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Clinical and Therapeutic Aspects of Sexual Violence Received at Yalgado Ouedraogo Teaching Hospital, Burkina Faso

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Abstract: Sexual abuse is a health problem that needs to be adequately and comprehensively managed. A preventive strategy must be conducted to deter potential abusers. The purpose of the study was to describe the cases of sexual violence received in the Department of Gynecology and Obstetrics at Yalgado Ouedraogo University Hospital. It was a retrospective and descriptive study covering a period from January 1, 2009 to December 31, 2013. The study involved victims of sexual violence received in the obstetrics and gynecology department of Yalgado Ouedraogo Hospital and whose files were usable. The average age of alleged victims was 16 years, ranging from 03 years to 32 years. Rape was the most frequent reason for consultation (93.1%). It was practiced nightly, usually in the residences. The most common genital lesion was vulvar lacerations (17.8%). The most frequent of non-gynecological lesion was scratches (10.9%). The victims' support was essentially medical and surgical. The short-term prognosis was favorable (100%). Psychological support was marginal.
Keywords: Sexual violence, lesions; medical care; Ouagadougou.

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Introduction

Sexual violence is a flagrant violation of fundamental human rights. It is a medico-legal and psychological emergency (WHO, 2012). It constitutes a serious attack on the physical and psychological integrity of the victims and has serious consequences. According to the WHO, sexual violence covers acts ranging from verbal harassment to forced penetration, as well as a

wide variety of forms of constraints ranging from pressure and social intimidation to physical force (WHO, 2012).

Patients and Methods

It was a retrospective and descriptive cross-sectional study covering a five-year period from January 1, 2009 to December 31, 2013. The study population consisted of all patients referred or admitted for sexual violence in the Department of Gynecology and Obstetrics of the Yalgado Ouedraogo Teaching Hospital Center during the study period. The definition of sexual violence used is that of WHO, which is followed " 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 victim, in any setting, including but not limited to home and work” (WHO, 2012).

All records of patients referred or admitted for sexual violence during the study period were included. Data collection was based on admissions records and medical records of patients were admitted for sexual violence. The variables studied were the sociodemographic characteristics of the patients, the clinical aspects of the sexual violence and the therapeutic aspects. Anonymity and confidentiality were respected during data collection and processing. The study was approved by the ethics committee.

Results

During the study period, 73 cases of sexual violence consultations were recorded out of a total of 34250 emergency consultations, representing a frequency of 0.2%.

Socio-demographic characteristics of alleged victims

The age of sexual violence patients ranged from 03 to 32 years with an average of 16 years. The distribution of patients by age group is summarized in Table 1. Patients came from urban areas in 93.1%, peri-urban areas in 4.2% and rural areas in 2.7% of cases. Their socio-professional profile was varied. Table 2 lists the profile.

Table 1. Distribution of victims of sexual violence by age

Age	Number	Percentage
under 9 years	14	19.2
9-14 years	23	31.5
15-20 years	19	26
Over 20 years	17	23.3
Total	**73**	**100**

Table 2. Distribution of victims by socio-professional category (n=73)

Socioprofessional status	Number	Percentage
Schoolgirl	35	48
Employee	4	5.5
Housekeeper	16	21.9
Unemployed	4	5.5
Informal sector	14	19.1
Total	**73**	**100**

Mode of admission

The patients admitted in consultation with requisition of the police or gendarmerie accounted for 71.2%. They came alone in 50.7% and in the other cases they were accompanied by the parents.

The reasons for consultation were attempted rape in 6.9% of cases and rape in 93.1%. Other types of sexual assault were not received in our structures. The consultation delay was less than 24 hours in 53.4% of cases (39 cases), more than 72 hours in 27.3% of cases. It was between 24 and 72 hours in 14 cases (19.1%).

Characters of sexual violence

The perpetrator was lonely in 75.3% of cases. Two assailants were identified in 10.9% of cases and more than 2 in 13.8% of cases. In the majority of cases the perpetrator was a stranger to the victim. The relationship between the victim and the abuser is shown in the figure 1.

