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Post gender-based violence care, support services and health outcomes among victims of gender-based violence in Akwa Ibom and Cross-River States Nigeria

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Abstract

Background: Gender-based violence has a negative impact on the physical and mental health of the victim, especially younger adults.

Methodology: This cross-sectional descriptive study was carried out in Cross River and Akwa Ibom States of Nigeria using both qualitative and quantitative approaches. The study population comprised young adults aged 15-39 years in Cross River and Akwa Ibom States. The principal researcher and three field assistants administered 426 copies of the questionnaire to respondents. The data were analyzed using Statistical Packages for the Social Sciences software (SPSS) version 22. Thematic analysis was used for the qualitative data.

Results: The majority of respondents 346(83.8%) knew that gender-based violence affects the health and wellbeing of victims; there were 267(64.6%) young adults who identified that gender-based violence poses both long-term and short-term effects on the health of the victims with 198(47.9%) who have suffered at least, one form of gender-based violence. Shame, (32.7%), anger, (27.8%), Bruises/injuries (25.2%) and low self-esteem (22.5) were the most frequently reported physical and emotional health effects of GBV. Many do not seek care due to shame. For those who sought care, counseling 97(49%), HIV/AIDS counselling and screening 66 (33.3%), STI screening 52(26.2%), and oral pills 24(12.2%) were some of the services accessed by victims.

Discussion: This finding is consistent with reports from other GBV studies whose respondents suffered depression (48.8%), fear and anxiety (31.0%), which they argued were more serious conditions than the physical health impact of gender-based violence. Mental and emotional health outcomes of GBV are mostly invisible to others, making it harder for victims to seek help.

Conclusion: Gender-based violence has negative impact on the physical and mental health of the victim, especially younger adults.

Keywords: Gender based violence; Victims; Support; Health

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1. Introduction

Gender-based violence is a global health problem that spans all social classes, cultures, tribes, and religions and has permeated our societies including tertiary institutions, worship places, workplaces and communities so far as humans have reason to interact with themselves [1]. While it is a fact that women suffer as victims of gender-based violence, recent researches has shown that men may also suffer as victims of gender-based violence. The International Center for Reason on Women described gender-based violence as any act or threat inflicted on a person because of his/her gender. It encompasses sexual violence, sex trafficking, harmful practices such as female genital mutilation\cutting, forced or early marriage, forced prostitution, sexual exploration, bullying, intimidation, corporal punishment among others [2]. The 2013 national demographic Health Survey shows that 28% of Nigeria women have experienced gender-based violence and this cut across all socio-economic, cultural and religious backgrounds. [3].

Gender-based violence has negative impact on the physical and mental health of the victim, especially younger adults [4]. Gender-based-violence seriously impacts survivors' immediate sexual, physical and psychological health, and contributes to greater risk of future health problems. Possible sexual health effects include unwanted pregnancies, complications from unsafe abortions, female sexual arousal disorder or male impotence, and sexually transmitted infections, including HIV [5].

Gender-based violence can have serious long-term and life-threatening consequences for victims/survivors [5]. These can range from permanent disability or death to a variety of physical, psycho-social and health-related problems that often destroy the survivor's self-worth and quality of life, and expose him or her to further abuse [6]. Gender-based violence can lead to a vicious cycle of violence and abuse as survivors risk being rejected by their family, excluded and ostracized by society, and even arrested, detained and punished and sometimes abused again for seeking protection, assistance or access to justice [7].

This study was conducted to determine the various health outcomes associated with Gender-based violence in the study location and to determine the availability and accessibility of post GBV care, support and treatment patterns in the study locations**.**

2. Material and methods

2.1. Study setting

The study was carried out in Cross River and Akwa Ibom States of Nigeria The study was done in the state capital of the two states i.e., Calabar for Cross River and Uyo, for Akwa Ibom State. Officially, Calabar is partitioned into Calabar Municipal and Calabar South Local Government Areas. Calabar Municipality local government constitutes of 11 Electoral wards while Calabar south has 12 electoral wards. The total population of Calabar as of census 2006 was 371,022. Uyo is the capital of Akwa Ibom State and has 11 electoral wards with a population of 1,135,775 [3].

