Original Article

Perception, Knowledge, and Management of Sexual Violence among Health Workers in a Tertiary Hospital in Nigeria

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Abstract

Introduction: Sexual violence against women is global public health and clinical problem which occurs in all culture, different levels of society and throughout the countries of the world.

Objectives: This study assessed the knowledge, perception and management of sexual violence among healthcare workers in Obafemi Awolowo University Teaching Hospitals Complex, Ile- Ife, Nigeria.

Methods: A cross-sectional research design was conducted among forty-eight respondents (doctors and nurses) working in the Obstetrics and Gynecology Department of the hospital. Data was collected using a pre-validated structured questionnaire comprising questions on socio-demographic variable, knowledge perception and management of sexual violence. Data collected were analysed descriptively and inferentially using SPSS version 16.

Results: The result shows that majority (85%) of the respondents agreed that sexual violence involves unwanted sexual comments and about 81% supported that sexual violence involves intentional touching of the genitalia, anus, inner thigh, groin, buttocks, and breast without the person’s consent. Moreover, 84.49% of the healthcare workers routinely recommended that survivors have a full medico-legal examination to obtain evidence and 89.13% never refer for trauma counselling. This study also reveals that 73.91% of healthcare workers have never had any formal training on the management of sexual violence. Furthermore, there is a significant association between knowledge and discipline of the respondents ($p= 0.002$)

Conclusion: Healthcare workers have good knowledge about sexual violence and fair perception of it, and they can manage cases of sexual violence fairly well. Therefore, further training should be organised for health workers to reinforce their skill and capacity in managing sexual violence.

Keywords: Health workers, knowledge, management, sexual violence

Background

Sexual violence is a global public health and clinical problem which occurs in all culture, different levels of society and throughout the countries of the world (García-moreno et al., 2014; Gatuguta et al., 2017; Mason et al., 2013; World Health Organization, 2003). Sexual violence usually starts in childhood or adolescence and can occur in different settings, including the workplace, home and schools (World Health Organization, 2003). It can take many different forms including acts of non-consensual intercourse and a wide range of sexual behaviours' such as attempts to obtain a sexual act, sexual harassment, coercion, trafficking for sexual exploitation and

female genital mutilation (World Health Organization, 2003).

The adverse effects of sexual violence on physical, mental and reproductive wellbeing of the victim are enormous. The reproductive consequences include unwanted pregnancy, increased risky sexual behaviours, HIV and other sexually transmitted infections (Ezema, 2016; Ige & Fawole, 2012; World Health Organization, 2003). The mental health impact is in the form of substance abuse, suicide, depression and post-traumatic stress disorder (PTSD) including re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the traumatic event and numbing of general responsiveness, and persistent symptoms of increased arousal (Edwards et al., 2010; Ige & Fawole, 2012; Mason et al., 2013; Stewart et al., 2016). The physical problem can be genital and bodily injuries(Ige & Fawole, 2012).

The role of health care providers includes identification of women and girls who have been sexually abused for prompt treatment and referral, initial supportive response to disclosure or identification and provision of clinical care, comprehensive post-rape care follow up (Oladeji et al., 2019) and support for the victim (García-moreno et al., 2014). The health care services for sexual violence victim must be available in every comprehensive secondary and tertiary health care facilities and should include prevention of pregnancy and sexually transmitted infection (García-moreno et al., 2014; Jina et al., 2010; World Health Organization, 2013)

There has been an advocacy for the training of health care workers on the effective management of sexual violence (Muganyizi et al., 2011). Management of sexual assault includes prophylaxis for sexually transmitted infections, management of the mental problem, counselling, treatment of injuries, providing emergency contraception and referral (Luce et al., 2010; Muganyizi et al., 2011). Health care environment should be conducive for the victim to get support and for healthcare workers to providing essential services for the sexual violence victim (García-moreno et al., 2014).

Factors that could affect the healthcare-seeking behaviour and re-traumatisation of the victim of sexual violence include stigma, distance from health facilities, the attitude of health care providers lead to poor quality services rendered, (Gatuguta et al., 2017; Smith et al., 2013).