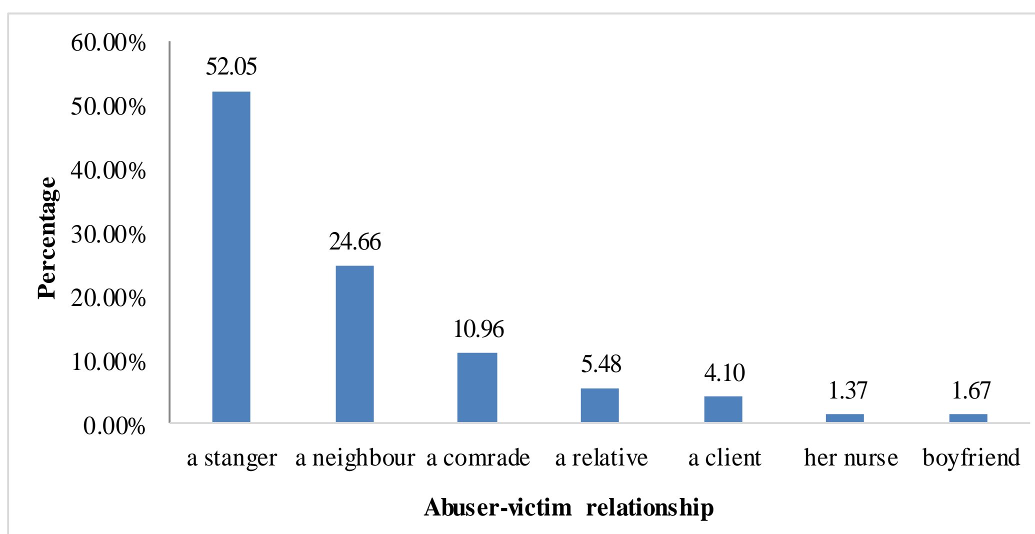

Figure 1. Distribution of victims according to the social relationship with the abuser (n = 73)

The route of penetration was vaginal in 85.8% of cases, anal 1 case, oral 3 cases, combination vagina-anus 2 cases, vagina-mouth-anus 1 case, vagina-mouth 3 cases. In 82.5% of cases, patients reported that their abuser had not used a condom. In 59.4% of cases the aggression was done nightly between 6 pm and 6 am. Aggression occurred in homes (70.6%), empty spaces (22.1%), workplaces (4.4%) and hotels/motels/hostels (2.9%). No weapon was used in 76.4% of cases. A stab would have been used in 12.5% of cases and a firearm in 11.1% of cases.

Clinical examination noted as complaints: vulvar pain in 34.2% of cases, leucorrhea in 28.8% of cases, genital hemorrhage 14.1%, initial loss of consciousness in 8 cases and anxiety in 6 cases.

The hymen bore old lesions in 57.7% of cases, recent lesions in 13.7% and it was intact in 28.8% of cases. It was noted a case of anal tear and 2 cases of anal fissures. The condition of the vulva at admission is noted in the table 3.

Table 3. Distribution of victims according to the condition of the vulva examination (n = 73)

Condition of the vulva on examination	Number	Percentage
Scrapes - vulva tear	13	17.8
Erosion	2	2.7
Vulvar erythema	2	2.7
Vulva intact	53	72.6
Vulvar laceration	2	2.7
Swollen Vulva	1	1.5
Total	**73**	**100**

Speculum examination noted vaginal abrasion in one case, 2 cases of vaginal tear, one case of cervical injury and 2 cases of cervical bruising. Non-genital lesions were observed. There were back scratches (8 cases), skin wound in 5 cases, shoulder contusion in one case. The psychological state was visibly disrupted in 22.2% of cases.