2.2. Study design

The study was a community-based cross-sectional descriptive study with both qualitative and quantitative approach.

2.3. Study population

The study population comprised young adults (males and females) aged between 15-39 years in Cross River and Akwa Ibom States. This included selected young adults in the 21 electoral wards (10 in Uyo, 11 in Calabar Municipality LGA) who gave their consent to partake in the study.

2.4. Sample size determination

2.4.1. The quantitative part of the study

The sample size for the study was determined using Bluman's formula [8].

$$n = \frac{z^2pq}{d^2} = \frac{z^2p(1-p)}{d^2}$$

Where n = sample size for the population

z= Level of confidence which is 1.96 (i.e. 95% confidence interval)
p= Set at 51.7% (0.517) Prevalence of GBV in Southern Nigeria [9].
q= probability of non-occurrence (1-P = 0.483)
d= margin of error which is 5% (0.05)

Therefore, sample size was:

$n = \frac{1.96^2 0.517x0.483}{0.0025}$ = 383.716 ≈ 384

The sample was increased by 10% to account for non-response.

$$\text{Number to enroll} = \text{n} = \frac{384}{0.9} = 426.6 \approx 427$$

Therefore, sample size (n) = **427**

2.5. The qualitative part of the study

This part of the study employed purposive sampling to conduct two Focus Group Discussions (FGDs) involving a total of 10 participants of which 2 were selected from 6 of the local wards purposively selected for the FGD. 10 Key Informant Interview comprising the two Village heads (or their representatives), two Women leaders, two youth leaders, two Medical Superintendents of secondary healthcare institutions in the states and two Community Health Extension workers (CHEW) in charge of the Primary health care centers in the selected communities. These were chosen based on the fact that they are believed to be residents or work in the community as well as holding leadership roles and hence have knowledge of GBV and occurrences among young people dwelling in the selected communities. Participation was voluntary with each respondent giving informed verbal consent prior to the study.

2.6. Pre-testing of the instruments

The questionnaire was pre-tested with 10% of sample size in Akpabuyo Local Government Area, a close Local Government to Calabar Metropolis, Cross River State Nigeria. This was done to ensure that the instruments for data collection are reliable and measures what they are designed for. A multi-staged sampling technique was used to select 42 young adults for the pretest. This was done to ensure reliability of the instrument. The Instrument was also validated by the Gender Focal Person/ Program officer for Heartland Alliance International, a USAID Funded organization that implements GBV services for Key populations. Findings and feedback from the pretest were used to restructure the self -administered questionnaire.

2.7. Methods of data collection

2.7.1. Questionnaire

A total number of 426 copies of the questionnaire were administered to respondents by the principal researcher and three (3) field assistants. The field assistants were trained by the principal researcher on public relations, cultural sensitivity, questionnaire dissemination and data collection to ensure completion, consistency and accuracy.

2.7.2. Focus Group Discussion and Key Informant Interviews

These were used to obtain in-depth understanding of the topic of study. The guides were administered to purposively selected individuals in the study area who are concerned or have vast knowledge of the subject of discussion. The principal researcher was the facilitator of the FGD, while research assistants were assigned the role of note-taker and observer respectively. FGD was conducted in a serene environment to avoid distraction, safe, accessible and convenient place for the respondents. FGD was recorded using tape recorder and all process ensured confidentiality. The principal researcher conducted the KII, while research assistants were assigned the role of note-taker and observers respectively. Ten (10) sessions of KIIs were conducted in the two State capitals. Adequate and appropriate, information of the research and research team, voluntary participation, confidentiality and anonymity were provided to the respondents and informed consent sought before the interview.

2.8. Methods of data analysis

The data from the questionnaire were analyzed with the use of the Statistical Package for Social Sciences software (SPSS) version 2.2. Simple descriptive statistics which include mean, median and mode, standard deviations and frequencies were used for all continuous variables.