Evidence has shown a gap in the healthcare perception and management of sexual assault victims (Acosta, 2002; World Health Organization, 2003). Sexual violence is widespread, yet relatively few survivors receive healthcare or complete treatment in low and middle-income countries (Gatuguta et al., 2017). Also, in Nigeria, there are scanty of studies on assessment of the health care providers' knowledge and perception of management of the sexual assault victims. Therefore, this study assessed health care workers' knowledge, perception and management of sexual violence victims in OAUTHC

Materials and Methods

Study setting and design: A descriptive cross-sectional research design was used to collect data among health workers at the Obstetrics and Gynecology Department of OAUTHC, Ile-Ife. OAUTHC is a conglomeration of six(6) health facilities namely: Dental Hospital OAU, Urban Comprehensive Health Center, Eleyele Ile-Ife; Ife hospital Unit along, Ile-Ife; Wesley Guild Hospital, Ilesha; and the Rural Comprehensive Center Imesi-Ile. It is one of the foremost federal teaching hospitals in Nigeria, and it is unique in the sense that it offers primary, secondary and tertiary care. It also serves as a hospital for different cadres of patients with different ailments and with a wide spectrum of health professionals.

Sample size determination and procedure: The respondents for this study were nurses and doctors working at the Obstetrics and Gynecology Department, OAUTHC. All doctors (36) and nurses (23) were enlisted for the study. However, only twenty-seven doctors and twenty-one nurses completed the questionnaire. Other were not available because of different types of leave and those who decline participation.

Data collection method and instrument: The instrument for data collection was a self-administered questionnaire comprising four sections. Section one describes the socio-demographic characteristics of the respondents, including age, marital status and qualification.

Knowledge about sexual violence was assessed with the second section of the questionnaire comprising fifteen items with true, false and I don't know the format. Correct option attracts 1 point while an incorrect option is scored zero. The third and fourth sections elicit information on the perception and management of sexual violence by the respondents, respectively. Perception comprises 14 items rated on four Likert scales from SA to SD. Management of sexual violence was assessed under the general, medical, psychological and legal management. Respondents were approached and informed about the purpose of the study on their willingness to participate in the study. Permission for data collection was obtained from the authority of the institution and the unit leader where the study was conducted. Respondents who gave their consent were thereafter administered the questionnaire. The questionnaire was retrieved immediately, and their confidentiality was ensured.

Data Analysis: Data collected was analysed using Statistical Package for Social Sciences (SPSS) version 16. Descriptive statistics, including frequency and percentage, were used to describe the level of knowledge, perception and management of health workers on sexual violence. Inferential statistics: chi-square was used to test the association between the variables.

Results

The characteristic socio-demographic characteristics of the respondents are presented in table 1. It shows that the respondents were equally distributed between the males (50%) and the females (50%), most of the respondents interviewed were between the ages 26 and 30 years (41%). Majority were married (56%) and a similar proportion were medical doctors (56%).

The table on the knowledge level (table 2) reveals that most of the respondents agreed that sexual violence involves the following: unwanted sexual comments (85%), completed non-consensual sex act (87%)., attempted (but not completed) nonconsensual sex act (93%). The table also shows that intentional touching of the genitalia without the persons' consent (90%), intentional touching of the anus without the person's consent (83%), intentional touching of the inner thigh without the person's consent (88%), intentional touching of the groin without the persons' consent (85%), intentional touching of the buttocks without the persons' consent (85%) and intentional touching of the breast without the persons' consent (90%).

Table 3 shows the perception level of health workers about sexual violence. The finding reveals that: sex is the primary motivation for rape and rape is perpetrated by a stranger (71%), rape involves a great deal of physical violence and the use of a weapon (73%), Some women lie about rape to punish men (93%), a child who has been raped is an emergency medical case (98%), rape is more serious for someone who is a virgin (77%), sex workers can be raped (82%), if a woman is drunk, it is impossible to say she didn't agree to sex (64%) and woman who is raped could not bring shame on her family (63%). The table (3) also shows the respondent's perception as rape leaves the obvious sign of injuries (76%), certain types of women cannot be raped (89%), it is not disgraceful for women to bring rape cases to court (82%), and a man can rape his wife (89%). In addition, we computed the aa composite score for knowledge and perception of sexual violence among the respondents. The results showed that an overwhelming majority of the respondents have good knowledge of sexual violence and the proportion of doctors with good knowledge was higher than that of nurses. (see Figure 1). Similarly, n, 79.2% of the respondents had a fair perception of sexual violence (see Figure 2).

