Acta Scientific PAEDIATRICS (ISSN: 2581-883X)

Volume 8 Issue 4 April 2025

Research Article

Sexual and Physical Abuse in the Paediatric Surgery Department of the Aristide Le Dantec University Hospital in Dakar

Seye C[1]*, Mbaye PA[2], Fall M[2], Ndour O[2] and Ngom G[2]

[1]*Alioune Diop University, Diourbel, Senegal*

[2]*Cheikh Anta Diop University, Dakar, Senegal*

***Corresponding Author:** Seye C, Alioune Diop University, Diourbel, Senegal.*

Received: March 11, 2025

Published: April 29, 2025

Abstract

Introduction: Child sexual and physical abuse is a form of child maltreatment. The objective of this study is to report on epidemiological and lesional aspects in child victims of these forms of maltreatment.

Patients and Method: This is a descriptive retrospective study carried out in the pediatric surgery department of the Aristide Le Dantec Hospital in Dakar, over a period of 5 years, on sexual and physical abuse in children.

Results: We selected 16 children's cases in 5 years. Children under the age of 10 accounted for 75% of cases. The sex ratio is 0.33. Half of the patients were abused in the family home. Sexual abuse was the most common with 9 cases compared to 7 cases for physical abuse. The perpetrators of sexual abuse (9 cases) were unknown in 5 cases and in 4 cases they were close relatives. For physical abuse, parents were the main perpetrators (5 cases). The causative agent was the penis for sexual abuse, the stick (6 cases) and hot water (1 case) for physical abuse. The lesions encountered in sexual abuse were anal fissures in boys, bruising, hemorrhage, defloration in girls. Physical abuse included burns, bruises, dermabrasions, scarring and a fractured forearm.

Conclusion: School-age girls are the main victims of abuse. The perpetrators of physical or sexual abuse are often relatives of the victim. Sexual abuse is more frequent. The causative agent is the penis, which always causes perineal lesions.

Keywords: Physical Abuse; Sexual Abuse; Girls

Introduction

Child abuse refers to the abuse and neglect of anyone under the age of 18 [1,2]. Sexual abuse is now part of a new context in which the liberation of morals, socio-economic and moral misery, and the questioning of judicial infallibility pose a real problem for society [2]. In Senegal, sexual abuse is defined as all acts of sexual assault characterized by violence or with consent on a minor: rape, indecent assault, excision and forced marriage [3]. There is no work devoted exclusively to child abuse in the pediatric surgery department of the Aristide Le Dantec Hospital in Dakar. This is why we carried out this work, the aim of which was to determine the epidemiological and lesional aspects of sexual abuse and physical violence of children.

Patients and Method

It is a retrospective, descriptive study that concerns all patients under the age of 16 who were victims of sexual abuse and physical abuse and received in the surgical emergency unit of the pediatric surgery department of the Aristide Le Dantec Hospital from December 1, 2016 to November 30, 2021. We studied the annual frequency of sexual abuse and physical abuse cases, gender, age (1-5 years; 6-9 years; 10-15 years), schooling, time of accident (6-12 p.m., 1-3 p.m., 4-6 p.m., 7-00 p.m.), location of sexual abuse and physical abuse, vulnerability, perpetrator and lesional aspects.

Results

In five years, we have recorded 16 cases of child victims of sexual abuse and physical abuse in the pediatric surgery department of the Aristide Le Dantec Hospital, i.e. a frequency of 3.2 cases per year. Twelve children were girls and four were boys, with a sex ratio of 0.33. The mean age of patients was 7.5 years with extremes of 3 years and 15 years. The 1 to 5 and 5 to 9 age groups were the most represented (Figure 1). Fourteen children were in school and two were not. Sexual abuse and physical abuse occurred mainly between 4 p.m. and 6 p.m. (Figure 2). Sexual and physical abuse occurred in half of the cases in the family home (Figure 3). The causative agent for sexual abuse was the penis, with six cases of vaginal penetration (girls) and 3 cases of anal penetration (boys). For the 7 cases of physical abuse, the causative agent was hot water in one case and the stick in 6 cases. In the 9 cases of sexual abuse, the perpetrator was unknown in 5 cases and in 4 cases it was the cousin (2 cases) and the brother-in-law (2 cases). For the 7 cases of physical abuse, the teaching staff was responsible in 2 cases; The father and mother of the child were responsible in 2 cases and 3 cases respectively. Injuries depended on the perpetrator of the sexual and physical abuse (Table 1).

