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Ethical and methodological challenges involved in research on sexual violence in Nigeria

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Research on sexual violence is fraught with ethical and methodological challenges due to its sensitive nature. This paper describes the ethical and methodological challenges encountered in planning and conducting two exploratory studies on sexual violence that included in-depth interviews of eight female adolescent rape survivors in Ibadan and four married women in Lagos Nigeria who were raped, forced to perform sexual acts and sexually deprived. The first challenge encountered was an Institutional Review Board (IRB) requirement to obtain parental permission from adolescents, when such a requirement may place the adolescent at risk if a parent was a perpetrator of sexual violence. Using arguments emphasizing the Council for International Organization for Medical Sciences guidelines helped convince the IRB to provide a waiver of parental consent. Second, the privacy required to conduct in-depth interviews for rape survivors was difficult to achieve because five of the rape survivors were apprentices who work in public settings that which are typically used to conduct business in the informal sector. To overcome this challenge, interviews were conducted in safe locations, investigator's offices and homes of survivors. The culture of silence associated with sexual violence posed a challenge because it encourages perpetration of violence with impunity causing rape survivors to suffer in silence. None of the affected adolescents had sought judicial redress for rape despite availability of stringent punishment for this behaviour. Referral information was provided on where survivors could seek care. Interviews with the women could not be recorded on audio-tapes because of concerns that their partners might identify their voices from the tapes and punish them for this. Although research on sexual violence poses ethical and methodological challenges, it is not only desirable but also feasible to conduct such research in ways that ensure safety of participants.

Introduction

Sexual violence is a serious public health problem that occurs throughout the world [1]. The World Health Organization (WHO) defined sexual violence as 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 [1]. Violent sex is a continuum of behaviours and circumstances in which individuals have diminished ability to exercise control over their sexuality including verbal intimidation, threats (such as being dismissed from a job, or not obtaining a job being sought), rape, attempt to rape, forced marriage, female genital cutting, sexual trafficking and forced prostitution [1,2]. Sexual violence occurs in a variety of settings namely the home, school, workplaces, on the streets, in prisons, in police custody and in health facilities [1]. Forced sex may have a profound immediate and long term impact on the physical and psychological health of survivors including chronic pelvic pain, sexually-transmitted infections (STI), unwanted pregnancy, and adverse pregnancy outcomes such as miscarriage, forced abortion, low birth weight, stigmatization, depression, suicidal behaviour and death [1-3]. Death from sexual violence may be a result of suicide, HIV infection or murder which may occur while the act is being perpetrated or subsequently as 'murder of honour'; a situation in which a victim is killed in order to alleviate 'the shame' associated with rape [1]. Forced sex is also of concern because it violates the rights of survivors and reinforces women's subordination to men [2].

Non-consensual sex has attracted greater public and research attention in recent years because it has been directly linked to HIV infection [4]. Coercive sex directly increases a woman's risk of HIV infection through the resulting physical trauma [4] which creates a pathway for HIV to enter the woman's body during sex with an infected person. One study from Rwanda found that women who had experienced forced sex were significantly more likely than those

with no history of forced sex to be infected with HIV [5]. Young girls are especially vulnerable to HIV infection through forced sex because their reproductive organs are not fully developed to provide the more effective barrier that develops in adulthood [1]. In addition, the use of violence, or a threat of violence, in sexual relationships undermine a woman's ability to negotiate safe -sex with the perpetrator. Women who have been sexually abused in childhood have greater propensity to participate in risky sexual activities as adolescents or adults, thereby increasing their chance of infection with STI/HIV [6]. At the same time, being infected with HIV or having someone with HIV as a family member can also increase a woman's vulnerability to violence. Because of the stigma associated with HIV infection in many countries, an HIV infected woman may be ejected from her home, forcing her to enter risky occupations such as sex work which further increase her risk of both re-infection with HIV and sexual violence [1].

Although there is growing evidence that boys and men also report experience of non-consensual sex, young girls and women are disproportionately affected. The vulnerability of females to forced sex is influenced by several factors including being young, use of alcohol, having multiple partners, educational level, poverty, gender norms or role expectations [1]. This paper describes what is currently known about sexual violence in Nigeria, discusses two recent research studies conducted on the subject and highlights the ethical and methodological challenges encountered in implementing the studies.