The management of sexual violence is presented in Fig 3. The respondents agreed that they seldom manage cases of sexual violence (60%), victims of rape express injuries, HIV/AIDS, STIs, pregnancy and mental health concerns (40%). Most also ascertain that they did not have any formal training on rape case management (74%) and perception of sexual violence affects the way they treat survivors (51%)

On medical management of sexual violence Fig 4, Some of the respondents (41%) revealed that they offer VCT, a prescription for PEP/PEP drugs and referral for VCT to rape patients (41%). Offer abortion counselling/ information, emergency contraceptives and IUD insertion as pregnancy services (54%); give prophylactic treatment and send the swab to a lab to test as STI related

services for the rape patients (39%), everyone that has a rape incident gets STI treatment (89%).

On legal management Fig 5, most of the respondents (84%) recommend that a rape survivor to have a full medico-legal examination to collect evidence whether they choose to report the rape to the police or not. Most (53%) of the respondents disagree that forensic examination takes place at their facility. Also, some (41%) of the respondents always refer to rape victims for legal advice/support. Most of the respondents (55%) agree that they collect a sample for forensic evidence. Many respondents (50%) revealed that most of the sample collected is vaginal swabs.

Table 1 Socio- demographic data of respondents

	Frequency	Percent(%)
Sex		
Male	24	50.00
Female	24	50.00
Total	48	100.00
Age		
21-25	8	19.51
26-30	17	41.47
31-35	8	19.51
36-40	5	11.10
41-45	--	--
46-50	3	7.32
Total	41	100.00
Marital status		
Married	27	56.25
Single	21	43.75
Divorced	--	--
Separated	--	--
Total	48	100.00
Discipline		
Nursing	21	43.75
Medicine	27	56.25
Total	48	100.00

Table 2 Knowledge of Sexual Violence among Health Care Workers

	Questions	True	False	I don't know
1	Sexual violence includes			
I	Unwanted sexual comments	39 (85%)	6 (13%)	1 (2%)
Ii	A completed non consensual sex act	41 (87%)	6 (13%)	--
Iii	An attempted (but not completed) non consensual sex act	42 (93%)	2 (4%)	1 (3%)
Iv	Intentional touching of the genitalia without the persons consent	43 (90%)	3 (6%)	2 (4%)
V	Intentional touching of the anus without the person's consent	39 (83%)	4 (8.5%)	4 8.5%)
Vi	Intentional touching of the inner thigh without the persons consent	42 (88%)	5(10%)	1(2%)
Vii	Intentional touching of the groin without the persons consent	38 (81%)	6 (13%)	3(6%)
Viii	Intentional touching of the buttocks without the persons consent	41 (85%)	4 (8%)	3 (6%)

Ix	Intentional touching of the breast without the persons consent	43 (90%)	4 (8%)	1 (2%)
2	Female genital mutilation is a form of sexual violence	32 (68%)	13(28%)	2 (4%)
3	Sexual violence occurs only in some settings	12 (27%)	32(71%)	1 (2%)
4	Males can be sexually violated	42 (95%)	1(2.5%)	1(2.5%)
5	All types involve victims who do not consent, or who are unable to consent or allow the act	40 (91%)	4 (9%)	--
6	Sexual violence can take place within marriage	45 (96%)	2 (4%)	--

Table 3 Perception of Sexual Violence among Healthcare Workers

	Questions	SA	A	SD	D
7	Sex is the primary motivation for rape	19 (40%)	22 (47%)	1 (2%)	5 (11%)
8	Rape is perpetrated by a stranger	3 (7%)	10 (22%)	13(28%)	20 (43%)
9	Rape involves a great deal of physical violence and the use of a weapon	14 (30%)	20 (43%)	4 (9%)	8 (18%)
10	Some women lie about rape to punish men	12 (26%)	31 (67%)	--	3 (7%)
11	A child which has been raped is an emergency medical case	35 (74%)	11 (23%)	1 (2%)	--
12	Rape is more serious for someone who is a virgin	25 (57%)	9 (20%)	2 (5%)	8 (18%)
13	Sex workers cannot really be raped	4 (9%)	4 (9%)	22(46%)	17 (36%)
14	If a woman is drunk, it is impossible to say she didn't agree to sex	3 (7%)	26 (57%)	7 (15%)	10 (22%)
15	A woman who is raped brings shame on her family	9 (20%)	8 (17%)	9 (20%)	20 (43%)
16	Rape leaves obvious sign of injuries	15 (33%)	20 (43%)	1 (2%)	10 (22%)
17	Only certain types of women are raped	2 (4%)	3 (7%)	18(39%)	23 (50%)
18	It is disgraceful for women to bring rape cases to court	3 (7%)	5 (11%)	22(48%)	16 (35%)
19	A man cannot rape his wife	4 (9%)	1 (2%)	18(38%)	24 (51%)