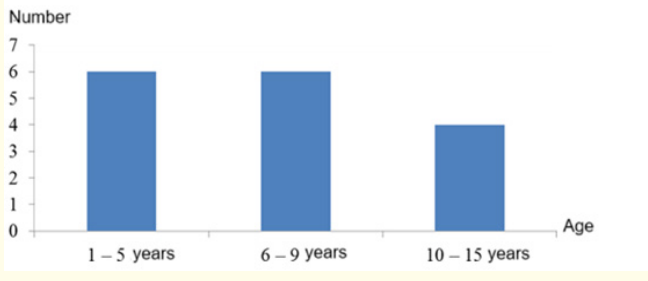

Figure 1: Distribution by age range.

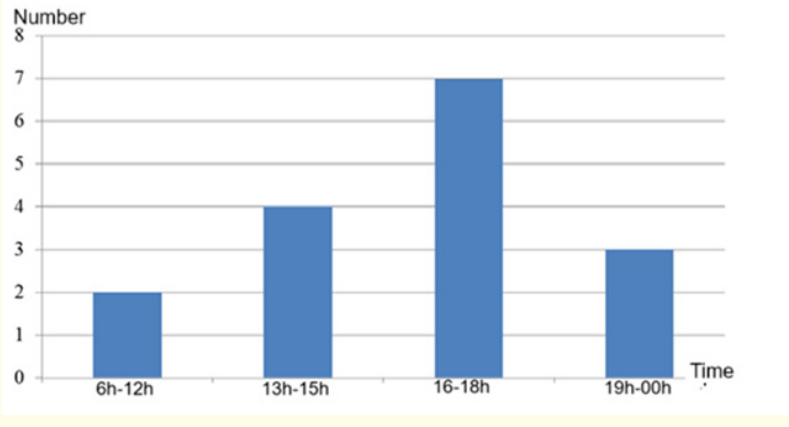

Figure 2: Distribution by time of occurrence.

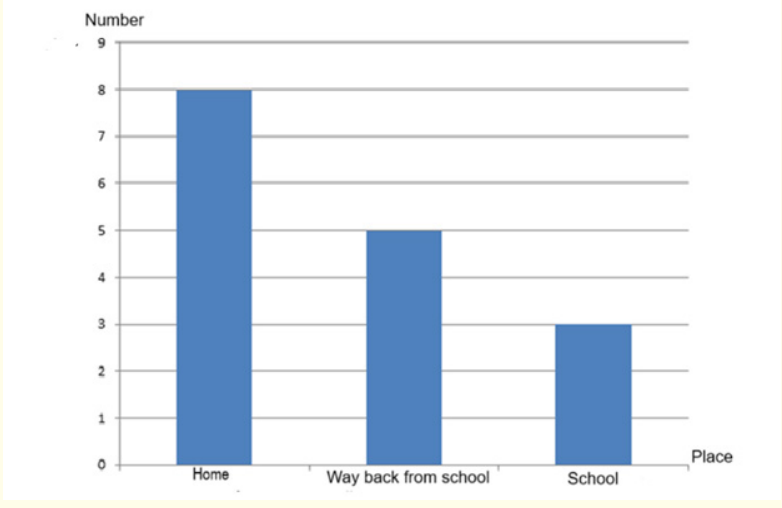

Figure 3: Distribution by location.

Table 1: Responsible agent and lesions observed.

Responsible agent	Number	Lesions observed
Hot water	1	Hand burns (Figures)
Stick	6	Hematomas, dermabrasions, scars, forearm fracture
		Anal fissures in boys
Penis	9	Bruising, hymen hemorrhage, defloration in girls (Figures)

Discussion

Sexual abuse and physical abuse fall within the nosological framework of child abuse [4]. The frequency of this violence against children will depend on individual, family and social factors [5]. In a large national study carried out in the USA, Finkhelor., *et al*. [6] estimated sexual assault at 5.7%. In Togo, this prevalence ranged from 2% to 6.4% [7,8]. In Senegal, it is about 1.4% [2].