Sexual violence in Nigeria

There are four sexually-related offences recognized in the Nigerian laws: rape, attempt to rape, defilement and indecent assault. Rape is unlawful sex with a woman or girl without her consent, or with her consent if the consent is obtained by force, threat or intimidation, fear of harm, or by means of false and fraudulent representation [7]. Rape and the attempt to rape are punishable by life imprisonment or 14 years imprisonment for convicted perpetrators respectively. Defilement is sexual intercourse with a girl under the age of 13 years, an offence also punishable by life imprisonment. Indecent assault refers to unwanted contact in the form of touching, or fondling, which is punishable by a three- year jail term. However, the availability of these laws has not deterred potential offenders because the incidence of sexual-related offences is believed to be increasing in the country [8].

Sexual violence is a neglected area of research in Nigeria because of the sensitivity of the subject. There are currently no national data on the nature and extent of the problem in the country. The available data on sexual violence are derived from small- scale reproductive health surveys and police records. Indecent assault in form of unwanted touching of the breast and 'backside' is the commonest type of violent behaviour found among young survey respondents [9]. Rape tops the list of sexual offences reported to the police. For example, in a six year analysis of police records in Lagos, Akinyemi found that of the 691 cases of sexually-related offences reported, rape accounted for 40% [10]. Data on rape from surveys show a prevalence ranging from 4% among female apprentices working in the informal sector [11], and 4.4% in secondary school students [9] to 6% in female hawkers [12]. Males are typically the perpetrators of sexual violence and young girls the victims. However, recent surveys suggest that boys have also reported experience of rape [9]; more research is required to document the context in which rape occurs in this population.

Despite the availability of laws that stipulate serious punishment for offenders, survivors of sexual violence seldom seek judicial redress or health care [8,13]. Four factors hinder successful prosecution of sexual offences in Nigeria. First, the fact that the Nigerian police do not keep adequate records of sexual offences undermines [10,14] the successful prosecution of perpetrators. Second, the police often terminate prosecution of reported sexual offences because complainants withdraw them, preferring to settle the case out of court due to the stigma associated with rape [10,14]. The study by Akinyemi revealed that the police stopped the prosecution of 77% of cases of rape because complainants withdrew them [10]. Third, due to a weak infrastructure, the prosecution of sexual offences takes an unduly long time such that complainants abandon the case. In addition, the Nigerian culture has a tolerant attitude towards rape and typically blames victims. Finally, the conditions required for conviction of rape are stringent. According to the Criminal Laws of Oyo State the essential requirements for convicting a perpetrator of rape are that sexual intercourse was forced; that there is evidence of marks of violence on the body of the victim; that there is a sign of struggle at the scene of rape; that the victim made an outcry whereby she could be heard; that the immediate report of rape is extracted from the victim without force; and, that the victim submits herself for medical examination [7]. Consequently perpetrators of sexual offences go unpunished while victims continue to suffer in silence. Yet, punishment is a necessary deterrent for rape and other forms of sexual violence.

Recent research on sexual violence

The present authors, consisting of a male and female, recently conducted two studies on sexual violence among female adolescents in Ibadan and married women in Lagos, two of Nigeria's largest cities. The

objectives of these studies were to document the experiences of survivors of sexual violence, identify the context in which this occurs, describe health seeking behaviour, and recommend appropriate interventions in order to address the problem. The studies were approved by the University of Ibadan/University College Hospital Ethics Review Committee.

The first study explored, through in-depth interviews, the experiences of eight adolescent female rape survivors. The participants for this study were recruited from a large survey of sexual violence among a randomly selected sample of 1025 adolescent secondary school students and apprentices aged 15-19 years. For the survey component of the project, eight trained research assistants conducted face-to-face interviews with respondents. In order to minimise discomfort in responding to sensitive questions on sexual violence, the interviewers were young and were of the same gender as the respondent. Other details about the methodology and findings of the survey have been published elsewhere [9]. The eight in-depth interviews of female rape survivors were conducted by a male interviewer who supervised field activities. He was considered most suitable to conduct the in-depth interviews because he had considerable rapport with young persons, as well as having many years of field experience and training on gender-based violence. A summary of the data for the eight rape survivors is provided in Table 1. All the adolescents were Nigerians. Perpetrators of rape were well known to survivors and included boyfriends and acquaintances, rape occurred mostly in homes and offices of perpetrators, and few of the survivors sought care or judicial redress.