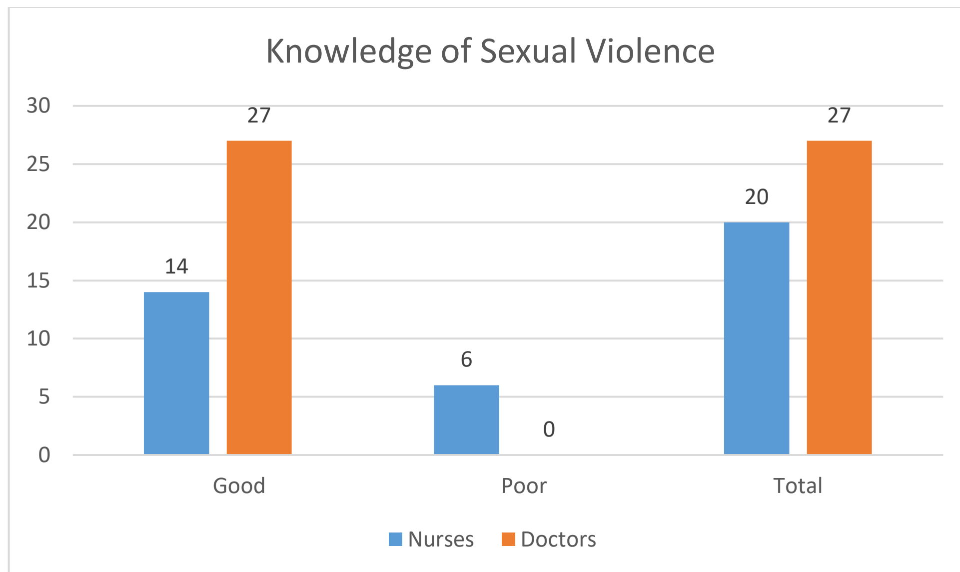

Figure 1: Knowledge of Sexual Violence

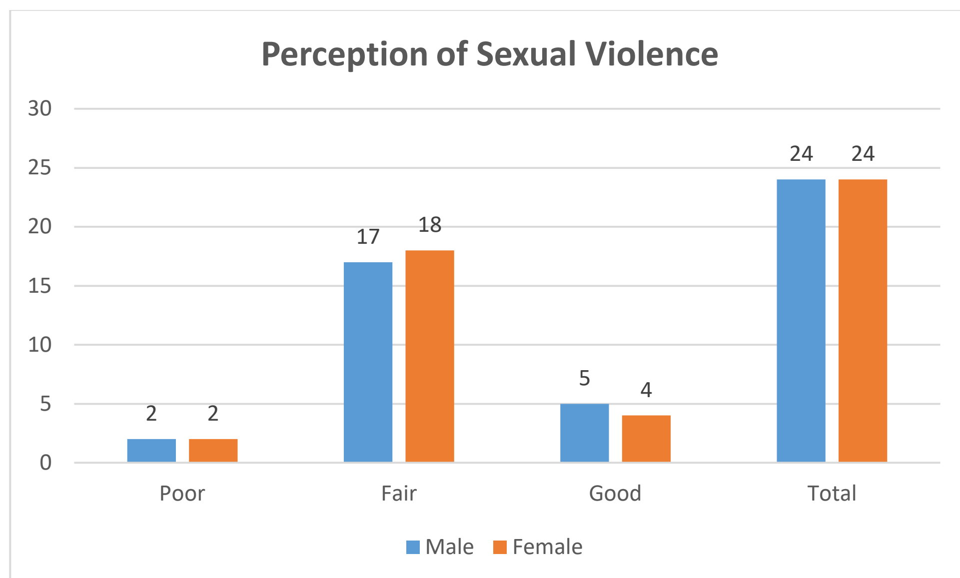

Fig 2: Perception of Sexual Violence

Management of Sexual Violence

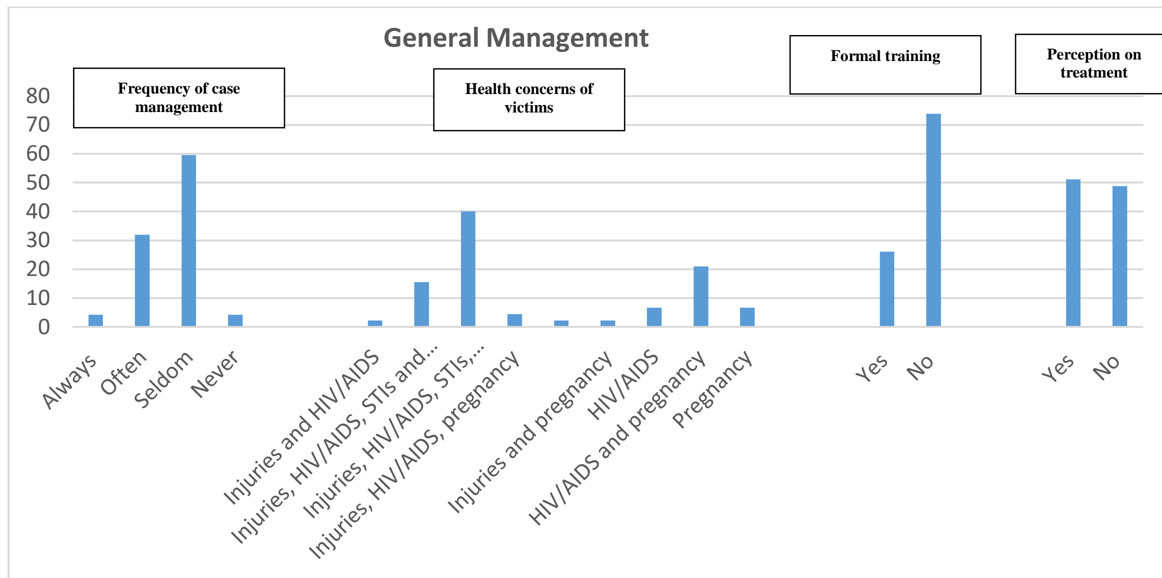

Figure 3 General Management of Sexual Violence among Health Workers

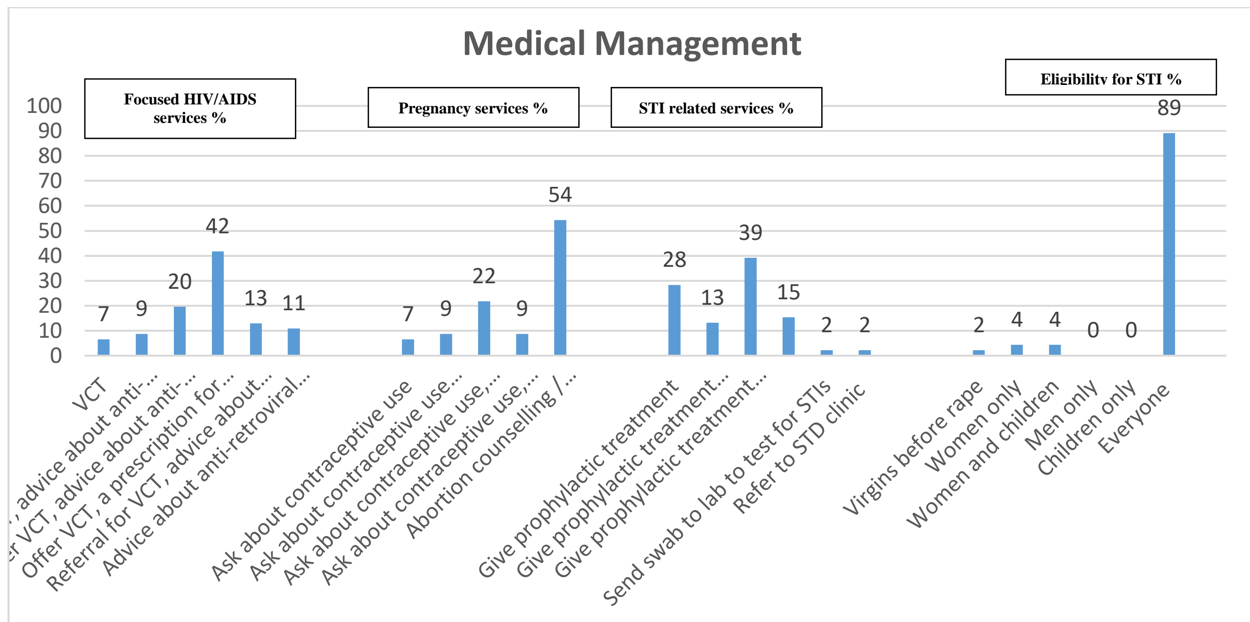

Figure 4 Medical Management of Sexual Violence among Health Workers

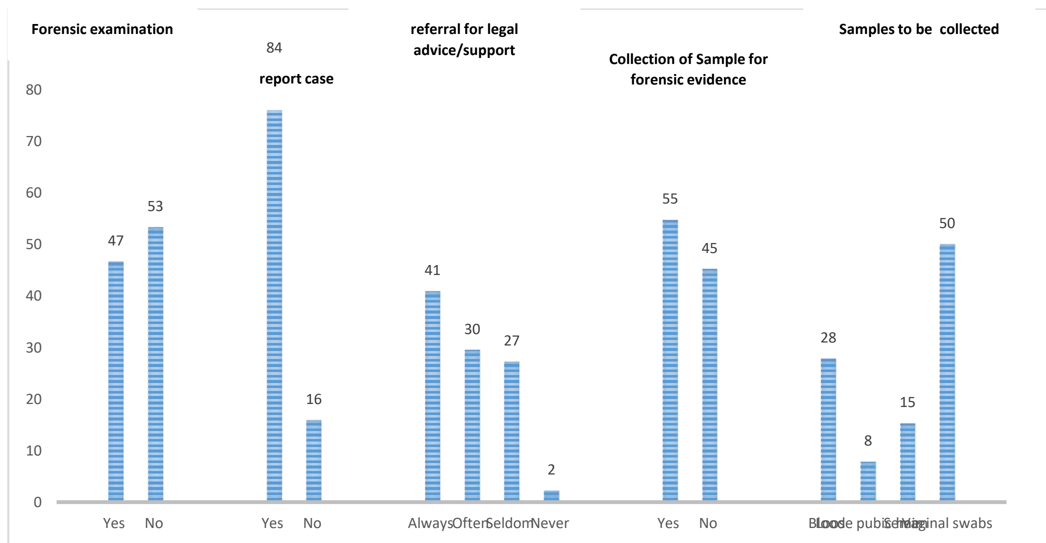