For physical assaults, based on the report of the Secretary of State for the Family in France, 21,000 children are victims of abuse and the majority of cases concern child victims of physical violence [9]. In Burkina Faso, Diallo, in a retrospective study over 5 years, found 74 children who were victims of physical violence, i.e. 14.8 cases per year [10]. In many societies, the use of physical violence as a disciplinary measure against children is accepted by children, sanctioned by public institutions and permitted by law. There is therefore a lack of uniformity in the definitions. This problem explains the lack of reliable global estimates of the prevalence of physical violence. The problem is much more common in girls than boys when reading literature. In the USA, for example, Brière and Elliot [11] reported that 32.5% of girls and 14.2% of boys had acknowledged at least one episode of sexual abuse in childhood. A few rare studies mention a male predominance; this is the case of McGee., *et al*. [12], in Ireland, who find a prevalence of sexual abuse of 20.4% for boys and 16.2% for girls. This is also the situation found in the Madu study [13] where he notes a prevalence of 53.2% among girls and 56% among boys. In our series, both for physical violence and sexual abuse, we note more girls than boys.

The age of child victims of abuse varies from one study to another. In a study carried out by Sy [2] in Dakar on sexual abuse between 2000 and 2008, the average age of the victims was 2.29 years old and children aged 8 were the most represented. In Burkina Faso, the average age of child victims of physical abuse is 9

years old [10]. It is 5.1 years in the series of Halperin., *et al*. [14] in Switzerland. In our study, we find few annual cases of physical violence and sexual abuse. We also see more sexual abuse than physical violence. The weakness of our sample can be explained by the fact that we are not the only reference service in the capital. On the other hand, some cases may have been dealt with in peripheral health centres and settled amicably. In our series, apart from the home, which is the usual place where sexual abuse and physical violence occur, the way home from school is also incriminated in 5 out of 16 cases.

The preferred time of mistreatment is between 4 p.m. and 6 p.m. It is during this time slot that the children return from school; It is also during this period that the home is least monitored because the parents (father and mother) have not yet returned from the workplace or have just arrived, exhausted by long work, which means that parental supervision is less close.

In our study, all cases of sexual abuse are caused by men and the mechanism is penetration of the vagina or anus by the penis. There is therefore a tropism of men by the opposite sex. For physical violence, the stick is the element of corporal punishment most often. In Diallo's series in Burkina Faso, 11 types of objects are used for corporal punishment, with the stick also being the most widely used vulnerant agent [10].

Our cases of abuse are essentially of intra-family origin. In our series, sexual abuse is always the responsibility of the child's parents (brother-in-law, cousin), when it is specified. In the literature, this sexual abuse is carried out in 75% of cases by a family member or a close friend [2,4]. In 5 out of 9 cases, the person responsible for the sexual abuse is not identified in our work. This situation is noted in many series [2,4,15]. Sexual abuse can take the form of fondling, kissing, touching or rape. The first three forms of sexual abuse do not lead to lesions and therefore children who are victims do not consult a paediatric surgery department. Their situations are more related to child psychiatric medicine. On the other hand, rapes lead to lesions that are the subject of consultations in paediatric surgery [2]. In our study, all girls who are victims of rape have small haemorrhages, bruises, and defloration. Boys who are victims of anal penetration suffer from anal fissures. In our study, it is the severity of the lesions that leads parents to consult. Thus, the lesions can range from a simple hematoma to defloration. In a study carried out by Adama-Hondegla [15] in Togo on sexual assault in female subjects, 75% of patients had deflorations of the hymen. It should be noted, however, that his study included both children and adults. He also noted 7.5% of vulvoperineal trauma, 6.5% of skin trauma and 0.3% of femur fracture [15]. In our study, physical abuse leads to various injuries: dermabrasions, bruises, burns, fractures. All children have skin trauma. The severity of the lesions encountered is therefore variable, as in the study by Diallo in Ouagadougou [10] and in that of Doutaz in Switzerland [16] and Roussey in France [20]. Trauma varies in age in our study, which testifies to the continuous nature of the abuse. This association of recent and old lesions is also reported by many authors [17-19].

Other lesions may be encountered. We thus report in our study, a fracture of the two bones of the forearm, which testifies to the violent nature of the abuse; this violent attitude was reported by Diallo in Ouagadougou [10]. In his study, 10.8% of patients had osteoarticular lesions including fractures, dislocations, cranioencephalic lesions. He even reported a case of a child with a visceral lesion with massive pneumoperitoneum of fatal course.

