6
Limb	8	38.1
Others	2	9.5
Total	**24**	**100**

*Multiple responses

Foreign material such as grass and sand was seen on the bodies of 11.5% of cases. Of the 26.9% found with evidence of extra-genital injuries; most common site of injury was the face and eyes (47.6%), and followed by the limbs (38.1%).

Table VII: Genital clinical examination findings in patients (N=78)

Clinical finding	Frequency (n)	Percentage (%)
Genital trauma		
Present	56	71.8
Absent	22	28.2
Total	**78**	**100**
Vaginal discharge		
Present	69	88.5
Absent	9	11.5
Total	**78**	**100**
Spermatozoa demonstration in vulva		
Present		
Absent	34	43.6
	44	56.4
Total	**78**	**100**

Genital trauma which were mostly abrasions was seen in 71.8% of cases while 28.2% of victims had no evidence of genital trauma. Swab collected from the vulva demonstrated the presence of spermatozoa in 43.6% victims.

Disclosure

Table VIII: Informal report/disclosure of rape (n=78)

	Frequency (n)	Percentage (%)
Parent	38	48.7
Relative	15	19.2
Neighbour	1	1.3
Nurse	7	9.0

Police officer	6	7.7
Siblings	8	10.3
Employer	1	1.3
Friends	2	2.6
Total	**78**	**100**

Most (48%) of the victims informed a parent, while 19% informed other relative other than a parent or sibling. Siblings were disclosed to by 10.3% of cases.

Table IX: Formal disclosure to Police (n=78)

Activity	Frequency (n)	Percentage (%)
Reported	29	37.2
No report	49	62.8
Total	**78**	**100**

37.2% of victims reported the event to the Police.

IV. Discussion

The prevalence of rape was quite high (2.3%) in this study. This is similar to that of 2.1% in Oshogbo, South-west Nigeria but differs from 5.6% in Jos, North-central, Nigeria and 0.9% in Abakaliki, South-east Nigeria.[6, 13, 14] While this study referred to the total population of females 24 years and below during the study period which was large compared to the numerator; other studies total population (denominator) was the total number of same age clients over a longer period in the gynaecological unit which was small. The other studies also relied only on information gathered from case notes.

The mean age in this study was closely approximated by 12.0 ± 4.4 years reported in Jos, North Central Nigeria[57] and 12.9 ± 8.758 years by Akinlusi*et al* in Lagos State University Teaching Hospital (LASUTH), Ikeja, Nigeria[15] but lower than 17.7 ± 8.8 years reported in Obafemi Awolowo University Teaching Hospital (OAUTH), Ile-Ife.[16] The mean age in this study may be similar to Jos because the same age range of 24 years and below was studied while in Lagos study even though this is a more metropolitan city than Benin City probably due to a larger gynaecological consultations of a wider age range of 2 to 50 years in Lagos. This study may have a difference in mean age to that of Ife study; which was a more academic and enlightened society that can result in more disclosure from respondents aged between 4 and 50 years.

The increased frequency with age in this study and the decrease seen in late adolescence from 20 years were corroborated by findings in studies done at Osogbo and Ikeja, Nigeria.[6, 15] This may be because younger children are most likely unaware of wrong doings, may lack basic communication skills necessary to disclose their experience than in adolescents who are more likely to be able to express themselves and report. Children are often shy or frightened and most likely to be raped by relatives which mostly is not disclosed. The decline in late adolescence may be due to more maturity, more assertiveness, more adept at self-protection and the likelihood of being occupied either at school or work place. This is also supported by a study done in Australia where the rate for 10 – 14 years was highest and almost double that of below 10 years.[17] This may be because it is very common to see mothers with children 10 years and below under their supervised care even in their places of work like shops than those 11 years and older who usually are left unsupervised by an adult. It is possible that many more exist for those below 10 years but are undisclosed because a child may be too young to understand the impropriety of the rape. Adolescents in age group 11 – 15 years may also be at increased risk because they are more likely to run errands, participate in work activities like hawking or are more adventurous, may seek more emotional attention not available from busy parents.

From this study, the higher the level of education, the lesser the risk of rape. This may suggest that the higher the education, the better the awareness of the consequences of rape which can explain the lesser frequency of rape in those with higher education. It is also possible that most of the victims lacked appropriate for age sex education that predisposed them to being raped more than the control group as a lot of parents in this society still 'hide' the topic of sex from their children. It can therefore be deduced that literacy could facilitate understanding unwanted sexual gestures and the need for adoption of lifestyle to rape preventive and self-protective measures.

