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Epidemiological and Clinical aspects of the management of victims of sexual abuse in the Obstetrics and Gynecology Department of Hospital Principal Dakar

Abstract

Introduction: Sexual abuse or sexual assault, a major public health problem, is defined as any sexual violation committed with violence, coercion, threat or surprise on the person of another. This worldwide societal tragedy has dramatic repercussions on the physical and psychological health and social well-being of victims. The objective of this study was to determine the epidemiological and clinical profile and to evaluate the management of sexual violence at Hospital Principal Dakar.

Patients and methods: This was a retrospective study of all cases of alleged sexual assault received at the maternity ward of the Hôpital Principal de Dakar during the period from 1 January 2018 to 15 April 2022, i.e. 4 years.

Results: During this period, 57 assault cases out of 77 were collated which represent 75% of medico-legal cases and 0.35% of admissions. The patients were immediately referred with a judicial requisition (91.2%) and were accompanied by their relatives in 90.7% of cases. The average consultation time after the attack was 17 days, with extremes ranging from 5 hours to 3 years. The epidemiological profile of the victim was that of an adolescent girl aged on average 15 years, a student (75%), nulligest (96.4%) and living in an urban area (51.9%). The sexual assault took place during the day (82.6%), at the victim's home (15.7%) or that of the alleged perpetrator (35.3%), and was perpetrated by an adult (81.6%) belonging to the victim's entourage in 78.6% of cases (parents, spiritual guide, teacher, driver, roommate, family friend). The mode of sexual abuse was genital contact in 62.3% of cases. The examination most often revealed hymenal trauma (78.5%), three quarters of which were old lesions, with no sign of physical violence in 91.1%. In almost all of the presumed victims, the psychological impact was not assessed on admission. Five pregnancies were recorded; emergency contraception was prescribed for 23.1% of patients. An infectious disease assessment, antibiotic prophylaxis, ARV prophylaxis and a psychological consultation were prescribed in 90%, 85.7%, 78.5% and 54.9% of cases respectively. Only 14.8% of the victims had been followed up.

Conclusion: Sexual abuse, the scourge of our time, is a disturbing reality. The real prevalence of this growing phenomenon is poorly known because of the many taboos and patriarchy. Optimal care for victims inevitably involves raising awareness among the population in order to break the silence, setting up specialised structures and collaboration between the various actors to condemn these crimes and, above all, to provide medical and psychological assistance and safe social reintegration for victims.

Keywords: sexual assault, epidemiology, ano-genital examination, care, Senegal

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Gaye Yaye Fatou Oumar, Ngom Papa Malick, Niang Ndama, Sylla Mafing Aya, Bentaleb Hajar, Inzale Mohamed Amine, Konaré Khadidiatou, Fall Zahara, Dème Bassirou, Faye Dieme Marie Edouard

Department of Gynecology and Obstetrics, Cheikh Anta Diop University, Senegal

Correspondence: Gaye Yaye Fatou Oumar, Department of Gynecology and Obstetrics, Cheikh Anta Diop University, Senegal, Tel 00221775235277, Email yifigaye@gmail.com

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Introduction

Sexual assault is a global societal drama defined as any sexual assault committed with violence, coercion, threat or surprise on another person. In addition to damaging the honour of the individual and his or her family, it exposes victims to other forms of violence (marital, physical, psychological and economic) and can have dramatic repercussions, the severity of which is largely underestimated, on the physical and psychological health and social well-being of victims. Sexual abuse is one of the precursors of mental health disorders, drug addiction, suicidal behaviour and self-harm in adults. It is a real brake on the socio-economic and even political development of a country.