A paraclinical assessment was performed on some victims. The pregnancy test performed on 32 victims at the admission in consultation, was positive in 5 people. Vaginal sampling in 26 patients noted the presence of spermatozoa in 6 cases and vaginal infection in 61.1% (15/26). The identified organisms were Chlamydia Trachomatis, Gonococcus and Candida albicans. Syphilitic serology and hepatitis B serology performed in 25 victims, were positive in 1 case and 5 cases respectively. The HIV test performed on 39 patients, was positive in 1 patient.

Regarding the management, the antibiotics were prescribed in 31.5% of cases (23 patients), a local antiseptic in 14 cases, an analgesic associated with an anti-inflammatory drug in 11 cases, a hemostatic agent in 3 cases, and a local antifungal agent in 5 cases. Vaginal packing and vaginal suture were performed in 2 cases each. Emergency contraception was prescribed in 35.6% of cases.

To prevent HIV transmission, 48% of victims have been referred to the infectious diseases department. All patients with obvious psychological effects (22.2% of patients) received psychological assistance. Medical and psychological monitoring was effective in 9.7% of cases. These patients achieved their biological and serological control. Only 35.6 % of the victims claimed a medical certificate.

Discussion

Sexual violence accounted for 0.2% of admissions in the Department of Gynecology and Obstetrics. This frequency is almost similar to those of Faye-Dieme *et al.,* (2008) in Senegal and N'Guessan *et al.,* (2004) in Ivory Coast, which found 0.4%, 0.68% respectively. Traoré *et al.,* (2010) in Mali reported a higher frequency (3.12%). This low frequency in our series, can be explained by the fact that many victims do not go to the health services. According to the WHO, the reasons are, among others, inadequate support systems, shame, fear of reprisals, fear of being blamed or accused. According to the same source, the best prevalence data on sexual violence come from population surveys (WHO, 2012). Police reports and studies from clinical services and non-governmental organizations are sources of data on sexual violence, but because a small proportion of cases are reported in these settings, the prevalence is underestimated (WHO, 2012).

The average age of the victims which is 16, is identical to that of Traoré *et al.,* (2010) in Mali. In the MBacké Leye *et al.,* (2014) series, the mean age was 12.3 years. Patients aged between 10 and 21 years accounted for 57.5%. This result is lower than that of Buambo-Bamanga *et al.,* (2005) which is 66.7%. According to Jaspard and Chetcuti (2006), everywhere, it is the youngest women who experience the most violence, whatever its nature. The under-9 age group represented 19.2%. This result is inferior to that of Buambo-Bamanga *et al.,* (2005). The sexual curiosity of boys of this age and the lack of sex education could explain this situation.

In half of the cases the victims had come to the department of gynecology and obstetrics themselves. This result is different from that of Traore A who found 54.8% of patients accompanied by a parent and 44.3% of patients self-referred (Traoré *et al.,* 2010). The victims had come with a requisition in 71.2% of the cases. Traoré *et al.,* (2010) in Mali had noted 94%. According to Jaspard *et al.,* (2005), after a physical assault in the public space, the main recourse is to go to the police station, the gendarmerie or directly to the courthouse, but for sexual assault, these remedies are about ten times rarer. Victims who visited within 24 hours were 55.7% of cases. This rate is higher than that of Buambo-Bamanga *et al.,* (2005) (24.4%) but lower than that of N'Guessan (2004) (80.6%). Early use of health services promotes better care and helps to situate responsibilities more effectively. For younger children, the late discovery of sexual violence by parents increases the consultation delay.

Rape was the most represented type of sexual violence with a rate of 93.1%. This is the same observation made by other authors (N'Guessan *et al.,* 2004 ; Buambo-Bamanga *et al.,* 2005; Traoré *et al.,* 2010 ; MBacké Leye *et al.,* 2014). Other types of sexual violence such as sexual harassment, touching, exhibitionists do not require a medical consultation.

The greatest number of sexual abuses occurred at night (59.4%). In Mali this rate was 72.28% Traoré *et al.,* (2010). The lack of public lighting in the neighborhoods of our cities would be a factor favoring these acts. In Senegal, however, the day was the favorite moment of rape (Faye Dieme; 2008, MBacké Leye *et al.,* 2014).