Data from the in-depth interview of married women in the second study were collected by the second author (OA) who is female. This study documented the experiences of four married women who had suffered sexual violence perpetuated by their spouses [15]. In this study, sexual violence was defined in a broader context to include a range of sexual practices including being forced to have sex, being forced to perform sexual act, or withholding of sex by a spouse, a type of violent behaviour identified in the study by Watts and colleagues [16]. As with the first study, the four interviewees were recruited from a community-based randomly selected sample of 606 married women in Lagos.

A summary of the data collected from the women

Table 1: Summary of data on sexual violence among eight survivors of rape in Ibadan, Nigeria [13]

Cases*	Brief profile of victim	Victim's relationship with perpetrator	Setting of rape	Health seeking behaviour	Consequences
1. Nimota*	18-year-old apprentice living with Mum	Boyfriend	Perpetrator's home	Did not seek care or inform anyone	Quarrelled with boyfriend; currently still going out with him
2. Medina	19-year-old apprentice living with parents	Boyfriend	Perpetrator's home	Did not do anything	Lost virginity; bruises and pains in vagina; shame
3. Funke	20-year-old student in senior secondary school living with both parents	Boyfriend	Perpetrator's home	Did not inform anyone	Vagina bled; cleaned vagina with water; shame
4. Bimbola	16-year-old student in senior secondary school living with both parents	An acquaintance and his friend (gang raped)	Perpetrator's home	Parents were informed; police was informed; care was given in a health facility	Vagina bled; pains all over the body; had nightmares
5. Foluke	16-year-old student in junior secondary school	An acquaintance who had requested victim to be his girlfriend	Bush path	Told close friends but not parents	Shame; lost virginity; sad
6. Sidikat	20-year-old apprentice living with husband	Boyfriend	Perpetrator's home	Did not tell anyone; went to a patent medicine seller who prescribed some drugs	Shame, regret; fought with him; pleaded and now married to him
7. Taiwo	15-year-old apprentice living with aunt	Neighbour	Perpetrator's home	Did nothing	Information not provided
8. Monisola	17-year-old apprentice	Instructor in Koran school	Perpetrator's office	Did not tell anyone; perpetrator bought drugs	Vagina bled; pain and sadness

** These are not the real names of the participants.*

Table 2: Summary of data for survivors of sexual violence in Alimosho, Lagos, Nigeria [15]

Cases	Brief profile	Type of violence	Inception of violence	Health seeking behaviour	Reported consequences
Mrs. A	38-year-old teacher	Forced sex	2 years	Sought medical care	Threatened Abortion
Mrs. B	43-year-old civil servant	Withholding of sex	8 years	None	Sadness
Mrs. C	45-year-old nurse/midwife	Forced to perform oral sex	Since the last 5 years	Nothing	Vomiting and sadness
Mrs. D	35-year-old trader	Withholding of sex	2 years	Nothing	Sadness

is presented in Table 2. All the women are Nigerians. The table shows that the types of violence experienced by the women were rape, withholding of sex, and being forced to perform oral sex, that these behaviours followed a pattern, and that women endured them. None of the rape survivors reported becoming pregnant as a result of the rape.

In recruiting respondents for the in-depth interviews prospective participants who reported an experience of sexual violence during both community-based surveys were asked that they might be contacted later for a more detailed interview of their experiences. The interviewer documented the contact details of such prospective participants. One to two months after the survey had been completed the study team re-contacted these respondents and invited them to participate in the in-depth interviews. A written informed consent was obtained from each of the persons who participated in both the survey and the in-depth interviews.

An interview guide was developed and used for these in-depth interviews. A dialogue approach was then used for conducting the interviews in which interviewer allowed the respondents to provide full explanation of responses to questions posed.

As with studies on other sensitive issues such as HIV testing, trials of vaccines and microbiocides [17], research on sexual violence is fraught with a number of ethical and methodological challenges. The sensitive nature of the subject implies that issues of privacy, safety, confidentiality, interviewer skills and training are more important here than in many other areas of study [1]. The ethical challenges involved with research on sexual violence may be particularly acute in a developing country setting like Nigeria where there is limited research experience on this type of inquiry. We encountered several ethical and methodological challenges in conducting these two studies and will describe the nature of these challenges and how we addressed them. We hope the lessons learnt from these experiences will serve as guides to other investigators willing to conduct research on sexual violence and similar sensitive topics in a developing country setting.

