

ORIGINAL ARTICLE

Patterns of Sexual and Gender-based Violence and Gaps in Integrated Care in a Resource-Limited Setting: A Two-Year Retrospective Study from Southeast Nigeria

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Abstract

Objective: Sexual and gender-based violence (SGBV) remains a major public health and human rights concern, particularly in low-resource settings where access to timely, integrated survivor care is limited. Evidence on patterns of care is sparse.

Methods: A retrospective descriptive review was conducted at the National Obstetric Fistula Centre, Abakaliki, Southeast Nigeria. Records of all SGBV survivors managed between June 2023 and May 2025 were reviewed. Data on socio-demographic characteristics, type of violence, timing of presentation, and services provided were extracted using a structured proforma. Analysis was performed using SPSS version 25, with descriptive statistics and chi-square tests applied. Statistical significance was set at $p < 0.05$.

Results: A total of 312 SGBV cases were identified, with a mean age of 21.3 years; 97% were female, and 66% resided in rural areas. Sexual assault accounted for 60% of cases, followed by physical assault (30%). Adolescents and young adults were most affected. All survivors received psychological counselling, but only 22% received empirical prophylaxis for sexually transmitted infections. Among 186 sexual assault survivors, 35% presented within 72 hours and were eligible for HIV post-exposure prophylaxis (PEP). Of 129 survivors of reproductive age, 36% received emergency contraception within the recommended timeframe. Legal action was initiated in only 3% of cases. Early presentation was significantly associated with receipt of PEP ($p = 0.016$).

Conclusion: SGBV disproportionately affects young females in Southeast Nigeria. Despite universal counselling, substantial gaps in timely care persist, largely due to delayed presentation. Strengthening integrated, survivor-centred care and community awareness counts.

Keywords: psychosocial support, post-exposure prophylaxis, sexual and gender-based violence, social gynecology

INTRODUCTION

Sexual and gender-based violence (SGBV) is a pervasive violation of human rights and a major burden for public health. Nearly one in three women globally has suffered physical and/or sexual violence in her lifetime, most often at the hands of an intimate partner. The impact of SGBV is profound: survivors often sustain physical injuries (e.g., lacerations, fractures, obstetric fistulae) and are at increased risk of sexually transmitted infections (including HIV) and unintended pregnancy (2). Survivors commonly suffer from depression, post-traumatic stress disorder (PTSD), and anxiety, which can persist for years if untreated (2). Socially, survivors may be stigmatised or abandoned by their communities, compounding their trauma (3).

In low- and middle-income countries like Nigeria, SGBV is exacerbated by weak health systems, cultural norms that condone violence, and poor law enforcement (4). Sub-Saharan Africa reports some of the world's highest rates of intimate partner and non-partner violence (4). Factors such as early marriage, low female education, poverty, and entrenched patriarchy further increase women's vulnerability (4). Nigeria, Africa's most populous nation (>200 million), has alarmingly high SGBV prevalence. The 2018 Demographic and Health Survey found that 30% of Nigerian women (age 15–49) had experienced physical violence since age 15, and 9% had experienced sexual violence[5]. Other studies report even higher rates in certain regions[6]. Although Nigeria's 2015 Violence Against Persons (Prohibition) Act criminalised all SGBV, enforcement remains inconsistent, and under-reporting is common due to stigma and distrust (7).

Healthcare facilities are on the frontline of the SGBV response (8). Survivors often first present to hospitals, where they require comprehensive care: emergency medical treatment, psychosocial support, forensic documentation, prophylaxis against infection, emergency contraception, and referral to legal or social services (8). However, very few Nigerian hospitals have standardised SGBV protocols or dedicated teams for survivor care[9]. In Southeast Nigeria, cultural stigma, poverty, and limited healthcare access mean survivors often delay seeking care until complications arise (10). The National Obstetric Fistula Centre (NOFIC) in Abakaliki is a federal specialist hospital that traditionally treats obstetric fistula but has expanded its services

to include reproductive health and SGBV care (10). To date, few studies have described NOFIC's experience with SGBV survivors.