Sexual assault affects millions of people around the world every year. Indeed, one in four women is a victim in her lifetime. Men are not spared (8-10%).[1] However, the actual prevalence of sexual abuse is far underestimated due to the bias of the silence injunction. Africa lags far behind in terms of knowledge and management of this scourge, which is far from new or rare. Senegal has no figures on the prevalence and incidence of sexual assault due to the absence of national registers. Only a few sporadic studies on a small population have been carried out. In order to contribute to the constitution of national data, we conducted a study on cases of alleged sexual assault in the gynaecology-obstetrics department of Hospital Principal Dakar during the period from 1 January 2018 to 15 April 2022.

The objective of this study was to:

a. Determine the epidemiological and clinical profile of the victims
b. Determine the epidemiological and clinical profile of the abusers and
c. Evaluate the management of sexual violence at Hospital Principal Dakar.

Patients and methods

This was a retrospective study conducted in the gynaecology-obstetrics department of Hospital Principal Dakar during a period of 4 years, from 1 January 2018 to 15 April 2022. Our study population was represented by all persons for whom a requisition was sent to the gynaecology-obstetrics department during the study period. All cases of alleged sexual assault received during this period were included in our study. We did not include in our cohort all other cases of requisition.

The parameters studied for each case were the following

i. Socio-demographic characteristics (age, sex, marital status, parity and place of residence)

ii. Circumstances of the assault and characteristics of the perpetrator

iii. Type of sexual contact

iv. Any injuries found during the physical examination,

v. Consequences of the assault

vi. Treatment

The data were collected using a survey form and analysed using Excel.

Results

Prevalence

During this period, 57 sexual assault cases out of 77 requisitioned cases were collated, which represent 75% of the forensic cases and 0.35% of admissions. On average, 1.11 presumed victims of sexual abuse were received each month in the gynaecology-obstetrics department of the Hôpital Principal de Dakar.

Socio-demographic characteristics

Socio-demographic characteristics of the alleged victims: All the alleged victims were female, and the majority were single (94.5%). Three patients were married. The average age of the patients was 15 years, with extremes ranging from 4 to 32 years. One in eight victims was a minor (79.8%). Figure 1 show the distribution of the alleged victims according to their age.

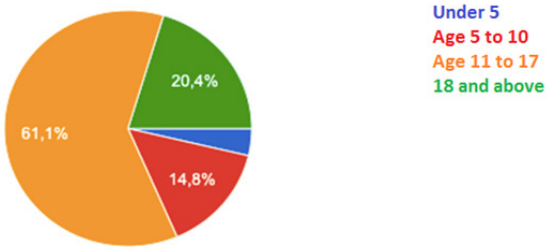

Figure 1 Distribution of alleged victims by age group.

Nulligravid women represented almost all of our patients (96.4%). There were two pauciparous patients (3.6%). The majority of patients (51.9%) lived in downtown Dakar. The others came from the suburbs of Dakar (42.6%) or the interior of the country (5.6%). In summary, the epidemiological profile of the victim was that of an adolescent girl aged on average 15 years, a student (75%), nulligest (96.4%) and living in an urban area (51.9%).

Time and place of the attack: The sexual abuse took place most often during working hours, between 8 a.m. and 6 p.m. (82.6%). Seven alleged victims (12.04%) were assaulted between 6 p.m. and midnight. Only 5.35% of the assaults were committed after midnight. Most sexual abuse took place in the home of the alleged perpetrator (35.3%) or the victim (15.7%). Twenty-one victims were unable to identify the location of the assault (41.1%). Figure 2 shows the distribution of victims according to the location of the assault.

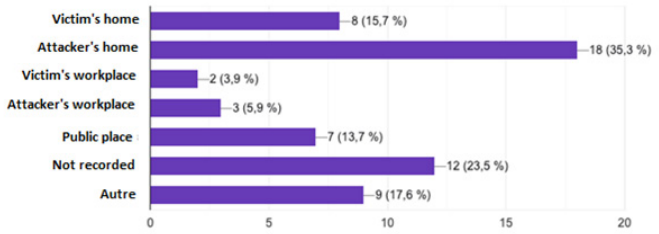

Figure 2 Distribution of victims according to the location of the attack.