Qualitative data from the focus group discussions and key informant interview collected from the field were transcribed verbatim. The data were coded and analyzed manually to derive themes associated with factors influencing gender-based violence among young people in Cross River and Akwa Ibom States Nigeria.

2.9. Ethical Considerations

Ethical approval was sought and gotten from Cross-River State Ministry of Health with the Ethical Approval number: CRS/MOH/RP/REC/2020/127.

3. Results

Table 1 Socio-demographic characteristics of respondents

Variables	Frequency n%(413)
Age	
15-19	39 (9.4)
20-24	152 (36.8)
25-29	141 (34.1)
30-34	53 (12.8)
35-39	28 (6.8)
Sex	
Male	199(48.2)
Female	214(51.8)
Marital Status	
Single	255(61.7)
Married	89(21.5)
Divorced/separated	26(6.3)
Widowed	10(2.4)
Cohabiting	33(7.9)
Religion	
Christianity	31776.8)
Islam	35(8.5)
African traditional	31(7.5)
Others	30(7.3)
Parents Occupation	
Civil Service	99(24)
Business	122(29.5)
Self-employed	75(18.2)
Farming	15(3.6)

Unemployed	102(24.7)
Highest Education Level	
Primary	28(6.8)
Secondary	106(25.7)
Tertiary	235(57)
Vocational Studies	31(7.5)
No Formal Education	13(3.1)

Table 2 Negative health and Psychological outcomes associated with gender-based violence

Variables	n% (Frequency =413)
GBV affects health/wellbeing	
Yes	346(83.8)
No	21(5.1)
Don't Know	46(11.1)
GBV poses long/short term effects	
Yes	267(64.6)
No	33(8)
Can't Tell	113(27.4)
Ever experienced GBV	
Yes	198(47.9)
No	215(52.1)
Health impacts experienced*	
Bruises/Injuries	104(25.2)
Sprains/Dislocations	42(10.1)
Bleeding	53(12.8)
Threatened Abortion	38(9.2)
Unwanted Pregnancy	27(6.5)
STIs(including HIV/AIDS)	36(8.7)
Depression	81(19.6)
Solitude/Withdrawal	73(17.7)
Fear/Anxiety	95(23)
Suicidal Ideation	65(15.7)
Low Self-esteem	93(22.5)
Anger/Hopelessness	115(27.8)
Shame	135(32.7)

*Multiple responses allowed

As shown in Table 1, a total of 413 copies of the questionnaire were properly filled and returned, giving a response rate of 96.7%, with 214(51.8%) female and 199(48.2%) male respondents. A greater proportion of respondents 152(36.8%) were within the age bracket of 20-24 years, followed by those within the bracket of 25-29 years, having 141(34.1%) young adults, those within the age bracket of 35-39 years had the least respondents with 28(6.8%) young adults. The

mean age of the respondents was 25.4±4.9 years. Most of the respondents 255(61.7%) were single while 89(21.5%) and 33(7.9%) were married or co-habiting respectively. Most of the respondents 235(57.0%) had tertiary level education, there were 106(25.7%) and 31(7.5%) young adults who had secondary and vocational studies education respectively with 13(3.1%) respondents who had no formal education.

Table 2 further reports other negative health/psychological outcomes associated with GBV. Majority of respondents 346(83.8%) knew that gender-based violence affects the health and wellbeing of victims; there were 267(64.6%) young adults who identified that gender-based violence poses both long-term and short-term effects on the health of the victims with 198(47.9%) who have suffered at least one form of gender-based violence. The most identified negative health/psychological impact of gender-based violence faced by victim was shame as reported by 32.7% of the study participants. It can be deduced from table 2 that 47.9% of the study participant had experienced GBV. Perceived Health and psychological outcomes of GBV indicated by respondents include fear and anxiety (23.0%); depression (19.6%); solitude/withdrawal (17.7%); bleeding from nose and other body parts (12.8%); sprains/dislocation (10.2%); STIs including HIV/AIDS (8.7%); threatened abortion (9.2%); unwanted pregnancy (6.5%); suicidal ideation (15.7%), and low self-esteem (22.5%).