In the study centre, majority of the parents of the respondents had low educational attainment and were principally unskilled workers. These especially low educational attainments may translate to low socioeconomic status and the rate of rape is high in low income regions.[1] A higher level of education of an individual can increase the socio-economic status of the family. Level of education of father was found to be significantly associated with rape while the occupation of father was not statistically significant to rape in this study. While mothers occupation was significantly associated with rape but their level of education was not statistically significant. This may mean that the occupation of fathers irrespective of the economic power may keep him

away from home but does not predispose to victimization while a mothers' occupation may make her to be unavailable to supervise her children enough to prevent rape. Studies however suggest that females with more educated parents are less likely to be raped than females with less educated parents.[18] Unlike this study, literature did not separate the influence of fathers' from mothers' level of education. A mother has ingrained motherly qualities that ensures that she is able to supervise her children irrespective of her level of education while a father is able to bring awareness and knowledge to the family based on his level of education.

Skilled mothers can afford to provide for paid help to overlook their children while they are away from home and unemployed mothers are available themselves to supervise their children. However, unskilled mothers usually cannot afford helps to supervise their children away. In order to supplement the family income of the unskilled, their children tend to participate in occupation such as hawking putting them at risk.

A good number of respondents, were from families living above the World bank international poverty line of $1.25 per day (which was defined as living on 37.5 dollars per month, approximately 6,000 Naira per month).[19]This level of income is expected to empower families in order not to seek to augment family income through occupation of parents that can significantly predispose to rape through prolonged absence due to lack of supervision or the participation of a female child in occupations such as hawking that can expose her to rape.

The number of individuals (looking at the birth order) in the families depending on the family income was quite high which tended towards poverty and economic downturn on a broader outlook. Poverty is a significant contributory factor to rape.[1, 20]

Majority of rape events occur in a location that is familiar to the victim: either the residence of the victim or that of the perpetrator. This is not surprising as most perpetrators are known to victims. This has also been corroborated by other studies.[13, 14, 17]

The association between family structure and rape in this study was statistically significant. Similar result was obtained in a study by King et al in Cape Town, South Africa and in Australia.[17, 21] Also, in Addis Ababa research evidence though based on different methodology from this present study reported similarly that 26.6% of victims resided with both parents with the others (about three quarter) residing with either a parent, relative or other living conditions such as alone or with employer.[22] In Nigeria, a study to determine the likelihood of rape based on basic deprivation also support that girls who live with both parents are about three times less likely to experience rape than those residing with a single parent.[23] From this study, it can be deduced that children living with both their biological parents, have a greater advantage of being protected as compared to those who live with single parent, relatives or guardians.

Tenement housing type usually houses many families. A typical example in the Nigerian society is the 'face to face' apartments or passage houses. Most victims in this study resided in tenement houses. This may explain the close proximity to neighbours and their ready access to victims, hence, conforms to studies where majority of the perpetrators were neighbours to victims with the location (victim and perpetrator's house) being easily accessible to the perpetrators.[13, 14] A study by Peters et al also stated that living in a tenement house can engender rape.[24]

Patterns of relating or interactions (family function) in the family determines the degree of emotional bonding among the members which ensures that the needs of every individual family member and the group as a whole are met through strategies that the family has devised. A dysfunctional family creates emotional pressures and individual members may seek to fill such interactive gap through dependence on others which may lead to life-changing crisis. In particular, children and adolescents (require good emotional bonding for healthy adult life) often bear the huge impact of such dysfunction. The response to such family dysfunction is a chronic inability to respond to the needs of members; to cope with changes and stress in the society. A study reported that risk of rape victimization is higher among adolescent girls with poor family function which provokes them to seek emotional support from older men.[25] Studies based largely on experience in North American countries support that children from dysfunctional families have been identified to be more vulnerable to rape.[26]

In this study, a good proportion of participants were from dysfunctional families but rate of rape in functional family is low. It can be inferred from this study that, less proportion of victims from functional families could have been documented if the rate of social violence in the study location was less. This is of note because, levels of prevention of rape should also vigorously pursue prevention at the societal level with firm policies around crime.

In our study, only a few may have had signs of extra-genital injury because of the study population. The use of force is commoner in older victims. The absence of physical injuries may delay hospital presentation.