The injuries reported in the literature following physical abuse are therefore of varying severity and age [20]. In this regard, X-rays may be necessary to confirm the diagnosis [10], as is the case in our patient with a forearm fracture who received a standard X-ray.

Conclusion

School-age girls are the main victims of abuse. The sexual abuse and physical abuse were committed mainly in the afternoon. The perpetrators of physical or sexual abuse are often relatives of the victim. Sexual abuse is more frequent. The agent responsible for sexual abuse is the penis, which always leads to perineal lesions.

Bibliography

1. Gabel M. "Principales Données Épidémiologiques Sur La Maltraitance: Éthique Et Chiffres". In : Chanoit PF, De Verbizier J, editor. Les sévices sexuels sur les enfants. Ramonville Saint-Agne: Erès, Psychiatrie et société; (1998): 19-31.

2. Sy OF and Gueye M. "Les abus sexuels à ker xaleyi: aspects sociodémographiques en contexte d'intervention". *Neuropsychiatrie de l'Enfance et de l'Adolescence* (2011): 59-13.

3. Ndoye D. "Code de procédure pénale du Sénégal annoté". Edition juridique Africaine (2005).

4. Mbassa Menick D. "Violences sexuelles envers l'enfant et lien parenté en Afrique. Analyse poolée des études réalisées au Cameroun". *Neuropsychiatrie de l'Enfance et de l'Adolescence* 642 (2015): 102-112.

5. Lalor K and Mcelvaney R. "Intrafamilial child sexuel abuse, link to subsequent sexuel exploitation and prevention/treatement programme: a literation review". Working paper prepared for ISPAN (interventionel society for the prevention of child abuse and Neglect, as part of ISPCAN'S submission to 3Nd world Congress against sexuel exploitation of children; (2008).

6. Finkelhor D. "The international epidemiology of child sexual abuse". *Child Abuse and Neglect* 18.5 (1994): 409-417.

7. Dassa SK., *et al*. "Typologie de la maltraitance des enfants au Togo". *Schweizer Archiv fur Neurologie und Psychiatrie* 156.5 (2005): 240-246.

8. Dassa SK., *et al*. "Maltraitance des enfants et adolescents au Togo". *Perspectives Psy* 46.4 (2007): 341-348.

9. Bader-Meunier B and Nouyrigat V. "Prise en charge initiale des enfants victimes de mauvais traitements". *EMC - Med d'urgences* (2007): 25-210-B-20:1-9.

10. Diallo O., *et al*. "Maltraitance physique à l'enfant ou traumatisme non accidentel: Rôle de l'imagerie: à propos de 74 cas à Ouagadougou". *Journal Africain d Imagerie Médicale* 7.4 (2011): 375-384.

11. Briere J and Elliott DM. "Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in general population sample of men and women". *Child Abuse and Neglect* 27.10 (2003): 1205-1222.

12. Mcgee H., *et al*. "The SAVI report: sexual abuse and violence in Ireland. A national study of Irish experiences,beliefs and attitudes concerning sexual violence". Dublin: The liffey press & Dublin Rape Crisis Center (2002).

13. Madu SN and Peltzer K. "Risks factors and child sexual abuse among secondary school students in the northern province (Saouth Africa)". *Child Abuse and Neglect* 24.2 (2000): 259-268.

14. Halperin DS and Chamay C. "L'enfant victime de sa famille: facteurs des risques". *Médecine et Hygiène* 53.2087 (1995): 1931-1936.

15. Adama-Hondegla AB., *et al*. "Aspects épidémio-cliniques et prise en charge des agressions sexuelles chez les sujets de sexe féminin à Lomé". *African Journal of Reproductive Health* 17.1 (2013): 67-72.

16. Doutaz M., *et al*. "Maltraitance infantile. Quelque chose m'échappe-t-il?" *Forum Méd Suisse* 20 (2003): 469-474.

17. Clarot F., *et al*. "Maltraitance à l'enfant : Apport de l'imagerie". *Rev Int Péd* 293 (1999): 68-74.

18. Hymel KP., *et al*. "Head injury depth as an indicator of causes and mechanisms". *Pediatrics* 125.4 (2010): 712-720.

19. Mallet J F., *et al*. "Le syndrome de Silverman ou syndrome des enfants battus". *La semaine des hôpitaux de paris* 60 (1984): 1825-1833.

20. Roussey M and Morellec J. "Les enfants victimes de sévices". *Rev Int Péd* 293 (1999): 75 -85. 52