3.1. Availability and accessibility of post gender-based violence care, support and treatment

A significant proportion of respondents 303(73.4%) know that there are available services for post gender-based violence management with 246(59.6%) respondents indicating that their communities have available post gender-based violence care, support and treatment services for victims of gender-based violence. There were 159(38.5%) persons who stated that the post gender-based violence services available in their communities are easily accessible. A good number of respondents 262(63.4%) know of someone who experienced gender-based violence and visited a health facility. The type of facilities visited include special post gender-based violence care center 40(9.7%); private health facility 31(7.5%); Primary Healthcare 33(8.0%); General Hospital 24(5.8%); Teaching hospital 16(3.9%); non-governmental organization 24(5.8%) and 94(22.8%) did not visit a health facility. Figure 1 below shows Services received by GBV victims in the visited facilities to include counseling 97(49%); HIV/AIDS Counselling and screening 66 (33.3%); STI screening 52(26.2%); emotional support 16(8.0%) and oral pills were given to 24(12.2%). During the post gender-based violence management period, 97(49%) respondents felt safe and respected over the period of care and treatment with 163(82%) who indicated that financial support was provided to them.

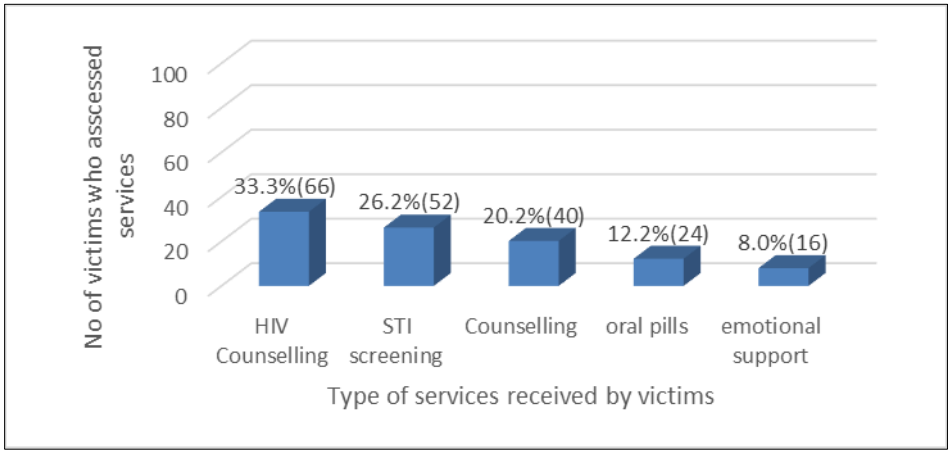

Figure 1 Post GBV services received by victims

3.2. Qualitative Results: Key Informant Interviews with Healthcare Staff

Healthcare workers admitted that cases of GBV and abuse have been reported to their facilities. They further reiterated that gender-based violence has numerous negative health impact on the victims.

“Gender based violence is deprivation and humiliation and affects everyone, even children. The last care that I handled was a girl about 7 years old that was raped and we did our best to give care” (Medical Superintendent).

“This thing happens about almost every day and reports are brought to us, maybe for advice or treatment. Two weeks ago, I treated a lady that was beaten by her husband and wounded” (Medical Doctor)

Healthcare personnel acknowledged that there could be male victims of gender-based violence and they finally provide care for every victim, regardless of gender.

"Anyone can be a victim of gender-based violence. In fact, I treated a small boy that was sexually abused by another male" (Female Nurse).

"Gender-based violence as the name goes affect both male and female. Although the most reported cases are sexual abuse on ladies and children" (Medical Doctor).

Healthcare workers at the community health centers provided basic post gender-based violence care referral while medical persons at General hospitals provided advanced care.

"Here in this facility, we treat injuries from gender-based violence like wounds, give drugs like analgesics and post exposure prophylaxis" (Medical Superintendent).