Socio-demographic characteristics of the alleged abusers: The sexual abuse was generally perpetrated by an adult (81.6%). The age of the alleged perpetrator varied between 11 and 52 years. He acted alone in almost all cases (87.8%) and sometimes with several people, up to ten alleged offenders. Most often, the perpetrator was part of the alleged victim's direct family circle (78.6%). It was a relative (9.5%), a boyfriend (28.6%), a flatmate (23.8%) or an unknown person (21.4%). In rare cases the alleged perpetrator was the victim's brother, teacher or spiritual guide as shown in Figure 3.

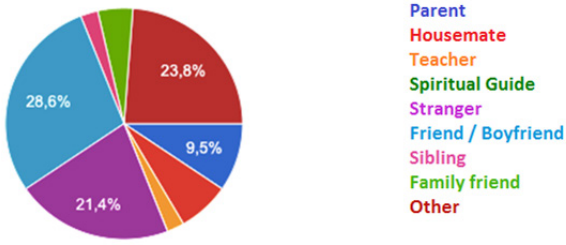

Figure 3 Distribution of alleged perpetrators.

Type of sexual contact: The mode of sexual abuse was genital-to-genital contact in 61.1% of cases. Eleven alleged victims were unable to specify the type of sexual contact, i.e. 20.4%. Other types of contact were listed, namely genito-anal (9.3%); genito-oral (5.6%); genitodigital (7.4%) as shown in Figure 4. Eight patients were touched (14.8%).

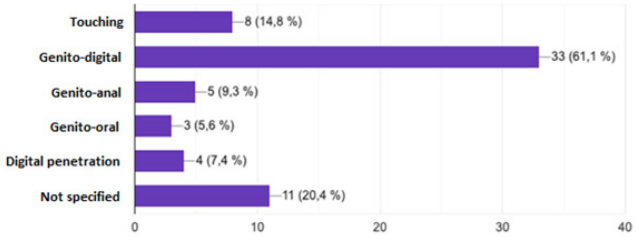

Figure 4 Distribution by type of sexual contact.

Twelve presumed victims declared that they had given their consent (21%), although they were all minors. A notion of recidivism was found in more than one victim in four (26.3%).

Clinical and paraclinical aspects

Mode of admission and consultation time: The majority of patients were referred immediately with a judicial requisition (91.2%). For the rest, the requisition was received secondarily (8.8%). 90.7% of the

presumed victims were accompanied by their relatives. The average time for consultation after the attack was 17 days, with extremes ranging from 5 hours to 3 years.

Type of traumatic injuries: The examination most often revealed hymenal trauma (78.5%), three-quarters of which were old injuries (46.4%). One in five patients had an intact hymen (21.4%). Eight victims had recent genital trauma injuries such as tears (5.3%) or peri-orificial redness (8.9%). Figure 5 shows the distribution of victims according to the results of the genital examination.

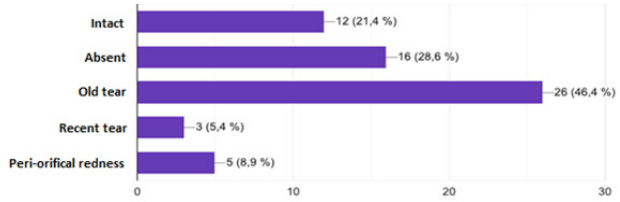

Figure 5 Distribution according to the type of genital trauma injury.

Two patients (3.5%) presented anal injuries. In almost all of the presumed victims (91.1%) no extra-genital traumatic injury was reported as a result of physical violence. It should be noted that one patient had a fracture (1.8%).

Behaviour of the victim after the attack: Almost all (90.9%) of the victims had taken a shower or performed intimate hygiene and changed clothes before the consultation. One out of nine victims (9.1%) had consulted immediately and the examination found traces of blood and/or semen; tears in the clothing.

Signs of pregnancy: Five pregnancies were recorded, most often at a fairly advanced stage, which represent 8.7% of cases.