Figure 5. Legal Management of Sexual Violence

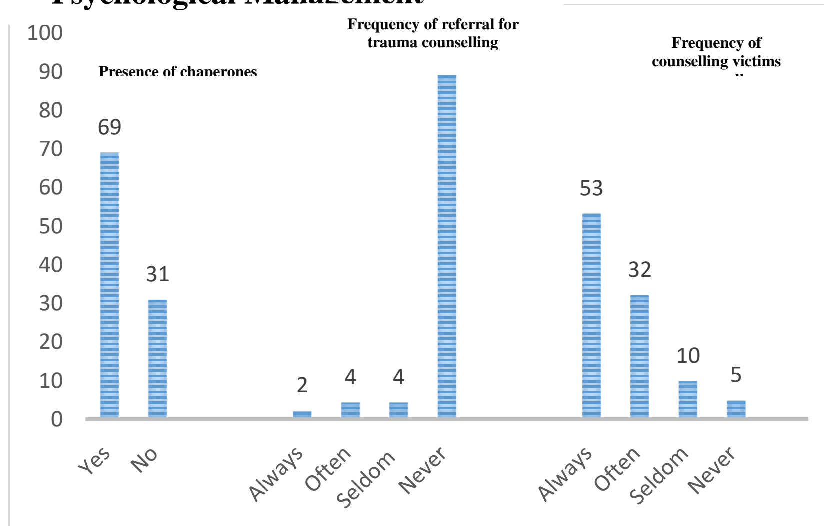

Figure 6 Psychological Management of Sexual Violence

Table 4 Association of Knowledge and Management of Sexual Violence and Profession

	Profession				
Knowledge	Nurses	Doctors	Total	X	p
Poor	6	1	7	9.29	P=0.002
s	14	27	41		
Total	20	28	48		
Management					
Poor	2	4	6	12.27	0.268
Fair	8	16	24		
Good	11	7	18		
Total	21	27	48		

Table 5 Association of Sex and Perception of Sexual Violence

	Perception of sexual violence					
Gender	Poor	Fair	Good			
Male	2	17	5	24	0.1397	0.933
Female	2	18	4	24		
Total	4	35	9	48		

Psychological management Fig 6 shows that most of the respondents (69%) agreed that chaperones are allowed in the examination rooms if the survivor is an adult. Most of the respondents (89%) never refer rape victims for trauma counselling. Average of the respondents (53%) always do counselling with patients themselves.