In majority of cases, there were various degrees of genital trauma such which mirrors the high percentage obtained by Duru et al in Bayelsa, Nigeria.[27] This may be attributable to their young age which makes their genitalia to yet achieve adult form maturity and could be related to the reason a much lower value of 15.6% was obtained in a study in Maiduguri, Nigeria.[28]

Presence of spermatozoa was demonstrated in only a few cases. This finding corroborate the result of Daru et al in Nigeria who using high vaginal swab test found spermatozoa in 43.0% of cases.[13] All cases did not

demonstrate semen presence in genitalia because most of the victims had bathed or cleaned up (therefore destroying evidence) before presentation. Some however, did not present early following rape event. This is bothersome as management is best effective when commenced within 4 hours following event.

Majority of the respondents in this study who had experienced rape first informed a confidant about it. It means that credibility of police data to formulate statistics is highly unreliable. The response a victim receives by the first persons they inform following rape can be very important in their long-term recovery. The informed person usually help them either seek for medical care or legal services. This reflects how much of importance the family has to play and offer in supporting a member in crisis especially in the immediate period following rape. Perceived family support helps in disclosure and subsequently encourages help-seeking behaviour. They are usually the ones to offer or suggest to the victim some form of help and where to seek such help. Studies document that the physical presence of a support whether in the hospital during examination or when they inform the police aids in the speedy recovery and provides a good long-term outcome for the victim.[17]

Majority did not disclose to law enforcement agency in this study. This is in variance to a study done by Akinlusi et al in Lagos, Nigeria where 92.2% of the victims reported the event to the police prior to presentation[15] and another in Ife where 69% reported to the Police before presenting at the hospital.[16] A much lower rate of 18.1% disclosure to the police was found in Abakaliki, Ebonyi State.[14] The higher reporting rate in Lagos may most likely be due to greater awareness of rape as a criminal act in a more urban Lagos than Benin while the academic town of Ife may be more enlightened than Benin and thus, interested in pursuing medico-legal action. The low rate of reporting may be from the tendency to settle out of court such sensitive issue as rape due to shame, victimization or fear of the perpetrator and not ruling out the fact that perpetrators are mostly known to the victims. Other possible reasons are; lack of funds to go through the legal process, prolonged or delayed court process, public nature of rape trial and lack of trust of the judicial system. In a Police Clinic study by Akhiwu et al, only 7.1% of the total cases that reported to police went further to court.[29] They described this rate as low given that all the cases were reported to police and cited difficulty in getting a conviction and publicizing the victims' violation which may stigmatize her especially in African culture settings where "virgin bride" is extolled as contributory reasons why legal prosecution is not pursued. Our study did not determine the number that went to court. However, failure to seek court prosecution encourages rape perpetration.

In this study, the disclosure of rape is characteristically much lower to formal agencies (37.2%) than to friends and family (91%), which means studies based on hospitals or police records grossly underestimate the prevalence of rape in the community. However, statistics indicate rape as the most underreported crime, [2] which suggests the complexities of rape disclosure, hospital management and documentation.

V. Conclusion

Rape is of public health significance in this environment and found to be common in Central Hospital, Benin City with a prevalence of 2.3%. Family structure with majority of the victims residing with a single parent and function were associated with rape victimisation.

This study showed a gradual increase in frequency with age with a peakratein early adolescence period but a decline observed in late adolescence. Individuals with educated mothers were less likely to be raped and though majority belonged to families that had income above poverty line, the number of persons dependent on such income was high which tended to poverty.

VI. Recommendations

- Rape is common. Healthcare providers should inform appropriate authorities (including social departments of health facilities, law enforcement agencies) in cases of rape of children;
- The parental supervision or care cannot be overlooked in this age group for adequate guidance and vulnerability to perpetrators.
- Educational interventions to ensure improved reporting and prevent rape should be ensuredand also the number without formal education need to be reached through enlightenment programs and pre-schoolers need more supervision in the absence of their parents.
- The assessment of family structure and function of clients routinely by healthcare providers is therefore important as it has been documented that rape has risk factors engraved in the family. The biopsychosocial model should be used for children and young persons to detect at-risk-population and prevent rape appropriately;
- It is advised that the judiciary and police should be strengthened as they are the most visible aspects of rape at state level.

Competing interests

The authors declare no competing interests.

Authors' contributions

EnobakhareEgbe conceptualized and designed the study, data collection, analysis and drafting/finalization of manuscript. Eromon Pauline and, Ohenhen Victor andOdiko David were involved in analysis and interpretation. All authors have read and agreed to the final version of this manuscript and have equally contributed to its content.

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