Ethical challenges

Our first challenge in the study among adolescents related to parental permission. During the initial review of the proposal the local Institutional Review Board (IRB) insisted that investigators must obtain not only consent from each adolescent but also official permission from parents before it could receive approval. The IRB took this position because some of the prospective respondents were under the age of 18 years, the legal age for consent in Nigeria. This was resolved by three arguments that the investigators put forward in support of the autonomous participation of adolescents [18] in their study. First, in Nigeria, the father of a minor is traditionally expected to provide permission for the participation of his underaged adolescent. However, it is not uncommon for a father to be the perpetrator of rape of his adolescent daughter [18]. Second, a father who had raped his daughter is unlikely to give permission for the affected girl to participate in research on that same subject because of fear that 'his secret' may be exposed. Third, such denial would further reinforce the unacceptable culture of silence associated with rape in this environment. Ultimate exclusion from participation in the research would deny a potential victim of rape the benefits of care and support which would result from her participation. These arguments were supported by the commentary of Guideline 14 of the Council for International Organization for Medical Sciences (CIOMS) which recommends that an IRB may waive parental consent in studies involving sensitive issues such as use of recreational drugs, sexuality, or domestic violence, sexual abuse, if parental knowledge of the subject matter may place the adolescents at some risk of questioning or even intimidation by their parents [19]. These arguments convinced the local IRB whichwhich subsequently waived parental permission for the study.

The second challenge related to the privacy required for the interviews. One of the essential requirements for conducting ethically acceptable research involving human participants is a guarantee of safety from harm arising either from direct partici-

pation, or as a consequence of participation, in a study. Privacy is an important means of ensuring safety of study participants. Upholding this basic ethical requirement proved to be a challenge during the interviews with six of the eight adolescent rape survivors. These six adolescents were all young apprentices undergoing vocational training in tailoring, patent medicine selling or hair-dressing. An apprentice is a young person with limited formal education who learns a vocation under the direct supervision of an instructor operating in the informal sector of the Nigerian economy. Typically, apprenticeships are part of small businesses and are largely informal. Apprenticeships are conducted in shops, but the owners have no government recognition, registration or support. The privacy required to conduct in-depth interviews on rape was difficult to achieve in these workplaces because, by their very nature, these settings are busy – the instructors sometimes have many apprentices at a time as well as also attending to clients. At the same time, conducting the interviews outside the workplace would mean asking for permission from instructors which potentially meant disclosure of the purpose of the interview to a third party.

To resolve this issue the research team discussed alternative sites for interview with each of the adolescents individually and eventually six agreed to be interviewed in the offices of the investigators. The research team provided a transport allowance to enable them visit the offices of the investigators where the interviews were safely conducted. The remaining two adolescents were interviewed in their homes at a time that was convenient for them. These interviews were conducted in private rooms with only the interviewer and subject present. The adolescent introduced the interviewer to members of her family as someone from the university who wanted to ask her questions about 'health issues'. She did not disclose the exact nature of the interview because she had previously not informed anyone about her experience of rape. The interviews, which were recorded on audio-tapes, were stopped on the few occasions when a family member came into the room. The flexibility adopted in selecting the sites for interview ensured that the safety of participants was protected.

The third challenge was how to deal with the culture of silence associated with rape and other types of violent behaviour experienced by the study participants. Virtually all the adolescent rape survivors had never disclosed their experience to their parents or guardians nor had they sought medical care. In addition, three of the women survivors had not sought help. Yet, the health and psychological impact of rape can be mitigated if survivors receive appropriate health care including anti-retroviral drugs to prevent sexual transmission of HIV and counselling to address the psychological trauma associated with rape. Only one of the adolescent rape survivors received care from trained health workers; others endured their experiences. When asked why they had not taken steps to receive care and redress, the interviewees cited the shame involved as their primary reason for silence. Rape is stigmatized in Nigeria and the society believes that the publicity resulting from prosecution of a case of rape may have long-term adverse consequences on the victim, including difficulty in finding a suitable husband. Yet the perpetuation of a culture of silence has long- term implications both for rape survivors and for the prevention of the problem. If incidents of rape are not reported to law enforcement agencies, perpetrators cannot be brought to justice; if perpetrators are not punished, other persons who have a propensity to sexual violence would not be deterred, and survivors would continue to suffer.