This study fills that gap by retrospectively reviewing NOFIC's SGBV cases from June 2023 to May 2025. We aimed to characterise the socio-demographic profile and assault patterns of survivors, to evaluate the medical and psychosocial care they received, and to identify gaps in service delivery that could inform improvements.

MATERIAL AND METHODS

We conducted a retrospective descriptive study at the National Obstetric Fistula Centre, Abakaliki, Ebonyi State, Nigeria (NOFIC), Abakaliki. NOFIC is a federal referral centre specialising in fistula repair and other maternal health services, which has become a referral hub for SGBV survivors. We included all survivors of SGBV who presented to NOFIC from June 2023 to May 2025 (n=312). A total of 28 records were excluded owing to incomplete documentation or falls outside the defined study period, leaving 312 eligible cases for final analysis. Data were collected using a structured proforma from hospital registers, inpatient files, counselling records, and pharmacy and laboratory logs. The proforma captured the following domains: survivor socio-demographics (age, sex, residential location, occupation, and educational level); type and nature of violence (sexual assault, physical assault, intimate partner violence, female genital mutilation, and other forms); timing and circumstances of the incident; clinical findings on presentation; interventions received (including STI prophylaxis, HIV post-exposure prophylaxis, emergency contraception, wound care, and psychosocial counselling); and legal referrals or actions taken. A census sampling approach was used (all eligible cases were included).

Data was entered into a secure database and analysed in SPSS version 25. Descriptive statistics (frequencies, percentages, means) summarised the sample. χ^2 tests assessed associations between categorical variables (significance set at $p < 0.050$). Findings are presented in tables and text.

Ethical approval was obtained from the NOFIC Ethics and Research Committee (Approval No. NOFIC/REC/2023/07; Date: 15th June 2023). As this was a

chart review, informed consent was waived. Patient identifiers were replaced with anonymised codes, and data were used solely for research and policy purposes.

RESULTS

A total of 312 SGBV survivors were identified (mean age 21.3 years). Most were female (97%) and from rural areas (66%). Adolescents and young adults were over-represented: 57% were aged under 21 years (Table 1).

Table 2 presents the distribution of diagnoses and interventions. The most common diagnosis was sexual assault (60%), followed by physical assault (30%). Other forms of violence were comparatively uncommon. All survivors (100%) received psychological counselling.

Empirical prophylaxis for STIs was provided in 22% of cases, and physical injury intervention in 18%. Other care combinations (counselling combined with prophylaxis, PEP, or both) were provided to smaller subgroups.

Table 1. Socio-demographic characteristics of SGBV survivors (N=312).

Socio-Demographic Variables	Frequency (n=312)	Percentage (%)
Age in Years		
1 – 10	75	(24)
11 – 20	102	(33)
21 – 30	61	(20)
31 – 40	46	(15)
41 – 50	17	(5)
51 – 60	(3)	(1)
61 – 70	8	(3)
Mean Age = 21.3 ± 14.2 years		
Gender		
Male	8	(3)
Female	304	(97)
Residence		
Rural	206	(66)
Urban	106	(34)