In 70.6% of cases, sexual violence occurred in homes, most often perpetrated by neighbors. The vaginal route was the most used by the abusers (85.7%). This is the same observation made by most authors (N'Guessan *et al.,* 2004; Buambo-Bamanga *et al.,* 2005; Faye Dieme; 2008, Traoré *et al.,* 2010; MBacké Leye *et al.,* 2014). This seems normal because the vagina is the usual sexual way. The use of other ways is devious if we refer to the cultural values of our countries. Moreover, these ways expose more to the risk of transmission of diseases like HIV.

Rape was reported to have been committed in 75.3% of cases by a lonely aggressor as in many series (N'Guessan *et al.,* 2004, Faye Dieme; 2008, Traoré *et al.,* 2010). One of our patients was allegedly raped by a group of 10-person abusers. In gang rapes, it is known that the risk of infection and serious injury increases with the number of abusers. The abusers were unknown to the victim in the majority of cases (52.05%), unlike studies in Europe and some African countries, which found that the abusers are rarely unknown (Buambo-Bamanga *et al.,* 2005; Faye Dieme, 2008, Traoré *et al.,* 2010, MBacké Leye *et al.,* 2014), Jaspard and Chetcuti, 2006, Gigandet *et al.,* 2010). The proximity of the abuser with his victim, makes her vulnerable. The abuser in this case takes advantage of the naivety of his victim and then looks for the moment and the propitious place to commit his act.

At the clinical examination at the admission, the predominant functional sign was vulvar pain with a proportion of 34.2%. The national network of counseling centers on violence against women in Algeria noted that pain is the most frequent sign of sexual violence with a rate of 30% (Balsam, 2010). This pain, especially in children under 9 years can constitute a circumstance of discovery of sexual violence. Indeed, lameness and crying could alert parents to an investigation. The gynecological examination revealed that 60.9% of the victims had old lesions of the hymen. For these victims, no new lesions were associated. Traoré *et al.,* (2010) in Mali noted the absence of lesions in 76.4% of cases. In this case the search for spermatozoa is important. In 14.5% of the cases, the victims had a new hymenal tear. This rate is similar to that of Traoré *et al.,* (2010) in Mali, which was 13.48%. Tears in the vulvar commissures and vaginal walls were noted in respectively 17.8% and 4.1% of cases. This could testify to the brutality with which the sexual act was committed. The bodily injuries were little recovered. These results would mean that the victims may not have resisted the abuser.

In our study, 22.2% of the patients had psychological problems on admission. According to Mbassa-Menick *et al.,* (1999), of 17 victims of sexual abuse, all had psychic and somatic symptoms. N'Guessan *et al.,* (2004) noted 77% of psychological disturbance. In our context the appropriate psychological evaluation is not applied, which may explain this low rate in this study.

It is therefore important that the psychosomatic and affective state is well assessed after sexual violence and the victim must have adequate supervision. The impact of psychic violence may be more destructive than physical sexual abuse itself. Sexual violence has the sad privilege of sharing with torture the record of the most serious, the most destructive and the least denounced violence. They have the most lasting and important psychological and physical consequences (Salmona, 2010; 2013).

In addition to medication management, psychological assistance is essential in case of sexual violence. In our series, only 22.2% of patients received this assistance on admission. This rate is very low compared to other studies (N'Guessan *et al.,* 2004, Mbassa-Menick *et al.,* 1999). As mentioned above, this could be an underestimation of the psychological impact due to insufficient assessment or non-holistic care of the victims, which is contrary to an approach of integrating care.

Conclusion

Sexual violence remains a concern in the Department of Obstetric Gynecology although its frequency is low. This scourge mainly affects teenagers. A strategy of preventive protection at individual, family and even national level for children must be rigorously conducted. Case management should be improved by taking the psychological component more into account as part of a holistic approach.

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