"When a person is brought and is a victim of rape, we give the person post exposure prophylaxis and first aid treatment and counseling, but if it is severe and may involve surgery, we refer them to the General or Teaching hospital" (PHC Nurse).

"Most of the cases we handle here are referred to us from communities and we offer services like counseling, PEP and surgical services" (Medical Doctor).

Key Informant Interviews with the community leaders (Community Heads, youth leaders and Women leaders)

Key informants knew that healthcare facilities in the communities are the first port of call when anyone faces a form of abuse. They however were not sure of the available services offered by the health facilities in relation to post gender-based violence care.

"We have a community health Centre. I built it there for them. But when you go to them, you can ask them of their services. I am not a health person" (Community Head).

"There is a government community health facility here, but I am not too sure of the exact services that relate to gender-based violence that they provide" (Youth Leader).

"What I know they do there is delivery and I think HIV counseling and testing, I am not too sure of others" (Women Leader).

3.3. Focus group discussion with young adults

Key questions were used to elicit information from young adults about gender-based violence, its occurrence and their views and opinions towards Post gender-based violence care and treatment. Several themes emerged including that Young adults do not know of various health services that can be offered to Victims of GBV and where they can access them.

On discussions about access to support and care offered to GBV Victims, Participants stated that they were not aware of any services to be accessed and do not think victims accessed same.

"For me, I don't think there was any support given to the guy I talked about. He was quite young and could not deal with the shame" (Male FGD Participant).

"The thing happened and the next time I saw the girl (the victim), she was smiling like nothing happened. I do not think there was any care or support accessed" (Female FGD Participant).

4. Discussions

4.1. Health outcomes associated with gender-based violence

The study revealed that 64.6% respondents knew that gender-based violence impacts long and short-term health effects on victims. Gender-based violence seriously impacts the immediate physical and psychological health of survivors and contributes to a greater risk of future health problems. Osuna-Rodrigues et al agreed that the impacts of gender-based

violence lasts long even after the incidence and can affect the survivor's self-esteem and quality of life, while contributing to exposing him or her to further abuse [10].

This study showed that shame (32.7%) was the highest reported effect of gender-based violence. Depression was reported by 19.6% respondents and 12.8% reported bleeding. This finding is consistent with reports by another study whose respondents suffered depression (48.8%), fear and anxiety (31.0%), suicidal ideation (11.3%), which they argued is far more a serious condition than the physical health impact of gender-based violence [11]. The sexual and reproductive health of victims of gender-based violence has been reported to be affected in several studies. Another similar study revealed consistent associations between gender-based violence and gynecological conditions such as sexually transmitted infections, unwanted pregnancy and abortions [12].

A study in 2018 through in-depth interviews and focus group discussions with adult men and women in Ghana explored the health impacts of gender-based violence and the implications for the survivors, families and communities [13]. They revealed physical injuries and disability, as well as impacts on mental health such as anxiety and thoughts of suicide as health-related impacts of gender-based violence [13]. Also, congruent with this study's finding is the reports from a study on GBV in 2013 which showed that the most reported social health impact of gender-based violence was stigmatization 23.2%, isolation and poor social relationship 16.35% [14]. In general, Gender-based violence has acute physical, Psychological and social consequences and in whatever form, deprives people of their equal enjoyment and exercise of human right and freedom. In this study, psychological and social health impacts were reported over other consequences of gender-based violence.

4.2. Availability and accessibility of post gender-based violence care, support and treatment

This study revealed that 246(59.6%) respondents indicated that their communities have available post gender-based care, support and treatment services for victims: however, only 38.5% persons indicated that the services are easily accessible. Service provision for survivors of gender-based violence is significant: it is a source of support, with information, empathy, support and redress. However, it becomes disturbing when these services are available but people who need them are unable to access them. The accessibility of healthcare services results from an interaction between different factors, including health systems coverage, affordability and the availability of services to the population who needs them [15]. Accessibility may be low if health systems are too complex and lack transparency. Previous studies had reported that although services were available to young people, accessibility was not maximized. The reports from the qualitative part of this study clearly shows that Key informants in the communities are not well informed about GBV services that are ongoing in community health facilities both at the Primary and secondary level facilities. This calls for community engagement in interventions targeted towards GBV eradication in the communities.