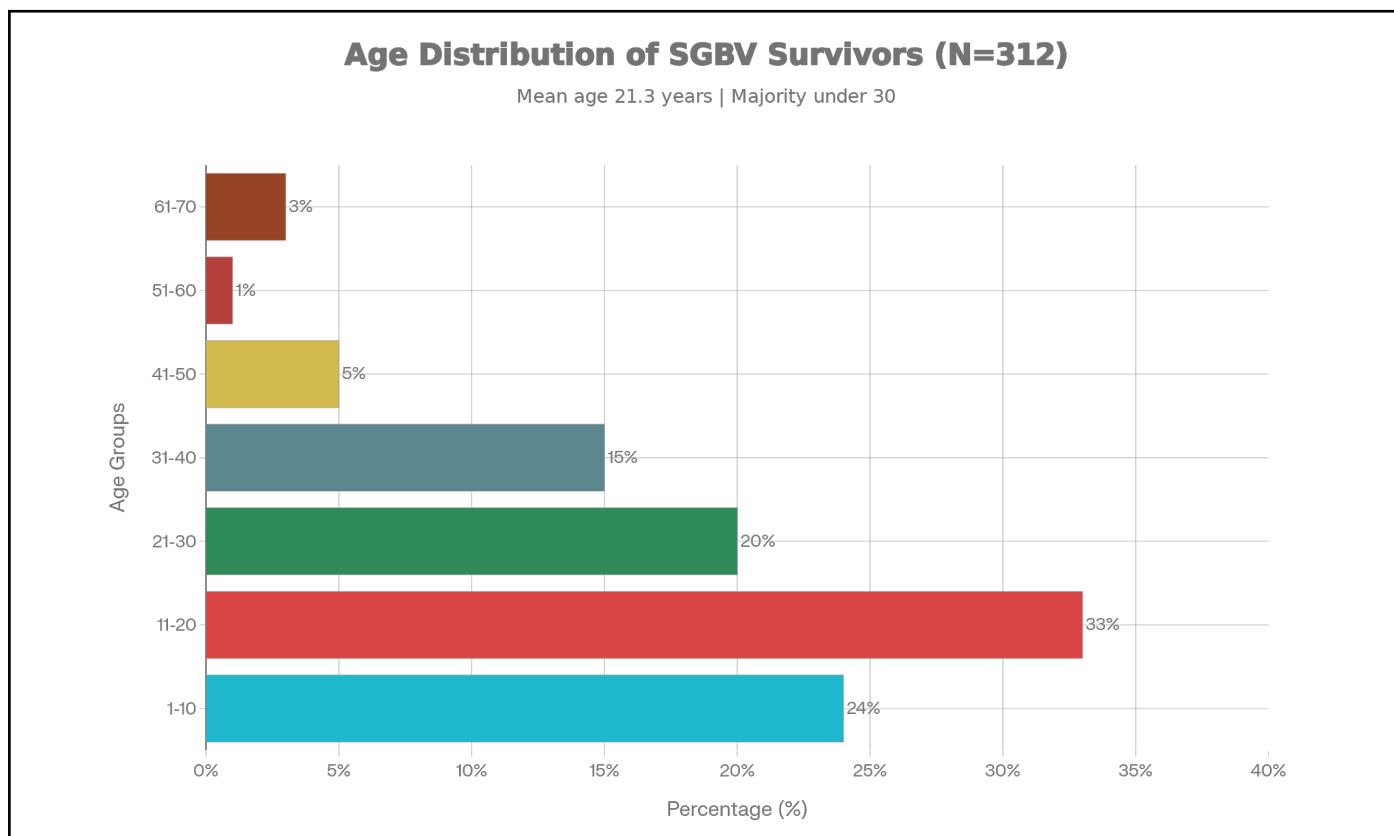


Figure 1. Age distribution of survivors.

Table 2. Diagnosis and Intervention of SGBV survivors (N=312).

Variable	Frequency (n=312)	Percentage (%)
Diagnosis		
Sexual Assault	186	(60)
Physical Assault	93	(30)
Psychological & Emotional Assault	22	(7)
Domestic Violence	4	(1)
Female Genital Mutilation	3	(1)
Abandonment	2	(1)
Forced Marriage	1	(0)
Socio-economic Assault	1	(0)
Intervention		
Psychological Counselling	312	(100)
Empirical Prophylaxis STI	70	(22)
Empirical Prophylaxis & PEP	68	(22)
Physical Injury/Wound Intervention	55	(18)
Physical Injury & Psychological Counselling	26	(8)
Empirical Prophylaxis & Psychological Counselling	25	(8)
PEP, Empirical Prophylaxis, Physical Injury Intervention	23	(7)
PEP & Psychological Counselling	20	(6)
Empirical Prophylaxis, Psychological Counselling, Physical Injury Intervention	12	(4)
Empirical Prophylaxis STI, Physical Injury	8	(3)
Psychological Counselling, Empirical Prophylaxis & PEP	8	(3)
Shelter Provision	1	(0)