Psychological state: In almost all the presumed victims, the psychological impact was not assessed on admission. It should be noted that one victim was completely mute at the time of the examination and another was in a state of agitation.

Therapeutic aspects

An infectious disease assessment and a psychological consultation were prescribed in 90% and 54.9% of cases respectively. After the clinical examination, 13.7% of the victims had benefited from antibiotic prophylaxis, most often with cyclins (85.7%). Prevention of HIV infection by prescription of antiretroviral drugs was instituted in 78.5% of the victims. Almost a quarter of the patients (23.1%) had received emergency contraception. One patient admitted with a full-term pregnancy had given birth by caesarean section for an immature pelvis. Another victim admitted at 6 months of pregnancy was followed up in the department and delivered at term by vaginal delivery. The other pregnant patients were lost to follow-up. Only 14.8% of the victims were followed up. The rest of the series was lost to follow-up.

Discussion

The analysis of our results shows that sexual assaults have a relatively low place in the management of emergencies in our department with a frequency of 0.35%. In fact, our department receives about 1 case of sexual abuse per month. These data are superimposed on those of the sub-region of Africa. Faye Diémé[2] (Senegal 2008); Sawadogo[3] (Burkina 2020) and Bambara[4] (Mali 2016) found an incidence of 0.4%; 0.2% and 0.15% respectively. However, Dembélé[5] (Mali 2021) and Eouani[6] (DRC 2020) reported higher incidences (2.6% and 2.15%). This could be explained by the war in these countries, where rape is used as a weapon of war.

Sexual abuse mainly affected minors in our series (79.8%). The same victim profile was found in Africa (Niang[7] 11 years old; Doumbia[8] 13 years old and Diallo[9] 8 years old). Whereas in developed countries the victims were older as reported by Almuneef[10] in Saudi Arabia (34 years old) and Fryszer[11] in Germany (26years old). This high frequency of underage girls in developing countries could be explained by the fact that this group is vulnerable due to several factors (search for easy gain, curiosity and especially the low socio-economic level). In developed countries, on the other hand, older people were more vulnerable.

All victims in our study were female, as were Niang[7] and Doumbia.[8] Almuneef[10] (Saudi Arabia) reported 52.1% male victims. These gender differences in victims vary from country to country due to cultural beliefs and values that are reflected in disclosure and reporting rates.

The sexual assault took place during the day (82.6%), at the victim's home (15.7%) or at the alleged perpetrator's home (35.3%). In the literature, less than half of the assaults occurred during working hours. In Niang's series,[7] only 31.7% of sexual abuse took place between 8am and 6pm, as did Sawadogo[3] (40.6%). In our series 78.6% of sexual assaults were perpetrated by an adult (81.6%) belonging to the victim's entourage. Our results are similar to those of Faye Diémé[2] in 2008 in Senegal (78.2%) and Tjaden and Thoennes[12] in the United States (80%). Familiarity between the aggressor and the victim through blood or neighbourhood ties or ancestry (marabout, teacher, Koranic master) facilitates the hold on the victim. However, the intra-family origin of abuse was rather low in our study (9.5%), which is in line with Niang's rates[7] (7.88%). It should be noted that the frequency of incest is largely underestimated due to its taboo nature. Indeed, Daligaud and Bourgeois[13] found that 2 out of 3 cases of sexual abuse were intrafamilial. Nevertheless, incest is very often kept silent for fear of breaking the family fabric, hence the complexity of its management. This has been pointed out by a number of African authors.[7]

The aggressor was often an adult, however like Faye Diémé[2] and Bambara[4] we found adolescent perpetrators (11 years, 10 years and 17 years).