Table 4 shows that there is a significant difference between nurses' and doctors' knowledge of sexual violence. All doctors have knowledge about sexual violence, while only 70% of the nurses know about sexual violence. However, there is no significant difference between the gender of the health workers and their perception towards sexual violence. Table 5 also reveals that there is no significant difference between the discipline of the health workers and the management of sexual violence

Discussions

The result of the study showed that healthcare workers have good knowledge of sexual violence. Most of the respondents were in agreement with the description of sexual violence, including sexual violence, involves unwanted sexual comments and intentional touching of the genitalia. This is consistent with the definition of World Health Organization that sexual violence can take many different forms including acts of non-consensual intercourse and a wide range of sexual behaviours' such as attempts to obtain a sexual act, sexual harassment, coercion, trafficking for sexual exploitation and female genital mutilation (World Health Organization, 2003). However, though most of the healthcare workers knew that sexual violence is not limited to occurring only in some settings, an appreciable proportion (27%) of them do not know this. Mason and colleagues stated that

sexual violence occurs virtually every place and at any time; in the home and outside the home, in peace and conflict (Mason et al., 2013). Also, an appreciable proportion of healthcare workers (28%) do not agree that female genital mutilation is a form of sexual violence. This is contrary to the assertion of Oladeji and colleagues that sexual violence includes female genital mutilation (Oladeji et al., 2019). The reason for disagreeing on the inclusion of female genital mutilation among sexual violence is not known. Nevertheless, healthcare workers need to understand that female genital mutilation is a form of sexual violence, and they should not let their values come in the way of practice.

This study also found that most (73%) of the healthcare workers' belief that rape involves a great deal of physical violence and the use of a weapon. However, this is contrary to the WHO definition of sexual violence which stated that sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advancement acts to traffic or otherwise directed against a person's sexuality. This can be done using coercion by any person regardless of their relationship to the victim in any setting, including but not limited to home or work. Sexual violence does not only involve physical force, but may involve psychological intimidation, blackmail, and other threats(World Health Organization, 2003).

The findings from this study also indicate that most healthcare workers believe that rape leaves an obvious sign of injury. These beliefs imply that in the event of rape without a high degree of physical force and use of weapon and no obvious sign of injury, though psychological trauma may be present for the victim. Consciously or otherwise, healthcare workers may deny the fact that the victim is raped. This may affect the diagnosis of sexual violence, and this situation nullifies the purpose of effective management. Therefore, it is expedient that healthcare workers understand that rape does not always leave an obvious sign of injury. Evident upon this, Tshabalala-Msimang reported that in a series of 432 cases of rape examined in Johannesburg 37% of rape survivors had evidence of non-genital injury (Tshabalala-Mstimang, 2003)

Also, this study found that an appreciable proportion (37%)of the healthcare workers believe that a woman who is raped brings shame on her family. This finding support Harris and Freecero that sexual violence can rend the fabric of families and communities. They stated in many countries, spouses or partners may abandon victims because of shame and stigma associated with sexual assault (Harris & Freccero, 2011).

In the context of management and professional skills most (84.49%) of the healthcare workers routinely recommend that survivors have full medico-legal examination to collect evidence whether they choose to report the rape to the police or not. This finding is consistent with Menaker which states that any evidence, forensic or otherwise, which would potentially lead to prosecution should be appropriately collected and stored (Menaker et al., 2016). Most of the healthcare workers stated that the sample is usually collected. Most of them reported that that the sample collected is vaginal swabs; a lesser majority reported that they collect blood, and some others semen only 7.85% reported collecting loose pubic hair. Majority of the healthcare workers refer for legal advice some often refer while others seldom refer for legal advice. Most of the healthcare workers (89.13%) never refer for trauma counselling; however majority always (53.3%) or often (32.11%) give trauma counselling to survivors. The most pregnancy-related service offered by healthcare workers includes abortion counselling/information; emergency contraception and IUD insertion and the most HIV focused service offered include voluntary counselling & testing.

In this study, the majority (73.91%) of the healthcare workers stated they have never had any formal training on management of sexual violence. Survivors of sexual violence require adequate care to counteract the negative impact of sexual violence. The adequacy of care is not just in quantity but in the quality of care given. To achieve the delivery of quality care training of healthcare workers is essential. Though it may seem that the lack of training does not affect the management of survivors, but if time is taken to follow the victims the loopholes in their management due to lack of management skill would be surely evident. This is consistent with

World Health Organization suggestion that adequate training for the proper management and prevention of sexual violence(Garcia-Moreno et al., 2012)

Conclusion: This study concluded that a sizable number of nurses in this setting have fell short of the required knowledge, and they have a fair perception of sexual violence management. They, however, manage cases of sexual violence fairly well. It is therefore suggested that efforts should be put in place to improve nurses knowledge as well as skills required in the management of sexual violence victims.