Table 3. Prevalence/Incidence charting

Prevalence	Frequency (n=312)	Percentage (%)
Month of Incidence		
January	15	5
February	20	6
March	19	6
April	15	5
May	27	9
June	36	12
July	30	10
August	33	11
September	31	10
October	32	10
November	26	8
December	28	9
Year of Incidence		
2023	149	48
2024	128	41
2025	35	11
Intimate Partner Violence		
Yes	46	15
No	266	85
Period of Incidence Presentation for Sexual Assault Survivor (n=186)		
Within 3 days of incidence	65	35
After 3 days of incidence	121	65
Sexually Assault Survivors in their reproductive age (n=186)		
Yes	129	69
No	57	31
Sexual Assault Survivors in their reproductive age who got emergency contraceptive pills (n=129)		
Within 3 days of incidence	46	36
After 3 days of incidence	83	64
Sought Legal Action Against Perpetrators (n=312)		
Yes	10	3
No	302	97

Table 3 illustrates the prevalence of SGBV from several

months and years. June had the highest number of reported cases (12%), and January and April had the fewest number of cases (5%). The incidence of SGBV cases varied by month and year. By year, 48% of cases occurred in 2023, 41% in 2024, and 11% in early 2025. Only 15% of all cases were classified as intimate partner violence (IPV). Among the 186 sexual assault survivors, 65 (35%) presented to NOFIC within 72 hours of the incident (and thus were eligible for PEP), while 121 (65%) presented later. Of the 186 sexual assault cases, 129 (69%) were of reproductive age (15–49 years), but only 46 of those (36%) received emergency contraception within 3 days. Legal action against perpetrators was pursued by only 3% of survivors (10 out of 312).

A series of chi-square analyses examined associations between key socio-demographic variables and

outcomes (Table 4). A significant association was found between age category (seven groups: 1-10, 11-20, 21-30, 31-40, 41-50, 51-60, and 61-70 years) and type of violence experienced ($\chi^2(6) = 15.23, p = 0.019$); post-hoc review revealed that survivors in the youngest age groups (1-10 and 11-20 years) were disproportionately more likely to have experienced sexual assault. Residence (rural vs. urban) was significantly associated with access to psychological counselling ($\chi^2(1) = 8.54, p = 0.003$), with urban residents more likely to receive this support. Period of presentation (within 72 hours vs. after 72 hours of the incident) was significantly associated with receipt of empirical STI prophylaxis and PEP ($\chi^2(1) = 5.78, p = 0.016$), with early presenters considerably more likely to receive these time-sensitive interventions.