The alleged victims in our study consulted on average within 17 days, with extremes ranging from 5 hours to 3 years. Bambara[4] and Diallo[9] also reported late consultation times (8 and 5 days). On the other hand, in the series by Sawadogo[3] and Niang,[7] the patients consulted early on average at day 1. The delay in consultation was not favourable to the collection of forensic evidence (sperm search). This delay in consultation is most often linked to the fact that victims hide their misadventure out of shame or fear of reprisals. Thus they only seek help when their parents or guardians have doubts about their suspicious behaviour. In our study, one victim in ten had a requisition (91.2%) and was accompanied by a family member (90.7%), the same observation was made by Sawadogo,[3] Niang[7] and Traoré.[14]

The most common sexual contact in our series (61.1%) as well as in the literature was genital contact. Niang,[7] Faye Diémé[2] and Bambara[4] reported 80.9%, 67.3% and 61.9% genital contact respectively. Sometimes the type of contact was other (oral, anal, digital) and/or multiple. In his series Dembélé[5] found 15.68% genito-anal contact. Genito-oral contact was found in 7.7% of cases in the Sawagogo[3] series.

The clinical examination of the majority of the presumed victims (78.5%) revealed genital trauma, which in three-quarters of the cases were old hymenal lesions. Our results (old hymenal lesions 46.4%)

were superposable to those recorded in other Senegalese series (Niang[7] 49%; Faye Diémé[2] 54.5%). On the other hand, Coulibaly[15] and Eouani[6] reported 86.2% and 72.7% respectively of old hymenal lesions. The gynaecological examination revealed recent hymenal lesions in 34% of our patients, which corroborated the results of Diallo[9] (31.1%). Anal lesions were around 3.5% as in Coulibaly's series[15] (3.3%). One victim in five had an intact hymen (21.4%); these figures were similar to those of Eouani[6] (20%), Faye Diémé[2] (29.1%) and Niang[7] (34%).

It is important to emphasise that the absence of hymenal lesions does not in any way indicate that there has been no sexual abuse (touching and oral and anal penetration being sexual abuse). Furthermore, the oestrogenised hymen of adolescents and young women is elastic, allowing penetration without rupture up to a certain diameter. The long delay before consultation means that some lesions can heal without leaving a scar, especially in the peri-pubertal period, or leave an old hymenal lesion in its place.[11] All this makes it difficult to reach a legal decision because the medical certificate remains a key element in the legal process.

The psychological impact had not been evaluated at the time of the first consultation for most of the victims in our study, even though psycho-trauma constitutes a fundamental element of the charge. In Africa, few studies provide information on the psychological impact of sexual assault. This is due to the scarcity of psychologists, the lack of training of personnel in the management of sexual abuse and the absence of specialised centres for the care of victims. However, a referral for better psychological care was prescribed to all our patients.

Our protocol for the management of victims of sexual abuse was the same as in the literature. The infectious work-up came back negative in all our patients. Emergency contraception was prescribed to all patients of childbearing age who consulted within the required timeframe. Some victims were not able to benefit from antiretroviral prophylaxis because of the delay in consultation.

The follow-up rate was very low in our series, around 14.8%. It was higher than the rates reported by Coulibaly[15] (3.3%) and Dioussé[16] (zero rate). This could be linked to financial difficulties or show the interest of families in the legal aspect (medical certificate). The lack of follow-up for victims results in the failure of their infectious and psychological care.

Conclusion

Sexual abuse is a disturbing reality and a flagrant violation of basic human rights. The rampant prevalence of this scourge remains poorly known because of the many taboos and the patriarchy.

The medical profession, the first point of contact for victims, must know how to recognize this violence, which is passed over in silence, and which is distilled into a daily routine of hopelessly chronic pain, sexual disorders, exhaustion and even depression.

This medico-legal and psychological emergency therefore requires public awareness, the setting up of specialised structures (medico-judicial units) and multidisciplinary care (gynaecologists; psychologists; lawyers; police officers; gendarmes; social workers, etc.) for the condemnation of these crimes and, above all, the medico-psychological assistance and safe social reintegration of the victims.

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Conflicts of interest

All authors declare any financial interest with respect to this manuscript.

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