The culture of silence is particularly acute among married women because of the popular belief in Nigeria that women are expected to endure all problems encountered in marriage [20]. The general belief in Nigeria is that the rape of a wife by her husband is ridicule because the bride-wealth the husband paid during the wedding guarantees that he has unconditional sexual access to the wife. The culture of silence and endurance of violence can also be understood within the context of the work of Herman [21] who defined post-traumatic disorder as events that instilled a feeling of terror and helplessness. The investigators addressed this problem by providing the women with information on the location of organizations that provide care and support for survivors of domestic violence.

Methodological challenges

Three methodological challenges were encountered during in-depth interviews of the women survivors. The first related to confidentiality, which has been identified as foundational for the trust that must exist between investigators and research participants if the research enterprise is to flourish [22]. Study participants must trust investigators to keep secret the information they disclose during research; otherwise they might be reluctant to disclose reliable and more 'intimate' information about themselves. In an attempt to collect comprehensive information from the women, the researchers planned to record all in-depth interviews on audio-tape as was done with the adolescent's survivors. However, this could not be achieved because each of the women raised objections perceiving there to be a serious potential risk. Despite assurances by the interviewer during the informed consent procedure that the data collected would be kept confidential, that names would not be mentioned during the interviews, that the tapes would be destroyed after the completion of the

research, the women feared that somehow their partners might identify their voices from the tapes and punish them for their participation. Consequently, the researchers had to cancel the plan to audio-record the interviews and, instead, the interviewer listened to the stories each woman had to tell and took down notes, a situation that, it was recognized, may have affected the completeness of the data collected.

There are two possible explanations for the difference between the behaviour of adolescents and women with respect to use of audio-tapes for interviews. Firstly, married women are more likely than adolescents to suffer serious consequences such as threats to their marriage or more violent practices if the contents of the tapes were to be revealed to a third party. Secondly, women expressed concern for fear of reprisals because they were still married and living with such men, whereas many of the adolescents may have broken up their relationships with those who raped them.

The second methodological challenge was that the interviewer needed to make several visits to the homes of women before the ideal atmosphere for interview, ie privacy between interviewer and respondent, could be achieved. The women were under constant fear that their husbands could come into the homes during the interviews, a situation that would place them in danger since the investigators had not received an 'official' permission from their husbands. In Nigeria approval from husbands is required before women can participate in research because women are expected to be under the 'control' of their husbands. Nonetheless, the team did not obtain official permission from husbands in the current study because of concern about the women's safety which mightay have been compromizsed if full disclosure on the purpose of the research had been made to the husbands. As a result, interviews had to be terminated on many occasions when a relative or visitor showed up during the interview. Under such situations the interviews were rescheduled for a later date. Despite the difficulties, at the end of the interviews, the women expressed appreciation for the referral information that the interviewer had provided on how to access care and support from a local organization which the women had not been aware of prior to the research

The third challenge related to the fact that a male researcher was conducting interviews on the female adolescent survivors of rape. Unfortunately, at the time of the survey, it was not possible to identify a female with sufficient training and experience to perform this important task. In Nigeria, the Yoruba cultural mores indicate that comfort level increases when one discusses sexual matters with someone of the same gender. In addition, a female interviewer might be expected to show greater empathy to the situation of the rape survivors than a male. This empathy was apparent during debriefing that took place after the interviews with married women. The female interviewer revealed that she became emotionally involved with the women whose stories she had listened to. After listening to their stories, she said she felt 'depressed' about the experiences of the women and became 'very sad' when some of them broke down in tears when narrating their experiences.

Conclusion

Conducting research on sexual violence is fraught with many ethical and methodological challenges due to the sensitive nature of the subject and the stigma associated with it in Nigeria. Despite the challenges involved, our experience shows that it is not only desirable but also feasible to conduct research on such a sensitive subject in ways that promote the best interests [17] and safety of the study participants. A number of factors influenced some of the steps taken during the study. These included the availability and access that the investigators had to the guidelines developed by the WHO [23] for conducting research on domestic violence and these, provided the framework for conducting research in ways that were able to promote the safety of study participants. Prior to the commencement of the studies, the investigators had identified appropriate agencies that would serve as referral centreers for those who needed care, particularly important since the investigators worked in an institution that did not have experience in handling issues relating to domestic violence. The research team provided each of the participants with information of where they could access care and support. Despite all these preparations, however, it was not possible to anticipate all the ethical and methodological challenges at the conceptual stage of research and researchers need to be alert to, as well as flexible in being able to deal with, new ethical and methodological issues that might arise during any research on a sensitive subject.

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