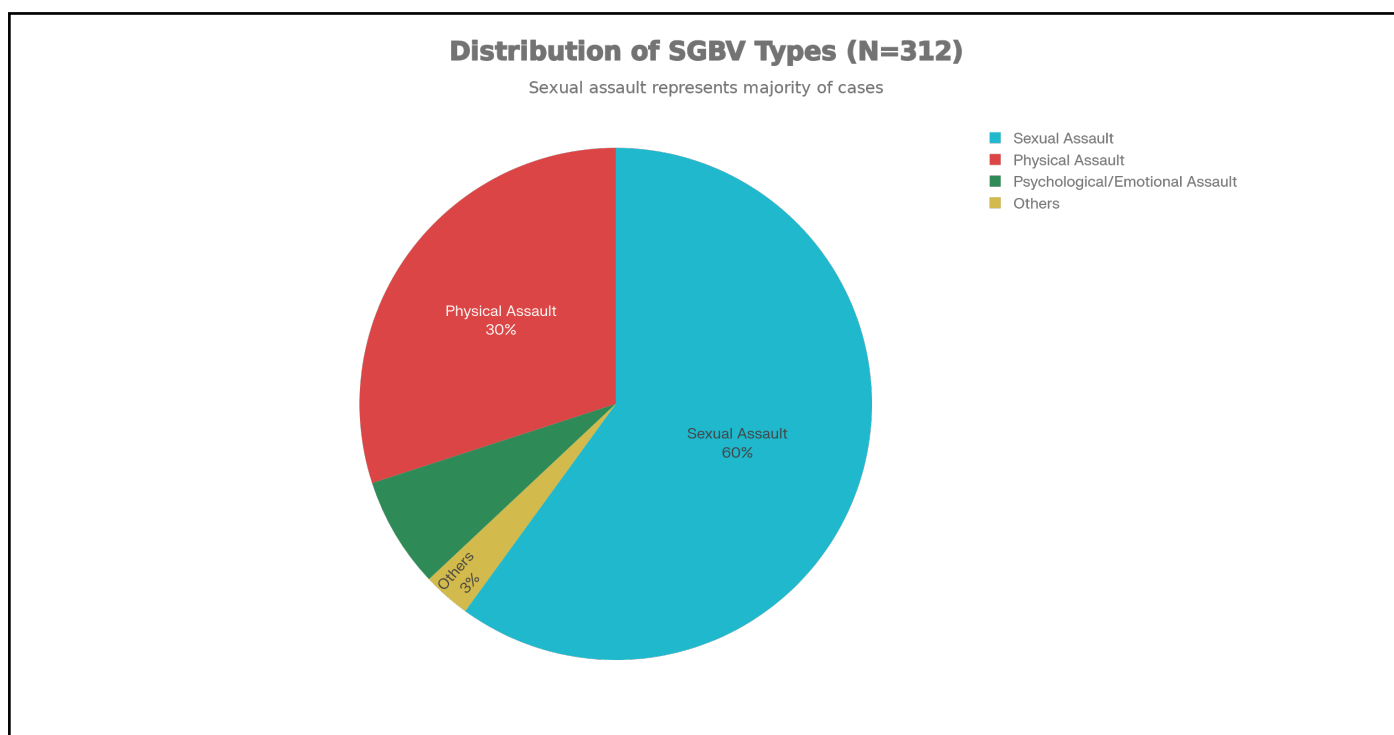


Figure 2. A pie chart, depicting the violence types based on our study findings.

Table 4. Chi-Square Analysis Results

Socio-demographic Variable	Diagnosis and Intervention	χ^2 Value	df	p-value
Age Category	Type of Violence	15.23	6	0.019
Residence	Access to Psychological Counselling	8.54	1	0.003
Period of Incidence Presentation	Empirical Prophylaxis STI	5.78	1	0.016

DISCUSSION

This review of NOFIC's data provides important insight into the profile of SGBV survivors and services in Southeast Nigeria. The predominance of sexual assault (60%) is consistent with other Nigerian studies (14). The fact that nearly all survivors were female (97%), most of them adolescents or young women, underscores the gendered nature of SGBV. Our finding that younger survivors were significantly more likely to have experienced sexual assault highlights the urgent need for child and adolescent protection programmes. The majority of survivors coming from rural areas align with evidence that rural women face greater vulnerabilities due to limited education, poverty, and weaker legal protections (10-14).

The high provision of STI prophylaxis (22%) and injury treatment (18%) indicates that NOFIC appropriately prioritised immediate medical needs. Importantly, every survivor (100%) received psychological counselling. This universal counselling is a strength of care at NOFIC and reflects adherence to trauma-informed standards. Addressing psychological trauma is paramount to long-term recovery (15). However, the finding that urban survivors were more likely to receive counselling than rural survivors suggests unequal access to mental health resources outside the centre. This urban-rural disparity may reflect the concentration of qualified counsellors in cities (15-17).

Timely presentation to care was critical. Survivors who presented within 72 hours were significantly more likely to receive PEP for HIV prevention. This reinforces global recommendations that PEP should be given as soon as possible after exposure (17). Unfortunately, only 35% of sexual assault survivors reached care in time for PEP. Delayed presentation is a well-known barrier; survivors often delay seeking help due to stigma, shame, lack of awareness of PEP, or logistical challenges [15-18]. Similar studies have documented low PEP utilisation linked to these factors (19-22).

Emergency contraception represented another critical gap: only 36% of reproductive-age survivors received it within 72 hours (23-25). Since emergency contraceptives are most effective soon after assault (17-18), this underuse may reflect delayed presentation and missed counselling opportunities. Training healthcare providers to routinely offer emergency contraception

could address this need.