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References

Acosta, M. L. (2002). Collecting evidence for domestic and sexual assault: highlighting violence against women in health care system intervention. *International Journal of Gynaecology and Obstetrics*, *78*, 99–104.

Edwards, D., Burnard, P., Bennett, K., & Hebden, U. (2010). A longitudinal study of stress and self-esteem in student nurses. *Nurse Education Today*, *30*(1), 78–84.

Ezema, I. J. (2016). Reproductive Health Information Needs and Access among Rural Women in Nigeria : A Study of Nsukka Zone in Enugu State. *The African Journal of Information and Communication*, *18*, 117–133.

Garcia-Moreno, C., Guedes, A., & Knerr, W. (2012). Understanding and addressing violence against women Sexual violence. *Pan American Health Organization W*.

García-moreno, C., Hegarty, K., Flavia, A., Koziol-maclain, J., Colombini, M., Feder, G., & Paulo, S. (2014). *Violence against women and girls 2 The health-systems response to violence against women* (Vol. 6736, Issue 14). https://doi.org/10.1016/S0140-6736(14)61837-7

Gatuguta, A., Katusiime, B., Seeley, J., Colombini, M., Mwanzo, I., & Devries, K. (2017). *Should community health workers offer support healthcare services to survivors of sexual violence ? a systematic review*. 1–15. https://doi.org/10.1186/s12914-017-0137-z

Harris, L., & Freccero, J. (2011). *Sexual Violence: Medical and Psychosocial Support*. University of California.

Ige, O. K., & Fawole, O. I. (2012). Evaluating the medical care of child sexual abusive victims in a General Hospital in Ibadan, Nigeria. *Ghana Medical Journal*, *46*(1).

Jina, R., Jewkes, R., Munjanja, S. P., Mariscal, J. D., Dartnall, E., & Gebrehiwot, Y. (2010). Report of the FIGO Working Group on Sexual Violence/HIV: Guidelines for the management of female survivors of sexual assault. *Int J Gynaecol Obstet*, *109*, 85–92.

Luce, H., Schrager, S., & Gilchrist, V. (2010). Sexual Assault of Women. *Am Fam Physician*, *81*(4), 489–495.

Mason, F., Bs, M. B., Dfp, F., Psychiatrist, C. F., Medical, C., Lodrick, Z., & Hons, B. A. (2013). Best Practice & Research Clinical Obstetrics and Gynaecology Psychological consequences of sexual assault. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *27*(1), 27–37. https://doi.org/10.1016/j.bpobgyn.2012.08.015

Menaker, T. A., Cambel, B. A., & Wells, W. (2016). The Use of Forensic Evidence in Sexual Assault Investigations: Perceptions of Sex Crimes Investigators. *Violence Against Women*.

Muganyizi, P. S., Nyström, L., Axemo, P., & Emmelin, M. (2011). *Managing in the Contemporary World : Rape Victims ' and Supporters ' Experiences of Barriers Within the Police and the Health Care System in Tanzania*. https://doi.org/10.1177/0886260510393006

Oladeji, O., Owoaje, E., Oladeji, B., & Fatiregun, A. (2019). *COMMUNITY MEDICINE AND PRIMARY HEALTH CARE A Community-based Intervention for improving Utilisation of Medical Services by Rape Survivors in Refugee Camps in Zambia Keywords : discussion ,*. *31*(1), 11–21.

Patterson, D. (2011). *The Impact of Detectives ' Manner of Questioning on Rape Victims ' Disclosure*. https://doi.org/10.1177/1077801211434725

Smith, J. R., Ho, L. S., Langston, A., Mankani, N., Shivshanker, A., & Perera, D. (2013). Clinical care for sexual assault survivors multimedia training : a mixed-methods study of effect on healthcare providers ' attitudes , knowledge, confidence , and practice in humanitarian settings. *Conflict and Health*, 1–10.

Stewart, D. E., Vigod, S., & Riazantseva, E. (2016). *New Developments in Intimate Partner Violence and Management of Its Mental Health Sequelae*. https://doi.org/10.1007/s11920-015-0644-3

Tshabalala-Mstimang, M. (2003). *National Management Guidelines for Sexual Assault*.

World Health Organization. (2003). Guidelines for medico-legal care for victims of sexual violence. *World Health Organization*.

World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. In *World Health Organization*.