Furthermore, findings from this study revealed that only 23.5% respondents felt safe and respected over the period of care and treatment. This finding is rather disturbing to the researcher owing to the fact that confidentiality and empathy during care are basic in ensuring a holistic healthcare delivery. This is however in contrast with the findings from a report in 2013 that showed that over 52% of victims received post gender-based violence care and support in a confidential setting and with respect [16]. Thus, when healthcare personnel treat survivors with compassion and respect, and speak out against gender-based violence, community norms begins to shift. Findings from this section reveals that less than one quarters of victims received care with safety and respect; this does not reflect adherence to the guideline by the Nigerian Federal Ministry of Women Affairs which instructs that survivors' rights, wishes and needs are prioritized in the provision of care and support, with treatment given with dignity and respect [17].

In addition, the study showed that counseling (33.3%), STI screening (26.2%) HIV/AIDS Counselling and testing (33.3%) and emotional support (8.0%) were some of the services received at healthcare facilities visited. This finding reveals adherence to the Nigerian Federal Ministry of Women Affairs policy guideline on GBV which outlines that asides medical care, emotional/psychological support must be part of the post GBV services to be offered to victims [18]. Care and support for victims help them to have a sense of self-worth and belonging, and to learn, develop life skills, participate in the society and have faith for the future. Healthcare services for gender-based violence victims showed also to include provision of confidential HIV and other STIs screening [17]. This study found that the voluntary testing and counselling for HIV as well as Pre-exposure prophylaxis (PreP) were given to victims.

5. Conclusion

Gender-based violence has negative impact on the physical and mental health of the victim, especially younger adults. Gender-based-violence seriously impacts survivors' immediate sexual, physical and psychological health, and contributes to greater risk of future health problems.

Furthermore, shame (32.7), Anger/hopelessness (27.8) Bruises and injuries (25.2) low self-esteem (22.5) the most reported psychological/health outcomes implicated to be associated with gender-based violence among respondents.

Recommendations

Based on the findings of the study, the following recommendations are made:

Individual level

- Early reporting of Gender based violence by victims is encouraged for immediate health intervention. This can be achieved through regular health education on gender-based violence among young people.

Institutional/healthcare level

- There is need to establish the presence of active special post gender-based violence care, support and treatment sections in community health facilities as over a quarter of respondents stated that these services are not available in their communities.
- Healthcare workers should be trained to ensure confidentiality and respect to gender-based violence victims during the process of care, support and treatment.
- Health sector response to gender-based violence survivors including medical and psychological support should be strengthened and counseling centers should be established to provide safe place to survivors of gender-based violence.

National/policy level

- The study found reported that Gender-based violence has serious negative health outcomes on victims. Most of these health outcomes reported had physical, psychological and social consequences. The government should ensure implementation of the GBV Policy guideline in the 36 states of the federation. This will help ensure that victims of GBV have access to Support, care, treatment and referral services where necessary.

Limitations of the study

This study was conducted in the capital of Cross-River and Akwa Ibom states Nigeria which are urban settings, hence this may not be a true reflection of what obtains in rural settings and therefore may not reflect the status of gender based violence in both states.

Further studies

- There should be studies to find out reasons that hindered access to post gender-based violence care, support and treatment from victims, even when these services were reportedly available.

Compliance with ethical standards

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Disclosure of conflict of interest

The authors declared no conflict of interest.

Statement of ethical approval

Ethical approval was sought and gotten from the Cross-River State Ministry of Health with Ethical approval number: CRS CRS/MOH/RP/REC/2020/127.

Statement of informed consent

Adequate and appropriate information about the research and research team, voluntary participation, confidentiality and anonymity were provided to the respondents and informed consent obtained prior to Key informant interviews and focus group discussions.

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