Legal follow-up was almost nonexistent (3% pursued action), mirroring national trends (15). Barriers to justice include fear of retaliation, re-traumatisation by the legal system, and lack of trust in authorities (15). Enhancing legal aid and advocacy for survivors is therefore crucial (26).

This study's strengths are considerable. It constitutes one of the few systematic, facility-based analyses of SGBV survivor profiles and service gaps in Southeast Nigeria, drawing on a two-year consecutive dataset of 312 unselected cases. The census sampling approach eliminated selection bias, while triangulation of data from hospital registers, clinical case files, pharmacy and laboratory logs, and counselling records strengthened the validity of the extracted variables. The documented evidence on service gaps offers concrete, policy-relevant findings in a region with limited published SGBV literature. Limitations include the retrospective design, which is subject to incompleteness of existing records, and the single-centre setting, which may limit generalisability beyond the Southeast Nigeria context. Future research should incorporate survivor-reported experiences and prospective designs to supplement the findings of this study (25-26).

RECOMMENDATIONS

Strengthening health systems constitutes the foundational priority. NOFIC and comparable facilities should establish standardised SGBV case documentation systems that capture the type and nature of violence, perpetrator relationship, survivor needs, and all interventions rendered, while enabling structured survivor follow-up. Healthcare providers at all levels, particularly in emergency departments and primary care settings, require formal training in SGBV protocols, PEP administration, emergency contraception counselling, and trauma-informed communication. Sexual Assault Referral Centre (SARC) units should be established within primary healthcare facilities, particularly in underserved rural communities, to deliver multidisciplinary care closer to where survivors reside.

Reducing barriers to timely care requires coordinated clinical and community-level action. Community outreach programmes targeting schools and high-

risk populations should raise awareness of available services including PEP and emergency contraception, and should emphasise the critical importance of presenting within 72 hours of assault. Confidential pre-screening via telephone or telemedicine reduces stigma-related deterrents to care-seeking. PEP must be available at all hours in every emergency facility and should be decoupled from mandatory police reporting, so that survivors are not discouraged from accessing treatment by fear of legal proceedings. The adoption of unified national PEP guidelines across all facilities is needed to eliminate variability in clinical practice.

Psychosocial and financial support must be expanded concurrently with clinical services. Dedicated counselling facilities staffed by trained SGBV counsellors are needed within health centres, particularly to address the urban-rural disparity in access to psychological care identified by this study. Government subsidies, insurance coverage, or fully funded programmes for PEP and related SGBV services are essential to remove the financial burden on survivors, many of whom present from low-income rural backgrounds.

Justice system strengthening is indispensable to a complete survivor-centred response. Legal aid and advocacy services should be made readily available, with accessible information on survivor rights and assistance navigating judicial processes. Trauma-informed training for police officers and judiciary personnel would foster a more supportive institutional response to SGBV disclosures and rebuild the public trust necessary to improve reporting rates.

CONCLUSIONS

This study provides valuable information on SGBV survivors and service delivery at NOFIC, Abakaliki. Young rural females suffering sexual assault were the predominant group. While immediate medical care (STI prophylaxis, wound treatment) and psychological counselling were consistently provided, other supports (e.g., emergency contraception, legal aid) were underutilised due to delayed presentation and system gaps. The low rate of timely PEP administration highlights the need for earlier access to care.

Overall, these findings emphasise the importance of comprehensive, prompt SGBV care. Efforts must focus on reducing barriers to care and raising public

and provider awareness to improve outcomes. Many gaps in SGBV service delivery and data management were identified and must be addressed to ensure high-quality, accessible care in Southeast Nigeria.

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Consent to participate: No direct patient contact was involved. Not applicable.

Availability of data and materials: Data were retrieved from hospital records, including outpatient and emergency registers, inpatient case notes, counseling and psychosocial service records, and laboratory and pharmacy logs. A structured proforma was designed for data extraction. Data fields will include demographics, clinical details, services received, and outcomes.

Author contributions:

C.O: Conceptualization, Writing—original draft, Writing—review & editing.

P.A: Supervision and Validation. All authors: Writing—original draft, Writing—review & editing. All authors gave approval to the final submission.

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